

Achieving Universal Coverage through Comprehensive Health Reform: The Vermont Experience

Year 1 Preliminary Findings

Presentation to

State Health Research and Policy Interest Group (SIG) Meeting

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INTRODUCTION

UNE/CHPPR conducting two-year comprehensive evaluation of health care reform in Vermont initiated by the 2006 Health Care Affordability Acts (HCAA)

Evaluation addresses three key dimensions of Vermont's comprehensive health reform, including:

- 1) Health coverage affordability,
- 2) Health services access (especially access to primary health care), and
- 3) Sustainability of the reforms.

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INTRODUCTION

Year 1 Report includes preliminary analyses of:

- Findings from interviews with key stakeholders,
- Initial findings from enrollment data,
- Analysis of affordability using data from the 2005 and 2008 Vermont Household Health Information Surveys (VHHIS), and
- Preliminary analyses of Sustainability.

HEALTH REFORM IN VERMONT

Key dimensions distinguish the HCAA from other state health insurance reform initiatives.

- Expands insurance coverage within the context of comprehensive health system reform.
- Establishes a voluntary approach for individual enrollment
- Assessment on employers if they do not offer health insurance to employees, or if their employees choose not to enroll and are uninsured.
- Uses a unique combination of income-generating and system-changing policies in attempt to achieve fiscal sustainability.

HEALTH REFORM IN VERMONT

History & Background of Reform Legislation

- Long history of health reform efforts in VT
- Public engagement process helped to develop political will
- Signing of the Global Commitment Waiver Provided Mechanism to Fund Health Reform
- Rising Costs as key theme across political spectrum
- **COLLABORATION & COMPROMISE**

HEALTH REFORM IN VERMONT

The 2006 HCAA had three primary goals:

- Increase access to affordable health insurance for all Vermonters;
- Improve quality of care across the lifespan; and
- Contain health care costs.

HEALTH REFORM IN VERMONT

Description of New HCAA Programs

- The Catamount Health Insurance Program (Catamount Health) is a public ins plan that is marketed and administered by Blue Cross & Anthem and MVP. The state subsidizes premiums for people:
 - who are not offered coverage through their employer and
 - do not exceed the income limitations for current state and federal Medicaid programs (up to 300% FPL).
- The Employer-Sponsored Health Insurance (ESI) Premium Assistance Program provides premium assistance to certain uninsured employees who wish to take advantage of insurance offered by their employer.

HEALTH REFORM IN VERMONT

Catamount Health Enrollee Share of Premiums by Family Income Level (as % FPL)

Income (as % FPL)	Cost per person to enroll in Catamount Health
Up to 175%	\$60
175-200%	\$65
200-225%	\$110
226-250%	\$135
251-275%	\$160
276-300%	\$185
Over 300%	Full price (currently \$393 per month for single coverage)

HEALTH REFORM IN VERMONT

Other HCAA Initiatives include:

- Blueprint for Health (funding & alignment)
- Outreach and enrollment study
- Immunizations
- Potential individual insurance mandate

If less than 96% of Vermont's population is insured by 2010, the legislature will re-evaluate whether a health insurance mandate on individuals is needed to achieve universal coverage.

RESEARCH DESIGN

Process Evaluation

Interviews with key informants to:

- clarify the historical context, policies, and practices involved with implementation
- gain insight around lessons learned that might be helpful as other states consider implementing health care reform.

RESEARCH DESIGN

Outcome Evaluation

Primary and secondary data sets include:

- Administrative data on enrollment,
- The 2005 and 2008 VHHIS,
- The Current Population Survey (CPS),
- The 2006 Medical Expenditure Panel Survey
- Office of Vermont Health Access (OVHA) Revenue and Expenditure data

PROCESS EVALUATION: FINDINGS

How has implementation compared to
what was expected?

- Outreach has been successful in identifying newly eligible and previously eligible populations
- Enrollment into new programs (Catamount & ESIA), while less than projected, has shown a steady increase since inception

PROCESS EVALUATION: FINDINGS

How has implementation compared
to what was expected?

- Reported Barriers to Enrollment
 - Cost of premiums
 - 12 month waiting period
 - Multi-step enrollment process
- Lack of Federal Match for 200-300% FPL

PROCESS EVALUATION: FINDINGS

What lessons were learned during implementation?

