



State of Vermont

Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System



Submitted by Governor Peter Shumlin to the Vermont State Legislature
December 30, 2014



Acknowledgements

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PETER SHUMLIN
Governor



State of Vermont
OFFICE OF THE GOVERNOR

December 30, 2014

Dear Vermonters:

Today we are releasing the Green Mountain Care financing report we developed that led me to the difficult conclusion that now is not the time to move forward with a publicly-financed health care system in Vermont. In the coming weeks we will be publishing additional materials from our research on the website <http://hcr.vermont.gov/library>. Vermonters will have access to all of the analysis that we used to come to the difficult decision we made.

I hope this report gives us a common understanding of the detailed assumptions and facts needed for the work we must do over the coming legislative session to continue long-lasting, meaningful health care reform in Vermont. I also hope these materials provide a foundation for future efforts to usher in a publicly-financed health care system that is more equitable than the one we have now, when the time is right.

Listening to the public discussion following the announcement that we will not move forward with public financing of health care in Vermont at this time, I have been struck by how many people on both sides of the debate have mistakenly declared that this decision means our work on health care reform is finished. Let me be clear: We will continue to move forward reforming the health care system in Vermont. We will do so because we must; as a state, we simply can't afford not to. If health care costs continue to grow as they have, they will consume every other opportunity for economic improvement for businesses, families, and individuals.

I have supported a universal, publicly financed health care system my entire public life, and believe that all Vermonters deserve health care as a right, regardless of employment or income. Our current way of paying for health care is inequitable. I wanted to fix this at the state level, and I thought we could. I have learned that the limitations of state-based financing – limitations of federal law, limitations of our tax capacity, and sensitivity of our economy – make that unwise and untenable at this time.

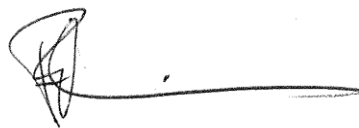
We must continue to make great strides, as a state, in addressing some of the other flaws in our health care system – unsustainable costs, funding priorities that are misaligned with promoting good health, and a complex and inefficient system of service delivery and record-keeping. I commit myself to working with the legislature, providers, advocates, and everyone willing to engage to continue to make meaningful improvements to Vermont’s health care system and to improve access for those Vermonters who are left out today.

We must continue to pursue the goals of reducing the number of uninsured Vermonters and support high-quality primary care for all Vermonters. We must strengthen the Green Mountain Care Board so we have better path to long-term cost containment. We must implement an all-payer payment system that is transparent and fair, rewards quality not quantity, and reduces the cost-shift to private payers. We must continue build-out of a cutting-edge system of health information exchange, with appropriate oversight to assure that it meets the needs of Vermonters and their health care providers and invests our dollars wisely.

My goal as Governor, what brings me to work every day, is helping make life better for all Vermonters. That means working together to focus on what we can solve, not fighting over what we cannot. While I do not believe the time is right for moving Vermont to a publicly financed universal coverage system based on what we learned, I believe even more strongly that together we must press forward.

I know many Vermonters are disappointed my decision not to pursue public financing. I know others are mistrustful of any reform following years of contentious debate about health care both nationwide and here in Vermont. But we can’t allow disappointment or cynicism to cloud the areas where consensus exists or grind to a halt reforms that we all agree must happen. There is too much at stake for our economy, our kids and our future to do anything else.

Sincerely,

A handwritten signature in black ink, consisting of a stylized initial 'P' followed by a long horizontal line extending to the right.

Peter Shumlin
Governor

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Executive Summary

On December 17, 2014, after receiving our recommendations on the policy choices necessary to implement public financing, the Governor announced that he could not recommend that the legislature move forward with public financing *at this time*. Given the current economic climate and other factors, the risk of economic shock is too high. The policy choices that are necessary—such as a transition plan for small businesses that this report will show to be absolutely critical—are not affordable at this time, and lower-cost alternative plans that strip out these policy features were not acceptable to the Governor. The Governor also indicated, however, that we would provide our complete report on Green Mountain Care coverage and financing to show the promise of Green Mountain Care as a future step and to provide complete information to the public regarding the analysis.

Act 48 of the 2011 legislative session established Green Mountain Care (GMC) as a universal, publically financed health coverage program for all Vermonters. The law required Vermont's Executive Branch to develop a plan for financing and operating GMC. This report fulfills that mandate and describes the proposals considered by the administration for GMC design and implementation.

In developing our recommended design of GMC, we kept in mind six central goals:

- Cover all Vermonters;
- Provide coverage that is comprehensive;
- Simplify the system for Vermonters and their health care providers;
- Provide for excellent customer service and capable administration;
- Spread costs fairly;
- Ensure that the program is financially sustainable for Vermont and does not hurt our economy.

Chapters in the report describe how GMC, if approved by the legislature and the federal government, would address these goals and:

- Replace employer and family premium payments with a fair and equitable system of tax-based funding;
- Pay for benefits that cover the needs of Vermonters and encourage healthy choices;
- Guarantee health care cost control;
- Pay health care professionals and organizations fairly while encouraging better coordination of care and a stronger emphasis on keeping Vermonters as healthy as possible;
- Operate as a public-private partnership, maximizing the strengths of the private sector to administer the program;

- Interface with existing programs of universal coverage, such as Medicare, to assure that those programs are maintained and protected.

Green Mountain Care would make Vermont's health care system more fair, equitable and sustainable. GMC would:

- Guarantee that all Vermonters have coverage, regardless of their income or employer and that the out-of-state employees who commute to work at Vermont businesses have access to coverage;
- Fund coverage with a combination of an 11.5 percent payroll tax, which does not include a preferred phase in over 3 years for small businesses, and income-based family contributions, rather than premiums;
- Cover a broad array of benefits, consistent with what most employers now cover;
- Limit Vermonters' out-of-pocket costs for care to an average of six percent of total costs, equivalent to what state employees and teachers currently enjoy;
- Simplify enrollment so that Vermonters go through one door, regardless of income, to obtain coverage;
- Change provider payment so that doctors and other professionals are paid for the outcomes of their work, and not simply the volume of services they provide, and innovative networks of providers are rewarded for managing overall costs and quality of care;
- Replace the funds generated by the current provider tax, employer assessment and claims tax to ensure a transparent financing system without these types of hidden taxes;
- Be governed by an annual process that determines a reasonable growth in health care costs to support a high-quality health care system.

GMC is intended to cover all Vermonters, except those who have coverage from Medicare or TRICARE (military coverage). We estimated that 519,000 Vermonters would be covered by GMC in the first year of the program and 538,000 in the fifth year.

GMC would provide a wide array of benefits, consistent with what most employers provide today and include primary, preventive and chronic care, urgent care and hospital services. GMC would cover vision and dental care for Vermonters up to age 21, as required by the Affordable Care Act. GMC would not cover long-term services and supports.

Under our proposal, cost-sharing in GMC would be limited to, on average, 6 percent of total costs, meaning GMC would have an actuarial value of about 94 percent. Cost-sharing requirements would be limited by an out-of-pocket maximum expense for all Vermonters, unlike the coverage provided to state employees today.

GMC should operate through a public-private partnership between state government and a designated entity¹ with the ability to contract with providers, implement innovative payment policy, contract with an out-of-state provider network, establish reserves against insurance risk and provide excellent customer service.

This could include a process by which the state, the designated entity, the Green Mountain Care Board and the legislature interact to assure that GMC payments and payment methodologies are consistent with GMCB-established cost control trends, GMCB payment reform policy and available state revenues. This process could include implementation of an all-payer rate setting system under which consistent and transparent payments would be made to providers for Vermonters covered by Medicare and GMC. These payment methodologies would continue the shift away from volume-based payments toward payments that increase provider responsibility for managing total costs and quality of care and improving the health of Vermonters.

We estimated that GMC would cost \$4.3 billion in the first year of the program and \$5.2 billion in the fifth year. These cost estimates are based on current health care expenditures in Vermont, trended forward to 2017 and inflated at a rate of four percent per year after that. Importantly, these cost estimates do not include a specific one-time reduction in provider payments to account for potential reduced administrative costs under GMC. We do not believe that such a reduction can be accurately estimated, and instead proposed that the GMCB annually consider efficiency gains in Vermont's health care system, including administrative cost reductions, in setting actual annual growth rates for GMC. At a growth rate of four percent, GMC would yield savings of \$378 Million over the first five years of the program relative to current predicted trends.

We estimated available state and federal funds for GMC. We determined the amount of state Medicaid funds available to support GMC by taking current revenue sources, removing the revenue associated with the employer assessment, the claims tax, and certain Medicaid premiums, and then trended the revenue forward. Federal Medicaid funds were based on projections of those who would be income-eligible through a Section 1115 Medicaid waiver with an assumption that any lost state revenue would be replaced through the new GMC revenue sources to ensure the required state match. Federal funds also would come from a "pass-through" of funds currently paid to Vermont residents in the form of refundable tax credits and cost-sharing reductions. This pass-through would have to be authorized through a new Affordable Care Act Section 1332 waiver. The 2013 estimates of available federal ACA funds were downgraded significantly as we entered into actual discussions with the federal government about such a waiver. In addition, microsimulation modeling improved our ability to estimate these funds with greater specificity.

We found that GMC could be paid for under these assumptions and program designs with two new sources of funding to cover the remaining costs of GMC and replace employer-based

¹ This concept is explained in more detail in chapter four.

premiums: a payroll tax on all Vermont employers and a “public premium,” which is an income-based payment that would be made by all Vermonters on a sliding scale. We estimated the payroll tax at 11.5 percent for the preferred policy choices we are including in this report. Additionally, to fully fund GMC, the highest-income Vermonters would pay 9.5 percent of income through a public premium, up to a maximum of \$27,500, while lower-income Vermonters would pay based on a sliding scale tied to a lower percentage of income ranging from 0 up to 9.5 percent.

Estimates of the costs, available state and federal revenues and necessary new revenues for GMC were derived from actuarial and microsimulation modeling. The modeling approximated the impact of the assumed changes in the sources and uses of health care financing on the distribution of health care costs across Vermont households, employers, state government and the federal government.

Our estimated GMC revenues do not include any phase-in of the taxes described above.² We modeled phase-ins and exemptions that would cushion the blow of the GMC taxes for Vermont employers, but found those modifications to the taxes to be unaffordable and would raise the proposed tax rates significantly.


Legislative action would be necessary to implement the program described in this report. Specifically, it would be necessary for the legislature to approve GMC revenue sources, changes to the statutes governing the GMCB, changes to the processes required under Act 48, and modifications to eligibility to include commuters to Vermont businesses.

Green Mountain Care Board approval and action also would be necessary to implement the recommendations contained in this report. The Board is responsible for approval of the benefits to be covered through GMC, is the lead agency responsible for implementing the cost-control and payment reform elements of this plan, and is required to rule, prior to program implementation, on specific statutory tests of whether GMC is likely to have a beneficial effect on Vermont. The GMCB also has a central role in designing and administering the all-payer rate setting system that is assumed as an underpinning of GMC.

We assumed a four percent rate of growth in health care costs over the first five years of Green Mountain Care. We believe this is a reasonable assumption and an achievable rate of growth, but it would require an explicit agreement through an all-payer waiver between the state, the federal government and Vermont’s health care providers to continue our efforts to change provider payment and achieve efficiency in our system.

Lastly, the program described in this report, and the financing proposed for it, would only work if Vermont has federal approval of necessary waivers and we are able to maintain current federal financial support for health care spending in Vermont. We have embedded in this proposal certain assumptions about federal approval and federal financial participation that we

² See Appendix F for discussion of these items.



believe are reasonable, but actual federal concurrence with those assumptions has not yet been received.

The chapters in this report explain how GMC would work, and what we predicted to be its impact on Vermont. Chapter 1 provides background on why Vermont would want to pursue a universal, publicly financed system of health care. Chapters 2 through 6 explain in more detail how the program would work, what it would cost and how it would be financed. Chapter 7 explains the predicted impacts of GMC on the distribution of health care costs in Vermont. Those interested in additional detail will find substantial additional information and analysis in the appendices.

Given the promise of GMC for Vermonters, we must preserve for another day the vision of universal publically financed health care paid for based on ability to pay. As a part of his budget proposal and legislative agenda for the 2015 legislative session, Governor Shumlin will propose changes designed to strengthen the Green Mountain Care Board, continue progress on payment and delivery reform, increase access to primary care and other vital health care services for all Vermonters, and better integrate information technology utilization and oversight statewide.

Chapter One: Background

Green Mountain Care: What's in it for Vermont?

