# VHCF ISSUE BRIEF: Quality and Spending
# 08-10-12

## The current state of health care in Vermont

The governor insists that we are in a crisis, but the facts suggest something a bit less dire. For example, Vermont's physicians are extremely efficient in taking care of patients. Medicare spends the smallest percentage of total cost on physician and clinical services per Medicare beneficiary in Vermont than in any other state (half of the national average - 12.4% versus a national average of 23.2%). (http://www.statehealthfacts.org/comparemaptable.jsp?yr=92&typ=2&ind=626&cat=6&sub=72&sortc=2&o=a

We don't know how much of the 12.4% is for physicians and how much is for clinical services, but of the nation's total health care budget, approximately 8% represents physician compensation, and probably 20-35% of that 8% gets taxed back into the system.

Here are some other favorable things about Vermont and health care.

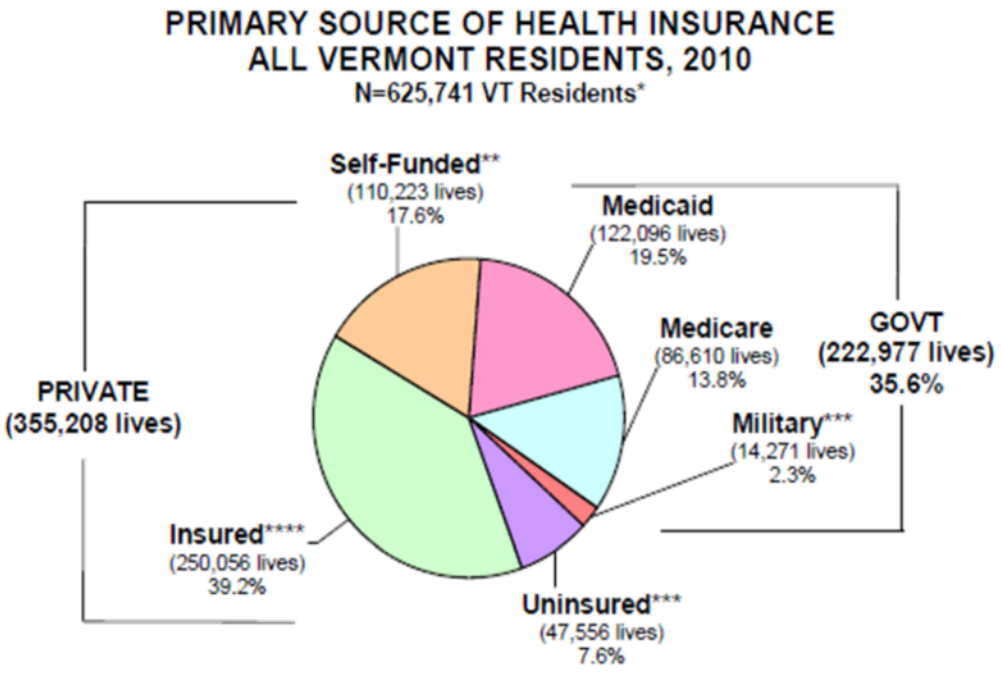
- Vermont has been ranked healthiest state in the nation for 5 years in a row (http://www.reuters.com/article/2011/12/07/uk-usa-health-states-idUSLNE7B602220111207 )

- Vermont has one of the lowest uninsured rates of the 50 states (second lowest, behind Massachusetts: http://minnesotaindependent.com/87356/gallup-minnesota-has-nations-third-lowest-uninsured-rate )

- The 2009 Commonwealth Fund's *State Scorecard on Health System Performance* ranked Vermont #1 in the United States (http://www.commonwealthfund.org/Publications/Fund-Reports/2009/Oct/2009-State-Scorecard.aspx).

Regarding the uninsured, the state estimates that there are 47,000 uninsured Vermonters, or about 7.4%. Of these, 22,000 are eligible for Medicaid but have chosen not to enroll. So the number who lack access to insurance is not the same as the number of uninsured. Indeed, of the remaining 25,000 some are certainly young people who could afford insurance but prefer not to spend the money and still others who are out of state college students covered under their parents' plans but show up as 'uninsured' in these statistics. The argument that single payer is the only way to achieve universal access is simply not true. We have nearly achieved it already.

So by nearly every measure almost all Vermonters enjoy relatively efficient, high quality health care services.




* 2010 U.S. Census Bureau state-level annual population estimate.
** BISHCA does not regulate or collect data on Self-Funded. This is an estimate of the total Vermont lives covered by Self-Funded plans which includes Federal Employees Health Benefit Plan
***2009 Vermont Household Insurance Survey number trended forward and weighted based on the U.S Census Bureau uninsured estimates
****This number includes 61,796 Vermonters covered by health plans licensed in other states.

