Reviving Health Insurance In Vermont

How unwise laws and regulations have almost destroyed Vermont's health insurance market, and how sound policies will revive it.

April 2000

An Ethan Allen Institute Report
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The members of the advisory committee do not necessarily agree with every opinion, characterization, conclusion or recommendation that appears in this final version.

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John McClaughry, President
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(Senator, 1989-92)

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An Ethan Allen Institute Report

Reviving Health Insurance in Vermont

Executive Summary

This report explains why unwise laws and regulations have almost destroyed Vermont's health insurance market, and how sound policies will revive it.

Today's health insurance crisis is the direct result of the near-collapse of Blue Cross/Blue Shield of Vermont in the late 1980s. For Blue Cross, survival as an insurer with a "social mission" required getting the state to impose community rating on its competitors, with the aim of driving them out of the state. By the end of 1992 Blue Cross had for all practical purposes become a ward of the state.

Gov. Howard Dean's Act 160 (1992) enacted an elaborate structure for the purpose of creating a state "universal access plan". By the end of 1994 this effort was in ruins. So in 1995 Gov. Dean embarked on expanding Medicaid to cover more and more Vermonters. By January 2000 taxpayer-funded programs covered children from families of four with incomes of up to $50,100.

This decade-long expansion of state protection for Blue Cross and underfinanced government health care has produced -

- a massive exodus of commercial health insurers, and the collapse of a competitive health insurance market.
- an unfair burden on healthy young families, who are forced to subsidize the health care costs of sicker older people even though the older people are in their peak earning years and have long since paid off their education loans and home mortgages.
- an unfair burden on people who practice a healthy lifestyle, who are forced to subsidize others who smoke, drink to excess, use drugs, are obese, and underexercise with little regard to their health.
- the steady conversion of privately insured Vermonters into uninsured Vermonters, and then into government-insured Vermonters.

- the effective elimination of one of the most promising health insurance reforms of the 1990s, the Medical Savings Account, from the Vermont market.
- the recurring – and sometimes extralegal – regulatory rescue of Blue Cross.
- the costly overutilization of health care by government-certified patients who have come to regard it as "free".
- serious and chronic state underpayment of hospitals and nursing homes for ever-increasing Medicaid services, which forces them to shift costs onto privately insured patients, thus driving up premiums and causing more Vermonters to drop their increasingly unaffordable coverage.
- serious and chronic state underpayment of doctors and dentists for ever-increasing Medicaid services, which forces them to limit the number of Medicaid patients they will treat, or to refuse to treat Medicaid patients at all.
- binding state control of hospital budgets, making hospital management and capital investment subject to political approval.
- an increasing cost burden both on businesses competing in interstate commerce, and on small businesses serving a local market, leading to reduced job growth and reduced employee insurance coverage.

All of this has been accomplished under constant pressure from political leaders for the expansion of government health care, with the goal of creating a state single payer health system that is managed by political appointees, provides virtually free health care for all Vermonters who are below Medicare age and do not work for large employers, does away with private health insurance, puts the state in control of all health care providers, requires them to ration care to meet po-
politically-determined budgets, and sends the bills for everyone's health care to the taxpayers.

A sound reform of health care in Vermont, including a badly needed revival of a competitive health insurance market, should be based on these principles and policies.

1. The primary responsibility for maintaining wellness and paying for health care rests with the informed individual and family, not with the government.

2. Wellness can be significantly increased and demand for expensive health care can be significantly reduced if individuals are educated as to the personal health consequences of their choices, especially those relating to smoking, drinking, drug use, exercise, nutrition, and sexual activity.

3. Health insurance exists to protect individuals from unexpected occurrences. First dollar or low deductible coverage leads directly to costly overutilization of health resources; the patient believes he or she is getting "free" care and thus consumes more of it, even though it yields little or no improvement of health outcomes. Such coverage should be strongly discouraged.

4. Individuals and families should be encouraged to create tax-favored medical savings accounts to pay for routine medical expenses.

5. The legislature should repeal community rating. Insurance carriers ought to be allowed to distribute the cost of insurance fairly among recognized actuarial categories such as age, gender, geography, and occupations. Community rating has the regrettable effect of overcharging younger, healthier, but poorer families in order to subsidize older, sicker but wealthier families. Government mandates which have the effect of making the poor subsidize the rich are inherently unacceptable.

6. Insurance carriers should also be allowed to offer healthy lifestyle discounts.

7. Government mandates that force insurance customers to buy coverage they do not want and will never use should be rolled back. These include pregnancy benefits, excessive drug and alcohol abuse coverage, and mental health parity.

8. The state should resolve to pay the true cost of services provided to Medicaid patients by hospitals, nursing homes, and medical professionals.

9. Medicaid for acute care patients (other than the elderly or institutionalized) ought to be converted into an MSA-style program, with the state providing sliding scale subsidies for individual accounts.

10. The state should explore a program for the recapture of unpaid medical bills of persons who choose to spend their resources on things other than adequate health insurance.

11. The legislature should create a high-risk pool to cover the health care costs of the medically uninsurable – persons with known, costly health care problems who have been denied coverage by an insurer.

12. The legislature should examine and tighten tort liability standards governing medical malpractice to reduce the exposure of health professionals, hospitals, nursing homes, and HMOs to predatory tort suits.

13. The state should actively promote the purchase of long term care insurance.

14. Vermont's nine independent community-based free clinics merit continued state support. A portion of the tobacco settlement fund should be set aside every year to assist the free clinics and encourage new clinics to organize in underserved parts of the state.

15. The legislature should, as essential housekeeping, revisit Act 160 of 1992 and systematically repeal all the provisions that failed, were ignored or abandoned, produced grievous consequences, or appear to commit the state to moving toward a government-controlled health care monopoly.

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How Today’s Health Insurance Crisis Began

The Vermont health insurance crisis of 2000 dates back to events that began to unfold in 1984. It derives directly from the troubled history of the Vermont Hospital Service Corporation, better known as Blue Cross.

Blue Cross, along with its affiliate Blue Shield (for reimbursing physicians), was created during the Depression by hospitals, at a time when modern health insurance did not exist. The idea was to get prospective patients to prepay for possible medical services before getting sick. Otherwise, people did not set funds aside for medical problems, and when one occurred, they were unable to pay for the care. In return for premium payments, hospitals promised to provide service benefits — care when needed. As the authors of a leading hospital management text put it, “Blue Cross was founded to save hospitals from ruin!”

The Blues have had a special deal with the state of Vermont since their founding (as New Hampshire-Vermont Blue Cross/Blue Shield) in 1944. The Blues are organized as nonprofit corporations under a special chapter of the Vermont insurance code (8 VSA Ch. 123.). Prior to 1991 the Blues, alone among health insurers, were required by Vermont law to observe “community rating”: insurance premiums could not be adjusted to reflect differences in age, gender, geographic area, occupation, or medical history. In return for premium payments, hospitals promised to provide service benefits — care when needed. As the authors of a leading hospital management text put it, “Blue Cross was founded to save hospitals from ruin!”

Despite this special relationship with the state, Blue Cross expected to be regulated on the same basis as other insurance corporations, which were reviewed only as to their premium rates and fiscal soundness. A major turning point came in 1984. Blue Cross had sought a 30 percent premium increase. Commissioner of Insurance George Chaffee, suspecting that Blue Cross was making sweetheart deals with the hospitals which had created it, denied the request. Instead, he ordered Blue Cross to reform its contracts with the hospitals, and reconstitute its board so that its directors were independent of the hospitals. Chaffee also wanted the authority to review all Blue Cross contracts, and to force Blue Cross to hire more staff to scrutinize hospital performance under those contracts.

Blue Cross was happy to be exempt from premium taxes, but it viewed with alarm the Commissioner’s intention of getting deeply involved in what the corporation saw as its internal management decisions. It appealed the rate increase denial.

The Vermont Supreme Court made quick work of the appeal. In holding for the Commissioner on all counts, the Court declared that Blue Cross was “not a private business operating freely within the competitive marketplace; it is a quasi-public business subject to the regulation of the commissioner.” The Court was persuaded that the Commissioner could scarcely be expected to make an informed judgment on rate requests when he was banned from examining the deals Blue Cross had made with the hospitals.