The Vermont legislature passed Act 48 because it recognized a problem: Vermont's health care system is broken. It is less broken than the system in many other U.S. states, but it is broken nonetheless. It provides good care to those who have the good fortune to access it, but today our disjointed system:

- **Leaves people out:** At last report about seven percent of Vermonters have no health insurance at all.³ And, ironically, when they receive health care services, they likely receive the largest bills, because they pay full charges without the negotiated discounts commonly provided to insurers.⁴
- **Is unfair in how it distributes costs:** Two Vermonters in the exact same family and job situation, with exactly the same means to pay, can face very different costs, depending on whether their employers offer coverage, how comprehensive that coverage is, and whether they get public subsidies.
- **Sacrifices wage growth and cripples business:** Of those Vermonters who do have coverage, about 44 percent⁵ get it through their work. This places a huge financial and administrative burden on their employers. Health care cost increases are a drag on wage growth, and a major reason why wages have been stagnant in recent decades.⁶
- **Is horribly complex:** Anyone who has dealt with signing up for insurance, or understanding a health care provider's bill, knows how complicated and frustrating the current system of insurance and billing is. It wastes Vermonters' time, wastes providers' time, wastes money and is nonsensical.
- **Is terribly expensive and grows faster than our economy:** Health care costs have grown, on average, at 7.3 percent per year between 1991 and 2009⁷ in Vermont. Our state economy has grown at 4.2 percent.⁸ This means that health care has been growing almost twice as fast as our economy.

³ http://www.dfr.vermont.gov/sites/default/files/VHHIS_2012_Final_Report.pdf

⁴ http://www.dfr.vermont.gov/sites/default/files/VHHIS_2012_Final_Report.pdf;

<http://content.healthaffairs.org/content/26/3/780.short>;

<http://www.nejm.org/doi/full/10.1056/NEJMp1205225>;

<http://content.healthaffairs.org/content/32/6/1101.short>

⁵ 2014 Population Estimates by Julie Peper, Wakely Consulting Group.

⁶ http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1932381; <http://www.wsj.com/articles/mark-warshawsky-and-andrew-biggs-income-inequality-and-rising-health-care-costs-1412568847>

⁷ <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.pdf>

⁸ <http://www.bea.gov/iTable/iTable.cfm?reqid=70&step=1&isuri=1&acrdn=1#reqid=70&step=1&isuri=1&7003=200&7004=sic&7035=-1&7005=-1&7006=50000&7001=1200&7036=-1&7002=1&7090=70&7007=1997,1996,1995,1994,1993&7093=levels>

- **Encourages waste and inefficiency:** With our current fee-for-service approach we pay for health care by the unit. In general, there is no reward for keeping people healthy or managing care well. An estimated 30 percent of health care services provided to Americans are unnecessary.⁹ That is potentially worth more than \$1.4 billion¹⁰ in Vermont.

The legislature included in Act 48 several mechanisms for addressing these problems. In Act 48, the legislature:

- Established the Green Mountain Care Board (GMCB) to control health care cost growth, change provider payment and oversee other major changes in Vermont's health care system;
- Created Vermont Health Connect to comply with the federal Affordable Care Act and draw down federal funds to make health insurance more affordable for low and moderate income Vermonters; and
- Codified Green Mountain Care (GMC) as a program of universal, publicly funded coverage for Vermonters.

The legislature specified certain parameters of GMC, including residency requirements for coverage, minimum benefit levels and general administrative responsibility for the program. The legislature delegated specific parameters of GMC to the executive branch and the GMCB to develop, including the specific benefits to be covered, specifics of how the program would be administered and the actual revenue sources to be used to fund the program.

We have worked since the passage of Act 48 to further define the design parameters, program requirements, implementation steps and partnerships necessary to fully implement Green Mountain Care, including the necessary funds for the program and our recommended funding sources. In doing so, we have kept in mind six central goals:

- Cover all Vermonters;
- Provide coverage that is comprehensive;
- Simplify the system for Vermonters, employers, and health care providers;
- Provide for excellent customer service and capable administration;
- Spread costs fairly;
- Ensure that the program is financially sustainable for Vermont and does not hurt our economy, employers, or employees.

⁹ <http://news.medicine.duke.edu/wp-content/uploads/2013/08/Eliminating-Waste-in-US-Healthcare-Berwick.pdf>

¹⁰ <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.pdf>

During this same time period, the GMCB has worked to establish appropriate health care cost growth through the hospital budget and health insurance rate review processes. Hospital budget growth was limited to 2.7 percent in 2014 and 3.1 percent in 2015 – an average of 2.9 percent.¹¹ In 2015, the GMCB reduced proposed rates for Vermonters insured under small group and individual plans by a total of \$6.9 million through the insurance rate review process.¹²

Vermont also launched Vermont Health Connect, the state’s health benefits exchange, which supports delivery of Qualified Health Plans, Advanced Premium Tax Credits, Vermont Premium Assistance, Cost-sharing Reductions, and provides eligible Vermonters access to Medicaid. The roll-out of all ACA exchanges has been challenging, but has resulted in expansion of coverage to many Vermonters.¹³ The implementation of the legislature’s decision to supplement federal premium and cost-sharing subsidies to make insurance more affordable for Vermonters was budgeted at \$11.5 million for 2014.¹⁴

Vermont also has made great progress since 2011 to implement innovative health care payment and delivery changes that would increase the sustainability and effectiveness of our health care system for decades to come. The state received a \$45 million State Innovation Model (SIM) grant in 2013. That grant has supported three core activities aimed at improving Vermont’s health care system:

- Enhancements to the state’s system of interoperable electronic medical records through the Vermont Health Information Exchange, which is maintained by Vermont Information Technology Leaders (VITL);
- Implementation of all-payer shared savings programs, a first step away from fee-for-service payment, for the state’s Accountable Care Organizations (ACOs);
- Development of a common system of care coordination and care management across Vermont’s Blueprint for Health primary care practices, our three ACOs, and other key health, long-term services, and social services providers.


Despite this progress, it is difficult to fully address the problems to which Act 48 was responding through any means other than an explicit public commitment to cover everyone, fund the system fairly and create a transparent process for determining where our health care dollars go. Decades of health reform have shown that to be true. Efforts to expand coverage, control costs, simplify health insurance and improve the health of Vermonters have fallen short in a

¹¹ Hospital budget data provided by the Green Mountain Care Board, 2014.

¹² Proposed versus approved 2015 VHC Health Insurance Premiums in total dollars. Data provided by the GMCB, 2014.

¹³ The updated Vermont Household Insurance Survey Results are expected to be available in 2015 and will include new statistics on the uninsured in Vermont.

¹⁴ We expect this budgeted amount to be reduced in FY15 Budget Adjustment. For more information, see BAA documents when available.



system where coverage is arbitrarily linked to either employment or low-income status. This is why the legislature endorsed moving to Green Mountain Care.

Green Mountain Care could address several central problems in the current health care system that have not been addressed by other efforts in Vermont to date. Green Mountain Care could:

- Guarantee that all Vermonters have coverage, regardless of their income or employer and that the out-of-state employees who commute to work at Vermont businesses have access to coverage;
- Fund coverage with a combination of an 11.5 percent payroll tax, which does not include a preferred phase in over 3 years for small businesses, and income-based family contributions, rather than premiums;
- Cover a broad array of benefits, consistent with what most employers now cover;
- Limit Vermonters' out-of-pocket costs for care to an average of six percent of total costs, equivalent to what state employees and teachers currently enjoy;
- Simplify enrollment so that Vermonters go through one door, regardless of income, to obtain coverage;
- Change provider payment so that doctors and other professionals are paid for the outcomes of their work, and not simply the volume of services they provide, and innovative networks of providers are rewarded for managing overall costs and quality of care;
- Replace the funds generated by the current provider tax, employer assessment and claims tax to ensure a transparent financing system without these types of hidden taxes;
- Be governed by an annual process that determines a reasonable growth in health care costs to support a high-quality health care system.

The recommended design of Green Mountain Care and other options considered by the administration are described in more detail in the chapters that follow.

Chapter Two: Who would be covered?

Green Mountain Care (GMC) would provide universal health care coverage to all Vermont residents except those who are enrolled in Medicare or TRICARE, ensuring universal health care coverage for all Vermonters. For Vermonters who are only able to rely on TRICARE when on active duty or part of the year, GMC would be there for them at all other times.¹⁵

We also would propose covering non-residents who commute into Vermont to work for Vermont businesses. This ensures simplicity for businesses along Vermont's borders and ensures that they are not faced with the necessity of having residents covered by GMC and non-resident employees covered in some other manner.¹⁶ These commuters would contribute to GMC through the public premium described in Chapter 6.

Employers could choose to continue offering health coverage to their employees. The employee could choose either:

- the employer-sponsored health insurance, and Green Mountain Care would act as secondary coverage, or
- Green Mountain Care.

Regardless, the employee would still financially contribute to Green Mountain Care through the tax system, much in the way parents who choose to send their children to private school still pay taxes supporting public education.

We estimate that 31,000 Vermonters would continue to have employer-sponsored coverage in the first year of GMC, dropping to 2,000 in year five. In all, we estimate that 519,000 individuals would be covered by GMC in the first year of the program, including 61,000 commuters working for Vermont businesses. In year three, GMC would reach maturity with enrollment of 544,000 individuals, which is reduced to 538,000 in year five due to Vermont's aging population.¹⁷

The table below shows the estimates of who would be covered by source of coverage in the first year of GMC compared to the status quo.

¹⁵ More information on how the public premium works for those on TRICARE for only part of the year, see Appendix F-4 Public Premium Exclusions and Credits.

¹⁶ This policy priority requires a change in Act 48, which currently only provides GMC coverage for residents.

¹⁷ All population numbers are based on the 94%AV Best Policies output from the microsimulation model.

Table 1: Source of Coverage 2017

Source of Primary Coverage	ACA	GMC
Green Mountain Care	n/a	519,000
Medicare	140,000	140,000
TRICARE and Veterans	10,000	10,000
Federal employees	10,000	(in GMC)
Employees with ESI	296,000	31,000
Individual market	49,000	(in GMC)
Medicaid	141,000	(in GMC)
Uninsured	17,000	(in GMC)
Non-resident commuters	61,000	(in GMC)

The primary requirement for GMC coverage is a showing of Vermont residency. Resident is defined as:

“...an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent. An individual shall not be considered to be a Vermont resident if he or she is 18 years of age or older and is claimed as a dependent on the tax return of a resident of another state.¹⁸

At the time of passage of Act 48, residency definitions were debated by the legislature and several options were considered and rejected. The legislature landed on this particular definition because it is similar to federal health care programs, such as Medicaid. The legislature considered a requirement that an individual reside in Vermont for a specified period of time (“durational residency requirement”), for GMC coverage. However, this type of requirement has been held to be unconstitutional for programs involving federal funding by the United States Supreme Court.¹⁹

¹⁸ 33 V.S.A. 1823(12)

¹⁹ See Shapiro v. Thompson, 394 U.S. 618, 22 L.Ed. 2d 606 (1969); and Appendix A-3 Vermont Legislative Council Memorandum to House Health Care.

Impact of GMC on Certain Populations

This section describes several special populations, describes their current coverage, and discusses how their coverage would be impacted by GMC. These groups include Medicare, state employees, teachers, municipal employees, state and teacher retirees (resident and non-resident), non-resident employees of Vermont businesses, and employees who work for self-insured companies. We have provided a summary chart in Appendix A of impacts on specific populations for those interested in further detail.

Medicare Beneficiaries

Vermonters who have Medicare would remain on Medicare. The supplemental market would also remain active. These Vermonters would not pay the public premium as part of funding Green Mountain Care.

We examined a number of approaches for providing supplemental coverage for Vermonters who have Medicare as their primary coverage. Three options for expanding coverage were presented in the 2013 Green Mountain Care report authored by the University of Massachusetts and Wakely Consulting Group.²⁰ Any additional analysis of these options should be postponed until GMC primary coverage is determined by the Green Mountain Care Board. It would be important at that time to determine whether further integration of Medicare with GMC is affordable and makes sense for Vermont Medicare beneficiaries and the state. For more information, see Appendix B.

Medicaid-eligible Vermonters

Under Act 48, Vermonters who qualify for Medicaid coverage would continue to receive coverage through Green Mountain Care, including Medicaid benefits.²¹ This means that Vermonters in Green Mountain Care who are eligible for Medicaid would receive the enhanced coverage available under Medicaid today, including transportation and no or low out-of-pocket costs for care, in order to ensure that lack of income is not a barrier to health care.

In order to ensure that all Vermonters have a similar experience under Green Mountain Care, Vermont would work towards an eligibility process for enhanced benefits funded by Medicaid that is as seamless as possible and uses data that is already available to the state, where available.

²⁰ This report is available here:

http://hcr.vermont.gov/sites/hcr/files/2013/Health%20Care%20Reform%20Financing%20Plan_typos%26formatting%20corrected_012913.pdf. Medicare is discussed in detail in Appendices 6 and 7.

²¹ 33 V.S.A. § 1825(b)(1)(B)

State Employees

Currently, approximately 26,000 state employees and dependents are covered by the state through a self-insured employer plan administered by Blue Cross Blue Shield of Vermont. Under Act 48, state employees would be covered by GMC as their primary coverage, but supplemental coverage may be provided if bargaining leads to that conclusion.²²

Education Employees

Similarly, nearly 43,000²³ teachers and school employees obtain coverage through the Vermont Education Health Initiative (VEHI), would be covered by GMC. VEHI is currently a municipal trust established under 24 V.S.A. § 4942.²⁴ The coverage for a given school district is bargained at the local level between the school board and the Vermont National Education Association (NEA). Under Act 48, education employees would be covered by GMC as their primary coverage, but supplemental coverage may be provided as a result of bargaining between the school district and the union.²⁵

State and Education Retirees

Retired employees of the state or a school currently receive retiree health care from the state of Vermont. This program is run by the Treasurer's Office.

