



**Report of the Health Access Oversight Committee
January 2007**

In Accordance with 2 V.S.A. § 852

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Part I. Statutory Authority and Responsibilities of the Health Access Oversight Committee

During the 1995 session of the Vermont General Assembly, the legislature through the enactment of Act 14 authorized the creation of the Vermont Health Access Plan (“VHAP”), offering health care coverage to uninsured, low income Vermonters previously ineligible for Medicaid. Act 14 also established the Health Access Oversight Committee (HAOC) in order to monitor the development, implementation, and ongoing operation of VHAP.

Recognizing that the authority of the HAOC had expanded significantly beyond the VHAP program since 1995, the committee recommended that its authority be codified at 2 V.S.A. chapter 24. Appendix 1. The general assembly accepted this recommendation in 2006 and directed the committee to “review of the operation of the Medicaid program and all Medicaid waiver programs that may affect the administration and beneficiaries of these programs.”

Part II. Summary of Findings and Recommendations

Global Commitment

The committee recommends that the standing committees monitor the ongoing progress of OVHA’s access and quality improvement initiatives as they have important implications for Medicaid beneficiaries. Also important are efforts to integrate physical health and mental health and to modify reimbursement strategies to support better preventive and chronic care.

Supplemental Payments to Dentists

The committee recommends that the standing committees or the appropriations committees assess whether the policy of providing supplemental payments to dentists who serve a large number of Medicaid patients has the intended effects, including improving access to dental care for low-income Vermonters or, at minimum, preventing the erosion of the existing level of access.

Medicaid Citizenship Rules

The committee recommends that the standing committees:

- review whether providing emergency pharmacy coverage pending verification of citizenship through general assistance is the most appropriate and effective method; and
- provide the Congressional delegation with any additional information needed in order to seek federal changes in this area as described in the committee’s letter of January 5, 2006.

Employer-Sponsored Insurance

The committee recommends to the appropriate standing committees of jurisdiction that the standing committees continue to consider the outstanding policy and implementation issues and assess the advisability of further pursuit of the ESI program.

Long-Term Care

The committee recommends that the standing committees review the two reports due to the legislature in mid-January 2007 that will offer recommendations for strengthening the overall financial viability of the long-term care system in Vermont:

- Long-Term Care Sustainability Report
- Nursing Home Reimbursement Study

In addition, the committee recommends routine reporting from DAIL providing information on Medicaid long-term care, the sustainability of nursing homes, and the home- and community-based care network.

Medicare Modernization Act

The committee recommends that the standing committees continue to monitor the progress of the Office of Vermont Health Access in seeking reimbursement from CMS and from the Medicare Part D Prescription Drug Plans for state expenditures during 2006 resulting from operational problems at the federal and PDP levels.

In addition, in last year's report, the committee recommended that the standing committees consider whether the VPharm program should cover cost-sharing for individuals in home- and community-based care through the Choices for Care waiver in order to ensure that these individuals have the same pharmacy coverage as individuals in nursing homes. The standing committees should consider this issue this year as this committee did not receive an update.

Part III. Summary of Committee Activities

The committee met eight times in 2006 and once in 2007, hearing from individuals and organizations representing a broad spectrum of perspectives and interests. Topics addressed by the committee included:

- Prescription drug counter-detailing program
- Coverage of transitional youth
- Global Commitment
- Choices for Care Medicaid 1115 Waiver and other long-term care issues
- Implementation of the Medicare Modernization Act prescription drug program and the V-Pharm Program
- Federal changes to the Medicaid rules on documenting citizenship of applicants
- State audit of Medicaid
- Reporting requirements for the Agency of Human Services
- Chronic Care initiatives and the Blueprint for Health
- Health care reform initiatives and Catamount Health

- CMS waiver amendment
- OVHA's generic drug reimbursement study
- Supplemental payments for dentists with a large number of Medicaid patients
- Advance Directives
- Health care information technology and the Vermont Information Technology Leaders (VITL)
- Reimbursement increases in Medicaid to health care providers
- Medicaid deficit information for the study
- Long-term care asset rule changes and an update on the long-term care partnership program

See Appendix 2 for 2006 Witness List.

Part IV. Global Commitment Update and Catamount Health Waiver Amendment to Global Commitment

Description of Global Commitment

Global Commitment for Health is a Medicaid 1115 demonstration waiver that allows the Office of Vermont Health Access (OVHA) to become a public managed care organization (MCO) with an active role in improving the quality of health services for beneficiaries served by Medicaid. See Appendices 3-5 for a chronology of Vermont's Medicaid and Medicaid-expansion programs and a brief description of current programs. OVHA as a public MCO is under contract with the state's Medicaid agency—the Agency of Human Services (AHS)—to provide all Medicaid services. OVHA subcontracts with the other departments in state government—e.g., DAIL, VDH, DCF, and DOE—to provide or pay for services for the populations served by the various specialty programs under Medicaid. These contracts are based on the Medicaid programs existing prior to the waiver, and the legislature appropriates each portion of the premium to be paid to OVHA and to the other departments.

Adopting a public MCO approach affords Vermont more flexibility in how it uses Medicaid resources. The state has fewer restrictions on the use of federal match dollars because the match applies not to individual fee-for-service payments (paid claims) as before, but to a single MCO premium that AHS determines at the start of the fiscal year and pays monthly to OVHA. The premium includes *all* Medicaid spending except the Choices for Care waiver, some administrative costs, disproportionate share spending, and SCHIP. The primary federal condition is that AHS establish the premium amount within an actuarially set premium range determined and certified each year by an independent actuary based on historical spending and current trends. This all-inclusive premium is matched with the federal share, which is about 60 percent of Vermont's Medicaid spending.