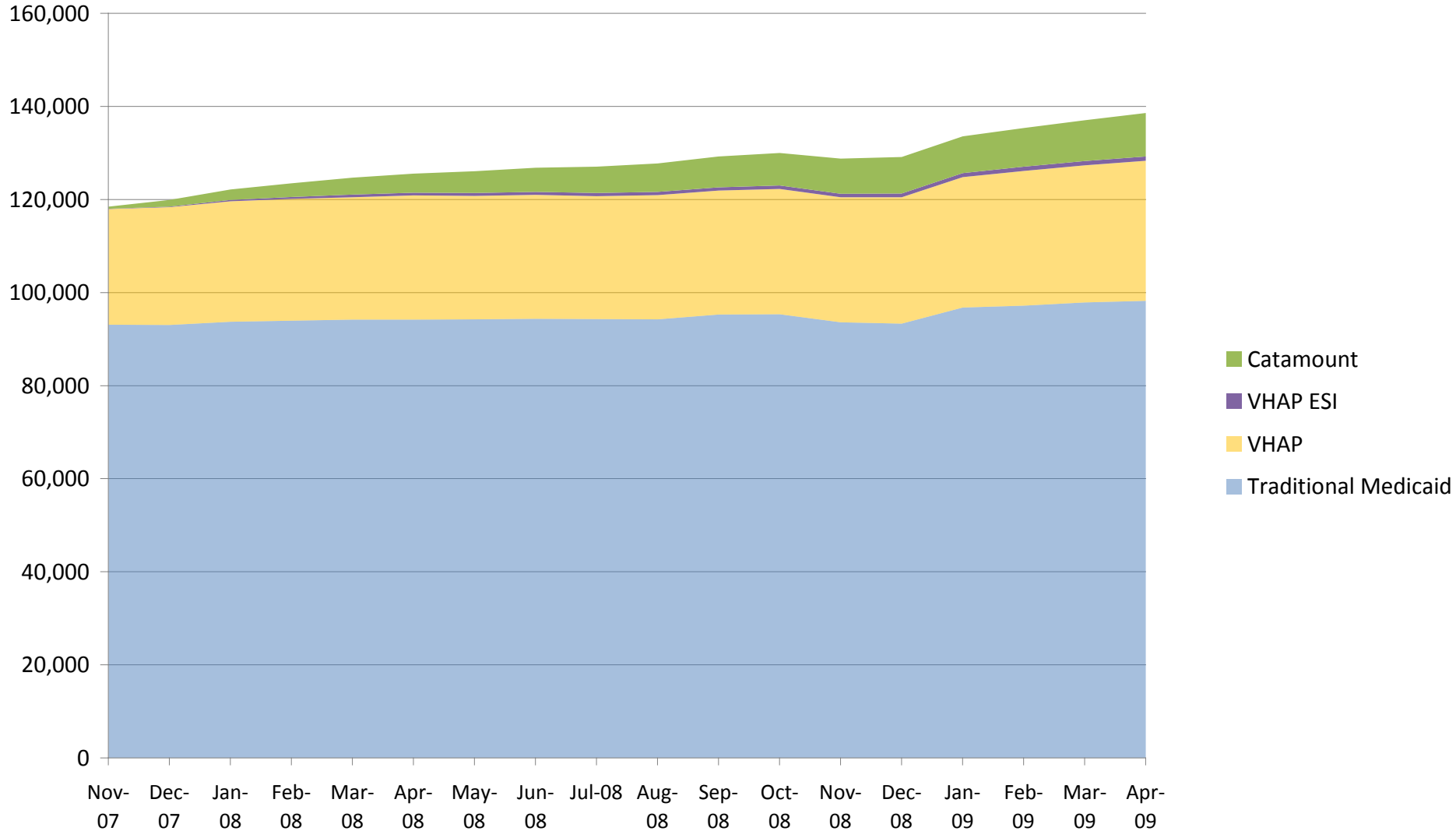
- Implementation of health reform involves ongoing changes to legislation and programs (“ongoing experiment”)
- Stakeholder Collaboration is Necessary (Bus, Govt, etc.)
- Federal Assistance Needed for Sustainability
- Making Eligibility & Enrollment Processes Easy is Key
- Health System-Level Improvements (e.g. Blueprint for Health) are Necessary for the long term