The 1984 case in effect defined Blue Cross as the only insurer to be a ward of the state. Before long it became obvious that this ward of the state could not be allowed to fail, and had to run its business as the state dictated.

The New Hampshire-Vermont Blue Cross Divorce

Until 1987 Blue Cross and Blue Shield were offered in Vermont by a bi-state corporation, Blue Cross/Blue Shield of New Hampshire-Vermont. This proved to be an awkward arrangement. The corporation was accountable to two separate Commissioners of Insurance under two different laws. The new Vermont Commissioner (Gretchen Babcock, appointed by Gov. Madeleine Kunin) was attempting to exert more control over the corporation’s activities. She reflected the attitude prevalent in her Department that somehow New Hampshire was getting too great a proportion of the action. She wanted more Blue Cross employees to work in Vermont instead of in New Hampshire, and more Vermont influence on the board. To avoid this departmental pressure the bi-state board decided to split the corporation into two single-state companies. The eventual separation made the Vermont company the smallest Blue Cross in the nation.

Labor union and socially liberal directors dominated the new Vermont board. They elected as chair Charles McHugh, an influential union leader from Springfield
Key Health Insurance Terms

Community Rating – the process of setting health insurance premiums that do not vary by a covered person’s age, gender, location, industry, health status, or personal habits. Under community rating, an insurer must charge the same premium to all their customers for the same type and amounts of coverage.

Copayment – The fraction of the charge an insured person is required to pay for each medical service received. A “50-50” copay means that the insurance company pays half the charge and the insured pays half.

Deductible – the amount an insured must pay for health care before the insurance policy begins to pay. Often when a deductible (such as $1,500) is reached, the insured must meet a copayment requirement up to some higher amount, after which the insurance company provides full payment (“$2000 deductible, 80-20 copay to $4,000”, means the insured is out of pocket $2,400 for medical expenses of $4,000 or more.)

ERISA – the federal Employee Retirement Income Security Act of 1974, which prohibits state regulation of companies which self insure. Such ERISA plans are usually administered by an insurance company or plan management company. Groups as small as 11 are now self-insuring.

Guaranteed Issue – the requirement that an insurer must enroll any customer who applies for insurance. New enrollees may not be covered for pre-existing conditions for some period of time, like six or 12 months.

Guaranteed Renewable – the requirement that the insurer renew coverage so long as the insured makes timely payment of premiums.

Health Maintenance Organization (HMO) – a managed care plan where the carrier offers health care through its own medical facilities or a network of contracted providers for a fixed premium.

Large Group Insurance – insurance provided to employer or association groups of 51 or more persons. Many large groups today are self insured under ERISA plans.

Mandates – required coverage mandated by state law on all insurance plans, such as coverage for pregnancy, mental health, substance abuse, chiropractic, acupuncture, mammograms, etc.

Nongroup Insurance – insurance purchased directly by individuals.

Premium – the monthly payment for insurance coverage.

Regulated Multi-Payer System – a government-controlled health care system characterized by compulsory enrollment in a variety of insurance plans, uniform benefits, taxpayer and employer financing, and state control of hospital budgets and capital expenditures. The best known model (at the national level) was Hillary Clinton’s 1994 managed competition plan.

Single Payer System – a government-controlled health care system characterized by universal coverage, a single entity which makes all payments to providers, uniform benefits for all, broad based taxpayer financing, and state control of hospital budgets and capital expenditures. The most common model is the Canadian system.

Small Group Insurance – insurance provided to employer groups of 1-50 persons.

who also chaired the Vermont State Labor Relations Board. These directors saw Blue Cross as a social service agency, and at least some of them saw it as the framework upon which a government-run health care plan could eventually be erected.

The pro-union board was determined to offer Cadillac policies with Yugo premiums. This practice provided very generous benefits to union workers under employer-paid plans. The workers got comprehensive first dollar benefits, but the cost was kept as low as possible so union contract negotiators would have more room to press employers for higher wage increases. The effect, of course, was that Blue Cross’s
reserves were steadily pinched. From an industry standard of 90 days of expected claim payments in reserve, Blue Cross of Vermont's reserves eventually shrank to 19 days.

Commissioner Babcock shared the view of the board's majority. She was against any innovation that might make Blue Cross look like less of a social service agency and more like a competitive insurance company. This attitude was illustrated by the Department's response to a proposal by Blue Cross of Vermont's first president, Timothy Meehan, during this period. He proposed a specialized new policy called "Don't Break the Chain". It was targeted at young, healthy adults who had just left their parents' coverage after graduating from college, but had not yet found coverage with an employer.

Meehan's idea was to offer a stripped-down policy to a very healthy group, at a price that low-earning young people (or their parents) could easily afford. The proposed policy excluded pregnancy benefits, on the theory that pregnancy could be planned for, and mental health benefits. Commissioner Babcock refused permission for Blue Cross to offer the policy. Committed to extensive benefits and low deductibles, Babcock did not want any insurer offering a low-cost limited benefit plan to low-risk insureds, and she did not want employers to get the idea that they could save money by going to such a plan.

The separation of the Vermont and New Hampshire companies required a very complicated conversion of financial and claims management data. The new Blue Cross of Vermont had hoped to have a parallel data management system with its parent, but Blue Cross of New Hampshire demanded too high a price for a management contract. Unwilling to pay, Blue Cross of Vermont then contracted with Blue Cross of Pittsburgh to make the switchover, in a very short time frame. This transition required cooperation from the rejected bidder. Not surprisingly, Blue Cross of New Hampshire was less than cooperative in dealing with the company that had beaten its bid.

The computer switchover became a disaster. Blue Cross of Vermont was unable to pay claims on a timely basis, even though it had the cash to make the payments. Its proposal to pay providers 80 percent of their customary revenue stream until things could be straightened out brought loud objection. Newspaper stories trumpeted Blue Cross's troubles. Many of the Vermont Blue Cross customers – particularly its small group plans – began to look elsewhere for coverage.

Up to that point competition between Blue Cross and private insurers had been mild. But once this crisis of confidence appeared, competitors rushed to gather in groups which had found Blue Cross service inadequate. Chief among these was Community Health Plan, a Health Maintenance Organization (HMO) based in Latham, New York. Offering attractive rates – deliberately underpriced to win market share – CHP attracted thousands of Blue Cross insureds. Worse yet, the customers most likely to defect to CHP were groups composed largely of young, healthy workers. Like Blue Cross, CHP observed community rating, but its marketing program tended to produce a low risk portfolio. This was mainly because CHP initially required patients to obtain treatment from a limited number of relatively new participating doctors, and offered few drug benefits. Older (and thus sicker) families with a long established family doctor relationship and with a need for greater drug coverage typically chose to remain with the Blues.

CHP's customer base went from 10,000 in 1989 to 60,000 in 1991, largely at the expense of struggling Blue Cross. Other private insurers also marketed aggressively. This became a feeding frenzy, with Blue Cross as the carcass.

In 1987 Blue Cross had again objected to close supervision of its management by the Commissioner, protesting three of five regulatory orders. In 1990 the Supreme Court finally decided its appeal, and again Blue Cross lost. In justifying the Commissioner's orders, the Court noted that Blue Cross had lost $9.6 million in 1985 and 1986, with more red ink on the way. At the time, Blue Cross had negative reserves of $5 million and was technically insolvent.

While Vermont Blue Cross was sliding into insolvency, so was Blue Cross of West Virginia. That company became the first Blue Cross company ever to fail. As a result the national Blue Cross-Blue Shield Association, which licensed the valuable trade name, quickly became much more stringent in enforcing soundness requirements on its 67 licensed companies. Of these 67, Weiss Research, the rating agency for the Blues, rated Vermont the shakiest, after the failed West Virginia plan.
Blue Cross Looks for a Corporate Life Preserver

For Blue Cross to continue as a viable company, something drastic had to be done to prevent the runoff of its customers to competitors offering low cost policies to low risk groups, leaving the high cost groups to drag Blue Cross into a "death spiral". There were in effect two ways out, one economic and one political.

The economic solution was for Blue Cross to convert into a mutual insurance company, forego the premium tax exemption, weed out its older, higher cost portfolio, and compete for younger, healthier insureds. The Blue Cross Board was not willing to entertain what its members viewed as an abandonment of Blue Cross's "social mission".