The legislature has retained approval authority over many elements of Global Commitment, especially eligibility and benefits. Close legislative oversight has encouraged cooperation between the legislature and administration in several areas, including:

- Fiscal impact of Global Commitment (five-year Medicaid projection and monitoring)
- Catamount Health (working out implementation details)
- Medicaid Chronic Care Management Program (legislative approval of RFP)
- Premium assistance for ESI coverage (legislative approval of implementation plan)

Medicaid Chronic Care Coordination/Management

During 2006, OVHA implemented a Care Coordination initiative and issued an RFP to select a vendor to implement a broader Chronic Care Management Program. OVHA intends the two programs to be complementary and closely interlinked. In addition, OVHA is working with the Blueprint for Health to coordinate the Medicaid chronic care initiatives with the system-wide goals established for chronic care management.

Care Coordination Initiative. Beginning early in 2006, OVHA began rolling out a Care Coordination (CC) program designed to assist the 1-2 percent of Medicaid beneficiaries with the most complex chronic care needs. The program's goal is to assist beneficiaries in meeting physician-recommended self-management goals while avoiding unnecessary utilization of services. The program is operated under the direction of a Field Services Director and locally based Care Coordination teams comprised of a nurse case manager and clinical social worker. The Care Coordination team works to facilitate communication between the beneficiary and the clinicians involved in care, as well as any community resources (e.g., transportation, child care, self-management education and support) that may be critical in helping a person manage his or her chronic condition effectively. OVHA's care coordinators also follow up after a beneficiary's visit to a hospital emergency room to make sure that the primary care provider is aware of the visit and is involved as needed in ongoing management. The Care Coordination program is currently operational in Caledonia and Washington counties, has commenced start-up in Chittenden and Franklin counties, and will be expanded statewide if successful in those counties.

Chronic Care Management Program. Consistent with section 1903a of Title 33, as enacted by Sec. 6 of No. 171 of the Acts of the 2005. Sess. (2006), OVHA released an RFP for a Chronic Care Management Program (CCMP) in early October 2006. The program will target Medicaid enrollees with one or more chronic conditions, anticipated to be 30,000 beneficiaries, more or less. The selected CCMP vendor will provide a range of disease management services:

- Stratify the population into "high," "middle," and "low" risk groups
- Perform evidence-based care management interventions for each risk group (intensity of intervention will vary by group), including:
 - Beneficiary mailings (e.g., self-management materials)
 - In-bound/out-bound telephonic and face-to-face nurse support and advice for beneficiaries with complex care needs
- Conduct ongoing outreach, education, and coordination with providers

A separate vendor (or possibly the same vendor) will administer health risk assessments

(HRAs) for the beneficiaries identified for the Care Coordination and CCMP program. This HRA initiative may be expanded over time to include all Medicaid beneficiaries. The health information on beneficiaries gained from the HRA will be provided to the CCMP vendor to assist in care plan development, and it will also be distributed to primary care providers to support coordinated patient care. The HRA information will also be used to monitor the effectiveness of the CCMP interventions.

Legislative Review of RFP for the Chronic Care Management Program

Under subsection 1903a(d) of Title 33, OVHA was required to present the Request for Proposals (RFP) to select a vendor for the Chronic Care Management Program for review by the Commission on Health Care Reform, whose approval was required to ensure that the RFP met with legislative intent. The Health Access Oversight Committee appointed a subcommittee of four members to keep abreast of this review process and offer advice and comment as appropriate to the Commission on Health Care Reform.

Process of Review.

From August 22–September 1, members of the Commission on Health Care Reform, the Blueprint for Health, and the HAOC subcommittee participated in a “big picture” review of the draft RFP. The key areas of comment from HAOC subcommittee members and other reviewers were as follows:

1. Coordination with Blueprint for Health

The RFP needed to place greater emphasis on coordinating with Blueprint activities – both at community level and “system” level. The vendor would need to coordinate with primary care physicians “at every step of the way,” as well as coordinate with the care management programs of private insurers (i.e., CIGNA, Blue Cross/Blue Shield, and MVP Healthcare). The vendor should utilize common standards established by Blueprint for diabetes, and other conditions as they become available. Data sharing with Blueprint should also be required.

2. Measuring Performance

Effective tools for measuring performance would be important for program monitoring, quality improvement, and at-risk payment. The CCMP should use state-of-the-art process and outcome metrics that would align with metrics to be adopted by Blueprint participants.

3. Separate Vendor for HRAs

The initial draft of the RFP required a separate vendor to administer HRAs. As a result of legislative review, the final draft allows flexibility to select a single vendor for both the HRA function and the disease management intervention if the vendor can demonstrate ability to avoid bias and achieve the multiple purposes for which HRAs will be used.

During September 2–18, OVHA circulated the revised draft of the RFP to a broad group of stakeholders (e.g., provider, advocacy groups) for public review, incorporating further changes as a result of public comments received. On September 26, the Agency of Administration presented the RFP for approval by the Commission on Health Care

Reform, which was granted.