OUTCOME ANALYSIS: FINDINGS

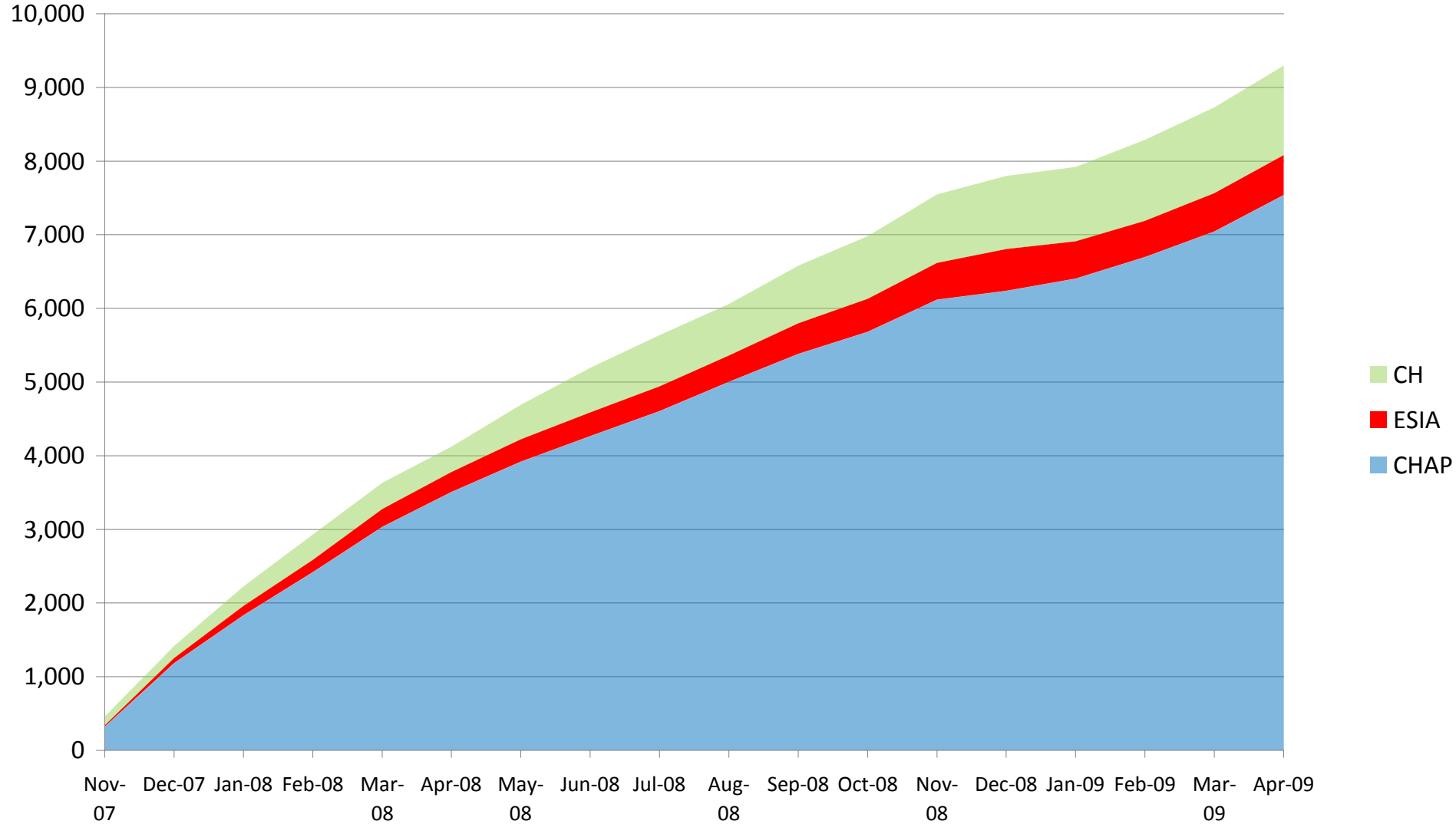
Examine enrollment as an indicator of affordability
looking at four programs.

- CHAP – Catamount Health with premium assistance
- CH – Catamount Health without premium assistance
- ESIA – Employer-sponsored insurance for those otherwise eligible for Catamount Health
- VHAP ESI – Employer-sponsored insurance for those otherwise eligible for VHAP

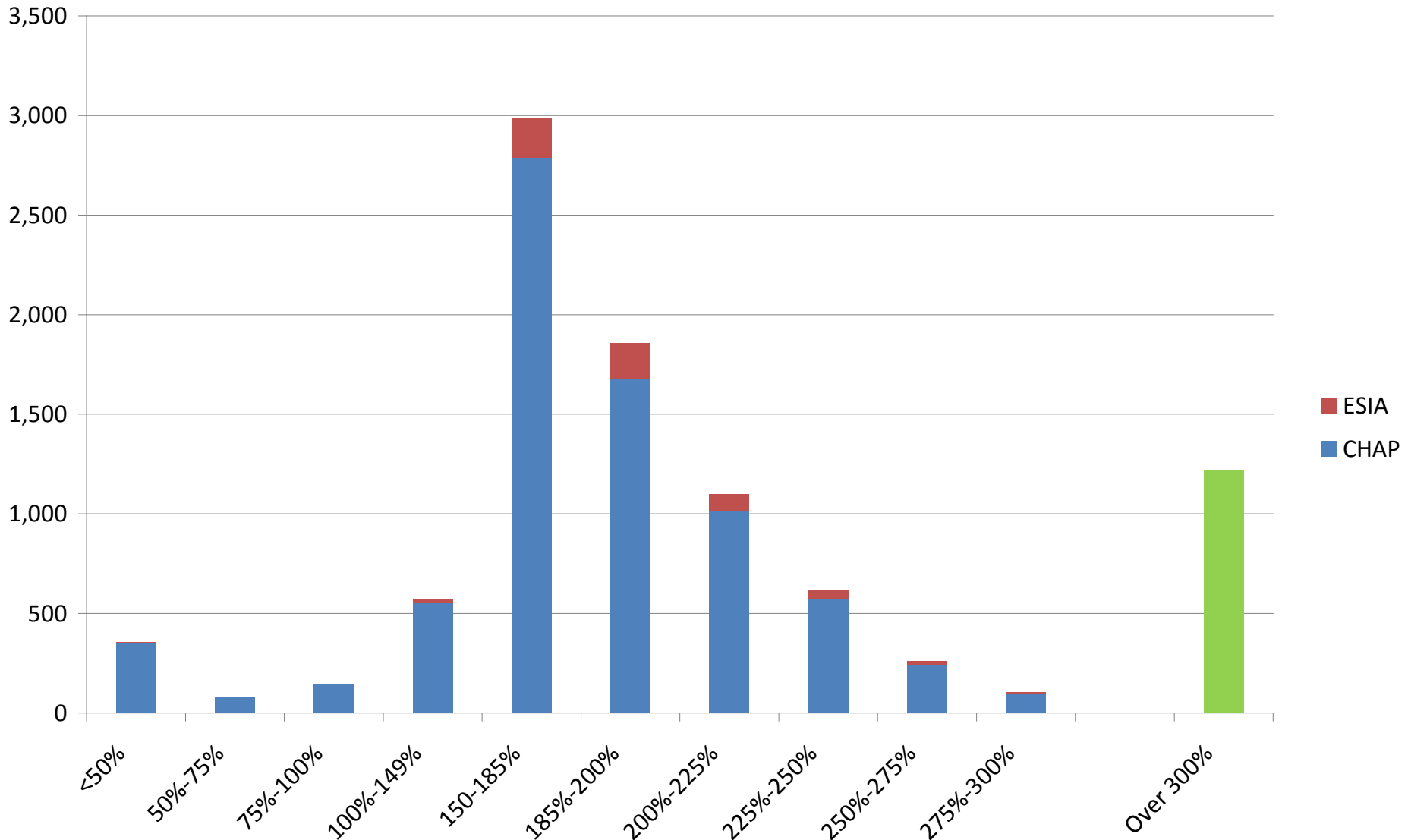
Overview - Enrollment in Vermont's Health Care Programs, November 2007 - April 2008