After implementation of Green Mountain Care, state and education retirees would continue to have the same level of coverage as they do today regardless of residency. If they are Vermont residents without Medicare, they would have coverage through Green Mountain Care.

For Vermonters with Medicare and non-resident retirees, the coverage would stay the same and be maintained through a private insurer, just like today.

Municipal Employees


Town and city employees historically were covered through an association run by the Vermont League of Cities and Towns. Currently, municipalities purchase a Vermont Health Connect plan as a small employer, a large group insurance plan as a large employer or, in the case of one city,

²² 33 V.S.A. 1830.

²³ VEHI Annual Summary Report for the year ending June 30, 2014. Available here: http://vehi.org/media/doc/VEHI_Annual_Report_Final.pdf

²⁴ There are currently two school districts that receive coverage through small group insurance plans provided by Vermont Health Connect. Under the Affordable Care Act, once a school district's insurance plan loses "grandfather" status, the district must purchase insurance through either the small or large group insurance market.

²⁵ 33 V.S.A. 1830.



have become self-insured. After implementation of Green Mountain Care, these employees would have GMC primary coverage the same as any employee of a Vermont business.

Non-resident employees of Vermont business

We would propose allowing nonresident employees of Vermont businesses to also receive coverage from GMC. Employers and members of the legislature had raised the issue of how nonresidents who work for Vermont businesses would be covered. This is most often an issue for employers who are located near the New Hampshire, New York, or Massachusetts borders, although there are some Vermont companies that have business sites out of state or employ nonresidents remotely. Currently, these businesses either purchase an insurance product with an out-of-state-network that covers the states where their employees live or purchase a different insurance product in each state where they have employees. In our modeling, we assumed that out of state residents who work for Vermont employers could participate in Green Mountain Care and would pay the public premium in order to minimize hassle and complexity for border employers and employees.

Self-Insured Businesses

Any business could continue to provide health benefits to their employees as provided for under the federal Employment Retirement Income Security Act of 1974 (ERISA). This includes the ability to self-insure, which is commonly done today by large, multi-state or national businesses. These types of companies are commonly described as “ERISA companies,” although ERISA covers all businesses of any size or type. Under Green Mountain Care, businesses could continue to choose to offer coverage. At the same time, employees would also have a choice—they could have GMC as their coverage and decline their employer-sponsored coverage or take their employer-sponsored coverage as primary and GMC as secondary coverage.

Chapter Three: What benefits would be covered?

There are three primary components of a benefits package:

- Covered services
 - What services are paid for in whole or in part?
- Cost-sharing
 - How much does an individual pay out-of-pocket when they get services?
 - Do individuals pay out-of-pocket through co-pays, deductibles, or co-insurance?
- Network of health care providers
 - Are there restrictions on the specific providers an individual can use?

Our recommendations regarding each of these components are described below.

Covered Services

Green Mountain Care would cover primary, preventive, and chronic care, as well as urgent care and hospital services. These are the categories of services customarily covered by a good health insurance policy in today's market. GMC would also cover dental and vision up to age 21 as required by the ACA. GMC would not cover long-term care, adult dental services, adult vision care, or hearing, though some of these services would be covered for Vermonters who would otherwise be eligible for the Medicaid program. Federal and state law requires that Vermont continue to cover an expanded range of benefits for people who are Medicaid-eligible. Vermonters, including Vermont employers, would be able to purchase supplemental coverage if desired.

We propose a package of covered services for Green Mountain Care that mirrors the coverage most insured Vermonters have today. Under this proposal, GMC would cover:

- Preventive care without any out-of-pocket cost;
- Ambulatory patient services (outpatient care without being admitted to a hospital);
- Emergency services;
- Hospitalization;
- Pregnancy, maternity, and newborn care (care before and after a baby is born);
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy);
- Prescription drugs;
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills);
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric dental and vision services.

Medicaid benefits would remain the same for Vermonters who are Medicaid-eligible, meaning that Medicaid-eligible Vermonters receive some benefits beyond the GMC “core,” such as screening and diagnostic testing for children and some transportation services.

We suggest these services because they meet the federal standards under the Affordable Care Act, and they are very similar, if not better than the covered services many Vermonters have today.²⁶ As required by Act 48, we considered including adult dental, adult vision, hearing, and long term care services. After costing out these benefits and reviewing the literature, we do not recommend covering these benefits during the first phase of Green Mountain Care.²⁷ For more information and background on these services, see Appendix B.

Cost-Sharing

Cost-sharing is typically measured through actuarial value (AV). Actuarial value is the average amount as a percentage of total health care costs that a health plan would pay. The higher the AV, the less an individual would pay out-of-pocket in co-pays, deductibles, and co-insurance and the more paid for through public financing.

We recommend that GMC benefits be pegged to a 94 percent actuarial value, meaning the average amount of the cost of covered services covered through public financing is 94 percent, while the average amount of costs covered through consumer cost-sharing (out-of-pocket expenses) would be six percent. This coverage is consistent with that provided by public sector employers and many large private sector employers. Our reasoning for choosing this level of actuarial value is:

- It is consistent with the current norm in Vermont. As of 2013 more than 50 percent of Vermonters who had purchased health insurance or had health care coverage through their employer had a similar level of cost-sharing.²⁸ In addition, 18 percent of Vermonters had even lower costs through Medicaid.
- It greatly reduces the extent to which Vermonters need to seek supplemental coverage to maintain their current level of coverage when they are covered by GMC
- It thereby reduces the potential complexity of the interface between primary and secondary coverage after implementation of GMC
- It eliminates the variation in coverage across the market, ensuring that all Vermonters have access to affordable coverage regardless of health status.

The chart below shows a comparison of the current state employee plan and two plan designs developed as options for Green Mountain Care at a 94% AV in 2017:

²⁶ See Appendix B for a chart comparing covered services.

²⁷ See Appendix B for PowerPoint presentations to the GMCB.

²⁸ Wakely Consulting Group based on Vermont data.

Table 2: Plan Comparisons at 94% Actuarial Value

Plan Type	State Plan – Original 2014	94% AV Option 1 2017	94% AV Option 2 2017
Deductible	\$0 - Med; \$25 - Rx	\$0 - Med, \$75 - Rx (non- generics)	\$100 - Med; \$0 - Rx
Out-of-pocket Maximum	unlimited - Med; \$775 - Rx (non- preferred brand excluded)	\$5,000 - Med; \$1,300 - Rx	\$650 - Med; \$200 - Rx
Inpatient hospital visit	\$250	\$300	20%
Outpatient Surgery	\$0	\$150	20%
ER Visit	\$50	\$75	20%
Medical devices	\$0	\$0	20%
Lab/X-Rays	\$0	\$0	20%
Physician/mental health office visit	\$20	\$25	\$10
Specialist office visit	\$20	\$35	\$20
Generic prescription drugs	10%	\$10	\$5
Brand prescription drugs	20%	20%	\$15
Non-Brand prescription drugs	40%	40%	\$30
DEDUCTIBLE APPLIES TO YELLOW HIGHLIGHTED CELLS			

Act 48 requires that we provide information to the Green Mountain Care Board about 80% AV plans, 87% AV plans, and no cost-sharing (e.g. 100% AV). These plan designs and their costs are in Appendix B.

Provider Networks

We have not assumed restrictions on provider networks in any of our plan designs, and GMC would be available to Vermonters who are out of state through a national network. We do expect that, to live within cost constraints and improve care for Vermonters, it may be necessary to require Vermonters to identify a primary care provider who coordinates their care. Also, as is true of both private and public insurers today, GMC might require specific licensing and/or credentialing in order to contract with a specific provider.

Supplemental Insurance Market

Supplemental health insurance policies are typically designed to add on more comprehensive health coverage. They “wrap around” and complement basic health insurance.²⁹ Supplemental plans can either cover services that are not offered by the plan or supplement cost-sharing under the plan. Supplemental insurance covering additional services includes adult dental and vision. We do not anticipate this market changing. Supplemental insurance covering alternative cost-sharing includes “Medigap” plans for persons with Medicare. We do not anticipate this market changing, either.

While supplemental policies can fill in gaps in coverage, they can also lead some consumers to pay for more protection than is necessary. Some consumers are “over-insured” and are paying for coverage they are unlikely to use. Supplemental insurance offerings should be tailored to complement comprehensive health coverage and to offer coverage for services that are beyond the scope of the comprehensive plan, but are not duplicative or unnecessary. Because the recommended GMC benefit package is relatively generous, it is unlikely that individuals would need or desire further coverage, other than dental or vision coverage.

²⁹ Insurance Basics. Supplemental Policies. www.healthcare.gov.

Chapter Four:³⁰ How would the program operate?

This chapter describes our proposal for how GMC would operate, including the role of state government, the role of private contractors or entities, the process for determining provider payment, and the process for determining the overall GMC budget.

GMC should be operated as a public-private partnership between the state of Vermont and a strong private sector partner under either a “designated public utility” or a “designated facilitator” model. Both are described in more detail below. The state has a responsibility and state statutory obligation to provide appropriate oversight and governance for the program, and the state is required by federal law to perform certain functions with respect to administering federal funds and fulfilling the requirements of the Medicaid program. However, we believe the right private sector partner would bring strengths to GMC, including:

- Appropriate financial reserves to guard against the insurance risk inherent in the program;
- Proven expertise in administering health care coverage for a broad array of Vermonters;
- A track record of negotiating fair and reasonable health care provider payment; and
- Access to a national and international contracted provider network.

The designated entity would assume primary responsibility for provider contracting and provider payment, within parameters defined by the Green Mountain Care Board (GMCB). Specifically, as described more fully in chapter 5, we suggest a process whereby the GMCB outlines general rules for provider payment consistent with the statutory authority granted them in Act 48 and the legislative directive to shift away from volume-based provider payment mechanisms. The GMCB also would outline:

- The expected rate of increase in GMC expenditures for the coming year, taking into account cost pressures and revenue constraints;
- Allowed administrative costs for the designated entity;
- Performance measurement requirements for the designated entity.

The designated entity would be responsible for contract negotiations with health care providers, adhering to the GMCB requirements for both the overall rate of growth in expenditures and the general methodology for provider payment. The resulting total cost would come before the GMCB in the form of a “rate case,” similar to a rate filing received by

³⁰ Act 144 of 2014, Sec. 7, the Secretary of Human Services is required to report to the General Assembly on or before January 15, 2015 the elements of Green Mountain Care, such as claims administration and provider relations, for which the Agency plans to solicit bids for administration pursuant to 33 V.S.A. § 1827(a), as well as the dates by which the Agency will solicit bids for administration of those elements and by which it will award the contracts. This chapter is meant to fulfil the requirement to describe the operational design of GMC. The administration does not intend to solicit bids at this time.

the GMCB today. The GMCB would approve, disapprove or modify the rate filing and would monitor the program for adherence to cost and other performance requirements.

Lastly, under Act 48, the GMCB is responsible for setting a three year budget for Green Mountain Care. We would propose some adjustments to today's consensus revenue process, specifically that the consensus process include the Green Mountain Care taxes and the addition of a consensus health care expenditure projection. Using these tools, the GMCB would develop a three-year rolling budget and would propose either cost reductions or an inflation factor to provide the legislature with a balanced budget. This process is described in greater detail later in this chapter.

We would recommend that further analysis be done to determine whether the state designated entity should be considered for executing the following functions, subject to discussion with that entity and a full assessment of state and federal requirements related to Medicaid administration in the context of both operational efficiency and service quality:

- Enrollment
- Claims adjudication
- Provider reimbursement
- Coordination of benefits and subrogation
- Primary care provider selection and referral management
- Medical necessity determination
- Adjudicating out-of-state coverage for non-emergent care
- Setting payment terms for covered services, within parameters established by the Green Mountain Care Board
- Negotiating provider payments, including developing population-based payments to ACOs
- Data analysis, reporting and settlement with at-risk providers
- Hospital, physician and other provider credentialing & network enrollment, including contracting a national network and covering services out-of-country
- Ongoing budgeting for medical and administrative costs related to the services paid for under GMC
- Financial management, including:
 - reserving
 - reinsurance
 - cash flow management
 - retroactive provider settlements
 - actuarial analyses, projections and reporting
 - budgeting for GMC administrative costs
- Program integrity, including some fraud and abuse detection
- Customer service

We would suggest that the state retain at least the following functions related to GMC:

- Eligibility determination, including determination of eligibility for federal Medicaid matching funds for Vermonters covered by GMC
- Interface with federal agencies responsible for GMC oversight and funding
- Oversight of provider payment policy
- Oversight of the total GMC budget and alignment of the budget with available state and federal funding (as described in further detail below)
- Oversight of the financial health and adequacy of reserves of the designated entity
- Overall evaluation of the performance of GMC and the designated entity in terms of costs, quality of care and consumer experience
- Appeals and grievances

Certain functions currently performed by the state (through the Department of Vermont Health Access) and by insurance carriers warrant further analysis, as they might reasonably transfer to ACOs as providers assume more responsibility and capability for managing medical risk in the future. These include:

- Care management and care coordination
- High-cost case management
- Chronic illness management
- Pre-authorization for referrals and drugs
- Pre-certification for certain types of care
- Utilization management

In addition, as ACOs evolve, there would be a need for continued examination of the appropriate state role in overseeing the degree to which those entities assume insurance risk, and the degree to which insurers could reduce their need for financial reserves as risk is transferred to ACOs. Responsibility for this determination would fall to the GMCB and the Department of Financial Regulation.