First-Year Impacts from Global Commitment

Key questions on the impacts arising from Global Commitment may be summarized as follows:

<p><i>1. Beneficiaries</i></p> <ul style="list-style-type: none"> - What changes might beneficiaries (or certain beneficiary groups) experience under Global Commitment? - What specific changes (e.g., in benefits, premiums) may be proposed to address the Medicaid shortfall?
<p><i>2. Providers</i></p> <ul style="list-style-type: none"> - What changes will providers experience as a result of the managed care arrangement? - What, if any, changes are under consideration for how Medicaid pays for care?
<p><i>3. Departments</i></p> <ul style="list-style-type: none"> - What changes will occur among OVHA and the subcontracting departments in decision-making authority – e.g., financial controls and policy authority? - Who controls contract authority (e.g., contracting with private vendors)?
<p><i>4. Budget Systems</i></p> <ul style="list-style-type: none"> - How will budget presentation and formatting change as a result of the waiver? - How will the legislature track expenditures under the waiver and ensure that all expenditures are monitored?
<p><i>5. Financial Sustainability</i></p> <ul style="list-style-type: none"> - What will the actuary calculate for the premium range for different Medicaid groups? - Will there be any changes in methodology for determining the premium range in FY08, '09, and '10, or other factors that could increase or decrease the premium range for any of those years? - What will be identified as an MCO investment item? - How do the annual expenditures compare with the annual targets for the five-year budget neutrality cap?

1. Beneficiaries

Changes in Premiums and other Cost Sharing. During the first year of implementation, beneficiaries experienced no changes in premiums or other cost sharing. Effective July 2007, premiums will be reduced for both children (Medicaid and SCHIP) and adults (VHAP) under Act 191 (“Health Care Affordability for Vermonters”).

Improvements in Access and Quality. The Global Commitment waiver requires OVHA to comply with federal Medicaid standards for MCOs, including the beneficiary protections relating to access and quality.

- Access—OVHA will link each beneficiary with a “medical home” and engage in a more systematic review of beneficiary access to providers. By the end of the first year (September 30, 2006), OVHA was in the early stages of devoting staff time and data resources to strengthen ongoing monitoring of the adequacy of provider networks, consistent with its waiver implementation time table.

- Quality Improvement—AHS will coordinate and align quality improvement activities across all OVHA and the different departments. In August 2006, AHS brought on a Quality Improvement Manager who has been working with all AHS departments to develop a more unified approach to performance monitoring and quality improvement.

Changes in Eligibility or Benefits. Global Commitment increases flexibility for OVHA or AHS to change Medicaid eligibility or benefits. The waiver provides that any changes to benefits received by *mandatory* beneficiaries (including optional services) will require an amendment to the waiver. The waiver allows changes in benefits for *optional and expansion* populations without federal approval so long as the changes result in no more than a five-percent increase or decrease in total Medicaid expenditures compared to the prior year.

No changes in the current eligibility and benefit structure of Vermont's Medicaid programs were proposed during the 2006 legislative session.

Medicaid Chronic Care Management. In its role as a public managed care organization (MCO), OVHA worked on developing two chronic care initiatives in 2006. These initiatives were designed to improve the chronic care provided to Medicaid beneficiaries, as described in the section below.

2. Providers

Changes in Provider Reimbursement. The all-inclusive premium provides flexibility for Vermont Medicaid to align provider payments in new ways to support best practices in chronic care for Medicaid beneficiaries. It enables the state to look beyond traditional fee-for-service (FFS) reimbursement to payment methods that may give providers better financial support and incentive for the types and quality of care needed by Medicaid beneficiaries. This flexibility includes use of new payment mechanisms (e.g., case rates, capitation, combining funding streams for different populations) and payment for services not traditionally reimbursable under fee-for-service (e.g., care coordination, psychiatric consultations for pediatricians). To date, implementation efforts have focused on two discrete pilots that were proposed in its 2006 budget recommendation:

- A strategy for paying primary care clinicians to attend group meetings for multidisciplinary coordination of care for Medicaid patients participating in the Care Coordination initiative.
- Enhanced capitation payment for primary care providers that enroll in a "best practice" program providing buprenorphine treatment for individuals with opiate dependency.

Medicaid Chronic Care Management. OVHA has reached out to primary care physicians in implementing its Care Coordination initiative and plans to work closely with physicians in the roll-out of the Chronic Care Management Program. In response to public comment on the RFP, OVHA provided that an advisory committee, including a variety of stakeholder groups such as the Blueprint for Health, practicing Vermont

physicians, and consumers, will review and approve the initial program design for the CCMP.

3. Departments

Financial Accountability. Global Commitment required a change in financial reporting and budgeting that has resulted in a more integrated perspective on Medicaid spending and revenues. The impact on policymakers is a greater understanding of the multiple components that comprise the Medicaid budget and each component's fiscal impact. Because of the global limit on federally matched expenditures (known as the budget neutrality cap), there is a need to monitor overall program spending closely and evaluate whether spending is congruent with current priorities.

During the summer, AHS directed the financial officers within the various AHS offices and departments that program opportunities that involve increased Medicaid funding (beyond that already appropriated) "must be approved prior to exploration."

Decision-Making Authority. Global Commitment has not substantially changed authority for policy decisions on the part of OVHA and the subcontracting departments. The waiver affords greater opportunity and incentive for different service systems to collaborate more closely on service integration. Discussion between departments—for example, OVHA and VDH to discuss initiatives that integrate delivery and payment of physical health and mental health—is still in early stages.

4. Budget Systems

Because of Global Commitment, the format of the Medicaid budget has been adjusted to be better aligned with the waiver. The Medicaid budget used to track spending only from OVHA. Under the new approach, the budget will now include all spending under Global Commitment.