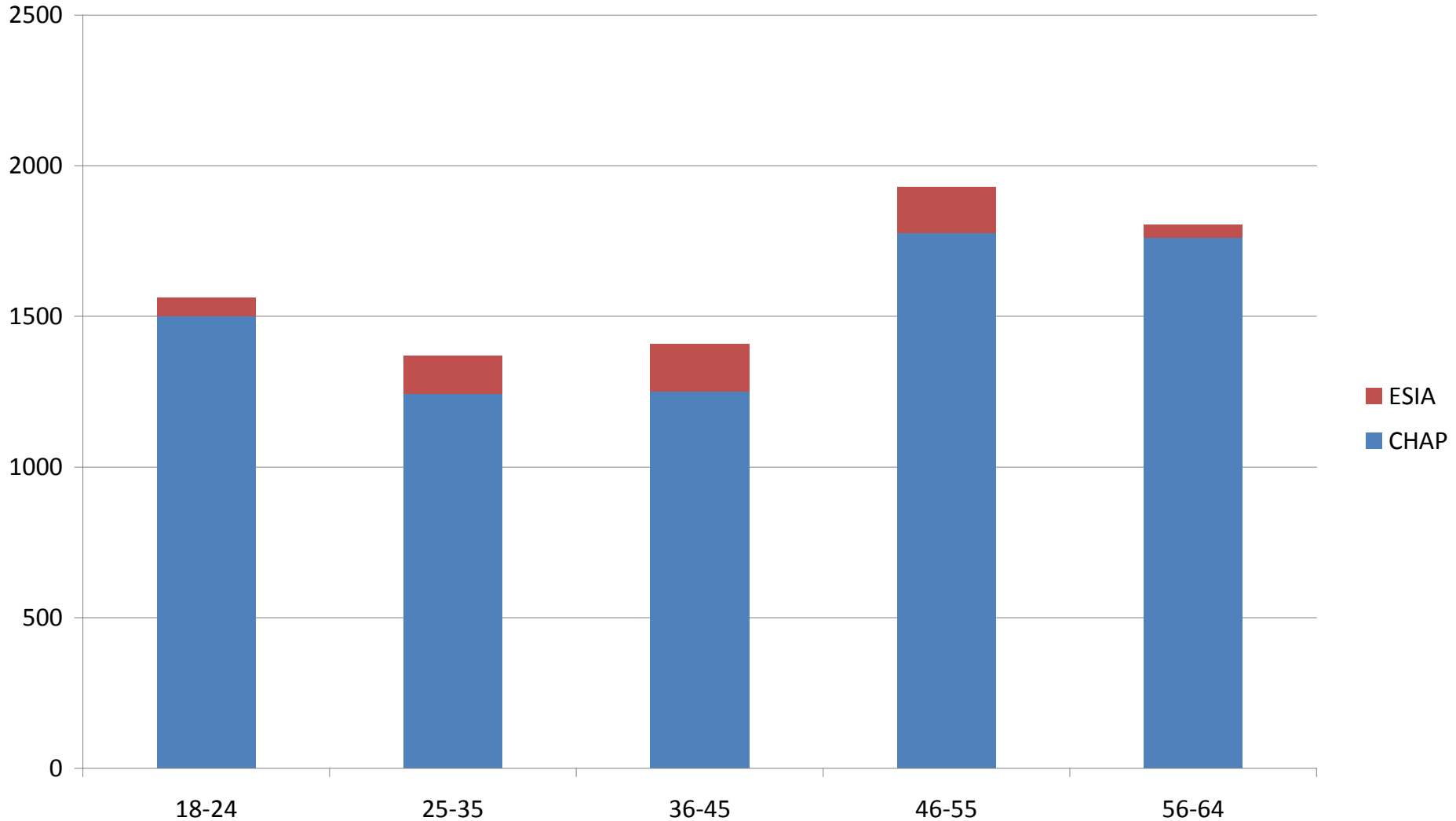
Enrollment in Vermont Health Reform Expansion Programs, November 2007 - April 2009



Enrollment in Catamount Health Programs by FPL*, April 2009



Enrollment in Catamount Health with Premium Assistance and Catamount ESIA by Age, April 2009



