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During the week of April 10-13 Robin Lunge, Director of Vermont Health Reform, and Steve Kimbell, Commissioner of the Department of Financial Regulation, provided a letter to Sen. Hinda Miller and a "Fact Check" sheet to members of the Democratic Caucus, both of which were widely distributed. The purpose of both documents was to refute claims made by critics of H.559, this year's health care reform bill. The arguments presented in both documents were similar and are combined here to offer a single response.

Lunge and Kimbell	VHCF response
"It is claimed that the state has estimated an 18% increase in premiums in the Exchange for current small group association plans. This claim is untrue . . . "	The *Act 48 Integration Report*, prepared by Lunge and Kimbell with assistance from others, was submitted to the Legislature on January 17, 2012, and states on page 28: *"Since the ACA requires each insurer to merge all its small groups into a single rating pool, groups within associations today may experience significant rate changes when these groups are rated together with other elements of the small group market."* On page 38 of the report, in Table 1.a., "Impact of Merging Markets with Contract Tier Normalization," this report estimates that the average premium change for members of associations with fewer than 51 employees will be an increase of 18.4%. This group is estimated to include 32,000 Vermonters (page 29, Table 10).[1]
"Regarding the supposed 18% increase, this limited, preliminary estimate was done by an independent actuarial analyst based upon *today's* market and did not take into account provisions in the ACA that will mitigate the increase."	The estimate was prepared by an actuarial analyst under contract to the State of Vermont in support of a legislatively mandated report that was prepared and submitted by the Agency of Administration under the direction of Director Lunge, BISHCA under the direction of Commissioner Kimbell, and the Commissioner of the Department of Vermont Health Access.
"Starting 1/1/14 small businesses that decide to offer coverage will be eligible for a federal tax credit of up to 50% of their contribution to premium."	Under the ACA, Small Business Health Care Tax Credits are not available to all businesses with fewer than 51 employees. First, the tax credits are available only to businesses with fewer than 25 employees; second, the average wage per employee must be less than $50,000 per year, and finally, the employer must currently pay at least half of the cost of premiums for employees.
"The actuarial analysis . . . [did not take] into account . . . the option for small employers to stop purchasing insurance for their employees without penalty . . ."	The Shumlin Administration is working hard to persuade all small businesses to dump their insurance coverage and send their employees to the exchange as individual purchasers. According to representatives of many affected businesses this is a poor business option. Even though small businesses are exempted from a federal tax penalty for dropping employees' coverage, there is a strong incentive to provide coverage. A study prepared by the Urban Institute and funded by the Robert Wood Johnson Foundation titled, "*Why Employers Will Continue to Provide*

[1] http://hcr.vermont.gov/sites/hcr/files/RJL%20Final%20Integration%20Report%20Act%2048%20Exchange.pdf

Lunge and Kimbell	VHCF response
	Health Insurance: The Impact of the Affordable Care Act" found, "*Whereas tax subsidies for employer benefits increase with income, the opposite is true for subsidies under the exchange. Analysts agree that only at or below an income of 250 percent of the federal poverty level do the ACA's subsidies make exchange coverage as good as or better than employer-sponsored coverage. Firms dominated by workers within this income range are likely to drop coverage, substitute extra wages (less penalties) for benefits and make their low-wage workers better off.** *But 80 percent of U.S. workers overall—and the group most likely to dominate most workers' firms—would lose out if employers drop coverage. Since compensating them for the loss of benefits would increase costs to employers, and thus create a disincentive to drop, most employers will continue to provide coverage."*[2] *Note that in Vermont firms dominated by low wage workers may be likely to drop coverage but will be less likely to substitute extra wages given the expectation that Vermont will assess a significant payroll or other business tax to fund Green Mountain Care in the near future. These firms are more likely to retain savings from dropping employee coverage to fund these increased state taxes.
"The actuarial analysis . . . [did not take] into account . . . the option for small employers to stop purchasing insurance for their employees . . . and allowing their employees to access federal tax credits to make insurance affordable. . . These credits limit their premium costs from 2% to 9.5% of their household income for those earning up to 400% of federal poverty level . . ."	Lunge and Kimbell fail to mention that the employer will stop contributing to the cost of premiums when they drop the coverage. Employer contributions are nearly always more than 50% of the premium cost, typically around 75%. Taking this into consideration and noting that federal tax credits are against *household* income, these subsidies will not make up for the loss of employer contributions for most wage earners and for a large majority of two-income families. Only lower income wage earners will see a savings by purchasing through the exchange. Assuming average household size (2.39 people)[3] and median household income ($53,000 per year)[4], and assuming the employer contribution toward premiums is 75%, then the current monthly cost to the household is about $313. This same median Vermont household would see Exchange premiums (after federal tax credits) of about $390[5]. Since this example is the median Vermont household, a majority of households will see higher premiums purchasing through the Exchange than they pay through employer provided insurance.
"The actuarial analysis . . . [did not take] into account . . . the [fact that the] impact of merging the individual market with the small group market will be minimized	The Affordable Care Act establishes a three-year transitional reinsurance program in each state to help stabilize premiums in the individual market due to individuals with higher cost needs gaining insurance coverage during the first three years of Exchange operation (2014 through 2016). However,