Designated Entity Models

The designated public utility and designated facilitator models are discussed in more detail below.

Public utility model

Under current law, public utilities are private companies formed under general corporate law. They must seek and obtain a certificate of public good from the Public Service Board before operating as a utility and once in operation are heavily regulated by the Public Service Board under Title 30. The Public Service Board has jurisdiction over virtually every facet of the

operation of a public utility's business, including the rates charged, quality of service, and overall financial management.³¹

Utilizing a public utility model to make a given entity the vendor for GMC would likely consist of these fundamental characteristics: (1) operation under a certificate of public good; (2) operation under the jurisdiction of GMCB; and (3) strict regulation by GMCB of all (or nearly all) aspects of the entity's business. This could be achieved through changes to the statutes governing GMCB as well as those governing the entity.³²

Designated facilitator model

Within the public service statutes, the Public Service Board has jurisdiction over the sale to electric companies of electricity generated from renewable resources and cogeneration.³³ The Public Service Board issued a rule designed to encourage such development of electricity.³⁴ Included in the rule is a provision stating that "the Board may by order designate one or more Purchasing Agents. Such an order may define appropriate terms and conditions, including the rights, authority, duties and obligations of the Purchasing Agent, and the authority of the Board to regulate and supervise the Purchasing Agent."³⁵ Generally, a purchasing agent serves as an intermediary between power producers and purchasing utilities.³⁶ The rule goes on to provide permissive criteria the Public Service Board may use in designating a purchasing agent.³⁷ Finally, the rule contemplates that the designated purchasing agent would be given the opportunity to accept the designation.³⁸

To follow this model, statutes governing GMCB or the executive branch could be amended to include the authority to designate a vendor. Because of the breadth of services it would provide, the GMC vendor would be more of a "facilitator" than simply a "purchasing agent." Once a state agency or the GMCB issues an order designating the facilitator, the law could either allow the entity the option of accepting the designation or could require the entity to accept the designation. If voluntary and it accepts, the state and the entity would negotiate a contract for specific services to be provided. The role of the facilitator could be described in the statute, the order designating the facilitator, or in the contract between the parties.

³¹ 30 V.S.A. §§ 209, 218, 249.

³² For example, Blue Cross Blue Shield of Vermont is a nonprofit hospital service corporation. These types of companies have specific enabling legislation in 8 V.S.A. Chapters 123 and 125. BCBSVT is the only nonprofit hospital service corporation operating in Vermont.

³³ 30 V.S.A. § 209(a)(8).

³⁴ Public Service Board Rule 4.100: Small Power Production and Cogeneration.

³⁵ Rule 4.102(C).

³⁶ Petition of Vermont Electric Power Producers, Inc., 165 Vt. 282, 285 (1996).

³⁷ Rule 4.102(C).

³⁸ Id.

Medicaid Operational Integration

We anticipate that operational integration of Medicaid and Green Mountain Care would happen in phases, staged according to the readiness of the state's new integrated eligibility and MMIS systems.

Provider Contracting and Provider Payment

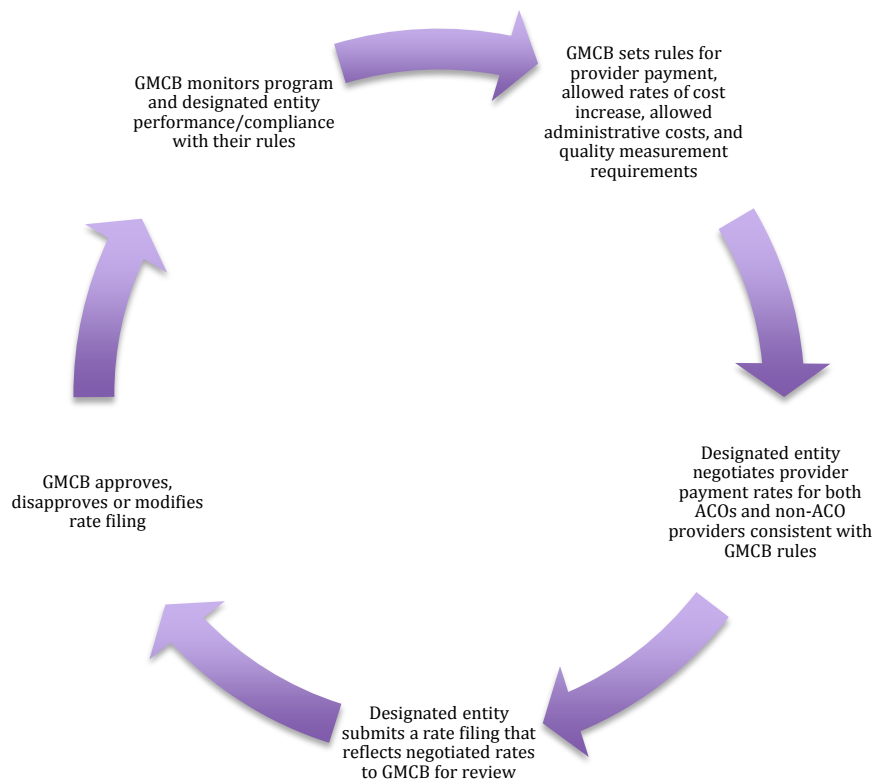
We are assuming that Green Mountain Care would operate in the context of an “all-payer system,” whereby health care provider payment rates in Vermont would be standardized across all payers, including Medicare, to achieve fairness, consistency and transparency in provider pricing while encouraging a deliberate shift from volume-based to outcomes-based provider payment. This plan is described in more detail in Chapter 5.

We suggest that the designated entity assume primary responsibility for provider contracting and provider payment under GMC, within parameters defined by the Green Mountain Care Board (GMCB). The GMCB would outline general rules for provider payment consistent with the statutory authority granted them in Act 48 and the legislative direction to shift away from volume-based provider payment mechanisms. The GMCB also would outline:

- The expected rate of increase in GMC expenditures for the coming year, taking into account cost pressures and revenue constraints;
- Allowed administrative costs for the designated entity;
- Performance measurement requirements for the designated entity.

The designated entity then would commence contract negotiations with health care providers, attempting to adhere to the GMCB requirements for both the overall rate of growth in expenditures and the general methodology for provider payment. The designated entity would bring the resulting total cost proposal for GMC to the GMCB in the form of a “rate case,” similar to a rate filing received by the GMCB today. The GMCB would approve, disapprove or modify the rate filing and would monitor the program for adherence to cost and other performance requirements. This process is illustrated below. Later in this chapter we describe how this process would interface with legislative and executive branch revenue forecasting and budgeting processes.

Figure 1: Green Mountain Care Provider Rate Oversight and Negotiation



Budgeting and Budget/Revenue Reconciliation

Green Mountain Care offers the promise of guaranteed coverage to all Vermonters, consistent cost control, transparency and fairness in the distribution of health care costs and a more explicit reflection of public policy goals such as health promotion and prevention in our health care spending. However, it also would create a very explicit tension between growth in public revenue sources and growth in health care costs, which have not been aligned historically in Vermont or the United States.

To address this tension, and provide for appropriate balance of interests in setting the GMC budget, we proposed:

- Three risk mitigation strategies to ensure that the state is prepared if expenditures are higher than expected or revenues are lower than expected; and
- A consensus process for projecting revenues and expenditures.

Each of these is explained below.

Risk Mitigation

We would recommend that GMC utilize three risk management strategies³⁹:

- Insurance reserves to cover insurance claims risk;
- Revenue reserves for the Green Mountain Care Fund; and
- A budget and revenue cycle that includes an adjustable tax rate to provide sufficient revenue to correct any systemic financial imbalances.

These strategies are described below.

Insurance and revenue reserves

We determined that the State would need to have access to reserves to account for claims risk and unexpected slowdowns in the economy. We asked our actuarial firm to calculate the needed reserves as though GMC was an insured product. They estimated that Green Mountain Care requires between \$70 and \$117 million in reserve capital depending on the level of capitation achieved through the all payer waiver.⁴⁰ We looked at providing these reserve funds in two ways, insurance reserves and revenue reserves.

We would recommend leveraging a relationship with the GMC administrator in a way that would allow Vermont to use or acquire *insurance* reserves without raising additional revenue for year one. Failure to leverage or acquire reserves would increase the GMC public financing amount by a commensurate amount.

Revenue reserves protect the State against an unexpected slowdown in state tax collection. All major state revenue funds carry reserves, and we would recommend that Green Mountain Care Fund also carry revenue reserves.

Major state revenue funds are required to carry a five percent reserve under state law. We calculated the minimum amount in reserves by looking at five percent on the amount of state taxes in the Green Mountain Care Fund. Stated another way, it would be a reserve of the entire fund value excluding federal contributions. This would have the additional effect of providing reserves for Medicaid, which do not exist under the current system. This calculation resulted in a reserve of approximately \$146.2 million.

³⁹ We considered reinsurance as a fourth risk mitigation strategy. We rejected this approach based on the advice of our actuaries. See Appendix D.

⁴⁰ For more detail, see Appendix D.

We would recommend a one-time bond issue to ensure that reserves beyond the minimum are fully available at program launch. The bond issue would raise \$200 million, setting reserves above the statutory minimum. Repayment of the bond would cost \$44 million annually for the first five years of operation. Failure to acquire these reserves through bonding would increase the GMC public financing required.⁴¹

Budget and revenue Cycle

It would be necessary to reconcile GMC outlays with the state's revenue and budget cycles. We would recommend managing the GMC budget and revenue cycle as follows.

Recommendation 1: Inclusion of GMC Taxes in State Revenue Forecast

GMC represents a significant enlargement of the State balance sheet. The GMC Special Fund should be added to the State's consensus revenue process and adopted by the Emergency Board. In this way, we can best understand the fund's revenue outlook in the same manner as other state funds.

Recommendation 2: Create a Consensus Health Care Expenditure Forecast

Similarly, a forecast should be developed to anticipate the relationship between GMC revenues and expenditures over a five-year period. We would need to determine the proper relationship between the administration, legislature, Green Mountain Care Board, and the designated entity for the production of this forecast and whether it ought to be approved by the Emergency Board or some other body.

These two forecasts would help execute the budgeting requirements set forth in Act 48, which require the Green Mountain Care Board, in collaboration with others, to develop a Green Mountain Care budget including recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

Recommendation 3: Amend Act 48 of 2011 Budget Requirements

Act 48 requires a budget for Green Mountain Care every three years. We would recommend modifying this requirement by having an annual budget and three-year cost projection. This rolling three-year budget would seek to align GMC budgeting with the current state budget and appropriation process while providing appropriate planning for the future.

⁴¹ Reliance on bond funding for reserves involves a number of considerations, including whether such a bond for reserves would impact Vermont's current bond rating.

Recommendation 4: Create a Legislatively Directed Process to Adjust Tax Rates over Time

Health care spending tends to grow faster than the economy. This could cause a gap between GMC health care expenditures and revenues, which track more closely with inflation over time. We would recommend that the legislature create a methodology in statute that ensures that health care expenditures and GMC revenues align as closely as possible.

We would recommend the following multi-step process.

- Step 1: The Green Mountain Care Board would determine the cost of GMC given the benefits package, health care expenditure forecasts, input from the designated entity regarding provider contracts and rates, and the state budget.
- Step 2: The Board would use the consensus revenue forecast to determine revenues available for the next year.
- Step 3: The Board would certify whether revenues and expenses aligned. If aligned, no further action would be needed.
- Step 4: If there was a revenue shortfall, the Board would certify the fiscal gap.
- Step 5: The Commissioner of Taxes would be required to appear before the Board and present adjusted tax rates that split the fiscal gap equally between the payroll tax and individual tax.

The legislature would maintain its authority and control by setting forth the methodology and creating guard rails that set a lower and upper boundary for potential tax adjustments. These guardrails would limit the maximum possible growth in tax rates.

The guardrails would set the annual tax rate adjustment at no less than 0% and no more than 5%. The inability to reduce the rate from the previous year without further direct legislative action insulates Vermonters from rate shock if expenditures vary significantly from year to year. The maximum rate ensures that taxpayers are protected in case of escalating costs. The Board and designated entity would need to find cost savings if the fiscal gap exceeds the maximum tax adjustment.

Recommendation 5: Create a Methodology for Reserves

We would recommend that Commissioner of the Department of Financial Regulation partner with the designated entity to create a methodology for monitoring reserves, using reserves, and rebating reserves to taxpayers if they are in excess of what is necessary. This methodology would need to be approved by the legislature.

This overall approach to managing risk is designed to ensure that GMC has sufficient revenue to pay for the health care of all Vermont residents and maintain access to appropriate health care facilities and providers.