Summary of Enrollment Findings

- By April 2009, 8,758 people enrolled in Catamount Health
- More than half of Catamount enrollees have family incomes between 150 and 200% FPL
- 13.1% of enrollees (1,220 people) have family incomes above 300% FPL and do not receive premium assistance.
- Catamount has been relatively successful in attracting a younger pop; take-up has been substantially higher among those 35 and over.
- Enrollment in traditional Medicaid and especially VHAP increased since Catamount program began

IMPACT ANALYSIS: FINDINGS

Findings from the Vermont Household Health Information Survey (VHHIS) to examine:

- Trends in health insurance coverage for Vermonters between 2005 and 2008 compared to the region (New England) and national trends
- Increases in public coverage to determine whether due to increased eligibility or increased take-up rates among already eligible residents
- Evidence of crowd-out (migration to public insurance from the privately insured)

Trends in Vermont Health Coverage

Vermont Health Insurance Enrollment (All Ages) 2005 - 2008

	Any Insurance	Public Insurance	Private Insurance	Uninsured
VT Health Insurance Enrollment 2005	90.2%	31.2%	59.0%	9.8%
VT Health Insurance Enrollment 2008	92.4%	33.0%	59.4%	7.6%
Vermont Raw Differential	2.2%*	1.8%	0.4%	-2.2%*

* Difference is statistically significant at $p < .05$ level

Trends in Vermont Health Coverage

Vermont Health Insurance Enrollment (Ages 0 - 64) 2005 - 2008

	Any Insurance	Public Insurance	Private Insurance	Uninsured
VT Health Insurance Enrollment 2005	88.8%	21.3%	67.5%	11.2%
VT Health Insurance Enrollment 2008	91.2%	22.9%	68.3%	8.8%
Vermont Raw Differential	2.4%*	1.6%	0.8%	-2.4%*

* Difference is statistically significant at $p < .05$ level

Trends in Regional Health Coverage

New England (excluding VT and MA)

Health Insurance Enrollment (Ages 0-64)

2005 - 2008

	Any Insurance	Public Insurance	Private Insurance	Uninsured
NE Health Insurance Enrollment 2005	88.2%	17.2%	71.0%	11.8%
NE Health Insurance Enrollment 2008	89.0%	17.3%	71.7%	11.0%
New England Raw Differential	0.75%	0.07%	0.68%	-0.75%

Accounting Decomposition

This method compares insurance coverage in 2005 and 2008 by classifying Vermont population into 3 groups:

- Always Eligible (for State Public Coverage 0-185%)
- Newly Eligible (for Catamount 185 – 300% FPL)
- Never Eligible (income exceeds 300% FPL)

ACCOUNTING DECOMPOSITION	2005	2008	Change
	%		
Any Health Insurance Coverage	Insured	% Insured	
Always Eligible for Public Coverage (05 & 08)	83.6%	86.7%	3.1%
Newly Eligible for Public Coverage (08 only)	80.7%	84.2%	3.5%
Never eligible for public coverage	95.0%	96.1%	1.1%
	% with public insurance	% with public insurance	
Public Health Insurance			
Always Eligible for Public Coverage (05 & 08)	53.3%	59.9%	6.6%
Newly Eligible for Public Coverage (08 only)	11.7%	12.4%	.7%
Never eligible for public coverage	3.5%	3.4%	-.1%
	% with private insurance	% with private insurance	
Private Health Insurance			
Always Eligible for Public Coverage (05 & 08)	30.4%	26.8%	-3.6%
Newly Eligible for Public Coverage (08 only)	68.9%	71.8%	2.9%
Never eligible for public coverage	91.5%	92.7%	92.7%

Blinder-Oaxaca Decomposition

This method allows us to explore the question:

How much of the differences in insurance coverage rates between two comparison groups (have coverage vs. do not have coverage) can be explained by differences in income level (characteristics effect) and how much by differences in behavioral response associated with income level (coefficients effect)?

In our Oaxaca regression model we included:

- Income level, age, marital status, working status, household size, and number of children
- Results show summed coefficients for entire model using VHHIS data for Vermont and CPS data for NE and US

Oaxaca Decomposition Regression Results

Any Coverage			
	Coefficients	Means	Total
Vermont	4.5%	-2.0%	2.4%
New England	0.61%	0.13%	0.74%
USA	-0.56%	0.09%	-0.47%
Public Coverage			
Vermont	0.5%	0.9%	1.4%
New England	0.61%	-0.54%	0.07%
USA	0.69%	-0.21%	0.48%
Private Coverage			
Vermont	3.9%	-3.0%	1.0%
New England	0.00%	0.67%	0.67%
USA	-1.25%	0.30%	-0.95%

Trends in Private Coverage

	2005	2008	
Household Income to Poverty Ratio	Proportion of population Privately Insured	Proportion of population Privately Insured	Difference in Proportion Privately Insured (%)
0-175%	25.9%	22.3%	-3.6%
176-185	40.0%	41.3%	1.3%
186-200	53.2%	42.6%	-10.7%
201-225	52.3%	67.6%	15.4%*
226-250	68.8%	63.4%	-5.4%
251-275	71.8%	78.0%	6.3%
276-300	78.1%	80.0%	1.9%
>300	91.0%	92.2%	1.2%
Total	67.5%	68.3%	0.8%

*Significant at <.05 level

Summary of VHHIS Findings

- Health insurance enrollment increased significantly in Vermont between 2005 and 2008.
- Public coverage increased due to a combination of newly eligible enrollees (i.e. newly eligible for Catamount) and increased enrollment among previously eligible populations (i.e. previously eligible for other Medicaid programs)
- Public insurance coverage increased as a result of both
 - increased propensity to get public coverage across all groups and
 - demographic shifts toward eligibility.
- Private insurance coverage increased as a result of an increased propensity for private coverage, despite demographic shifts that offset this.
- Crowd-out does not appear to be a significant issue for Vermont.
- Similar trends were not observed in New England or U.S. so results may be attributable to HCAA reforms.