5. Financial Sustainability

MCO Investments in Health Improvement. A key benefit of Global Commitment is the flexibility to use federal Medicaid matching funds on non-Medicaid health programs under specified conditions. Consistent with federal Medicaid MCO rules, and similar to private MCO practices, the waiver provides flexibility to use federal Medicaid funds to support health improvement programs serving Medicaid beneficiaries and uninsured individuals. Under the waiver, any MCO premium dollars that remain after payments for Medicaid services can be used for the following health-related purposes:

- Increase access to quality health care for the Medicaid beneficiaries and uninsured individuals (e.g., school nurses, immunization programs)
- Fund preventive and public health programs that improve outcomes and quality of life for Medicaid beneficiaries (e.g., smoking cessation, alcohol and drug abuse prevention)

- Reduce the rate of uninsured (e.g., Catamount Health)
- Support public-private partnerships in health care (e.g., Blueprint for Health)

Because each MCO premium dollar has a 60-percent federal match, budget “savings” result when these funds are available to support health improvement programs that previously were state-only funded. Current projections estimate “savings” of approximately \$150 million over the five years of the Global Commitment waiver.

Risk under the Five-Year Budget Neutrality Cap. Global Commitment puts the state at financial risk that the budget neutrality cap may be exceeded if growth in enrollment and spending is faster than expected. The aggregate cap limits overall Medicaid spending to \$4.7 billion over five years (Oct. 2005 – Oct. 2010). The Catamount Health initiative was crafted to leave sufficient “room” remaining under the cap. Potentially, the cap could be exceeded if those estimates were too low. On the other hand, more cap room would result if Medicaid were to spend less than is projected (e.g., cost trends decline), if Catamount Health were only partly approved by CMS, or if implementation of Catamount Health occurred at a slower pace than is anticipated. Currently, Vermont does not appear at risk of exceeding the five-year budget neutrality cap.

Risk under the Annual MCO Premium. Global Commitment also puts the state at financial risk if the “space” between the federally matched MCO premium and actual Medicaid program costs is smaller than projected. The result would be fewer premium “savings” and consequently fewer dollars available to support health improvement programs for Medicaid beneficiaries and uninsured individuals. The premium “savings” may get squeezed if program expenditures grow faster than expected, or if a sufficiently high premium cannot be justified based on the historical and current spending trends reviewed by the independent actuary (particularly a concern for the last three years of the five-year waiver).

Waiver Amendment for Catamount Health

On September 19, 2006, AHS requested necessary federal approval for implementation of key provisions of Act 191 (“Health Care Affordability for Vermonters”). First, the waiver amendment request summarized the new initiatives legislated in Act 191: (1) the Catamount Health expansion program; and (2) use of ESI premium assistance for VHAP and Catamount Health enrollees who have access to employer coverage. The main body of the letter provided details on the program design issues and cost estimates. Second, the letter notified CMS of four other changes effected by Act 191 which presumably did not require federal approval:

1. Changing the requirement of recertification of eligibility from every six months to every 12 months
2. Extending VHAP eligibility to college students on medical leave
3. Reducing Medicaid premiums
4. Launching the chronic care management program for Medicaid

AHS submitted the waiver amendment request letter for comment to the Medicaid Advisory Board over the summer. Subsequently, this committee reviewed the waiver

amendment request and approved it with minor comment.

Recommendation

The committee recommends that the standing committees monitor the ongoing progress of OVHA's access and quality improvement initiatives as they have important implications for Medicaid beneficiaries. Also important are efforts to integrate physical health and mental health and to modify reimbursement strategies to support better preventive and chronic care.

Part V. Supplemental Medicaid Payments to Dentists

The Vermont General Assembly authorized the establishment of a Supplemental Dental Payment Program under Sec. 108(b) of No. 215 of the 2005 Adj. Sess. (2006), An Act Relating to Making Appropriations for the Support of Government. The relevant provision states:

(b) The office of Vermont health access shall use \$242,836 of the appropriation in Sec. 107 of this act for supplemental payments to dentists with high Medicaid patient counts. The office shall design and implement the program by October 1, 2006. These funds are in addition to the funds in subsection (a) of this section. The office shall report to the health access oversight committee in September on the parameters of the program.

The goal of the program is to expand, or at least maintain access to, dental services for Medicaid beneficiaries.

Joshua Slen, director, Office of Vermont Health Access (OVHA), testified on the program at the September 19, 2006 meeting of the Health Access Oversight Committee. He described both the process that was used to develop a methodology for making the supplemental payments, and the methodology itself. Regarding the process, he indicated that the methodology was the result of input from representatives of OVHA, the Department of Health, and the Vermont State Dental Society.

The agreed-upon methodology for making supplemental payments was described by Joshua as follows: Beginning October 1, 2006, OVHA will make two payments of \$121,418 each fiscal year, at six-month intervals. The funds will be distributed to dental practices based on the amount paid by both Medicaid and General Assistance to each practice as a percent of its total revenue during specified six-month periods. Only practices that claim more than \$50,000 in services to Medicaid beneficiaries are eligible, which ensures that supplemental payments go only to dental practices with "high Medicaid patient counts." In addition, dental practices receiving cost-based reimbursements, which are considerably higher than fee-for-service reimbursements, are not eligible for supplemental payments. Specifically, then, the methodology requires that a practice that received 10 percent of the Medicaid claims paid to the "high count" group, receives 10 percent of the state's semiannual amount. Current estimates suggest that

approximately 30 practices will receive supplemental payments, ranging in amount from \$1,700 to \$9,400 for each period, which is the equivalent of an estimated three-percent rate increase for each practice.