Chapter Five: Who would provide health care services and how would they get paid?

The primary functions of Green Mountain Care would be to provide guaranteed coverage to Vermonters for the health care services they need and to pay health care professionals for those services. GMC must pay providers fairly and in a timely manner for the services Vermonters need. This is essential to maintain access to services, improve quality of services, and ensure our ability, as a state, to recruit and retain the providers we need over the long term. How we structure these payments, and the incentives we embed in payments, also would have an impact on total cost of the program, quality of services and, ultimately, the health of Vermonters.

There would be three central elements to determining provider payment under GMC:

- What process would we use to determine provider payment?
- What methodology would we use?
- What amount would we pay?


Our recommendations on each of these elements are described below.

We assume Green Mountain Care would pay providers both in and out of state. Today, most Vermonters have insurance coverage that provides an out of state network and about a third of all Vermont residents seek care at Dartmouth-Hitchcock Medical Center in New Hampshire. Consistent with the operational design described in Chapter 4, we would expect that the designated entity would contract with out-of-state providers as necessary to meet the needs of Vermonters.

Process to Determine Provider Payment

We would recommend that provider payment be determined through an all-payer rate setting process overseen by the Green Mountain Care Board (GMCB). The GMCB has expressed its intent to begin designing an all-payer system under their existing regulatory authority, and the state has begun discussions with the federal government regarding federal permissions necessary to include Medicare in a Vermont all-payer system. Design and implementation of such a system would take an estimated one to two years.

We believe the all-payer payment system is an essential underpinning of GMC in that it would standardize and make more rational and transparent the details of and variations in provider payment. The all-payer system also would require an all-payer waiver from the federal Center for Medicare and Medicaid Services (CMS), which would operationalize an agreement between the state, the federal government and providers about reasonable rates of growth in health care costs and expected changes in provider payment methods.



We anticipate that an all-payer system would determine both:

- General rules for payments to Accountable Care Organizations (ACOs). The vast majority of Vermont’s health care providers, and many long-term services and supports providers, currently are involved in the shared savings programs as participants in ACOs.
- General rules for fee-for-service payments to providers who are excluded from or choose not to participate in ACOs, and for services to visitors.

Each type of payment would be standardized according to GMCB parameters, and each would be subject to an overall growth cap, across all payers. The growth cap would function as both ceiling and floor – i.e., Medicaid and Medicare would grow at the same rate as other payers. For ACOs, the GMCB would set rules, as they have for the Medicaid and commercial shared savings programs, for such details as risk-sharing between ACO and GMC, risk adjustment and overall calculation of ACO payments. The GMCB and/or DFR might set additional requirement for ACOs with regard to risk assumption and reserves.

For non-ACO providers, the GMCB would require a transparent, standardized and “fair” fee schedule that is consistent with policy goals such as adequate support for primary care, prevention and population health management.

We believe that it is appropriate to use a process involving a third party vendor and the Green Mountain Care Board to determine provider payment levels and provider payment methodology for Green Mountain Care. This process can assure that GMC payments and payment methodologies are consistent with GMCB cost control trends, consistent with GMCB payment reform policy, and appropriately reflective of provider market dynamics.

Payment Methodology

The methodology to be used for provider payment ultimately would be determined by the Green Mountain Care Board. However, we believe it is essential to continue to build on the work of the Green Mountain Care Board, the Vermont Health Care Innovation Project and Vermont’s three Accountable Care Organizations and continue to move away from fee-for-service provider payment, toward payment models under which providers assume greater responsibility for managing total costs and quality of care for Vermonters, and are rewarded for such outcomes. Continuing this shift would be essential to the long-term viability of GMC and its success at improving Vermonters’ health.

Reimbursement Amounts

The precise amount to be paid for GMC services would be a function of both the general rules established through the all-payer rate setting process and the contract negotiations of the designated entity. We have assumed in our analyses of GMC costs that current provider payment amounts and utilization would be trended forward, in aggregate and on average, at a rate of 3.3 and 6.6 percent for Medicaid and Commercial populations between 2012 and 2017.⁴² All populations covered by GMC are assumed to trend at a rate of four percent beyond 2017.

While there might be some changes in specific reimbursement methods or levels for providers, and some standardization across provider categories, overall payments would be inflated at a reasonable amount, consistent with GMCB policy. The trend from 2012 to 2017 was developed in consensus with the RAND Corporation, which was hired by the legislature's Joint Fiscal Office. The trend from 2017 and beyond of four percent was developed based on assumptions about the success of payment and delivery system reform, as well as experience of Maryland, the only state that currently has an all-payer waiver to support its all-payer rate setting system. More information about the trend is available in Appendix D.

⁴² Our actuaries applied the trends at the sub-population level to reflect current differences in morbidity and utilization in these populations.

Chapter Six: What would GMC cost and how would we pay for it?

This chapter describes our estimates of the costs of Green Mountain Care and our recommendations for financing mechanisms to cover those costs.

Introduction: Vermont Health Care Spending in Context

Vermont residents spend billions of dollars on health care today, and this spending is expected to grow annually at a rate that exceeds the rate of growth in our economy. Vermont residents spent \$5.123 billion on health care in 2012.⁴³

This aggregate health care spending number incorporates billions in spending by Vermont residents on insurance premiums, out-of-pocket expenses, and taxes paid that were spent by federal, state, and local governments on health care. For example, in 2012, Vermonters spent \$1.886 billion in private insurance premiums and paid \$715 million out-of-pocket for health care.⁴⁴ These big numbers convey two points. First, Vermonters already make a substantial and growing financial commitment to health care, regardless of the implementation of Green Mountain Care. Second, Green Mountain Care's financing system would incorporate and replace a vast pool of existing health care spending as Green Mountain Care would replace most private insurance premiums and some out-of-pocket spending for Vermonters.

Green Mountain Care Costs

We estimate that the total cost of Green Mountain Care would be \$4.34 billion in 2017, with another \$187 million paid out-of-pocket. All costs except for out-of-pocket costs would be paid from the Green Mountain Care Fund, created by Act 48 of 2011. These costs are detailed in Table 3 below.

The coverage cost represents the aggregate per member per year premium equivalent for all enrollees and an administrative cost that would be retained by the designated entity that functions as the claims payer.⁴⁵ State operations costs represent an estimate for those administrative costs not borne by the payer. These expenses include repayment of bonds issued for revenue reserves and health care innovation funding, including the cost of operating the Green Mountain Care Board, continuation of Health Information Technology Fund, and the estimated non-Medicaid cost of Vermont Health Connect. Also, we include an unallocated contingency for unexpected operational expenses. We consider these assumptions conservative, as Green Mountain Care and the development of the designated entity would result in efficiencies for state government that save taxpayers money; however, we are not prepared at this time to estimate and book these savings until GMC operations are further developed in final detail.

⁴³ 2012 GMCB Expenditure Analysis, see

http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB_2012_Expenditure_Analysis_Res_Prov_2014_2_20.pdf

⁴⁴ 2012 GMCB Expenditure Analysis

⁴⁵ A detailed breakdown of PMPM costs and administrative costs can be found in Appendix D

Table 3: 2017 Annualized Green Mountain Care Cost

GMC Plan Costs Excludes Out-of-pocket Costs	Value in Millions
Coverage⁴⁶	
GMC Primary (Non Medicaid Eligible)	2,171
GMC Medicaid Primary	1,126
State Medicaid Fixed Costs	680
Medicaid Dual Eligible	259
Employer Sponsored Insurance Wrap	28
Total Cost of Coverage	4,263⁴⁷
State Operations Cost	
Bonding for Revenue Reserves	44
Health Care Innovation Spending	23
Contingency	10
Total GMC Cost	4,340

Given these expenses, Table 4 sets forth the total GMC costs from 2017 – 2021.

Table 4: Green Mountain Care Costs, 2017 – 2021

GMC Plan Costs (Value in Millions) Excludes Out-of-pocket Costs	2017	2018	2019	2020	2021
Coverage	4,263	4,501	4,741	4,921	5,096
Total State Operations Cost	77	78	79	80	81
Total GMC Cost	4,340	4,579	4,820	5,001	5,177
Annual Growth Rate		5.58%	5.33%	3.80%	3.56%

Green Mountain Care health care coverage costs are trended forward at 4% annually; however, total costs do not grow at a flat four percent rate. Growth exceeds four percent annually the first two years as people move from employer-sponsored insurance to GMC. Costs grow by less than 4% annually in 2020 and 2021 as the GMC population shrinks due to more Vermonters growing older and moving to Medicare. State operational costs are trended forward at 3%.

⁴⁶ Includes administrative costs paid to designated entity.

⁴⁷ Total Cost of Coverage is \$1 million less than sum of all cost categories due to rounding.

Green Mountain Care Revenues

The state would use the Green Mountain Care Fund established in Act 48 of 2011 for the purposes of managing revenues and spending related to GMC. The Green Mountain Care Fund would capture three revenue sources:

- Federal funds
- Existing state revenues
- Green Mountain Care taxes, which would replace private insurance premiums

The amount of Green Mountain Care taxes needed is determined by subtracting federal funding and existing state revenues from the total cost, leaving a net amount to be funded by new state tax revenue sources. We estimate that amount to be \$2.580 billion. We would suggest two new state tax revenue sources to cover these costs:

- A payroll tax levied on employers only, based on the amount of their payroll; and
- A public premium paid by individual Vermonters based on their income and family size.⁴⁸

Federal funds include those funds provided through the Affordable Care Act Section 1332 waiver, such as advanced premium tax credit subsidies, cost-sharing subsidies, and employer tax credits that are passed to Vermont by the federal government⁴⁹ and federal funds used for current health programs, such as Medicaid. Existing state revenues include some current state Medicaid revenue. The payroll tax and public premium are new revenue sources that replace existing health care spending.

⁴⁸ The public premium would function as an income tax and would be deductible as such on federal taxes as described in Chapter 7.

⁴⁹ For details on the funds available through the ACA waiver, see Appendix E-2.

Table 5 summarizes these funding sources:

Table 5: 2017 Annualized Green Mountain Care Revenues

GMC FUND REVENUES	
<i>Excludes Out-of-Pocket Costs</i>	
Federal Funds	Value in Millions
Federal: Medicaid Match	1,310
Federal: ACA Waiver Funds	106
TOTAL Federal Funds	1,416
Existing State Funds	
State Medicaid Revenue	344
New GMC Taxes	
GMC Payroll Tax	1,510
GMC Public Premium	1,247
TOTAL State Funds	3,101
TOTAL GMC REVENUES	4,517

Below we address our assumptions about each of these revenue sources in more detail.

Federal Funds

Vermont’s health care system relies on substantial federal funding today. Green Mountain Care would draw down a greater level of federal support, because more Vermonters would be covered and federal funding would be maximized. Vermont would receive funding under the waiver provisions of the Affordable Care Act and under existing Section 1115 Medicaid waivers.

Under the Affordable Care Act Section 1332 waiver (ACA waiver), the state may receive funding that would have been paid to Vermont residents and businesses in the form of advanced premium tax credits, cost-sharing reductions, and small business tax credit payments had the ACA’s requirement to have an Exchange selling health insurance not been waived.⁵⁰

Currently, the federal government provides advanced payment of the premium tax credit and cost-sharing reduction payments directly to insurers on behalf of eligible individuals. Under the ACA waiver, Vermont would waive this requirement because residents would move from paying premiums for insurance plans through Vermont Health Connect to having publicly-financed health care coverage under Green Mountain Care.⁵¹ Under the ACA waiver, the federal

⁵⁰ ACA § 1332(a)(3); 42 U.S.C. § 18052(a)(3).

⁵¹ ACA § 1332(a)(2); 42 U.S.C. § 18052(a)(2).

government would pay Vermont the aggregate amount of the premium tax credits and cost-sharing reduction payments that would have otherwise been paid under the ACA.⁵²

We estimate that Vermont would receive \$106 million in federal pass through funding related to advanced premium tax credits and cost-sharing reductions. The estimate assumes that federal funds for all non-Medicaid eligible Vermont residents who would have received premium tax credits and cost-sharing subsidies would be provided to the state. The estimate is based on current discussions with multiple federal agencies regarding the waiver; however, our federal partners have not yet approved Vermont’s methodology for calculating pass through funding. This amount represents a substantial reduction from previous estimates. Specifically, the 2013 report estimated federal contributions via the ACA waiver at \$267 million.⁵³

In addition to the premium tax credit and cost-sharing reduction payments, the ACA waiver also allows for states to collect the small business health care tax credit that would have otherwise gone to small employers participating in Vermont Health Connect.⁵⁴ Vermont employers with 25 or fewer FTEs and average wages of less than \$50,000 per employee per year would be eligible for up to 50 percent of their contribution to employees’ insurance premiums (35 percent for tax-exempt businesses) if they purchase coverage through Vermont Health Connect. We did not include the small business health care tax credit in our estimates, however, because the credit is limited to two consecutive years starting in 2014,⁵⁵ and we estimate that employers who take the credit will do so in the years before implementation of GMC, resulting in little to no revenue after 2017.