SUSTAINABILITY

- When Catamount Health was created, the state chose to create a separate fund to finance it, rather than mixing revenues and expenses into existing funds.
- To evaluate the fiscal sustainability of the Catamount Health program, we evaluate the fund balance over time and net operating results, both monthly and cumulatively.
- We will assess the viability of the revenue streams, including the potential for cost savings from the Employer Sponsored Insurance (ESI) premium assistance program, to cover expense requirements of expanded insurance coverage.

SUSTAINABILITY

Catamount Fund Revenues come from five sources:

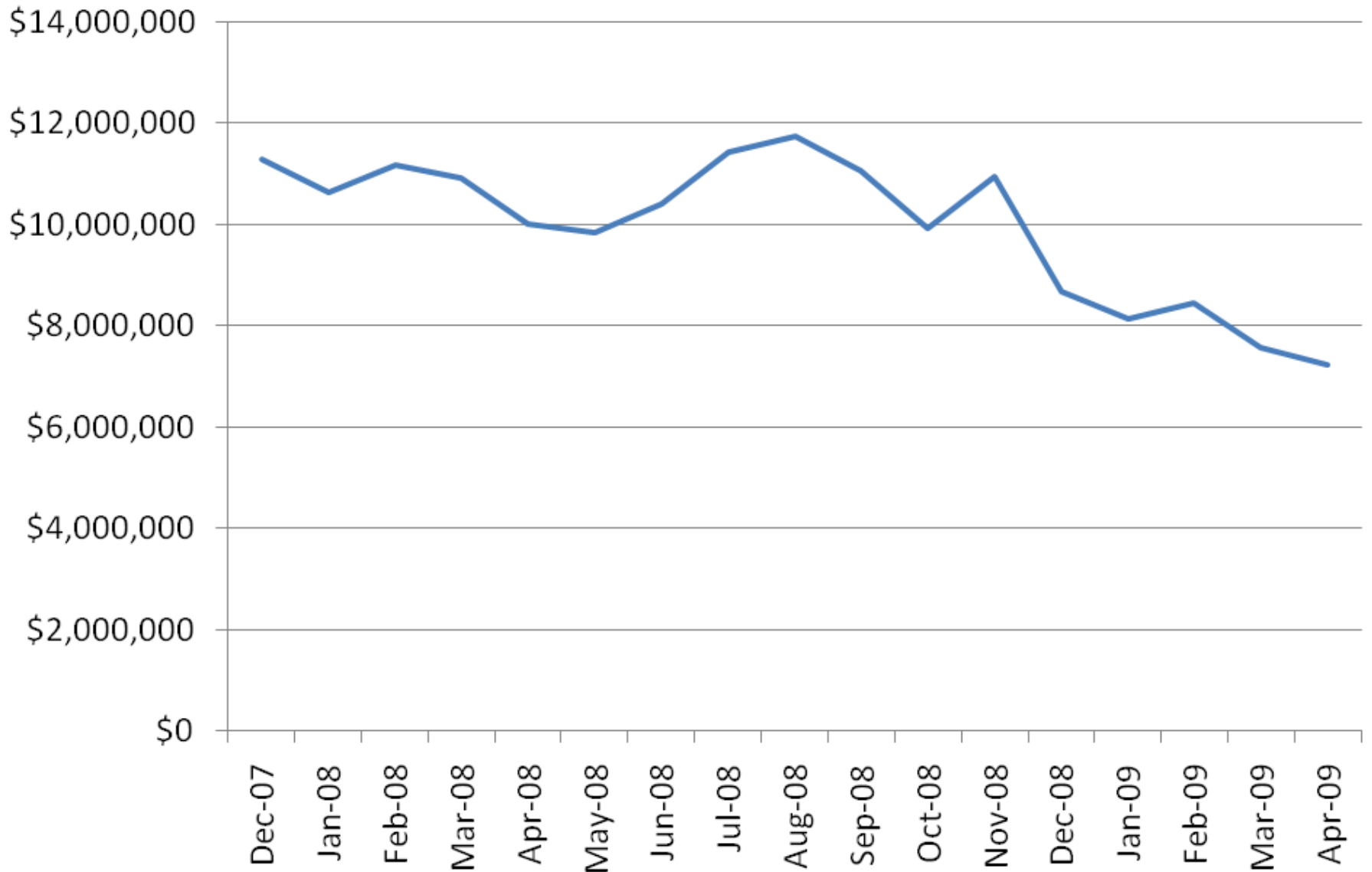
1. Incremental revenue from an increase in the state's cigarette and tobacco taxes
2. Federal Medicaid funds (matching \$\$ up to 200%FPL)
3. An assessment on employers who either do not offer insurance to some or all of their employees or who have employees who are eligible for coverage but are uninsured.
4. Beneficiary premiums
5. Interest on the fund balance