After a general discussion of the program, the committee unanimously approved implementation of the supplemental dental payment program.

Recommendation

The committee recommends that the standing committees or the appropriations committee assess whether the policy of providing supplemental payments to dentists who serve a large number of Medicaid patients has the intended effects, including improving access to dental care for low-income Vermonters or, at minimum, preventing the erosion of the existing level of access.

Part VI. Medicaid Reimbursement Increases

The Vermont General Assembly, in recognition of imbalanced Medicaid reimbursements, authorized the Office of Vermont Health Access (OVHA) to establish a plan for increasing reimbursements for specified services and providers, including: evaluation and management procedures; health care professionals participating in the care coordination program; current procedural terminology (CPT) codes significantly lower than 2006 Medicare reimbursement levels; dental services; and hospitals. Pursuant to the legislative parameters and priorities contained in Sec. 9 of No. 191 of the 2005 Adj. Sess. (2006), An Act Relating to Health Care Affordability for Vermonters, the increases shall begin January 1, 2007, upon a determination by the Health Access Oversight Committee that OVHA's allocation plan is equitable and consistent with legislative intent. In subsequent fiscal years, increases shall be made annually on July 1 and continue through 2010 or, in the case of hospital reimbursements, until the federal upper limit is reached. (See Appendix 6 for statutory language)

To fund the allocation plan for six months, the General Assembly appropriated \$3,428,363, of which \$300,000 was earmarked for adult dental services. See Secs. 107 and 108 of No. 215 of the 2005 Adj. Sess. (2006).

Joshua Slen, Director, OVHA, presented details of the allocation plan at the November 9, 2006 meeting of the Health Access Oversight Committee. The following table reflects the allocation of the appropriated amount for the four specified programs for six months.

	6 months	Annual
Hospitals	\$1,000,000	\$2,000,000
Dentists	\$150,000	\$300,000
Care Coordination	\$100,000	\$200,000
CPT Codes	\$2,178,363	\$4,356,726
	\$3,428,363	\$6,856,726

Under the allocation plan, OVHA made a determination that the appropriation was not sufficient to increase all evaluation and management procedure codes to the 2006 Medicare level, as called for in the legislation. In collaboration with the Vermont Medical Society, OVHA arrived at an allocation method believed to reflect the legislative intent of increasing access to primary care. Pursuant to that agreement, subsets of evaluation and management codes for office and preventive-well visits will be adjusted to the 2006 Medicare level.

With respect to care coordination, OVHA set aside \$100,000 to provide incentives and payment restructuring for health care professionals participating in care coordination programs.

The Hospital Association recommended that OVHA focus the rate increase on inpatient rates, which was agreed to. OVHA estimates that the appropriation will support an inflation increase of 6.1 percent to the "base" rate effective January 1, 2007, consistent with the Medicaid State Plan payment method.

Finally, regarding dental codes, the legislation required restoration of the earlier six-percent (\$223,309.00) reduction for adult dental services and application of the remainder (\$76,691.00) to both the fee schedule and the cap on adult dental services. The purpose of these increases was to ensure that adults do not experience a benefit reduction caused by rate increases. After consulting with the Government Program Committee of the Vermont Dental Society, OVHA determined that the preferred distribution option is to use \$56,691.00 of the \$76,691.00 to increase four oral surgery codes by \$3.00 each and to use \$20,000.00 to raise the adult dental cap by \$10.00 to \$485.00.

The committee approved the allocation plan at its December 2006 meeting without modification.

Part VII. Medicaid Outreach and Enrollment

During the 2006 session, the legislature included in the appropriations act a provision charging Bi-State Primary Care Association to research the issue of how to encourage enrollment in Medicaid, the Vermont Health Access Plan, Dr. Dynasaur, and Catamount Health:

Act 215, Sec. 342. MEDICAID OUTREACH

(a) Bi-State Primary Care Association, in consultation with the medical care advisory committee established in section 1901c of Title 33, will research efforts in Vermont and in other states that have succeeded in enrolling individuals eligible for Medicaid and Medicaid waiver programs. The association will report its findings and recommendations to the house committee on health care, the senate committee on health and welfare, the health access oversight committee and the agency of human services no later than November 15, 2006.

Over the summer and fall of 2006, Bi-state Primary Care convened a group of interested parties to conduct the study. The report was issued on November 15, 2006. At the December 12 meeting of the committee, Hunt Blair presented the report and findings to the committee.

The report urges the establishment of “a comprehensive program integrating outreach and enrollment for both Medicaid and Catamount.” Report page 3. The report suggests that the following must occur in order establish such a program:

- Outreach must be a policy priority.
- The Agency of Human Services should provide up-to-date, accurate information about the health care programs, which is coordinated across the agency.
- A marketing and education plan must be created.
- On-line tools should be available for screening, applying, and enrolling in Vermont’s health care programs.
- A tracking system must be implemented in order to ensure that the agency and others can use the enrollment system to flag potential enrollment issues.
- A system of one-on-one assistance should be created to assist individuals.

Part VIII. Federal Changes to Medicaid Citizenship Documentation Requirements

In the Deficit Reduction Act (DRA) of 2005¹, Congress changed the federal law governing documentation required of citizens applying for and enrolling in Medicaid. Prior to the DRA, citizens were required to swear under penalty of perjury that they were citizens, but were not required to provide documentation. Under the DRA, citizens are required to prove both citizenship and identity with original documents.