Table 6: Projected ACA Waiver Funds, 2017 – 2021

Year (Values in Millions)	2017	2018	2019	2020	2021
Tax Credits (APTC & CSR)	106	118	122	125	132

Additionally, the federal government would continue to match state Medicaid spending. To determine the federal Medicaid match in Green Mountain Care, we projected the populations in GMC that would be eligible for a federal match. Certain populations receive higher dollar matches from the federal government, so these populations were separately identified. Detailed descriptions of the populations and applicable Federal Medical Assistance Percentages (FMAP) rates are included in Appendix C and Appendix F.

⁵² ACA § 1332(a)(3); 42 U.S.C. § 18052(a)(3). The ACA does not define how the premium tax credits and cost sharing reductions payments would be calculated. After analyzing various options, Vermont proposed that the federal government calculate the aggregate amount of the premium tax credits and cost sharing reduction payments by using a modified formula that the federal government is already using with the Basic Health Plan (BHP). See Appendix E-2 for more information on the methodology of these calculations.

⁵³

http://hcr.vermont.gov/sites/hcr/files/2013/Health%20Care%20Reform%20Financing%20Plan_typos%26formatting%20corrected_012913.pdf

⁵⁴ ACA § 1332(a)(3); 42 U.S.C. § 18052(a)(3).

⁵⁵ ACA § 1421(a); I.R.C. § 45R(e)(2).

The total federal contribution is calculated as the product of the federal match rate and the projected cost of the populations. Overall, we estimate that the state would draw down \$1.31 billion in federal Medicaid dollars in 2017, a \$285 million increase. We estimate that this federal funding source would grow to \$1.505 billion by 2021. The increase in revenue is attributed to expanded Medicaid enrollment. Specifically, we assume that nearly all Vermont residents who are Medicaid eligible actually enroll instead of being uninsured or taking non-Medicaid insurance. The estimate is based on our actuarial and economic analysis and current discussions with multiple federal agencies and the state's current Section 1115 Medicaid waiver. As noted above, this estimate assumes current federal rules and provisions of Vermont's current Section 1115 Medicaid waivers would continue to apply.

Existing State Revenues

Most existing state revenue that supports Medicaid would be used to pay for Green Mountain Care. In our analysis we found that state Medicaid funding estimates face three types of downward pressure.

First, some current state Medicaid revenue sources would either go away entirely or be substantially reduced after implementation of Green Mountain Care. Specifically, the revenue sources are:

- the claims tax, which is generated by taxing private health insurance claims; and
- the employer assessment, which taxes employers who do not provide health care coverage, whose employees are uninsured, or whose employees have Medicaid or purchase as individuals through Vermont Health Connect.

These revenue sources are substantially reduced as Vermonters move from private insurance to GMC, resulting in fewer insurance claims to tax. We assumed that the claims tax and the employer assessment would be repealed.

Second, previous estimates of State Medicaid revenue assumed that the State would make progress toward reducing the cost shift prior to implementation of Green Mountain Care. This did not happen due to persistent State budget pressures related to less robust than forecast economic growth.

Third, we assume repeal of provider taxes, which provide substantial support to the State's Medicaid program today. Provider taxes would be by and large circular in a universal system. We would, in essence, be paying providers for the provider tax that we use to support the payment to providers. Repeal of the provider tax requires an additional \$150 million in replacement revenue.

Overall, we estimate that \$344 million in current state Medicaid revenue would be applied to Green Mountain Care. This is a substantial downgrade from the \$637 million estimated in the previous report. For more information about how existing Medicaid revenues change, see Appendix F.

Green Mountain Care Taxes

Most private insurance premiums would be replaced by Green Mountain Care taxes with the implementation of GMC. Vermont businesses would pay a payroll tax and each tax filer would pay a public premium, an income tax based on their income and family size. Both taxes would be directed entirely to the Green Mountain Care Fund.

Payroll Tax

The employer payroll tax would be levied at a rate of 11.5% on all Vermont businesses on their qualifying Vermont payroll. Qualifying payroll is all payroll except wages for any individual employee in excess of \$200,000 with that amount adjusted annually for inflation. The tax would not be paid on behalf of any individual employee. Accordingly, employee age, residency, and insurance status are irrelevant in calculating the tax. The tax would be deductible from federal taxes.

We chose the payroll tax due to its simplicity, large tax base, and steady growth rate. Businesses are easily able to calculate payroll and remit or withhold a variety of payroll taxes today. This makes it potentially simple in contrast to a per employee fee, which would prompt questions about how to count and characterize employees. The large base keeps rates lower. The steady growth rate attempts to ensure predictable revenue growth over time.

We estimate the payroll tax would generate \$1.51 billion in 2017 and grow annually. Our annual revenue estimates are shown in Table 7 below.

Table 7: Estimated GMC Payroll Tax Revenue, 2017 – 2021

Year	2017	2018	2019	2020	2021
Payroll Tax Revenue (Millions)	\$1,510	\$1,542	\$1,574	\$1,606	\$1,639

Self-Employed Exemption

The only exemption to the payroll tax would be an exclusion for the self-employed. Self employed Vermonters would pay the public premium only, not the payroll tax. This is in contrast to Social Security, which makes the self-employed pay both the employer and employee share. We suggest this exemption to promote simplicity in administration of the tax and keep the tax burden lower for the self-employed.

The payroll tax would be collected by the Vermont Department of Taxes. The Commissioner would develop policies, procedures, forms, and regulations necessary to implement the tax.

Public Premium

The public premium is the primary individual tax we would recommend to support GMC, replacing private insurance premiums for most Vermonters. The tax would be based on a tax filer's income and family size. The tax would be calculated as a percentage of Adjusted Gross Income (AGI). This percentage is based on the tax filer's AGI as a percent of the federal poverty

level (FPL). Taxpayers would use the number of personal exemptions (dependents) to determine family size and FPL. Next, a percentage of income would be assigned for tax liability.⁵⁶

The recommended design of the public premium tries to balance three competing concerns. First, the ACA waiver requires that the tax must be at least as affordable as the ACA for all taxpayers at or below 400% FPL. The ACA measures the affordability of health care based on the relationship between income and FPL, and the public premium as an FPL based income tax is meant to mirror the federal affordability calculation. Second, the tax should take into account ability to pay. Simply, taxpayers with more income by and large should pay more. Third, the tax design acknowledges that insurance is currently a product where people of very different income pay the same amount of money. The tax design balances these competing concerns by creating a tax that meets the federal requirements and takes into account ability to pay without being a general income tax, as the maximum tax is capped at the federal threshold for a high value health plan, commonly known as the Cadillac Tax threshold. The public premium calculation is discussed in more detail below.

The public premium is designed to create three types of taxpayers. First, we have a sliding scale based on income. These taxpayers are on *The Ramp*. Second, we have taxpayers who pay the maximum percentage of their income, the *Maximum Percentage Payer*. Third, we have taxpayers who pay the maximum GMC tax, the *Maximum Dollar Amount Payer*.

The Ramp


In order to account for ability to pay, and meet federal affordability requirements, the tax would be calculated on a sliding scale based on FPL up to 400% FPL. The minimum premium is 2.5% of AGI at 138% of FPL, starting where Medicaid eligibility ends. The ramp begins to climb after 150% FPL and moves in a straight line from 2.5% of AGI at 150% FPL to 9.5% of AGI at 400% FPL. 400% FPL was selected as the end of the ramp to ensure that all Vermonters were below the affordability threshold set forth by the ACA. By 2016, the ACA sets 9.66% of income as affordable for health care at 400% FPL.⁵⁷

Max Percentage Payer

The sliding scale stops at 400% of FPL, projected to be \$102,220 for a family of four by 2017. Taxpayers between 400% FPL and approximately \$289,475 AGI pay 9.5% of income. While the percentage stays the same, taxpayers with a higher income would pay more.

⁵⁶ We would recommend changing the calculation for a single person. We would use the FPL for a family of 2 so that the single person would pay slightly less. Stated another way, all families have at least two people for the purpose of determining FPL. This would be done to minimize the change in cost for single person households who otherwise would be exposed to disproportionate cost increases.

⁵⁷ IRS Rev. Proc. 2014-62 at <http://www.irs.gov/pub/irs-drop/rp-14-62.pdf>.



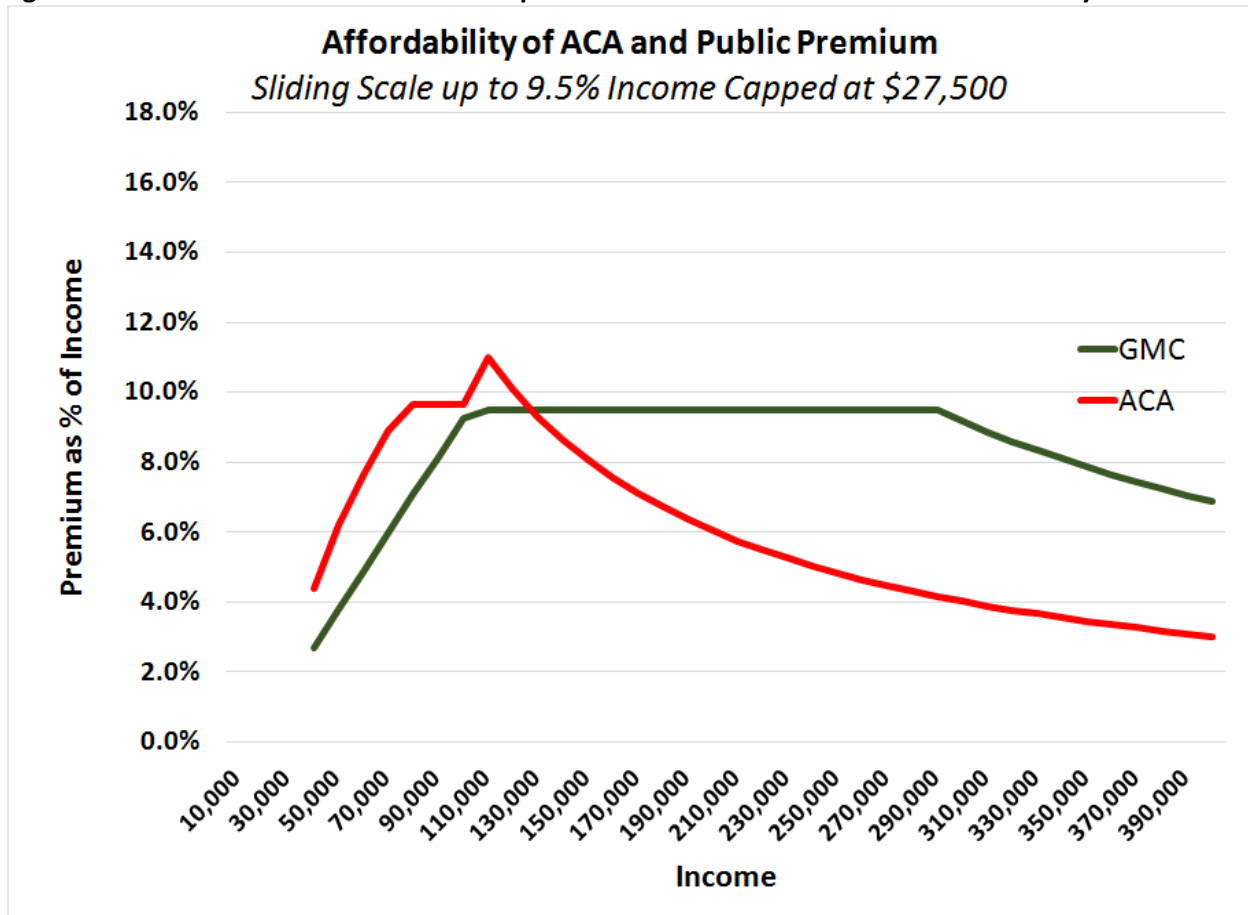
Max Dollar Amount Payer

Taxpayers with income greater than approximately \$289,475 AGI would pay a flat \$27,500 maximum tax. This amount declines as a percentage of income for every dollar in income beyond approximately \$289,475. This \$27,500 maximum GMC individual tax would be pegged to the Cadillac Tax threshold.⁵⁸

Figure 2 on the next page compares the Green Mountain Care public premium to the affordability requirements of the ACA. This is done to demonstrate the cost of the tax compared to the ACA affordability requirements and ensure that it meets federal affordability requirements.

⁵⁸ ACA § 9001; IRC § 4980I.

Figure 2: Public Premium Distribution Compared to ACA Silver Plan Premium Affordability



The red line is not what people have today. Instead, it represents what would happen if every Vermonter bought a silver level plan (70% AV) in the Exchange. The green line is what Vermonters would pay as a percentage of income under the public premium (94% AV).⁵⁹

Overall, figure 2 demonstrates several important points about the distribution of the tax. The system takes into account ability to pay as those who make more pay more in the case of 98.8% of taxpayers. Also, while people would likely focus on the maximum tax liability potentially due, the distribution of the tax is far less than the maximum amount for nearly all Vermonters. We estimate that more than 74.5% of Vermonters would pay less than \$5,000 in tax and nearly 96% pay less than \$15,000. Only 1.2 % of taxpayers, 4,349 households, would pay the maximum tax. Table 8 sets forth the distribution of tax liability for the public premium.

