

## Health Reform Update- February, 2011

### H. 202: A Closer Look

Governor Shumlin's legislative proposal to move Vermont to a single payer system was unveiled in early February and assigned bill number *H. 202*. Together, the House Health Committee and the Senate Health and Welfare Committee are reviewing the bill and taking testimony. Votes will be cast, first in the House and then in the Senate. The Speaker of the House has given the committee an aggressive timeline for consideration of the bill.

While the Governor did incorporate some of the Hsiao report recommendations into *H. 202*, it's very important to understand that it left out many key provisions (including a funding mechanism – e.g. payroll or other tax), and the bill also pushes several decisions out into the future, and delegates decisions on the benefit design, cost containment and other key elements to the Health Reform Board created in *H. 202*.

As a legislative staffer advised the committee the week before Town Meeting, the Hsiao report is history, and they shouldn't be assuming the costs and savings documented in the Hsiao report remain the same for *H. 202*. Hsiao has testified more than once that his recommendations are "All or nothing." They are not a menu of choices, so by leaving out many of his recommendations, we cannot assume that *H. 202* by itself will deliver "\$590 million in savings and 5000 jobs," as the bill's supporters, including the Governor, continue to say. Hsiao's response to comments from Fletcher Allen Health Care (FAHC) regarding his initial report, agreed with FAHC that we won't really know what the administrative savings from a single payer in Vermont will be until we do hospital and physician specific studies. His estimates are based on national studies, which may not apply in our small state with far fewer payers and a larger role for a few government payers.

Another important consideration in *H. 202* is how it proposes Vermont will implement the federal reforms. The federal reform law provides states with wide latitudes on how the new insurance *Exchanges* will be set up. Each state can decide who will govern the Exchange, (a state agency, non-profit, independent commission), who can buy in the Exchange, who is out, what the plans will cover and how they are selected, what rules are imposed on the carriers, and more.

The state has the option, for example, of offering coverage to employers of <50, or to allow employers up to 100 employees to buy through the Exchange (Effectively, this redefines "small group" to mean any employer <100, instead of current law, which is <50).

But *H. 202* establishes ground rules for the Vermont Exchange that go far beyond the options listed in the federal law. Many of the choices taken by Governor Shumlin in *H. 202*, whether deliberate or unintentional, appear to be risky business. There is no turning back, for example, when in 2014 Vermont outlaws the private insurance market for conducting *any business* with fewer than 100 employees. How does the state accomplish this?

First, the bill takes the option of redefining "small business" from the current limit of 50 employees to <100 employees. Then the bill states:

*No later than January 1, 2014, the commissioner of banking, insurance, securities, and health care administration shall require that all individual and small group health insurance products be sold only through the Vermont health benefit exchange.*

By making these two changes, *H. 202* says if you are an employer < 100, the employee of one of those businesses, or an individual buying insurance, the only insurance plan you can buy is what the state offers through the Exchange.

There will be no other authorized insurance carriers or plans. And, *H. 202* also says that unless prohibited by federal law, the state will select one carrier and one plan for the Exchange.

Furthermore, if Vermont gets a waiver from the federal law, the bill would add employers >100 and their employees to the Exchange, if they aren't self-insured. The Exchange therefore becomes the only place to "buy" health insurance.

Clearly, these are important steps toward consolidating the private insurance market into a single payer model. For many of us, however, there are more questions than answers in this plan:

- Hsiao made it clear that the savings he projected come from a single payer, not by just consolidating the small group, large group and individual markets into a single pool. That's less than half of the state's population, and less than half the money in the system. The toughest part of getting to single payer is moving the self-insured, Medicaid and Medicare populations into the single payer, because the state will need specific laws passed by Congress ("waivers") in order to do this. If Vermont can't get those waivers, all we've done is put everyone who used to have private insurance into a single plan for which the state of Vermont is responsible. The Hsiao report savings will be lost, and the state will bear the costs of subsidizing insurance and running the Exchange. Is there a plan B?
- Will the public employees and their unions voluntarily move into the Exchange? Or, will they exercise their ERISA preemption and stay outside? In the aggregate, this is a huge part of the state's working population. If they stay outside, the only groups left relying totally on the state plan are the small businesses who can't self-insure, and individuals.
- Hsiao also made it clear that without bringing all the payment streams into a single set of rules ("payment reform"), the savings he predicted won't happen. "Bending the curve" and reducing costs over time requires changing the financial incentives in our system by compelling providers to live within budgets and take on more financial risk. If we don't get the federal waivers to bring government payments and self-insured plan payments in line, we'd be trying to reform the whole using around 40% of the revenue (and none of the federal gorillas).

What's the alternative? A plan that doesn't put the taxpayers of Vermont, and businesses that rely on insurance, at risk.

Consider this:

1. Pass legislation to implement the Health Exchange as envisioned in the federal reform version: no waiver required, that does not outlaw the private insurance market as a competitor and allows for the insurance market to serve as a 'safety net' outside of the Exchange. This is what the federal law envisioned, and is a much safer first step for Vermont. There are no guarantees the Exchange will even work, that the plans will be affordable; we need a Plan B.
2. Focus on convincing the public employee groups (state employees, municipalities and teachers) to move their pools into the Exchange. This will provide a large and stable pool a relatively healthy pool, as a basis for the Exchange.
3. Next, the Exchange plans become an option for the current small groups (<50), individuals and the uninsured. Plans available to these same markets outside the Exchange will provide choice, competition to the Exchange-run plans, and importantly, a "safety net" if the Exchange model fails to reduce costs.

4. Focus on cost containment and payment reform by first applying for waivers that will allow Vermont to pilot “all payer” cost containment models, such as the Maryland all-payer hospital budgeting process (this has kept Maryland’s hospital costs growing at a rate well below national (and Vermont) rates). This model also builds on the “all payer” pilots we are currently running for the *Blueprint for Health*, creating new models of reimbursement for delivery of services. Build from this to the delivery and financing reforms possible from Accountable Care Organizations, as Hsiao recommends. This is where the real savings are, not from claims administration.

If we can’t demonstrate that we can implement payment reforms covering a multitude of revenue sources, we haven’t demonstrated we can do a “single payer.” This is a safer way to test our capability. If it doesn’t work, everyone still has their insurance coverage.

The steps to implementation of a single payer become terribly important: we shouldn't be forced by decisions made in *H. 202* to take irrevocable steps in 2014 from which there is no return, if things don't go as planned. In other words, let's make sure the implementation plan for *H. 202* recognizes that what we are embarking on is a very risky business, and we need to leave room for a Plan B.

What's the risk? What we are debating today is whether in 2015 we will *transfer several billions of dollars of spending* onto the state budget, tied to an entitlement to health care. That seems very risky without a Plan B.

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