SUSTAINABILITY

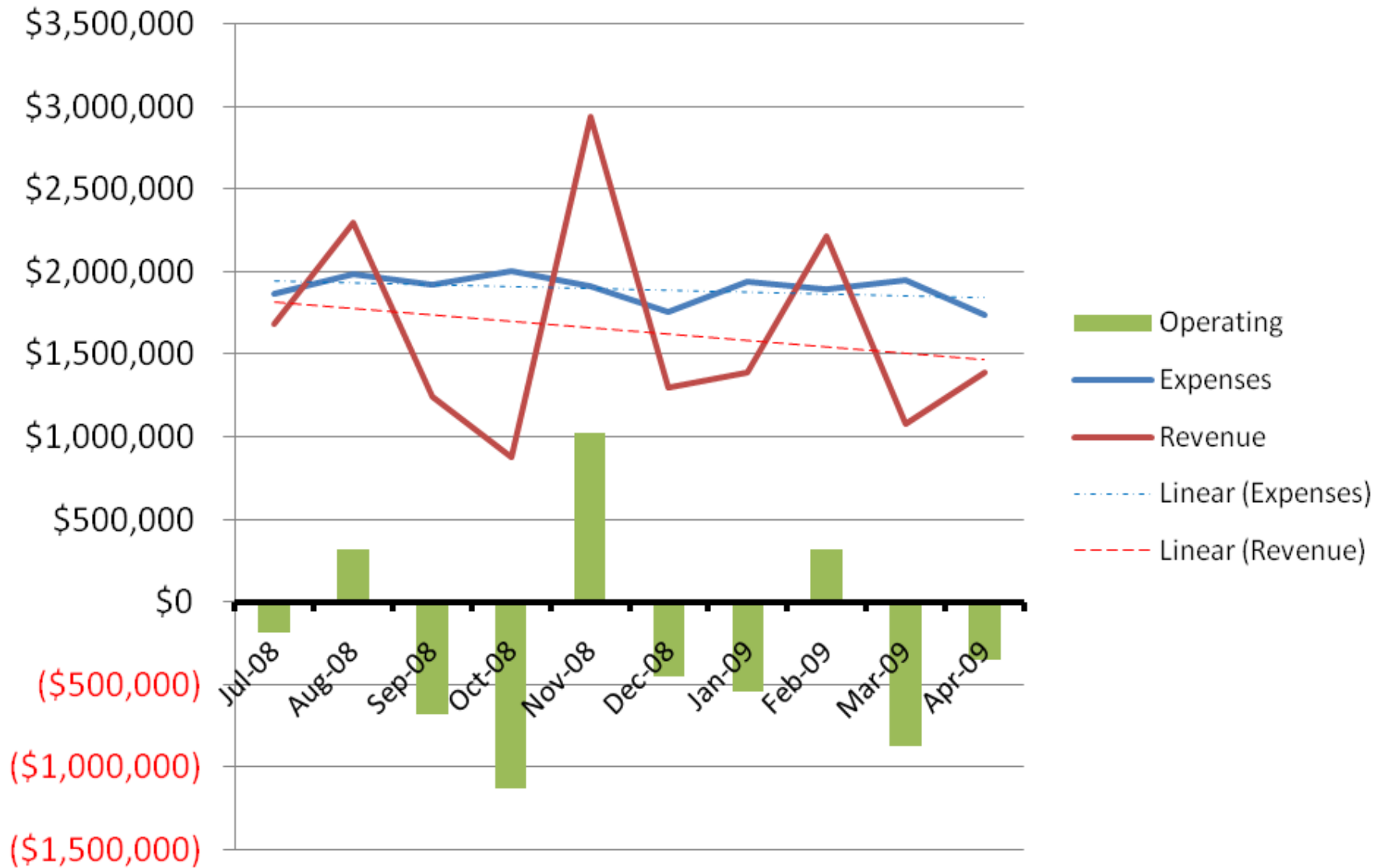
Catamount Fund pays for:

- Premium subsidies
 - State share, where federal Medicaid matching is available
 - Full cost, where matching funds are not available
- Administrative costs
 - Eligibility determination, enrollment, and premium payments for Catamount and Catamount ESI
 - Costs to administer the employer assessment
 - Marketing costs
- Other
 - Vermont's Immunization program
 - Vermont Blueprint for Health (partial funding)