⁵⁹ The silver level plan is the benchmark for affordability for ACA waiver purposes. Comparisons to what Vermonters pay today are in Chapter 7, which covers economic analysis.

Table 8: Distribution of Public Premium Tax Liability

Public Premium Distribution by Cost	Number of Households	% of Households
<\$5,000	271,398	74.50
\$5,000 - \$10,000	54,532	14.97
\$10,000 - \$15,000	23,697	6.50
\$15,000 - \$20,000	7,002	1.92
\$20,000 - \$25,000	2,391	0.66
>\$25,000	5,295	1.45

The tax is based on FPL, not solely income. Accordingly, larger families would pay less even if they have the same income, as FPL is reduced for each additional dependent. This is consistent with the subsidy calculations in the ACA and the general logic of tax filings, where larger families are allowed to deduct more money for each dependent. This is different than the typical logic of health insurance premiums where couples and families tend to pay more than single or couple filers. Table 9 demonstrates this FPL effect within the public premium.

Table 9: Distribution of Public Premium by Income and Family Size⁶⁰

Number of Exemptions	1	2	3	4	5	6	Average
AGI							
Under \$25,000	\$242	\$120	\$0	\$0	\$0	\$0	\$152
\$25,000 - \$49,999	\$2,475	\$1,866	\$1,389	\$681	\$207	\$180	\$1,682
\$50,000 - \$74,999	\$5,724	\$5,273	\$4,302	\$3,214	\$2,808	\$2,220	\$4,396
\$75,000 - \$99,999	\$7,873	\$8,302	\$8,075	\$6,861	\$5,561	\$4,419	\$7,312
\$100,000 - \$124,999	\$10,276	\$10,521	\$10,714	\$10,667	\$9,640	\$7,929	\$10,345
\$125,000 - \$149,999	\$12,727	\$12,851	\$12,924	\$12,985	\$12,793	\$11,925	\$12,848
\$150,000 - \$199,999	\$16,854	\$16,157	\$16,325	\$16,363	\$16,786	\$15,252	\$16,344
\$200,000 - \$299,999	\$27,500	\$22,947	\$22,668	\$22,937	\$23,935	\$21,088	\$23,197
\$300,000 - \$499,999	\$27,500	\$27,500	\$27,500	\$27,500	\$27,500	\$27,500	\$27,500
\$500,000 - \$999,999	*	\$27,500	*	\$27,500	*	*	\$27,500
\$100,000,000 +	*	\$27,500	\$27,500	\$27,500	*	*	\$27,500
Average	\$2,279	\$6,865	\$6,551	\$8,160	\$5,757	\$4,195	\$5,285

⁶⁰ The * symbol indicates a value of three or fewer taxpayers.

Tax Deductibility

The major tax goals of the system are to promote equity and maintain to the greatest extent possible the value of the employer-sponsored insurance exclusion, which makes health care premium spending exempt from federal and state income taxes and federal payroll taxes. A payroll tax system enables employers' contributions to remain tax exempt. Based on analysis of applicable federal law and discussions with United States Treasury, the public premium would be deductible for federal purposes on Schedule A as an income tax. This means that Vermont taxpayers who itemize on their federal tax return could reduce their federal tax liability for public premium paid subject to general federal limitations on itemized deductions. For example, a Vermonter charged the maximum public premium who itemizes at the federal level and is in the highest federal tax bracket could see a 39.6% reduction in their GMC effective public premium tax liability.

Not all Vermonters itemize their deductions. On average, approximately a third of Vermonters itemize and these tend to be the highest income Vermonters. The system is designed to maintain equity and protect against the loss of the employer-sponsored insurance exclusion in the following way.

First, the sliding scale is designed to keep public premium liability as low as possible for non-itemizers who tend to be low and middle income. Second, the deductibility of the public premium on Schedule A mimics the employer-sponsored insurance exclusion by making health care spending tax preferred for higher income Vermonters. The ultimate test of the efficacy of this approach is to measure total federal taxes paid with and without GMC. Overall, we estimate that Vermonters would pay \$191 million less in federal income taxes under GMC than the ACA. Furthermore, even after accounting for increased federal payroll taxes due to higher wages, Vermonters would pay \$159 million less in federal taxes under GMC than under the ACA. In this way, the strategy succeeds in addressing the legitimate concern about forfeiting the value of the employer-sponsored insurance exclusion set forth in I.R.C. 106. The resulting tax liability for Vermonters after GMC implementation is discussed more fully in Chapter 7 of the report.

Exemptions, Reductions, and Credits

As indicated above, the public premium would be compulsory unless an individual qualifies for a specific tax exclusion, reduction, or credit. It is important to note that taking employer-sponsored insurance does not generally relieve a taxpayer from the tax. In this way, the GMC tax mirrors the distinction between public and private schools. People are welcome to send their children to private schools, but this does not reduce their property taxes. Similarly, employers would be welcome to offer insurance within GMC and employees could take it; however, this generally would not change an employee's tax liability.

While the general rule is that everyone would pay the tax, some Vermont residents would be either excluded from the tax, charged a reduced tax liability, or receive a credit. For example, Medicare enrollees would be exempt from the finance provisions of Green Mountain Care. Overall, these special populations include Vermonters with coverage from Medicare, TRICARE, and certain retirees.

Table 10: Populations Exempt from Financing or Eligible for a Credit

Description	Primary Coverage	Contribution to GMC	Considerations
Seniors (over age 65)	Medicare	None	Medicare Supplemental Insurance would remain available. Current Medicare wrap programs, such as VPharm stay the same
Individuals with disabilities (over 24 months)	Medicare	None	Same as above.
Non Medicare Retirees, excluding state and teacher retirees	ESI	None	GMC creates a ten year window where non-Medicare retirees with employer coverage are exempt from GMC coverage and taxes.
Military:			
Active duty military ⁶¹	TRICARE	None while on TRICARE	GMC coverage is suspended. GMC is available as soon as the individual drops or is no longer eligible for coverage. Individuals who are eligible for enhanced benefits from Medicaid would maintain enhanced benefits through GMC
National Guard	TRICARE, while on active duty.	None while on TRICARE	Vermonters with the Guard would have GMC coverage while not on active duty & can suspend that coverage during the time period they are on active duty.
Veterans	VA facilities and new insurance, if applicable	None while using VA insurance	New VA Insurance provisions expires in August 2017. Veterans may use the VA Hospital for services as well, but are not required to under GMC.

Appendix F includes a description of the tax credit mechanism to be used to ensure that members of special populations comply with Green Mountain Care tax laws.

⁶¹ In order for TRICARE to be primary coverage, a state statutory change is needed. This is because, under federal law, TRICARE is always secondary, except to Medicaid.

Revenue Collection

The public premium would be collected by the Vermont Department of Taxes. The Commissioner would develop policies, procedures, forms, and regulations necessary to implement the tax. We would recommend that the Commissioner make these rules consistent with existing income tax withholding and payment laws and regulations. Specifically, the public premium ought to be subject to mandatory paycheck withholding and estimated payments, similar to the Personal Income Tax. This mirrors the current employer-sponsored insurance exclusion for taxpayers and ensures proper cash flow for the program.

Out-of-Pocket Costs

Like today, Green Mountain Care would feature cost-sharing. Vermont residents would be required to pay co-payments at the point of service. The recommended plan AV is 94%, meaning that on average the plan would cover 94% of expenses and leave 6% to be covered by the resident at the time of care. This is an important aspect of the system financing, even if it is not a public revenue stream.

In 2017, total out-of-pocket costs are estimated at \$187 million, a \$258 million reduction from the ACA. The out-of-pocket savings would increase annually. Table 11 sets forth aggregate out-of-pockets costs from 2017 to 2021.

Table 11: Estimated ACA and GMC out-of-pocket Spending, 2017 – 2021 (Values in Millions)

Year	2017	2018	2019	2020	2021
ACA	\$445	\$465	\$491	\$517	\$543
GMC	\$187	\$167	\$173	\$190	\$185
Change	-\$258	-\$298	-\$318	-\$327	-\$358

The total out-of-pocket cost yields an average estimated out-of-pocket cost of \$810 per family. This is a reduction of \$700 per family. Yet, it is critical to understand that out-of-pocket costs are not distributed equally. Many individuals and families use very little health care in any given year. Others use a lot of health care during any given year. Table 12 demonstrates the distribution of GMC plan out-of-pocket costs by decile of utilization.

Table 12: Estimated Distribution of GMC Out-of-pocket Costs by Decile for 2017

Range of Out-of-pocket Costs	Percent of Members
\$0-\$100	31%
\$101-\$200	19%
\$201-\$300	10%
\$301-\$400	6%
\$401-\$500	4%
\$501-\$600	3%
\$601-\$700	3%
\$701-\$800	3%
\$801-\$850	20%

Beyond its effect on individuals, we expect that Green Mountain Care would reduce health care providers' uncompensated care. Individuals who are uninsured, or who are responsible for paying a deductible or coinsurance, may owe a balance to their health care provider for care they received. If an individual does not have sufficient resources to pay an amount owed, a health care provider may waive the fee and write off the claim to charity care. In other cases, the provider may write off an uncollected amount to bad debt. Charity care and bad debt together are referred to as "uncompensated care." One study of hospital uncompensated care found that 75% of uncompensated care was incurred by individuals with family incomes below 100% FPL and 97% of uncompensated care was incurred by individuals with family incomes below 300% FPL.⁶²

Under Green Mountain Care, all Vermont residents would have comprehensive health coverage with low cost-sharing requirements. Individuals who currently have high cost-sharing requirements through an employer health plan would no longer incur large health care debts. The reduction in individuals' out-of-pocket costs for health care would in turn reduce the amount of uncompensated care experienced by Vermont health care providers. Providers and the designated entity should monitor whether the reduction in uncompensated care or bad debt occurs in GMC and work with the Green Mountain Care Board to determine whether this should impact provider rates.

Balance Sheet

Table 13 applies the cost and revenue estimates and reveals a difficult financial picture for GMC. The system would nearly balance for the first three years, including surplus in years 1 and

⁶² Weissman, J.S., Dryfoos, P. and K. London, "Income levels of bad-debt and free-care patients in Massachusetts hospitals," *Health Affairs* 18:4 (1999).

2. Yet, the system would fall into deficit in year 4 and 5. This affirms the primacy of cost containment in a publicly financed system. Any publicly financed system where expenditures rise faster than revenue would require tax increases or new tax sources in future years. Our best estimates for cost containment are that we can narrow the gap between revenues and expenditures to a greater degree than in today's system. However, health care costs, even at a 4% trend, would continue to rise at a higher rate than revenues. This is true to an even greater extent in today's world, which is why premiums increase every year more than wages or inflation. Even with our best estimates of cost-containment, we would need to accept some increases in tax rates in the same way that we accept increases in insurance premiums today.

It is important to note that this balance sheet does not include a phase-in of the payroll tax, which is a policy priority of the Governor's. See Appendix F-2 for discussion of the phase in.

Table 13: GMC Balance Sheet⁶³

Year	2017	2018	2019	2020	2021
Spending					
Cost of GMC Coverage and Operations	-4,340	-4,579	-4820	-5,001	-5,177
Revenue					
Federal Funding					
Federal Medicaid Match	1,310	1,364	1,413	1,445	1,505
Federal ACA Waiver Funding	106	118	122	125	132
State Funding					
State Medicaid	344	341	350	358	366
New Revenue Needed	-2,580	-2,756	-2,935	-3,073	-3,174
Payroll Tax	1,510	1,542	1,574	1,606	1,639
Public Premium	1,247	1,306	1,359	1,372	1,381
GMC Fund Fiscal Position	177	92	-2	-95	-154

⁶³ The balance sheet changed slightly since Governor Shumlin's announcement on December 17. Changes reflect a technical correction to State Medicaid revenue and a \$1 million change to federal ACA funding for both 2020 and 2021. These changes impact the new revenue needed and the GMC Fund fiscal position.

Chapter Seven: How would public financing impact Vermont businesses and families?

Coverage, finance, and cost containment would affect the distribution of health care costs from the ACA to GMC. In this chapter, we describe the potential changes to health care spending by employers, local and state governments, individuals, and families. Embedded within these figures are projected income changes and changes in tax liability. Also, we discuss savings estimates based on the ability to hold GMC costs below projected national growth trends beginning in 2017.

Effect on Employers

The economic modeling compared the projected health care spending of Vermont firms under the ACA to their projected health care spending under GMC. Today, health care spending varies substantially by firm. In Green Mountain Care, all firms would pay a uniform 11.5% payroll tax. The payroll tax would change the level and distribution of health care spending for Vermont firms.

Overall, as modeled, GMC would increase health care spending by Vermont employers \$109 million from \$1.595 billion to \$1.704 billion. On average, nearly all private firms would pay more under this design of GMC. The largest aggregate increase would occur in Vermont's smallest firms, those with fewer than 10 employees. The largest per employee increase would occur in small firms with between 10 and 49 employees. In contrast, public employers would spend less under GMC than under the ACA. We estimate that the federal government saves money as GMC enrollees choose to drop insurance rather than pay for both federal insurance and GMC taxes. We assume military insurance is unchanged.