Instead, the Board turned to a political strategy to save the company. That strategy was, in terms employed by Blue Cross's lobbyists, to get the government to "level the playing field" to prevent its competitors (all based out of state) from "cherry picking" Blue Cross's remaining low cost books of business. Blue Cross mounted an elaborate political campaign, hiring almost every high-powered lobbyist available and hosting breakfast meetings all over the state. Unless its out-of-state owned competitors were forced to use community rating, its spokespersons argued, Vermont's three year old Blue Cross was a dead duck.

The first vehicle of salvation was H. 176, which became Act 52 of 1991. It mandated community rating on all the other small group insurers operating in the state. It allowed a 20 percent premium variation for risk factors, but did not allow insurers to set premiums on the basis of actual medical histories. The law also put into statute the requirement that the 2 percent premium tax exemption was dependent upon Blue Cross's continued observance of community rating.

In 1991 former four-term (1977-84) Republican Gov. Richard Snelling returned to office. Facing a serious revenue shortfall for the level of state spending he had inherited, Gov. Snelling announced to a startled business audience that "we're going to tax everything you can conceive of as much as you can conceive." There was obviously no money available for any new spending initiative, but Gov. Snelling surprised health care advocates by declaring that "the time for a total approach is at hand". He named a 24-member Blue Ribbon Commission on Health, chaired by former Sen. Arthur Gibb (R-Addison). Two days before the Commission's first meeting, H. 176, the small group community rating bill, passed the House. Gov. Snelling signed it into law on June 6.

After nine months of work the Commission presented its report to the 1992 legislature. Although the Commission ranged far and wide in what proved to be a futile effort to put government in complete control of health care, it surprisingly made no recommendation about forcing all insurers to practice community rating. All it noted on this subject was that it was likely that the newly signed Act 52 would drive a number of aggressive insurers out of the state. There was a clear suggestion that this would be beneficial, not so much to Blue Cross as to the Commission's hopes for a state-controlled universal health care system, whether single payer or "regulated multiplier."

The Dean Era of Health Care "Reform"

Gov. Snelling died in August 1991, and Democratic Lt. Gov. Howard Dean MD became Governor. Eager to gain a national reputation as the young doctor-governor, Gov. Dean gave strong support to the work of the Blue Ribbon Commission. He used its recommendations as the centerpiece of his major health care "reform" bill of 1992. But even as the Commission concluded its work, Act 52 was producing important changes in the insurance market.

Not surprisingly, Act 52's requirement for community rating of small groups produced a hemorrhage from the market of small groups whose workers were young and healthy. Their employers did not want to pay the much higher premiums made necessary by community rating to subsidize the premiums for older and less healthy groups. Many small employers simply dropped their plans and suggested that their employees buy insurance in the non-group (individual) market.

With thousands of formerly small group insureds buying low-cost individual insurance from aggressive companies like American Republic, Time, and Golden Rule, their premiums were no longer available to subsidize the higher health costs of other workers mainly insured through Blue Cross. The prescription was obvious: this avenue of escape had to be closed off. The 1992 Dean health care bill quickly came to include a community rating requirement for the individual market as well.

This provision, like that of Act 52, was ardently backed by Blue Cross. Former Republican Gov. F. Ray
Keyser Jr., chairman of the Blue Cross-insured Associated Industries of Vermont Insurance Trust, became a leading Blue Cross advocate before the legislature. Still desperate to escape the death spiral, Blue Cross looked eagerly upon the prospect of its competitors exiting the state, leaving behind thousands of young, healthy people having no place to go but to Blue Cross.

But imposing community rating on the individual market meant enormous premium increases for many of these insureds, as their low-cost policies were outlawed and their insurance carriers abandoned Vermont. To dampen the inevitable protests, the 1992 bill (which became Act 160) offered a “solution”: the “safety net”. Blue Cross was a strong backer of this idea.

The safety net provisions required Blue Cross — not surprisingly the only carrier interested in administering it — to open its arms to these fugitives. It was required to insure them on “substantially similar terms” as their former carrier, at the same premiums they had been paying, adjusted only by the costs of medical inflation. In subsequent years the act allowed the Commissioner to increase the premiums at the rate of 15 percent per year, or even more if the commissioner found that only a 15 percent increase would have a “substantial adverse effect on the financial safety and soundness” of Blue Cross. This arrangement was intended to last only until the 1994 legislature adopted Act 160’s promised universal access plan.

What actually happened to Blue Cross was quite the opposite of what it expected. In a letter to the Governor during legislative consideration of Act 160, Blue Cross president Preston Jordan pledged his company to “offer to every individual covered by the commercial industry a comparable benefit program at the exact same rate they are currently paying today.” This offer was made to attract some 9000 new low-risk customers. But Blue Cross actually offered considerably richer policies to them at rates that didn’t cover the higher costs. Ironically, the new customers were initially buying insurance from Blue Cross at the rates that they could have gotten from their former private insurers, but the private insurers were not allowed to offer the same insurance at those same rates. This didn’t last long.

Soon after passage of Act 160 the commissioner allowed Blue Cross to increase safety net premiums not based on any medical inflation factor, as Act 160 required, but simply because Blue Cross found that it was losing lots of money. When the 1994 legislature failed to adopt a sweeping new universal access system, Blue Cross was stuck.

By mid-1995, even with the extralegal rate increase, Blue Cross had lost over $3 million on these “safety net” policies, and its level of reserves, still struggling back from the crisis of 1989, was approaching the disaster level. On August 24, 1995 Commissioner Elizabeth Costle invoked the “safety and soundness” exception to the “safety net” rate of premium increase allowed by Act 160. She authorized what turned out to be an average 37 percent increase for the safety net pool. This meant far higher percentage increases for the youngest, healthiest customers. The commissioner also allowed Blue Cross to community rate the pool, also apparently without any statutory authority.

Faced with this startling rate shock, thousands of customers gave up and went without insurance. This result caused the Burlington Free Press, previously supportive of the 1992 “reforms”, to editorialize: “The law eliminating ‘cherry picking’ must be repealed. It had the best of intentions, but has resulted in driving people who were paying their own way off of insurance, and toward dependency on the state.” (9/5/1995)

The Great Legislative Collapse of 1994

Meanwhile, in November 1993 the Health Care Authority created by Act 160 had presented to the general assembly the two universal access plans it had spent nearly a million dollars preparing. Both its initial supporters — the single payer forces and Gov. Dean, with his “regulated multipayer plan” — found nothing to like in the Authority’s proposals. At the beginning of the 1994 session, the Free Press was already moved to characterize the Authority’s efforts as “a massive political failure.” That failure was soon compounded by an even more spectacular failure on the part of the 1994 legislature. Five months later health care expert Howard Leichter could observe, “the little state that could, could not.” Reviewing the wreckage, the New York Times headlined an article “Vermont Shows How a Health Bill Can Fail”. This was certainly not what nationally-recognized health care reform leader Howard Dean had hoped Vermont would show the world.

The collapse of the Authority’s effort has been analyzed in depth in Leichter’s Health Affairs article
In the House, Speaker Ralph Wright (D-Bennington) appointed a special committee to produce a health care reform bill. Ostensibly this was a device to avoid the procedural morass of consideration by five or six different committees. In fact, this device, previously used by Wright to muscle a controversial land use planning bill through in 1988, was a means of assuring that his eleven hand-picked committee members would produce a unanimous vote for a bill that Wright liked.

In an appearance before this committee in November, Gov. Dean outlined his own version. It was based on universal access and government “global budget” cost controls. Employers and employees would be required to split the cost of premiums 50-50. The state would expand Medicaid to assist lower income workers. The plan would be funded by $38 million in gasoline, alcohol and tobacco tax increases. Gov. Dean was adamantly opposed to using the income tax as a funding source.

In December the single payer forces were heard from when U.S. Rep. Bernie Sanders issued a report claiming that the state could save $284 million by moving to a single payer system. The Republicans very cautiously proposed to increase splinter taxes to expand Medicaid coverage for lower income workers, avoiding employer mandates and global budgets.

“In the next five months,” wrote Leichter, “Vermont legislators would consider, only to abandon, every major option available: a single payer system, the governor’s proposal for an employer mandate, and the moderate Republican plan. These options ranged in cost from around $35 million to $750 million – the latter figure was $90 million more than the entire state budget.”