The Centers for Medicare and Medicaid Services (CMS) provided a letter to state Medicaid directors on June 9, 2006, outlining parameters for the documentation requirements. CMS then released an Interim Final Rule² on July 7, which became effective immediately, pending comment and the administrative rules process. The comments were due August 28, 2006. The committee filed comments, which are summarized below and are contained in Appendix 7.

The Interim Final Rule, established a hierarchy of documents which may be accepted by the state agency as proof of either citizenship or identity, or both. The agency is required to accept original documents and may not accept copies. MS exempted Medicaid applicants and beneficiaries from this requirement if they receive Supplemental Security Income (SSI) or Medicare, because in these instances, the individuals have already proven citizenship and identity to a federal agency. In addition, the states are allowed to use a “data matching” procedure in lieu of documentation. Data matching means that the state agency can check the electronic records of another agency which has the original

¹ Pub. Law No. 109-17.

² 71 Fed. Reg. 39214 – 39229 (2006).

document. For example, applicants for food stamps must prove identity to be eligible. If an individual is receiving food stamps, the Department for Children and Family Services can verify identity by verifying the receipt of food stamps.

The committee submitted comments to CMS on the Interim Final Rules. See Appendix 7. The committee urged CMS to extend the exemption from the requirement to other populations that have already proven citizenship and identity, including some foster care children, individuals receiving Social Security Disability Income (SSDI), independently living youth, and subsidized adoption Medicaid recipients. The committee also urged CMS to allow data matching broadly with other state and federal agencies to minimize the burden on citizens in applying for Medicaid. The committee requested that the rules be clarified to ensure that citizens and legal immigrants be treated equally and be allowed to enroll in Medicaid pending verification during a reasonable period. In addition, the comments indicated that the time frame provided by CMS was unreasonable and did not take into consideration that states would need, at minimum, to make rule changes. The committee also supported the comments made by the American Public Human Services Association (APHSA) and the National Association of State Medicaid Directors (NASMD). See Appendix 8.

The Department for Children and Family Services testified at the July and September meetings about the progress of meeting the federal requirements. The Department indicated that the general plan is to exempt individuals who receive SSI and Medicare. For the remaining individuals, the Department will rely on data matching where possible to meet the requirement. The Department estimates that “roughly 55% of Vermont’s 140,000 Medicaid applicants and beneficiaries will be relieved of the need to prove their citizenship and identity.” The Department also estimates that many of the remaining individuals may have one of the requirements met through data matching. In addition, the Department testified that it was intending to provide financial assistance to individuals who were unable to produce documentation due to the cost of obtaining the original or valid replacement documents.

The Department is implementing the new requirements over time and expects to have documentation for all the current beneficiaries by August 2007. New applicants applying in district offices were required to submit the documentation starting October 1, 2006. New applicants applying through the Health Access Eligibility Unit (HAEU) by mail began, subject to the requirements, on November 1, 2006. As of December 1, 2007, current beneficiaries who have periodic eligibility reviews through the district offices began to comply. Current beneficiaries who have periodic eligibility reviews through the HAEU must comply on February 1, 2007.

On September 7, 2006, the Department issued an Emergency Rule modifying the state rules on verification of citizenship and identity and, simultaneously, the permanent rule for comment. Representative Pugh offered several comments to the Legislative Committee on Rules (LCAR) based on the committee’s comments to CMS and its previous discussions regarding this issue. See Appendix 9. The comments included ensuring that the rules were broad enough to allow for additional exemptions from the

verification requirements and expansions to the approved list of documents and sources for data match should CMS expand the list. In addition, the comments supported including some provisions regarding the financial assistance in rule or, at minimum, in policy guidance. LCAR received comments from several other interested parties and advocates as well. At its November 16th meeting, LCAR approved the emergency rule after reviewing the supplemental procedures adopted by the agency. The final rules were submitted with changes incorporating suggestions made by Representative Pugh to LCAR at its November 29th meeting and were approved as well.

The Office of Health Care Ombudsman testified to the Legislative Committee on Rules (LCAR) and to this committee that one issue has arisen so far with this requirement. When an individual is applying for Medicaid or Vermont's pharmacy programs and has an immediate, emergency need for a drug, the individual is unable to receive expedited treatment until the citizenship and identity requirements have been met. Prior to this requirement, the Office of Vermont Health Access (OVHA) had been able to expedite the eligibility review in order to ensure that the individual receives the needed drug in a very short time. The Department suggests that the individual apply for General Assistance in the district office to address this emergency need.

At the December meeting, the department testified that one of the last acts of Congress was to modify the law establishing the citizenship and identity rule to exclude individuals receiving SSDI and children in foster care from the requirements. At the January meeting, the committee decided to send a letter to the Congressional delegation reiterating some of the continuing issues with the rule. Appendix 10.

Recommendation

The committee recommends that the standing committees:

- review whether providing emergency pharmacy coverage pending verification of citizenship through general assistance is the most appropriate and effective method; and
- provide the Congressional delegation with any additional information needed in order to seek federal changes in this area as described in the Committee's letter of January 5, 2006.

Part IX. Health Care Financing Reports

History

As part of the creation of the Vermont Health Access Plan (VHAP) in 1996, the Office of Vermont Health Access (OVHA) was required to submit monthly reports to the Health Access Oversight Committee:

The office of Vermont health access shall submit to the committee monthly progress reports that shall include revenue and expenditures from the health access trust fund for the prior month, enrollment and projected enrollment, projected expenditures related to enrollment for the fiscal year, and the geographic and provider capacity of health plans to enroll beneficiaries. *Act*

14, Section 13(e)

From SFY 1997 through SFY 2000, Health Access Trust Fund (HATF) dollars were spent only on the VHAP and pharmacy assistance programs, and on program administrative costs. Starting in SFY 2001, some HATF funds were spent on other Medicaid programs, but the majority of HATF funds were still used to support VHAP and the pharmacy programs.