## The true picture of future Vermont health care spending growth

But what about the cost? The governor and others keep repeating that if something is not done now, the $5 billion we spend on health care will become $10 billion in 2020. Let's look at the numbers. Shumlin gets the $5 billion increase between 2011 and 2020 by assuming 7.5% medical spending inflation and ignoring the underlying inflation rate.

If we use the more recent assumption of 3.5% (based upon statements by administration officials and the Green Mountain Care Board) to calculate expected growth in health care costs we get a very different result. Instead of a total cost of $10 billion in 2020, the cost to Vermont would be $6.6 billion. But that, too, is misleading because there is an inflation rate underlying the whole economy. In other words, if health care costs grow at the same rate as general inflation, then technically they have not grown at all – the money we are paying them with has 'shrunk.' If we take the average general inflation as measured by the CPI over the last 10 years and assume that the same trend will continue through 2020 we get an 'inflation adjusted' total health services estimate of $5.4 billion in 2020, assuming constant 2012 dollars.

The administration will argue that the 3.5% assumption is only valid if single payer is implemented. This is highly debatable given the expansion of coverage and incentives for overuse buried in Green Mountain Care, as well as the experience of Canada which has been struggling with uncontrolled single payer cost increases for decades (see below). But overall medical inflation in Vermont and nationally have been trending down in recent years, and this has happened without replacing the private insurance market with a government monopoly.

Even if we use the most recent measured Vermont cost increase (4.8% between 2009 and 2010) and apply constant 2012 dollars, the total cost in 2020 is $6 billion, not $10 billion.

Using more recent medical cost inflation rates and using 2012 dollars, the cost of health services to Vermonters will grow from $5 billion today to something between $5.4 and $6 billion in 2020. This result may deserve a response but it hardly constitutes a crisis justifying a government takeover of the industry.

Let's take a look at how well several entities restrained spending to put the health services sector into context. The chart below shows Vermont and U.S. total health spending, plus Ontario, which has global budgets and single payer, and finally the Vermont Legislature. 'Global' means global budgeting is used and FfS means fee-for-service. While Vermont and U.S. spending have been trending down Ontario has maintained a 6% plus growth rate for a decade.

| Spending Growth | Growth 2009-2010 |
|---|---|
| Vermont health care (global & FfS) | 4.8% |
| United States health care (FfS) | 4.0% |
| Vermont State Government | 7.0% |
| Ontario health care (global) | 6.0% |

There are two messages here: Canada has the system we are adopting and their experience is worse than ours, and, the Vermont Legislature has the worst performance of all (2010-2011 spending growth was only a bit better at more than a 6% increase).

## What about all those 'bronze' high deductible plans employers are turning to?

When the administration examines the actuarial value of any insurance product they look at the co-pays and deductibles to determine how much of the actual cost is covered by the insurance and how much by the insured. A 'bronze' plan by federal definition means the split is 60-40; the insurance covers 60% of the cost of services and the insured covers 40%. The Shumlin administration has blasted the trend toward these high deductible products as an unacceptable shift toward weaker coverage and even tried to eliminate them from being offered through the federally mandated health insurance exchange.

But the administration's financial analysis does not take into consideration employer contributions toward deductibles or co-pays, or the value of Health Savings Accounts (HAS), Health Reimbursement Accounts (HRA), or Flexible Spending Accounts (FSA). In most cases, employers who switch to these high deductible plans couple them with employer or employer/employee contributions through one of these account mechanisms. So the effective actuarial value of the 'bronze' plan may in fact be equivalent to a 'silver' or 'gold' level from the perspective of the employee but this is never recognized by the administration.

Vermont leads the nation in the percentage of insured enrolled in HSAs. As of January, 2012, Vermont enrollments stood at 19.9% of the total market. Minnesota was second at 14.3%. National HSA enrollments have grown from less than 1 million in 2005 to 13.5 million today. This includes an increase of 18% since 2011.

HSAs are patient-centered, market-driven plans credited with significantly reducing health care spending growth by a RAND Corporation study. VHCF has argued that the success of HSA's in Vermont is partially responsible for the recent overall drop in health care spending here. Green Mountain Care, the governor's single payer health care reform, would dismantle HSAs and similar market-based options in favor of a government monopoly program similar to that found in Canadian provinces.