The chairman of the Wright’s special committee, Rep. Sean Campbell (D-Rockingham), came up with a pseudo-single payer purchasing pool, financed with income and payroll taxes. Gov. Dean voiced disapproval. Then two Republicans on the committee, Reps. Richard Westman (R-Cambridge) and Tom Little (R-Shelburne), offered a $75 million employer mandate plan, with state subsidies for lower income people. On February 22, 1994 the committee gave this plan preliminary approval. Sen. Cheryl Rivers (D-Windsor), the leader of the single payer forces, declared that the proposal was “a disaster for the citizenry and the economy of Vermont.”
On March 4 the committee reported out (10-1) a version of what Rivers called the "Dean-Westman-Little plan". It created a Vermont Health Alliance to collect premiums and pay managed care providers. The $98 million funding would come from payroll, income, and splinter taxes.

On March 15 Wright announced that he would not support the committee’s recommendation. Instead he proposed a $750 million near-single payer plan, financed by income and payroll taxes. Gov. Dean, in what elsewhere would have been seen as a comic moment, urged House members to approve Wright’s plan "to keep reform alive", observing in the next breath that he would surely veto it if it ever reached his desk.

On the day of the expected House vote the Free Press ran a table on its front page showing how taxes would increase for sample families under the Wright plan. Gov. Dean and the Republicans reiterated their firm opposition to any income tax increase. Although many taxpayers would experience a premium decrease larger than their tax increase, terrified taxpayers lit up the state house switchboard. The Wright plan was quickly shelved.

On March 22 the House voted 99-39 for an empty shell of a bill. It made ringing declarations about sweeping benefits, favored premium caps and global budgets, and gave the now-discredited Authority another year to develop benefits and financing sources. Before that passage a single payer substitute went down to defeat on a vote of 29-112.

In the Senate, the Health and Welfare committee came forth with a low-benefit plan for the state’s 56,000 uninsured based on an individual mandate and purchasing alliances. Its $53 million price tag was to be financed through splinter taxes and an employer “play or pay” payroll tax. On May 3 the committee reported this plan on a 3-2 vote.

On the following day businesses, led by the state’s largest private employer, IBM, announced their strong opposition to the “play or pay” provisions. When Senate majority leader John Carroll (R-Windsor) enthusiastically presented the plan to his caucus, it was rejected 15-1 (Carroll). After two days of hearings, on May 11 the Senate Finance Committee voted 7-0 to do nothing on health care reform. Three days later Gov. Dean, at a news conference, conceded defeat. Subsequently he blamed the disaster on “an unholy alliance of the far left and the far right.” Whoever was responsible, the grand promise of Act 160 lay in smoking ruins. Two years later the dysfunctional Health Care Authority was abolished, and its remaining functions incorporated into the renamed Department of Banking, Insurance, Securities and Health Care Administration.

The Push for Expanded Taxpayer Financed Coverage

Since by mid-1994 a sweeping universal access system had been proven to be politically impossible, Gov. Dean embarked on a new tack: the accelerated expansion of Medicaid.

Medicaid is a state-federal program created by the 1965 amendments to the federal Social Security Act. Its mission is “to enable specified categories of individuals with limited financial means to meet their essential health care needs.” The federal government matches each state’s contribution according to a formula based on per capita income. For Vermont, the federal government pays about 60 percent of Medicaid costs, and the state pays the remainder. Medicaid will pay the first-dollar health care costs of individuals who meet one of two tests.

* The categorically needy are families on ANFC (welfare), and blind, disabled and aged individuals whose income and resources are below Medicaid eligibility limits.

* The medically needy are persons whose income is no more than one-third higher than the income test for ANFC benefits. Some individuals must spend down their income by paying for their own medical expenses before Medicaid will take over.

Adults age 21-64 are ineligible for Medicaid, no matter how low their income and resources or how high their medical bills, unless they meet the categorically needy criteria or are pregnant or the parent or caretaker relative of a minor child.

The Konin Administration had begun a modest but steady expansion of Medicaid starting in 1985. According to AHS budget documents, “Vermont sought to maximize its utilization of Medicaid as a vehicle for providing health insurance coverage to Vermonters of limited means... it elected to incorporate nearly all eligibility options available under federal rules. This policy has been extraordinarily successful. During this same period [1985-1994] Vermont’s Medicaid case-
load has increased by 115 percent (from 38,280 individuals in December 1985 to 82,376 individuals in December 1994.)

In 1986 the Kunin administration expanded Medicaid coverage to families leaving the ANFC program because a family member began to work and earn money. Even when ANFC cash payments ended, Medicaid continued.

In 1987 the income limits for medically needy individuals were increased by one-third to the highest level allowed under federal rules.

In 1988 the income limits for pregnant women and infants were increased to 185 percent of the federal poverty level (FPL); income limits for children born after September 30, 1983 increased to 100 percent of FPL. In that year a little more than 10 percent of the state population was receiving Medicaid.

In 1988 the first-ever Democratic-controlled legislature not burdened with a state deficit set in motion a process intended to produce a comprehensive health care system for the state. Act 214 created the Vermont Health Insurance Plan (VHIP) Board to develop a plan. The board was charged with being an insurer for the previously uninsured, and subsidizing employer insurance for the same population. The VHIP report, presented by its board to the 1989 session, advocated the end of risk underwriting by insurers and Medicaid expansion to lower income children and pregnant women.

VHIP, however, came to a crashing halt. Gov. Kunin, faced with sagging finances and mindful of the political firestorm that killed Gov. Michael Dukakis’ similar health care plan in Massachusetts, rapidly backed out of health care reform. Opposition from Blue Cross finished off VHIP.

At this point, in 1989, the Kunin Administration had pushed Medicaid expansion to the limit of what the federal government would pay for. To continue expanding services, the state had to create its own state-funded programs. The first such program was V-Script, a drug assistance program for the elderly and disabled created in 1989 to salvage something from the collapse of the VHIP idea. V-Script was initially offered to Vermonters with incomes 150 to 175 percent of the FPL, to pay for the cost of maintenance drugs. It required a $1 or $2 co-pay. In January 2000, the state expanded eligibility to the income group from 176 to 225 percent of FPL, with these clients paying half the cost of the prescriptions.

The other remnant of VHIP was a new program called “Dr. Dynasaur”. It was created in 1989 to provide health care for children under age 7 up to 225 percent of FPL, and to pregnant women up to 200 percent of FPL. The Medicaid resource test was eliminated for these two populations, provided the child was under 7. Covered families were required to make co-payments for some services.

In 1992, to shift some of its growing health care bills back to the federal government, Vermont integrated Dr. Dynasaur into the Medicaid program. To conform to federal rules, coverage under other health insurance no longer precluded eligibility, and co-payments were eliminated. Act 160 of 1992 expanded Dr. Dynasaur to cover children up to age 18 and up to 225 percent of FPL. The state eliminated the resource test for those under age 18, and increased the income test for pregnant women to 200 percent of FPL. Participation in all Medicaid programs jumped to 12 percent of the state’s population in 1992.

In 1998, coverage was further expanded through Vermont’s Research and Demonstration Waiver and the State Children’s Health Insurance Program authorized by Congress in 1996. Under these federal options the state offered coverage to children in families with incomes up to 300 percent of FPL. The federal waiver requires no resource test. Participation in all Medicaid programs jumped to 18.2 percent of the state population in 1998.

By January 2000 Dr. Dynasaur covered 53,400 of the 147,000 Vermont children under age 18, or 36 percent of that age group. A family of four could quality for government-supplied child health care even if it
had an income of as much as $50,100. Approximately 40 percent of the children enrolled in Dr. Dynasaur also have private coverage. "Through a combination of coverage under private health insurance and Dr. Dynasaur, Vermont has achieved virtual universal health insurance coverage for children," according to Paul Wallace-Brodeur, director of the Office of Vermont Health Access (formerly the Medicaid Division of the Department of Social Welfare).

The Vermont Health Assistance Plan (VHAP)

With his universal access proposal abandoned in the legislature and Dr. Dynasaur rapidly increasing its coverage of children, Gov. Dean moved in 1995 to deal with uninsured adults. In his state of the state message the governor called for the creation of a Vermont Health Assistance Plan (VHAP). It was far less than what he had expected would result from Act 160, but yet an important expansion. The legislature approved it rapidly, and Gov. Dean signed it into law in April (Act 14). As he did so, he remarked "it isn't everything, but it's more than nothing."