Beginning in SFY 2003, the HATF became the single source of state funds for all Medicaid expenditures in the OVHA budget. All other Medicaid-related spending (approximately one-third of the total) continued to be financed through a combination of general and special funds.

In October 2005, Global Commitment for Health, the state's comprehensive Medicaid Section 1115 waiver, began operations. One of the consequences of this waiver was a significant restructuring of Medicaid finances.

Current Status

As a result of the major changes in the financing and operation of the Medicaid program and related health financing programs, the Health Access Oversight Committee had several discussions about the reporting that it would need to carry out its oversight responsibilities. At the September 2006 meeting, legislative staff presented a recommended reporting format for the committee to consider. Appendix 11. Legislative staff received comments from the members and presented a final proposal at the November 2006 meeting, which was approved by the committee.

Legislative and AHS staff are designing a database to support the reporting format and to be used for a range of other analyses. One of the goals of this design process is to use enrollment and spending categories that would match those used by the AHS consulting actuaries in their calculation of the approved Global Commitment MCO premium range.

The exact format of the database is still in development, but a trial version has been provided to JFO for testing. Data elements included in the trial version are listed in Appendix 12. The proposed final design is included as Appendix 13.

Part X. Employer-Sponsored Insurance Premium Assistance Program

Introduction

Employer-sponsored insurance (ESI) is an approach to reducing the number of uninsured by using public funds (state or Medicaid dollars) to assist beneficiaries with payment of the employee share of health insurance offered by an employer. In addition to assistance with premium costs, ESI programs may include a wrap (supplemental payment) to cover some or all of the costs associated with services not included in the employer plan or to reduce the cost to the beneficiary of cost-sharing (deductibles, coinsurance) in the employer-sponsored plan.

ESI programs always include one or more tests to evaluate the employer-sponsored plan against an alternative, typically conventional coverage under the state's Medicaid program. The test may include comprehensiveness (what services are covered under the employer plan), affordability (how much the beneficiary could be required to pay), and cost-effectiveness (how much the state would spend in premium subsidy and wrap compared to how much it would spend if the beneficiary's health care costs were paid by the Medicaid program).

Background — Vermont

Act 191 ("Health Care Affordability for Vermonters") included an ESI option for two different populations—current and future VHAP beneficiaries and Catamount Health enrollees. The act requires that, prior to implementation of either plan, the Health Access Oversight Committee and the Joint Fiscal Committee review a report prepared by the Agency of Human Services and determine whether to release the balance of a \$1 million appropriation for planning and development of ESI. An initial \$250,000.00 was available to AHS at the beginning of the current fiscal year.

For individuals on VHAP (currently or newly enrolled), enrollment in an ESI plan will be mandatory if the plan meets the following standards:

- Comprehensive
- Affordable
- Substantially similar to the benefits covered under the certificates of coverage offered by the typical benefit plans issued by the four health insurers with the greatest number of covered lives in the small group and association market in this state

Any approved plan whose scope of benefits is less than VHAP or whose cost-sharing is higher will be wrapped to ensure that the individual's costs are no higher than they would be under VHAP.

For individuals who qualify for Catamount Health premium assistance, assistance will be provided toward the cost of ESI, rather than toward the cost of Catamount Health, if the ESI plan is:

- Comprehensive
- Affordable
- Substantially similar, as determined by the Agency (of Human Services), to the benefits covered under Catamount Health (standards for coverage of chronic diseases are temporarily lower than Catamount Health)

There are two options for treating plans with the same scope of coverage as Catamount, but with higher cost-sharing. These are to wrap plans to bring them up to the Catamount coverage or to approve only plans with cost-sharing equal to or less than Catamount. The agency decided to wrap plans in order to ensure similar coverage to Catamount Health.

Policy Issues

Several broad policy questions arise both in the design of an ESI program and in the decision whether to implement the program. These include:

- Eligibility and enrollment
- Net costs and savings
- Effects on beneficiaries
- Broader system impacts

A central concern is the number of beneficiaries who will enroll in the ESI program. Enrollment is a function of several variables, including:

- Financial eligibility
- Proportion of eligibles who enroll if the plan is optional, or the “take-up rate”
- Types of plans offered by employers:
 - Premium
 - Benefits
- Administrative complexity

Financial eligibility is based on the federal poverty level (FPL) up to which an individual is eligible. FPL is a function of both income and family size.

Not everyone who is eligible for a program will actually enroll. Each individual’s decision is based on the perceived costs (in this case, primarily the premium) and benefits of enrollment, compared with other goods and services that the individual may choose to purchase. Take-up rate is estimated as the proportion of an eligible population who will actually choose to enroll in the program.

The value of an ESI program in comparison to a traditional Medicaid program is dependent on the coverage offered by employers. For example, the more the employer contributes toward the cost of coverage, the more cost-effective the plan will be for the state.

If the enrollment process becomes too complex, it may reduce the number of eligible individuals who enroll in the program.

Among the possible advantages of an ESI plan is the capacity to save state funds. There are two types of savings – direct and cost avoidance. Direct savings occur when a currently covered individual is transferred from a state program to ESI. As long as the cost to the state for the premium subsidy (and wrap, if there is one) is less than the cost of paying directly for health services, the state saves money. Prospective savings are only an estimate.