John Goodman's Health Policy Blog contains a nice summary of the Center for Policy and Research census report here:
http://healthblog.ncpa.org/hsa-enrollment-keeps-growing/

The full census report is available here:
http://www.ahip.org/HSA2012/

The RAND study can be found here:
http://www.rand.org/pubs/external_publications/EP201100208.html

## What about all those medical expense personal bankruptcies?

Another popular claim is that "50% (or 60%) of all personal bankruptcies are caused by medical emergencies for which people lack insurance or adequate insurance." We continue to hear that single payer will finally make it so that no one needs to face bankruptcy for inability to pay medical bills. But the truth lies somewhere else, somewhere very far away from here.

VHCF's Jeff Wennberg conducted a survey of the five bankruptcy lawyers who handle close to 100% of all the personal bankruptcies in Vermont, either representing the debtor or as a trustee. The consensus of all five attorneys was that a safe number for the percentage of bankruptcies caused by uninsured medical expenses would be "no more than 10%". This would be somewhere between 100 and 120 bankruptcies per year, out of a population of 630,000.

So where does the 50% figure come from? From research conducted by Dr. Elizabeth Warren and others, who mixed bankruptcies caused by uninsured medical expenses with those caused by loss of income resulting from health complications. The Vermont attorneys explained that when people get sick, they cannot work (or a family member care giver misses work) and the household loses income. Lost income eventually results in missed mortgage or other payments and the mortgage holder is typically the creditor that forces the bankruptcy declaration.

But the critical point is this: nothing in the single payer program or any other version of health care reform is designed to address this issue. Bankruptcies resulting from unpaid medical bills are rare, as a large percentage of the costs are typically covered by insurance, and medical providers as a group are reluctant to pursue collection to this extreme.

## What about the missing single payer budget and financing plan?

VHCF and many others have repeatedly demanded that the administration present a budget showing how much Green Mountain Care will cost and how it will be funded. The administration has stonewalled Vermonters on this question, stating that they "need to define the plan before they can create a budget."

But the legislature had no problem helping to define the plan in Act 48. In the law, the legislature states that the benefits and coverages for Green Mountain Care will be determined by the Green Mountain Care Board, but at a minimum must equal or exceed those provided through the state funded Catamount Health program. Catamount health represents the baseline for coverage. So why can't the administration prepare a budget using the Catamount benefits as a model and also create a baseline for the cost of the program?

They can and probably have but have not released an analysis. But Rutland City Treasurer and State Treasurer candidate Wendy Wilton prepared an analysis using administration assumptions and Catamount Health as the benefit package. Her recently revised findings indicate that GMC will run a $1.6 billion deficit over its first 5 years of operation. This assumes 3.5% annual health spending growth, and a 14% payroll tax or the equivalent. Not included in Wilton's revenue model are any receipts through the federal Affordable Care Act, which could be as high as $200 million per year, trimming the overall 5-year deficit to about $600 million.

A summary of Wilton's analysis is available here:
http://vthealthcarefreedom.org/sites/default/files/wendy-wilton-Green-Mountain-Care-financing-funding.pdf

## How will the ACA help fund GMC?

The ACA creates health care 'exchanges' as new marketplaces for individuals and employers to compare and purchase health care insurance from a variety of insurers. Low and middle income people who purchase plans directly through the exchange will also qualify for federal subsidies and tax credits to help defray the cost of premiums. Federal support is on a sliding scale, based upon household income, but can pay for as much as half the cost of the premiums. But the mechanism for payment actually has the funds flow directly to the insurer so the up-front premium cost is reduced.

Assuming Vermont secures a waiver from the requirements of the ACA and implements Green Mountain Care all federal subsidies and tax credits previously directed to defray the cost of individual plan purchases will instead flow to the state. Therefore it is in the state's economic interest to maximize the number of individuals purchasing plans in the exchange before the switch to GMC.

Vermont is doing this in two ways; first, it has made participation in the exchange mandatory and has outlawed the sale of insurance products outside the exchange. This is unique among the states and a direct violation of the requirements of the ACA, which intends the exchange to be supplemental to the private market. Second, the state is encouraging every small business to drop their health coverage and direct their employees into the exchange as individuals.

Approximately $400 million per year might be generated if every Vermont business with 50 or fewer employees were to drop their coverage in 2014 and every individual, including those

whose employers dropped coverage, were to purchase insurance through the exchange. A more realistic expectation would be closer to $200 million, and some more conservative estimates go as low as $80 million.