VHAP had three goals.

- Fund health care services for some 25,000 lower income Vermonters whose access to care is limited, in part, by lack of insurance.
- Provide prescription drug benefit to the State's lower income disabled or elderly seniors on Medicare. (Medicare does not offer a drug benefit)
- Put VHAP and regular acute care Medicaid program enrollees into managed care, providing each enrollee with a choice of at least two HMOs.

The Dean Administration had the authority to seek a federal waiver for a "research and demonstration" project, but needed legislative approval to raise the state funds to meet the state's share. The new VHAP was funded by a 120 percent increase in the cigarette tax from 20 to 44 cents per pack. (The act also increased the tax on hospital revenues and nursing home beds to fund existing Medicaid costs.) In July 1995 the federal Health Care Financing Administration (HCFA) granted the required waiver for VHAP. (In December 1999 the state applied for a three year extension of the waiver, to the end of 2003.)

By July 1996 the state was enrolling families with incomes below 100 percent of FPL in a fee-for-service benefit plan called VHAP-Limited. In November 1996 AHS raised the eligibility cap to 150 percent of FPL, and in October 1998 the level became 185 percent of FPL.

Even as the legislature was enacting VHAP, the idea of pushing 25,000 people into a state wide managed care program came under heavy attack. In April 1995 Blue Cross vice president Jay Shak offered devastating testimony to the Senate Health and Welfare Committee. Shak said that there was no way that any organization in Vermont could deliver capitated managed care benefits to the 80,000 current and prospective Medicaid beneficiaries. Grimly noting the disastrous results of Blue Cross's "partnership" with the state, he reported that the combination of the safety net, individual coverage, and insuring catastrophically ill Medicaid recipients (for whom AHS cleverly purchased Blue Cross coverage to shift the high costs from taxpayers to other Blue Cross customers) had already cost Blue Cross $4.5 million.

Five months after Shak's testimony, Commissioner Costle granted Blue Cross a 20 percent rate increase for nongroup policies and a 37 percent increase for the safety net portfolio. The increase, she stated, was necessary to preserve the financial safety and soundness of the insurer. A month after that, Weiss Research, the national fiscal soundness rating organization for the Blues, rated Vermont Blue Cross an E+ on an A-F scale.

Early in 1996 the state put out a request for proposals to provide managed care to the VHAP/Medicaid pool. Only one firm responded, a newly formed New York company called AssureCare whose owners also

### Forced Cost Shift Endangers Hospitals

"At Gifford we have gross charges budgeted at $27.9 million for fiscal 2000. We expect to collect only $18 million, 64.5 percent. If Medicare increased what it pays Gifford by 20 percent, and if Medicaid increased what it pays by 25 percent, then Gifford could reduce what it charges everyone else by 20 percent. This part of the system needs to change or Vermont hospitals will be endangered."

- David H. Gregg Jr., president of Gifford Medical Center, Randolph Burlington Free Press, 11/7/99
owned a group of nursing homes. When the news media and low-income advocates discovered that the management of AssureCare had little or no experience managing health care, and had a reputation as penny-pinching nursing home operators, the state rejected the bid. Under strong state pressure Community Health Plan (CHP) began to provide managed care to the VHAP population in October. In January 1997 Blue Cross reluctantly got into the business. It wasn't long before both got out.

In February 1999 the VHAP-Pharmacy benefit was removed from the HMO contract, to bolster the plan's solvency. Eight months later Kaiser Permanente (previously CHP) announced it was leaving the Northeast. Significantly, although KP sold its businesses in New York, Connecticut and Massachusetts, it could not find a buyer for its 123,000 Vermont insureds. Blue Cross soon after announced that it would stop offering managed care to VHAP enrollees by March 2000. Blue Cross reported that it had lost $4 million on the VHAP HMO contracts in 1998 alone.

In October 1999, without a commercial carrier to offer managed care, the state began enrolling VHAP covered individuals in its own primary care management program, called PC Plus. In January 2000, AHS enrolled 60,000 VHAP and traditional Medicaid beneficiaries in PCPlus. Enrollment is handled under contract by the State's benefit counseling and member services organization, Maximus.

As of January 2000 about 17,200 individuals were enrolled in the VHAP program. Uninsured adults (over age 18) with incomes below 150 percent of FPL, and parents and caretaker relatives with incomes under 185 percent of FPL, are eligible for VHAP. In January 2000, 10,100 elderly or disabled individuals under 225 percent of FPL were enrolled in VHAP Pharmacy/VScript.

The Aggravated Cost Shift Problem

One major and increasingly serious negative effect of 12 years of Medicaid expansion has been the hospital and nursing home cost shift. This occurs when the government qualifies patients who must be treated by hospitals and nursing homes, but declines to pay the market price for their care. The provider must then recover the loss by shifting the cost to - in effect "taxing" - its other customers. This cost shift requires "private pay" patients - those covered by employer-paid or patient-paid insurance - to absorb the costs of government required cut-rate treatment of Medicaid eligible patients.

The cost shift theoretically applies to physicians as well, but few physicians are in a position to shift costs to other payers. Forty years ago the independent fee-for-service physician would adjust his rates informally depending on his patients' ability to pay. Thus the bills charged to affluent patients would cover a portion of care given free to the poor. But today most physicians are locked into payment schedules negotiated by Preferred Provider Organizations or HMOs. Once those schedules are fixed, a physician has little opportunity for making up the cost of Medicaid or Medicare underpayment by charging higher prices to others. Instead, more and more physicians and especially dentists are declining to accept patients for whom the government refuses to pay the full costs. By contrast it is illegal for a hospital to turn away a patient.

Both the federal Medicare program and the state Medicaid programs contribute to the hospital cost shift. Gov. Dean is fond of saying that Medicare is the major contributor and that Medicaid, whose expansion he has so avidly engineered, is a minor problem. Using AHS figures for 1998, the Medicare cost shift shortfall at Vermont hospitals was $19 million, and that for Medicaid was $16.5 million. But since Medicare spending in Vermont is 3.5 times as large as
Health Insurance Costs – A Comparison

It’s difficult to compare policies with different deductibles and copayments, but this example is at least suggestive (prices are as of March 2000).

INDIANA: Insured is a self-employed 35-year-old husband and wife with two school-age children in Anderson, an industrial city of 80,000. Their commercial policy has a $4,650 deductible, and an exclusion only for stock car racing injuries. Indiana has few mandates: cleft palate repair, newborn screening, diabetic supplies, DES exposure. The family pays $116/month for the insurance, and deposits $290/month tax free in its MSA, for a total monthly cost of $406. Over the course of the year their MSA accumulates $3,487 which can be used to meet the deductible, and for preventive care, drugs, eyeglasses, and normal health related expenses. After two years with no major medical expenses they have over $7,000 in their MSA, less what they have spent for preventive care and normal health maintenance. If they then have a major expense, the MSA balance will be enough to meet the $4,650 deductible. Non-smokers with a good health history can qualify for “preferred” status and a premium discount of up to 25 percent.

OKLAHOMA: Insured is a self-employed 35-year-old husband and wife with two school-age children in Norman, a university town of 80,000. Their Oklahoma Blue Cross policy has a $1500 deductible per family member, and a 20 percent co-pay from $1,500-$5,000. Oklahoma does not mandate maternity care, alcoholism treatment, or mental health benefits, which are not covered by the policy. The premium is $280 a month, with a $14 discount for non-smokers. Adding maternity coverage costs an additional $38 per month.

VERMONT: Insured is a self employed husband and wife of any age with two school age children in Burlington, a university town of 40,000. Vermont mandates coverage for pregnancy, mental health parity, substance abuse and other treatments. Blue Cross of Vermont offers its basic “Freedom Plan” with a $6,000 family deductible, and a 20 percent co-pay to $30,000, for $444.26 per month. Blue Cross does not offer an MSA plan to an individual policy holder (nor does any other carrier in Vermont.)

Medicaid spending, the percentage cost shift is much larger for Medicaid: 27.9 percent compared to 7.8 percent. Even this comparison is excessively favorable to Medicaid, because there is a controversy about whether the computation should credit the state for “DSH” reimbursements made to hospitals to pay them back for their payment of the health care provider taxes used to fund Medicaid, through a fiscal maneuver called “Mediscam” by its critics.