[2] http://www.rwjf.org/files/research/72971qs69employersandimpactaca2pager20111020.pdf

[3] U.S. Census Bureau, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

[4] U.S. Census Bureau, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

[5] DVHA Handout, ACA PERMIUM LEVELS IN 2014, 03/21/2012, 2011 FPL range for 3 person household, MHI=$4,417 per month

Lunge and Kimbell	VHCF response
by a federally-funded reinsurance program."	the federally funded reinsurance program will have no impact on rates as of 1/1/14, the effective date of the actuarial analysis.[6]
"In terms of choice, there will be multiple carriers offering multiple products at different metal levels within the Exchange . . . Employers can also continue to offer HSA, HRA, and other plans for individuals to pay with pre-tax dollars."	According to testimony before the Senate Finance Committee, Director Lunge stated that there will probably be 16 plans offered by two carriers in the Exchange. In reality there will be about eight different plans, with a choice of two carriers for each plan. Currently there are 65 plans available in Vermont. Elimination of the private insurance market will dramatically constrain choice. The ACA calls for the existing private insurance market to continue to operate alongside the Exchange. The remaining 49 states are expected to make participation in the Exchanges voluntary. Only Vermont is planning to eliminate the private insurance market and make the Exchange mandatory. As for employers continuing to offer HSA and HRA plans, the Administration fought against the inclusion of "bronze" level plans which are the basis for HSA and HRA programs. The Administration now has the duty of designing the Exchange bronze plans that they attempted to outlaw. Until we see these plan designs it is not unreasonable to expect that they will be largely unacceptable to employers seeking to continue their use.
". . . employees will have greater security than exists now if they lose or change their jobs."	Under the Vermont Catamount Health program displaced employees have access to non-employer sponsored coverage today.
"These choice and security protections would not be available for plans outside the Exchange."	This statement is not correct as it implies this is a federal requirement. Under federal law HSAs could be offered outside the Exchange. Under Vermont law displaced employees have access to Catamount Health or other government-offered programs.
"Some employers who have not changed their health plans since the ACA was passed . . . are "grandfathered" under federal law. Some suggest that Vermont is allowing public unions and large employers to be exempt from the provisions of the ACA, but the state has no choice if the plans meet federal requirements."	This statement is not correct. Section 43(f) of H.559 is a state-specific grant of extended grandfathering; it extends the federal date of March 2010 to January 1, 2013. Changes to collective bargaining benefits could have lost federal grandfathering protections and be forced into the Exchange, but will preserve protection under this provision.
"A final bit of misinformation circulating asks why, if Catamount Health is being repealed, the employer assessment that funds it is not being repealed . . . Catamount Health is not being repealed in the H.559 as passed by the House."	While it is true that the House did not accept the Shumlin plan to repeal Catamount Health, the central question remains - why can't the portion of the assessment that supported Catamount be sunsetted as Catamount is folded into the new system? The Joint Fiscal Office tracking document shows that in both the Governor's recommend and House budgets for FY2013 the Catamount Fund's entire revenues are folded into the SHCRF. These revenues net out at $20 million, including the Employer Assessment, the Cigarette Tax and 'Program Surplus.' The Administration has advocated for small

[6] http://www.healthcare.gov/news/factsheets/2012/03/risk-adjustment03162012a.html

Lunge and Kimbell	VHCF response
	employers to drop their coverage and have employees purchase from within the exchange. But as the employer stops offering coverage that employer will be subject to the Employer Assessment. If the Administration is serious about encouraging small employers to drop their coverage in favor of their employees enrolling in the Exchange, then they should not be taxing these employers for doing so.
". . . Several comments have confused the establishment of the Exchange with questions about the planning for the future Green Mountain Care, citing a lack of answers to questions about benefit design, cost, and financing. Answers to these questions are obviously complex and warrant careful consideration rather than a rush to judgment. We have the time to assess and debate the financing before Green Mountain Care is implemented; to do so now would be premature and with data that would be outdated and inaccurate."	As long as the Administration intends to make the Exchange mandatory and require the immediate dismantling of the private insurance market, answers to all of these questions are necessary before the Legislature and the affected businesses and individuals can make informed decisions. The critics are not demanding a rush to judgment on Green Mountain Care but decrying the state's rush to judgment on the Exchange without a shred of the necessary information.