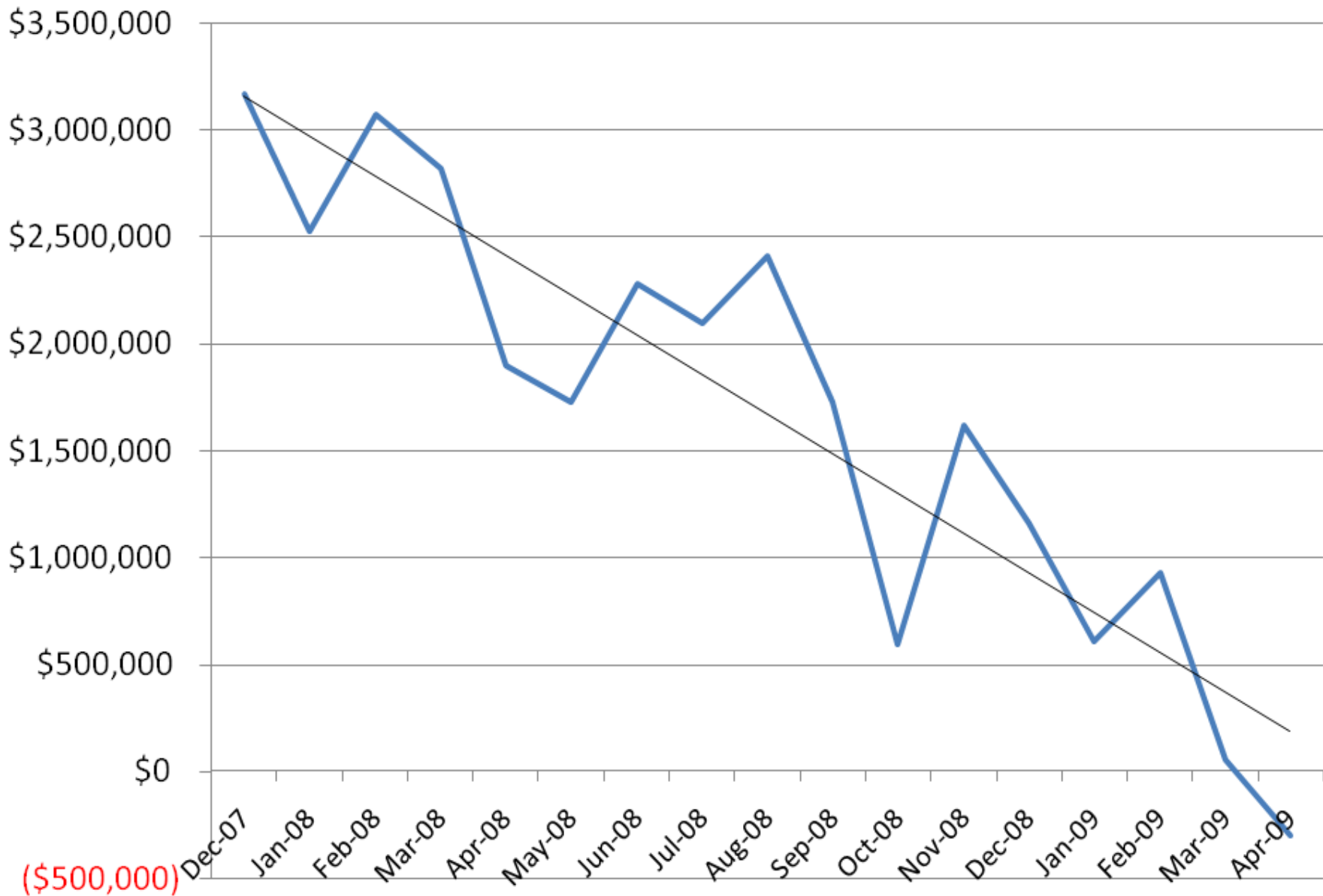
Catamount Fund Balance



Revenue, Expenditures, and Operating Results, Catamount Fund, FY2009 YTD



Cumulative Operating Results, Catamount Fund



SUSTAINABILITY

The long-term sustainability of the program is challenged by several different factors:

- The decision by CMS not to permit the use of matching funds to 300% of federal poverty
- Reliance on a tobacco taxes—thought to be declining revenue source—for a significant portion of program funding (48% of revenue in FY 2009 through April)
- Broader economic forces
 - Impact on enrollment
 - Reduced, then eliminated supplemental contribution to offset the loss of anticipated federal funds

SUMMARY OF SUSTAINABILITY FINDINGS

- The fiscal sustainability of the program, as currently funded, does not appear to be sound.
- If fiscal sustainability is to be achieved, a rebalancing of revenue and expenses will be necessary.
- More research is needed before we can reach a conclusion—especially given proposed changes at the federal level.

CONCLUSIONS

- Insurance in Vermont has increased.
- Enrollment in Catamount Health increased sharply and steadily during the initial months.
- Outreach campaigns appear to have been effective.
- Some barriers to enrollment exist, but modifications have been made to address these barriers.
- Take-up rates in Catamount are higher among older age groups
- Increases in public insurance appear independent of regional/national trends.
- Crowd-out from private coverage apparently not an issue.
- The program, as currently funded, does not appear to be fiscally sustainable.
- Despite challenges to reform, stakeholders are optimistic about health reform in Vermont.

YEAR 2 EVALUATION ACTIVITIES

- Conduct additional key informant interviews
- Further explore enrollment data from OVHA to examine the rates and reasons for dis-enrollment from Catamount
- Examine transfer rates from VHAP to VHAP ESI programs to better understand the impact of these programs on employers and costs.
- Use VHHIS 2009 results to analyze take-up rates in Catamount by health status and age and explore impact of reform on access to care.
- Explore sustainability with additional data (e.g. claims data) to determine actual costs of program to both state and insurers and trended per member per month costs.
- Rewrite the report

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