The Health Insurance Market Deteriorates

As this steady expansion of Medicaid progressed, conditions in the private insurance market deteriorated rapidly.

In May 1997 Gov. Dean signed the mental health parity mandate (Act 25), requiring insurers to provide for mental illness treatment on the same basis as physical illnesses. Advocates claimed that parity would increase premium costs by only 3.4 percent, but were unwilling to add that cap to the legislation. Since mental illnesses are notoriously difficult to cure, parity can lead to an open-ended series of patient visits with very expensive mental health professionals (who not surprisingly lobbied heavily for the act’s passage). Actuarial estimates for mental health parity range up to an additional 10 percent of premium costs, three times what advocates were willing to admit. The higher premiums mandated by Act 25 assure that more Vermonters and their employers will no longer be able to afford coverage.

In November 1998 Blue Cross sought a rate increase of 15 percent, and Kaiser Permanente said it would seek 10-15 percent increases on top of the 15 percent increase granted in 1997.
In January 1999 Fortis, one of the state's leading private insurers with 10,000 insureds, announced that it would pull out of the state in six months, citing the problems of community rating and mental health mandates.

In September Commissioner Castle approved increases for KP, Blue Cross, and MVP premiums on the order of 20 percent, starting October 1. A month later she announced that the +/- 20 percent rating band for individual and small group contracts will be terminated in 2000, giving Vermont 100 percent pure community rating.

Although it is not entirely clear how many companies actually sold a significant number of health policies in 1991, a good estimate would be 16, (not including Blue Cross). By mid-2000 there are likely to be only three companies (other than Blue Cross) offering non-group policies (Mutual of Omaha, State Farm, and Nationwide), and three companies offering small group plans (CIGNA, John Alden, and Mutual of Omaha). North American Preferred continues to offer small group plans in Vermont, but it is now owned by Blue Cross. MVP, a New York based HMO, continues to offer group plans in part of the state.

The disappearance of small group carriers from the Vermont market has predictably given an incentive to small groups to self-insure under ERISA. Previously, the industry rule of thumb was that self-insurance was a viable option only for groups larger than 50. Smaller groups involved too great a statistical risk, and the consequences of a major health claim in a small group could have very serious financial consequences for the company.

With small group carriers exiting the Vermont market, newly formed brokers such as Choice Plus of Vermont began to find ways to extend self insurance to groups of as few as 10 employees. This was achieved by finding a carrier to provide stop-loss reinsurance to protect small firms against a crippling claim. Since access to self-insurance allows firms to get out of the primary insurance market (and thus out of the clutches of the state), Commissioner Castle in November 1999 circulated a draft regulation governing stop-loss insurance. Her proposed rule would require that the individual stop-loss level for a self insured firm be at least $10,000 per employee, and that the "aggregate attachment point" (the point at which the reinsurance begins to pay the total claims of all covered employees) be made the greater of $4000 per insured, or 120 percent of expected claims.

The purpose of such a rule is obvious: to destroy any incentive for small groups to self-insure, by requiring them to be over-exposed to potential claims. If such a rule were adopted, many small groups would be forced back into the regulated insurance market where they have little choice of carriers, and where the policies available to them remain under the tight control of the Department. (As of April 2000 the proposed rule had not been finalized.) Interestingly, when Choice Plus objected to the Department that the proposed rule would destroy its business, the Department promptly served it with a detailed and time-consuming questionnaire, an obvious attempt to fish for some fact or practice that could justify an enforcement action.

Two months before the start of the 2000 legislative session, Gov. Dean responded thus to a question posed at the Warren Rotary Club: "what are we going to do about health care costs? It's a very difficult question to which I do not have the answer. And I get paid to have the answers, so that's a pretty scary proposition." The 2000 legislature seems unlikely to attempt any major health care reforms.

Vermont's Misguided Health Care Philosophy in 2000

For twelve years Vermont's state government has aggressively moved ever further into the state's health care market. A review of the events of these twelve years produces six major policy principles that underlie this progressive government intervention. They can be fairly summarized as follows:

1. Health care is "delivered". Patients are passive vessels into which competent professionals pour the elixir of "health care". Since "there is no such thing as an informed consumer of health care" (Howard Dean MD, 1992), health care should be delivered through managed care organizations, where treatment decisions are made by gatekeepers with incentives (or instructions) to restrain costs. Individual choices about health care and health insurance should be discouraged, because individuals make choices only in their own interest in mind, rather than the good of society as a whole.

2. The measure of social progress is the number of people whose health care expenses are covered by some form of "insurance", whether it is true actuarial-
ly-based insurance offered by an insurance company, or a promise to provide needed care offered by an HMO, Medicare, Medicaid or the Veterans Administration.

3. The ultimate goal of health policy should be "universal coverage", a medical-financial system comprehensively managed, through regulations, price controls, budget controls, reimbursements, taxes, and rationing, by a government "Authority". Only such a system can assure cost containment (that is, can ration care to match available revenues.)

4. Until such time as a "universal coverage" system can be put in place, the state should enroll more and more people, of higher and higher incomes, in taxpayer-paid Medicaid. Since the federal government pays 60 percent of Medicaid costs, every effort must be made to qualify proposed expansions with HCFA. State-managed health care programs like Medicaid are a bargain for state taxpayers. Since the state drastically underpays for hospital services, the remaining unpaid costs can be shifted to private health insurance premium payers. Many persons who then become uninsured because they can no longer afford the higher premiums can then be covered by expanding access to the government program which produced the cost shift. This process steadily puts more and more Vermonters into taxpayer-financed health care. This constitutes desirable progress toward a single payer system.

5. Blue Cross, Vermont’s only domestic health care insurer, has a special social mission. The Commissioner of Insurance must take all necessary steps to protect the financial stability and soundness of Blue Cross. This necessarily requires that the commissioner become deeply involved in its management decisions. An important part of the Blue Cross mission is to offer health care coverage to all customers at the same “community rated” price, regardless of the costs incurred by different kinds of customers. Thus the healthy and the sick, the old and the young, the rural and the urban, the male and the female, must all pay the same premium for the same coverage. This policy disallows any consumer discount for healthy behavior, because such a policy would create a financial advantage to people who take better care of their health, and reduce the premiums paid by them to cover the costs of other people who do not take care of their health.

6. Since by community rating Blue Cross can’t compete with private carriers who charge customer groups on the basis of their expected claims — the practice long observed in life, auto, workers compensation, and property and casualty insurance — the law must prohibit all carriers from using actuarial or experienced-based distinctions. This is the only way that Blue Cross can survive with its social mission intact. If competing insurers withdraw from the state rather than conform to this law, so much the better. Their political opposition to the expansion of government health care will thereby disappear, smoothing the path toward a single payer health care system.

What These Policies Have Produced
As a result of these policies, the political leadership of Vermont state government has brought about

- a massive exodus of commercial health insurers, and the collapse of a competitive health insurance market.

- an unfair burden on healthy young families, who are forced to subsidize the health care costs of sicker older people even though the older people are in their peak earning years and have long since paid off their education loans and home mortgages.

- an unfair burden on people who practice a healthy lifestyle, who are forced to subsidize others who smoke, drink to excess, use drugs, are obese, and underexercise with little regard to their health.

- the steady conversion of privately insured Vermonters into uninsured Vermonters, and then into government-insured Vermonters

- the effective elimination of one of the most promising health insurance reforms of the 1990s, the Medical Savings Account, from the Vermont market.

- the recurring — and sometimes extralegal — regulatory rescue of Blue Cross, which has become a virtual ward of the state.

- the costly overutilization of health care by government-certified patients who have come to regard it as “free”.

- serious and chronic state underpayment of hospitals and nursing homes for ever-increasing Medicaid services, which forces them to shift costs onto
Medical Savings Accounts

As originally proposed, the Medical Savings Account (MSA) is a personal savings account, like an IRA, held by a financial custodian such as a bank or a brokerage firm.

The individual (or his employer) buys a high-deductible major medical insurance policy. A typical family policy might have a $4000 deductible. Since the premiums for high-deductible policies are relatively low (compared to premiums for first dollar coverage or low-deductible policies), there is a substantial monthly premium cost saving.

From this saving the individual (or his employer) makes monthly contributions into the MSA. A typical contribution might be $300 per month. This contribution is tax deductible.