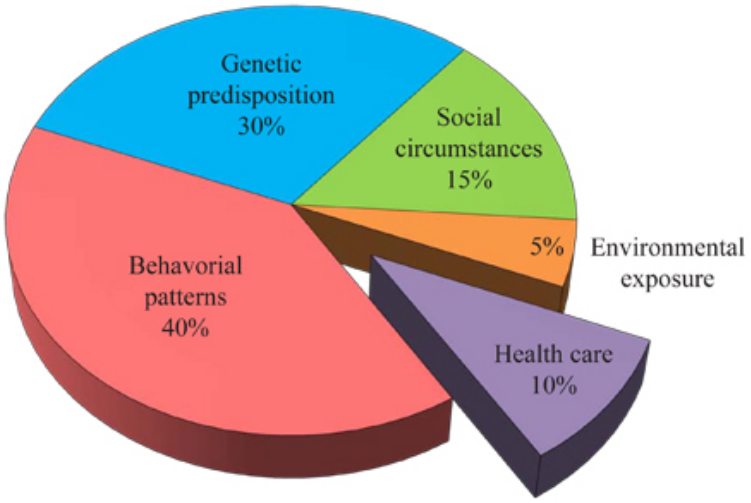
## How will GMC control spending?

Single payer promises to save approximately 17% of total cost through elimination of insurance profits and administrative efficiency. With the announcement by CIGNA that they will no longer market products in Vermont, there are no remaining for-profit insurers offering products in the Vermont market. Administrative savings are doubtful due to the fact that this will not be a 'single payer' in a true sense. Medicare, federal employees and ERISA self-insured businesses are likely to be exempt, representing about 200,000 lives. In addition, Vermont hospitals and other providers are expected to continue to serve patients from other states, representing over 100 different insurance plans.

The main tool of cost containment under Act 48 is the global budget. The concept is for the state to award the equivalent of formula-based block grants to providers and assign them the responsibility of meeting the needs of their communities within those resources. If the provider manages resources well and the community stays relatively healthy, the provider increases net income by spending less than the full grant. The key is revenues are not tied to the number of services provided.

The concern is this payment system creates an incentive for providers to treat healthy people and avoid patients who have multiple risk factors such as obesity, smoking, or substance abuse. An analysis of the factors that contribute to premature death by Steven A. Schroeder, M.D., was published in the New England Journal of Medicine on September 20, 2007.[1] The results are reproduced below

**Proportional Contribution to Premature Death**




Source: *N Engl J Med.* 2007 Sep 20; 357(12):1221-8, Figure 1.

[1] http://www.nejm.org/doi/full/10.1056/NEJMsa073350

Access to health care was only 10% of the cause, while behavior and genetic predisposition accounted for 70%. Some doctors fear that holding the health care provider responsible for 100% of the outcomes when they control only 10% of the inputs is unreasonable and ultimately unworkable.

## But will global budgets successfully control costs?

Canada, which has operated with global budgets for decades, has had far worse cost growth than Vermont or the U.S. as a whole. As a result British Colombia, Ontario and Quebec are moving their single payer compensation systems toward fee-for-service. Furthermore, global budgets have been a major cause of the rationing and excessive waiting lists Canadians face. It works like this: Provinces must fund health care alongside all the other government services – police, education, environmental protection, energy, etc. As a result global budgets are never fully funded. Hospitals create waiting lists for non-emergency services to ensure revenues and expenditures remain within pre-set limits. Over time, lists extend multiple budget years into the future. For example, bariatric surgery in Quebec is so backed up one Montreal hospital is refusing to take any new reservations; most others maintain waiting lists from 5 to 10 years in length. Colonoscopies are scheduled three years ahead for high risk individuals, five or more years for low risk.

Waiting lists, which are a form of rationing, are created by the hospitals so members of Parliament can tell their disgruntled constituents that they had no hand in the situation – it was a local decision of the hospital. This is exactly the same response given by GMC Board Chair Anya Rader-Wallack when asked by a reporter about the decision of the Rutland Regional Medical Center to close down the in-patient rehabilitative service unit to meet GMC Board mandated global revenue caps.

The concept of global budgets flows from the belief that health care spending is driven by providers performing unnecessary services to make more money. Take away the incentive and costs will be restrained. But another view is consumers demand more services and assume less responsibility for their own lifestyle and health choices as the responsibility to pay for their care is shifted more and more onto third parties (employers, insurers, government). The HSA and related plans described above are designed to reverse this trend and reconnect the consumer with the cost.

Single payer is an all-in bet on the theory that we can only constrain spending by placing limits on the availability of services (government rationing). Patient-centered market-based reforms are based upon the belief that rationing by the consumer and provider based upon informed choice and economic incentives is more humane and ultimately will be more successful in controlling health care spending.

Single payer advocates believe the problem is fee-for-service, and patient centered advocates believe it is the third party payer system. If the patient centered folks are right, single payer can only exacerbate the problem. The evidence from Canada supports this view.