Table 14: Employer Spending on Healthcare (Total \$ in Millions, per employee in \$)⁶⁴

Firm Size	ACA Spending	Per Employee ACA Spending	Total GMC Spending	Per Employee GMC Spending	Total Change from ACA	Per Employee Change From ACA
Under 10	242	1,005	437	1,819	196	814
10-49	121	3,013	174	4,337	53	1,324
50-99	56	3,580	70	4,467	14	887
100-249	90	4,940	97	5,312	7	372
250-500	89	5,279	87	5,164	-2	-115
500-999	75	5,699	77	5,851	2	152
1000-4999	280	5,733	294	6,004	13	271
5000+	92	5,422	98	5,744	5	322
Federal	46	3,946	0	-	-46	-3,946
State	183	7,502	111	4,578	-71	-2,924
Local	66	4,374	62	4,088	-4	-286
Municipal	205	6,178	146	4,380	-60	-1,798

The distribution of health care spending by employers today depends on the firm’s choice to offer coverage, the number of employees that enroll in employer coverage, the value of plan benefits, and in some cases the health of the workers. Accordingly, the impact of GMC on any specific employer depends greatly on whether the firm offers insurance today. Most classes of firms that offer health insurance today would spend less in GMC than under the ACA. This does not hold true for Vermont’s largest firms, those with more than 1,000 employees.

⁶⁴ For the employer tables, the employer category local represents local government employees. The municipal category represents education employees. The labeling was kept this way to ensure fidelity with the underlying modeling output documents.

**Table 15: Employer Spending on Healthcare for Firms Offering Prior to GMC
(Total \$ in Millions, Per Employee in \$)**

Firm Size	Total ACA Spending	Per Employee ACA Spending	Total GMC Spending	Per Employee GMC Spending	Total Change from ACA	Per Employee Change From ACA
Under 10	242	5,286	208	4,542	-34	-744
10-49	121	5,994	93	4,578	-29	-1,416
50-99	56	5,050	50	4,474	-6	-576
100-249	90	5,363	89	5,290	-1	-73
250-500	89	5,640	84	5,306	-5	-334
500-999	75	6,160	74	6,086	-1	-74
1000-4999	280	5,845	289	6,030	9	186
5000+	92	5,503	96	5,735	4	232
Federal	46	3,946	0	-	-46	-3,946
State	183	8,942	101	4,929	-82	-4,013
Local	66	5,916	50	4,492	-16	-1,424
Municipal	205	7,268	128	4,521	-78	-2,747

Firms that do not offer insurance under the ACA would see a much larger change under GMC. Overall, firms that do not offer insurance incur \$393 million in new expense under GMC. The majority of this cost (\$230 million) would be paid by businesses with fewer than ten employees. More than three quarter of this expense (\$312 million) would be paid by firms with fewer than 50 employees.

**Table 16 Employer Spending on Healthcare for Firms Not Offering Prior to GMC
(Total \$ in Millions, Per Employee in \$)**

Firm Size	Total ACA Spending	Per Employee ACA Spending	Total GMC Spending	Per Employee GMC Spending	Total Change from ACA	Per Employee Change From ACA
Under 10	0	0	230	1,179	230	1,179
10-49	0	0	82	4,094	82	4,094
50-99	0	0	20	4,451	20	4,451
100-249	0	0	8	5,561	8	5,561
250-500	0	0	3	3,087	3	3,087
500-999	0	0	3	2,952	3	2,952
1000-4999	0	0	4	4,649	4	4,649
5000+	0	0	2	6,355	2	6,355
Federal	0	0	0	-	-	-
State	0	0	11	2,748	11	2,748
Local	0	0	12	2,942	12	2,942
Municipal	0	0	18	3,582	18	3,582

The new and large cost placed on small businesses reveals just how critical it is to offer a transition strategy for these businesses. Simply put, many small businesses pay little or nothing today. They need a strategy to transition to GMC.

One additional effect of GMC on employers would be how it could change the amount paid by employers to their employees. We assumed that employers that pay less under GMC than under the ACA would gradually pay their employees more in wages.⁶⁵ Additional wages would have a major impact on Vermont households, which is discussed in the next portion of this chapter.⁶⁶

Impact on Vermont Households

GMC would change the health care spending, income, and taxes paid by Vermont households. Overall, Vermonters would receive more in wages under GMC. Additional wages would boost income and consumption of goods and services. In turn, increased wages and consumption

⁶⁵ See wage “stickiness” assumptions in Appendix C.

⁶⁶ Our assumptions around wage stickiness mean that some firms would collect considerable savings that are not immediately passed back to employees via higher wages. Additional macroeconomic analysis is needed to determine the impact of this unallocated cash on Vermont’s firms and the Vermont economy. Additionally, firms that pay more under GMC than under the ACA would be forced to adjust to changed circumstances. Macroeconomic analysis is needed to determine the effect of this on the economy.

would increase taxes paid by households. Ultimately, we are focused on net family income, which measures family resources available after all health care spending, wage effects, and taxes paid described above occurs.

Net Family Spending

Overall, we estimate that over time Vermont residents would have higher net family income on average under GMC. This is due to higher income, lower health care costs, and lower federal tax liability under GMC than without GMC.

Table 17: Average Change in Net Family Income from ACA to GMC, 2017 – 2021

	2017	2018	2019	2020	2021
Change in Net Family Income	-460	310	1,210	1,450	1,880

The public premium amount would change based on income and family size. Accordingly, net family income would change at various income levels. Table 18 on the next page sets forth average net family income changes by income class. Families with incomes of less than \$150,000 per year would on average see higher net family income under GMC. Families with incomes of more than \$150,000 per year would on average see decreased net family income in GMC.

Table 18: Average Change in Net Family Income from ACA to GMC by Income Class, 2017

Average Change in Net Family Income by Income Class	
Income Class	Average Change in Net Family Income
<\$10000	1,203
\$10k - \$19,999	952
\$20k - \$29,999	909
\$30k - \$39,999	2,012
\$40k - \$49,999	1,677
\$50k - \$74,999	2,645
\$75k - \$99,990	2,452
\$100k - \$149,999	739
\$150k - \$249,999	-2,120
\$250,000 +	-5,841

The table above tries to answer the question of whether Vermont household are better off economically under GMC than under the ACA. Table 19 on the next page depicts all the different component parts of that economic calculation. For each income class, you can see the change in health care spending, change in income, and change in tax liability that ultimately drives the net family spending result.

Table 19: Changes in Net Family Income by Income Class, including Health Care Spending, Wage Effects, and Tax Changes, 2017

Income Class	ACA					GMC					
	Number of Families	Average ACA Out-of-pocket	Average ACA Premium	Total ACA Cost	Average GMC Out-of-pocket	Average GMC Spending on Private Insurance	Average GMC Individual Tax	Average GMC Income Change	Average Change in Federal Tax	Average Change in State Tax	Average Change in Net Family Income
<\$10,000	46,919	870	369	1,239	464	23	0	488	55	-17	1,203
\$10,000-\$19,999	53,288	808	580	1,389	829	32	53	537	48	12	952
\$20,000 - \$29,999	45,161	725	813	1,538	713	136	410	727	90	7	909
\$30,000 - \$39,999	36,596	1,218	1,489	2,706	558	66	1,087	1,205	170	18	2,012
\$40,000 - \$49,999	29,495	1,332	1,714	3,046	389	110	1,980	1,289	150	29	1,677
\$50,000 - \$74,999	55,155	1,707	3,482	5,189	1,080	268	3,475	2,639	274	86	2,645
\$75,000 - \$99,999	37,671	2,081	4,843	6,924	894	454	5,971	2,821	-89	64	2,452
\$100,000 - \$149,999	35,929	2,175	5,010	7,185	847	424	9,359	2,636	-1,564	16	739
\$150,000 - \$249,999	15,841	2,152	5,179	7,330	842	744	14,466	2,137	-4,506	41	-2,120
\$250,000+	8,261	2,368	5,756	8,124	872	182	21,877	828	-8,043	-94	-5,841

The overall economic picture in Table 19 shows the merits of the public premium. Overall health care costs would decrease for low and middle income Vermonters. This, in tandem with wage growth, would increase net family income exceeding any additional tax burden. Higher income Vermonters would have losses minimized by the favorable tax treatment of the public premium as an itemized deduction.

Trend and Cost Containment

Cost containment is a key component to the economic viability of GMC. The goal is for the GMCB and designated entity to create a regulatory environment that would produce a sustainable health care spending trend that comes in under a maximum annual growth rate. Specifically, the GMCB could work with the designated entity and provider community to hit a target health care growth rate of not more than 4% from 2017 to 2021. This target trend is compared to our benchmark, the National Health Expenditure (NHE) trends published by the Office of the Actuary at the Center for Medicare and Medicaid Services. CMS projects health care expenditures to grow, on average, 5.8 and 5.1 percent annually for Medicaid and Commercial populations from 2017 to 2021.

Hitting this trend target would be the method for saving money in GMC. Each year costs stay at or below the trend, GMC would save money compared to the status quo. This trend approach is markedly different than the approach used in the universal health care reports published by Dr. William Hsaio in 2011 and the University of Massachusetts/Wakely Consulting in 2013. These reports quantified administrative savings that occurred upon implementation and reduced the revenue needed to operate the program from the start date of the program.⁶⁷ Specifically, the Hsaio report booked \$580 million in administrative savings for the first year of the program, and the UMASS/Wakely report identified \$122 million in reductions delivered through lower provider rates. In contrast, we accrue savings over time as Vermont follows a more sustainable fiscal trajectory. We consider this approach most prudent as it allows health care providers time to adjust to the new coverage, finance, and regulatory environment and the flexibility to determine how best to manage their costs. This would minimize dislocations for the provider community, their workers, and patients.

Overall, we estimate that GMC would save \$378 million over the first five years if it hits the 4% trend target as opposed to growing at the benchmark rate.

⁶⁷ 2013 UMass-Wakely Report:

http://hcr.vermont.gov/sites/hcr/files/2013/Health%20Care%20Reform%20Financing%20Plan_typos%26formatting%20corrected_012913.pdf ; Dr. Hsaio's report:
<http://www.leg.state.vt.us/jfo/healthcaresystemdesign.aspx>

Table 20: Anticipated GMC Savings Based on 4% Trend, 2017 – 2021

Year	GMC Cost at NHE Growth	GMC Cost at 4% Trend	Difference
2017	4,263	4,263	0
2018	4,512	4,501	11
2019	4,806	4,741	65
2020	5,042	4,921	121
2021	5,277	5,096	181
Total Savings			378

The trend is set at four percent, but overall spending does not grow at exactly this amount due to changes in population. Each year, some people would migrate from employer-sponsored insurance to Green Mountain Care. Other people would migrate from Green Mountain Care to Medicare. Cost growth estimates exceeds trend the first two years as more people move into GMC from their employer-sponsored insurance. Cost growth estimates are below trend in the fourth and fifth year as more people age and are covered by Medicare.

Retirees and Health Care


Vermont’s State Treasurer administers the retirement systems for state employees and teachers. Vermont must account for both the current and future projected cost of these benefits.⁶⁸ These liabilities are known as Other Post Employment Benefits (OPEB) liabilities. We estimate that Green Mountain Care has the potential to decrease OPEB liabilities substantially.

As described in Chapter 3, all non-Medicare state and local government retirees that are Vermont residents would receive GMC as primary coverage. Accordingly, the State’s projected future OPEB liability would be reduced as the health care costs of resident, non-Medicare retirees transition from the retirement system to Green Mountain Care. The retirement system would be responsible for out of state retirees, Medicare retiree benefits, and any additional benefit to retirees beyond GMC that the retirement system chooses to offer. At 94% AV, we expect that most resident, non-Medicare liability would be eliminated. OPEB liability would likely be substantially reduced even under 87AV and 80AV benefit scenarios.

State Revenues

We estimated that increased income due to GMC would stimulate spending. This would in turn result in increased state tax revenue. Specifically, we estimated that the State of

⁶⁸ States are required to report Other Post Employment Benefits (OPEB) liability per Government Accounting Standard Bulletin (GASB) 45. Specifically, states are required to report projected non-pension costs related to post-retirement medical, pharmacy, dental, vision, life, long-term disability and long-term care benefits.



Vermont would collect \$34 million in additional state tax revenue in 2017, rising annually thereafter. We did not allocate that increased revenue to GMC. Instead, we left the allocation of that increased revenue as a policy choice for a future Administration and Legislature.

Conclusion

Overall, the economic modeling of Green Mountain Care demonstrates promise and peril. On average, Vermont households would benefit, but this benefit takes time to materialize. Households with income below \$100,000 would benefit the most. The public premium shows the ability to tax based on the ability to pay while minimizing sticker shock to higher income households through tax deductions available through the federal income tax code. Businesses would pay more overall, but the firm specific results depend heavily on whether the firm offers insurance today.

Based on our analysis, the economic shock and transition issues were too great for us to recommend that Vermont proceed with public financing at this time. In the event Green Mountain Care is considered in the future, we would recommend additional macroeconomic analysis to understand business sector effects, job gains or losses, and the overall impact on Vermont's economy.