The account holder uses the funds in the MSA to pay providers directly for normal health care expenses, including preventive care, physical examinations, prescription drugs and treatments by a wide range of medical practitioners. MSA funds will also pay for the cost of treatments before the deductible level of the major medical policy is reached.

On the average, most families will not spend as much for health care each year as they deposit into the MSA. Thus funds will build up tax free in the MSA. These funds will be invested per the account holder's instructions. If the account holder wants to withdraw funds from his MSA instead of spending them for qualified health care expenses, there is a penalty, and the funds withdrawn become taxable income.

If an account holder remains healthy for several years, considerable funds will accumulate in the MSA. The account holder can then switch to a higher deductible policy with an even lower premium, and still have the funds in the MSA to cover the deductible in case of a major medical problem.

Because the individual is paying for services directly, and not through a third party payor, he or she becomes a more rational consumer. The patient also gains the benefit of provider discounts of as much as 25 percent for direct on the spot payment to the provider. Finally, the patient has an incentive to stay healthy so that the tax-free account will build up.

Unfortunately MSAs as authorized by Congress in 1996 do not allow individuals to make use of this ideal model. The law authorized only an experimental program capped at 750,000 MSAs. It also required unusual deductibles ($1500-2350 for individuals, $3100-4650 for families.). Thus many health carriers have declined to develop MSA-qualified policies or train their agents to market them. Instead of being allowed to deduct MSA contributions up to 100 percent of the insurance policy deductible, the law allows the MSA holder to deduct only 65 percent (for individuals) or 75 percent (for families). The law also prohibits employers and employees from both contributing to the same MSA. And only the self-employed or employees of a firm with less than 50 employees can create MSAs.

As a result MSAs have not achieved wide popularity. In Vermont, only Blue Cross offers an MSA option. It is only available to small group participants, not individuals, and Blue Cross salespersons are frank to say that it is not a good deal. The Blue Cross MSA account must use the Howard Bank as custodian, and it pays only two percent interest on MSA balances.

Mutual of Omaha offers a two person family policy with a $3500 deductible for around $240 per month. The insured can then deposit another $218 per month in the MSA. In case of a major health expense (over $3500) in the first year, the insured would have at most only $2616 in the MSA, and would have to pay an additional $884 out of pocket. Mutual of Omaha does not market an MSA tied to this policy. A person can, however, establish an independent MSA with a custodian, such as Mellon Bank (Pittsburgh) or Wells Fargo Bank (San Francisco). American Health Value (Boise, Idaho) is an MSA custodian with a special interest in promoting its customers' health care, not just in managing invested funds. Since the Vermont income tax piggybacks the federal, Vermonters can take a state income tax deduction for their MSA contributions.

Even with its awkward limitations, the MSA is an attractive proposition for individuals and families, especially those mindful of maintaining their good health.
privately insured patients, thus driving up premiums and causing more Vermonters to drop their increasingly unaffordable coverage.

- serious and chronic state underpayment of doctors and dentists for ever-increasing Medicaid services, which forces them to limit the number of Medicaid patients they will treat, or to refuse to treat Medicaid patients at all.

- binding state control of hospital budgets, making hospital management and capital investment subject to political approval.

- an increasing cost burden both on businesses competing in interstate commerce, and on small businesses serving a local market, leading to reduced job growth and reduced employee insurance coverage.

All of this has been accomplished under constant pressure from political leaders for the expansion of government health care, with the goal of creating a state single payer health system that is managed by political appointees, puts the state in control of all health care providers, requires them to ration care to meet politically-determined budgets, and sends the bills for everyone's health care to the taxpayers.

Real Health Care Reform

The past twelve years have seen some success in expanding health care programs to serve more Vermonters, instead of meeting their needs through traditional charity care. But the result of this “success” has been the progressive destruction of a competitive health insurance market, an increasingly serious shifting of costs to health care providers and their private pay customers, and the rapid escalation of health insurance costs for employers and employees alike.

A sound reform of health care in Vermont, including a badly-needed revival of a competitive health insurance market, should be based on these principles and policies.

1. The primary responsibility for maintaining wellness and paying for health care rests with the informed individual and family, not with the government. Over a lifetime — and especially up to Medicare eligibility age — individual choices are directly related to the great majority of health problems. The opinions of some doctors and program managers notwithstanding, patients are not mere passive receptacles for the delivery of health care. They are conscious human beings whose understanding, involvement and cooperation are essential to maintaining or restoring wellness. People who regularly make important decisions about family, career, and investments must be considered competent to recognize the essentials of healthy lifestyle choices and effective self-treatment for non-acute conditions.

2. Wellness can be significantly increased and demand for expensive health care can be significantly reduced if individuals are educated as to the personal health consequences of their choices, especially those relating to smoking, drinking, drug use, exercise, nutrition, and sexual activity. The explosion of health care information through periodicals and internet sources has led to a corresponding increase in patient awareness of health care considerations, self-medication, and lifestyle modification. Every public and private program, including especially high schools, should offer a strong health consumer education component, and reward individuals and families who make healthy choices.

3. Health insurance exists to protect individuals from unexpected occurrences. It was never intended to pay for expected and predictable wear and tear. First dollar or low deductible coverage leads directly to costly overutilization of health resources; the patient believes he or she is getting “free” care and thus consumes more of it, even though it yields little or no improvement of health outcomes. Such coverage should be strongly discouraged, even to the point of imposing a surtax on the premiums of first dollar policies.

4. Individuals and families should be encouraged to create tax-favored medical savings accounts (MSAs — see sidebar.) MSAs are coupled with a relatively inexpensive high deductible major medical insurance policy. Funds deposited in an MSA can be used to pay for such routine expenses as physical examinations, immunizations, vision care, prescription drugs, nutritional supplements, and all medical costs until the annual deductible is reached. MSAs give families a financial incentive to use preventive care to maintain wellness. As balances in their MSAs increase, they can switch to higher deductible coverage and pay lower premiums without giving up major medical protection. In addi-
tion, many doctors will give up to a 25 percent discount for patients who pay for treatment at the time of service, a practice that an MSA makes easy. (Tax-deductible MSAs are available under Federal tax law for the self-employed and employees in firms with no more than 50 employees. The deduction carries through to state tax law because of Vermont’s piggy-back income tax feature. Unfortunately the restrictions enacted by Congress in 1996 have discouraged their use. None of Vermont’s few remaining insurers actively markets MSA plans.)

5. The legislature should repeal community rating. Insurance carriers ought to be allowed to distribute the cost of insurance fairly among recognized actuarial categories such as age, gender, geography, and occupations. This traditional method of pricing coverage justly assigns costs in proportion to expenses incurred. Community rating has the regrettable effect of overcharging younger, healthier, but poorer families in order to subsidize older, sicker but wealthier (and thus more politically influential) families. Government mandates which have the effect of making the poor subsidize the rich are inherently unacceptable. Such mandates should be doubly unacceptable when their hidden purpose is to create a virtual monopoly for one struggling but politically influential health insurance company. The law should be changed to allow Blue Cross to use age and experience rating as well, while retaining its exemption from the premium tax through some transition period to subsidize its existing high cost books of insurance.

6. Insurance carriers should also be allowed to offer healthy lifestyle discounts. Auto insurance carriers offer discounts for safe driving records, the absence of traffic violations, security devices, and airbags. Property insurers offer discounts for fire protection. Most commercial health insurers offer discounts or “preferred” policies for non-smokers, etc. but such discounts are currently illegal in Vermont.

7. Government mandates that force insurance customers to buy coverage they do not want and will never use should be rolled back. These include pregnancy benefits, excessive drug and alcohol abuse coverage, and mental health parity. Lower income families ought to be able to buy a minimum-benefit policy that does not require them to subsidize the health care costs of others who choose to practice unhealthy lifestyles, or pay the costs of normal pregnancy and childbirth. (The latter mandated benefit was never required by act of the legislature; it was imposed by Commissioner Babcock in 1988.) By thus reducing the cost of basic coverage, thousands of Vermonters who have been incorporated into Medicaid will once again be able to pay their own way.

8. The state should resolve to pay the true cost of services provided to Medicaid patients by hospitals, nursing homes, and medical professionals. There is always some room for debate over what such “true cost” is, but the present practice of paying less than half of the going rate for Medicaid patients requires other patients to absorb a hidden tax on their own premiums to make up for what the government declined to tax openly. Unless the state resolves to pay its fair share for the care of “government patients’, providers will simply decline to provide treatment. In the case of hospitals, it is not possible to turn away patients; thus they – and probably many doctors as well – will eventually be forced to serve state-designated patients at state-specified prices. Bargaining over these price schedules will in time make Vermont’s medical profession into the equivalent of a trade union, with predictably consequences for professionalism.

9. Medicaid for acute care patients (other than the elderly or institutionalized) ought to be converted into an MSA-style program, with the state providing sliding scale subsidies for individual accounts. The MSA offers real incentives for involving customers in maintaining their own wellness, because they will not only live healthier lives but will benefit financially. It would almost certainly be less expensive for the state to fund MSAs and buy corresponding catastrophic coverage for such Medicaid-eligible Vermonters, rather than continually expand managed care or first dollar fee for service coverage. Since the taxpayers would fund these MSAs, there would presumably have to be some limitations on the use of the account balances. Allowed uses might include the purchase of long term care insurance, continuing education and job training, or other investments in family earning power, wellness, and independence.

10. The state should explore a program for the recapture of unpaid medical bills of persons who choose to spend their resources on things other than adequate health insurance. Such a program would be similar to an ordinary credit card account. The amount left unpaid by the patient would be debited to his account.
and added back, over a period of years, to his reportable Vermont income. The amount added each year would be related to the patient's expected income level as indicated by previous returns. The proceeds after administrative costs of the additional income tax would be shared with the providers. Such a program could not realistically be expected to recover a large fraction of unpaid bills, but it would forcefully emphasize the individual's responsibility for paying for care received. In so doing it would have a positive influence on patient behavior. The tax-based recovery could of course be avoided if the non-payer relocated outside of Vermont.

11. The legislature should create a high-risk pool to cover the health care costs of the medically uninsurable - persons with known, costly health care problems who have been denied coverage by an insurer. Over 100,000 people in 28 states now participate in such pools, commonly called Health Insurance Plans (HIPs), which date back to 1978. A typical HIP requires insureds to pay 150 percent of the average premium for a comparable coverage, with premium subsidies available for low-income insureds. It offers them a choice of competing insurance plans, including MSA plans and HMOs. Its costs are funded by assessing the premium receipts of all health insurers, a practice now supported by the companies themselves. Typically the fraction of the population covered by a HIP is around one percent. An added advantage of the HIP pool is that it makes it unnecessary to mandate guaranteed issue on insurers. However, the HIP must be viewed explicitly as a means of covering only the medically uninsurable, not as a vehicle for expansion of government-financed health care.

12. The legislature should examine and tighten tort liability standards governing medical malpractice to reduce the exposure of health professionals, hospitals, nursing homes, and HMOs to predatory tort suits. Provisions for arbitration of malpractice claims were included in Act 160 (1992) but were never put into practice because the universal access plan contemplated by that act was never adopted. The growing enthusiasm among trial lawyers for suing HMOs - and through them, the employer contracting with the HMO - makes this step one of top urgency.

13. The state should actively promote the purchase of long term care insurance. Act 160 of 1996 requires the state to “propose and implement methods that permit strategies to provide alternative financing of long term care services by shifting the balance of the financial responsibility for payment for long term care services from public to private sources by promoting public-private partnerships and personal responsibility for long term care.” In November 1997 the Department of Aging and Disabilities announced that it would implement a public education initiative to enhance the public's understanding of the need, cost and options for financing long term care. Unfortunately no such initiative has been launched.

14. Vermont's nine independent community-based free clinics merit continued state support. These clinics offer primary and preventive health care, wellness counseling, pharmaceutical assistance, and referrals to free or discounted specialist services for needy, uninsured Vermonters. They make use of the volunteer services of health care professionals, including complementary treatment practitioners, students and community residents. Patients pay "what you can, when you can". In 1999 the free clinics and the Burlington Health Center shared $200,000 from the state's tobacco settlement fund, and received grants from foundations, federal programs, and community contributions. The grassroots free clinics serve a population that is often transient, between jobs, or otherwise hard to enroll in Medicaid, and do it as a genuine community service. A portion of the tobacco settlement fund should be set aside every year to assist the free clinics and encourage new clinics to organize in underserved parts of the state. AHS should refrain, however, from incorporating the free clinics into a bureaucratic system.

15. The legislature should, as essential housekeeping, revisit Act 160 of 1992 and systematically repeal all the provisions that failed, were ignored or abandoned, produced grievous consequences, or appear to commit the state to moving toward a government-controlled health care monopoly. Typical of the provisions meriting repeal is the statement of policy: "Comprehensive health planning through the application of a statewide health resource management plan linked to a unified health care budget for Vermont is essential."

Effecting these steps will require a major rethinking of public policy toward health care, and considerable political courage on the part of elected officials. Both are long overdue.
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Footnotes:
- a 1-50 members, including self-employed individuals.
- b 51 or more members
- c Includes groups categorized as discretionary, union or trust.
- d Nongroup and group lives with major comprehensive medical coverage, 1998 Annual Statement Supplement, Vermont Division of Health Care Administration.
- e Estimated from lives reported under Stop Loss in Annual Statement Supplement and lives reported by selected self-insured employers.
The Cost Shift: A Hidden Tax That’s Hurting Vermonters

Like a cancer eating healthy cells, the Vermont medical system today has a flaw that is consuming the state’s economy at an accelerating rate.

This hidden tax stifles job growth, weakens hospitals, and encourages people to reject self-sufficiency in favor of relying on government.

What is this economic disease? Government-supplied health insurance. Because Gov. Howard Dean has helped these programs now reach 126,000 people at the same time he and the Legislature have consistently underfunded them, nearly every Vermonter is paying the price.

The time has come to either curtail the state’s role in health insurance, or add millions of taxpayer dollars to the programs. Otherwise Vermont’s economic stability will suffer, and individual Vermonters will be squeezed in countless ways.

You don’t have to be a health care expert to see the policy error at work. You have seen health insurance rates rocketing. You have watched your employer decrease his share of your insurance cost. You have seen charges for doctor visits go from $2 to $15 or more.

You have received small raises at your job because your employer is paying so much for your health insurance. If you’re self-employed, you might have become unable to afford insurance at all.

If you’re a small business owner who has provided insurance for his employees, now you see that the state will take care of your staff and their children if you drop coverage. So you do.

These forces stifle job and wage growth, and create growing dependency on government. They also leave a dwindling number of people to absorb the economic impact.

Conventional wisdom says that insurance rates are soaring because people are aging and need more treatment. True. But Blue Cross recently received a 25 percent rate increase. Did Vermonters age by 25 percent this year? Did they go to the hospital 25 percent more?

Of course not. The real culprit is the state’s growing cost shift.

What is a Cost Shift?

When government paves a road, it pays the whole bill. When the state builds a courthouse, it pays the full contract. Only when medical care is involved does government pay just part of the cost.

That tradition in this state and others is called cost shifting: adding the state’s unpaid bills onto the bills of people who have insurance.

The problems in Vermont are twofold: First, this state pays too small a share. For a gall bladder removal at Dartmouth Hitchcock Medical Center, for example, Vermont’s Medicaid pays 13 percent of the actual cost of the care. That shifts 87 percent of the bill onto people who have private insurance.

How big is the gap? Last year at Fletcher Allen Health Care alone, the state underpaid by $22 million. Last year, too, the state’s payments to dentists were so low, many of them stopped seeing Medicaid patients at all.

The second problem is that instead of filling the gap, Dean has sought a massive expansion of state funded health care through Dr. Dynasaur (for children) and the Vermont Health Access Plan (for low income people.)

These programs are wise investments in prevention to avoid later illness. But they have quadrupled in population since Dean became Governor — from 32,000 to 126,000 — without a comparable increase in funding. The sum effect is like putting an invisible noose around the economy’s neck.

Vermont can be proud of its success in expanding access to health care. But the underpayments burden the few heavily, instead of spreading the financial responsibility across all of society.

State leaders cannot continue to ignore that burden’s large effects on Vermont’s economy. It is time for the hidden tax to come into the daylight.
References


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U.S. General Accounting Office, Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight (April 1994).