Cost avoidance occurs when ESI is a component of any initiative to increase enrollment, including an eligibility expansion or a premium reduction. Cost avoidance is the difference between what a newly-enrolled individual would cost the state under a direct

payment model and what the premium subsidy and wrap would cost. The difference between savings and cost avoidance is that no funds are currently being expended for individuals in this category.

Estimating effects on beneficiaries is also complex. Possible positive consequences of enrollment in an ESI program include better access to care as a result of reimbursement at commercial rates rather than at Medicaid rates and behavioral changes tied to the individual's perceptions about being on Medicaid and being insured. Possible negative consequences of enrollment in an ESI program include increased complexity of coverage because the individual has two coverage sources and increased administrative burden on the individual who must complete paperwork for both the insurer and the state agency.

Among the complexities in the ESI program design process are the characteristics of employer-sponsored insurance in Vermont, including the scope of benefits, cost-sharing, total premium, and employee share of premium. Knowing all of these variables is important for estimation of costs and savings, but the sources of information are primarily limited to data from national surveys.

ESI programs are administratively complex. For each individual eligible for enrollment in his or her employer's plan, information must be gathered about the characteristics of the plan and about the health status of the individual in order to make an accurate determination of cost-effectiveness. A mechanism must be created to pay the premium subsidy and to coordinate wrap benefits with the underlying employer plan, if a wrap is part of the program. Consideration must be given to employer open enrollment periods and the consequences of beneficiary job changes.

One of the immediate effects of an ESI program will be, in certain circumstances, to increase the level of reimbursement paid to most providers, since, in most cases, Medicaid reimbursement is lower than that paid by commercial insurance. Increased reimbursement should reduce the cost shift to some extent, but the actual effect on private insurance premiums is extremely difficult to estimate. Actual effects will be dependent on how the wrap is designed. If the wrap reimburses only up to Medicaid reimbursement, as is the case in most other programs where Medicaid wraps other insurance, costs to the state will be lower, but effects on cost-shifting will be less. In addition, an ESI program will increase provider administrative burdens, because in many cases the provider must bill first the insurer and then the state agency to receive payment for the services.

Analysis and AHS Report

In order to provide the most accurate information possible for the design of the program and for the decision by the Health Access Oversight Committee and Joint Fiscal Committee, agency staff, consultants, and legislative staff have worked on several analyses. These include:

- Analysis of the 2005 Vermont Household Health Insurance Survey (VHHIS), conducted by BISHCA, to determine the number of individuals eligible for Medicaid, Catamount Health, and ESI under either plan.

- Analysis of a new survey of current Medicaid beneficiaries to improve estimates of the number who have access to ESI, and to link eligibility to claim costs to estimate better cost-effectiveness.
- Development of estimates of “take-up rates,” which is the proportion of eligibles who will actually enroll. This analysis was done by Ken Thorpe, the legislature’s consultant, and Sherry Glied, the administration’s consultant.
- Modeling to determine the sensitivity of cost-effectiveness to differences in premium and cost-sharing assumptions.
- Design of administrative processes for the program.
- Analysis of other states’ ESI programs by joint fiscal staff. Appendix 14.

On November 22, 2006, the agency provided a report as required by Act 191, which recommends approval of the ESI program and estimates state savings and cost avoidance of \$5.4 million over state fiscal years 2008 through 2010. Appendix 15.

The committee met with the Joint Fiscal Committee and interested members of the Commission on Health Care Reform on November 27, 2006 for a briefing on this issue. Legislative staff reviewed the statutory provisions and presented an overview of the analytical issues to consider. Betsy Forrest and Joshua Slen, OVHA, reviewed the report with the committees and explained the recommendation. The members discussed what additional information would be helpful in making a decision and requested legislative staff to provide the committees with an analysis of the issues.

In late November, legislative staff provided the committees with a written report analyzing the assumptions and methodology of the administration’s report and raised additional financial and policy issues for the committee’s consideration. Appendix 16.

Both committees again met on December 12, 2006 and heard from legislative staff and the administration. The committee decided to approve the expenditure of the remaining funds with ongoing review and oversight on implementation of the program. Appendix 17.

Recommendation

The committee recommends to the appropriate standing committees of jurisdiction that the standing committees continue to consider the outstanding policy and implementation issues and assess the advisability of further pursuit of the ESI program.

Part XI. Chronic Care and the Blueprint for Health

On October 1, 2006, the Vermont Department of Health submitted a revised strategic plan for the Vermont Blueprint for Health. The document was presented as an “interim” plan to allow broader input by the public and stakeholders by the end of 2006. In its final form, the plan will serve as a guide for operational planning and implementation and as a reference for evaluation for the Blueprint for the next five years.

Essentially, the interim plan calls for improvements in four broad areas: reduced prevalence of chronic disease, improved health status, improved quality of life, and moderation in health care costs. Specific objectives and strategies to accomplish these goals are spelled out for individual Vermonters, health care professionals, communities, health systems, and information technology. The plan describes how prevention services will be incorporated and provides target dates for implementation of all elements of the plan. The plan also addresses key management areas, including organizational structure and function, marketing, finance, and evaluation.

Part XII. Choices for Care Waiver and Long-Term Care Issues

The committee heard bimonthly updates on the first-year implementation of the new Medicaid long-term care waiver, known as Choices for Care, which began in October 2005. This Medicaid 1115 demonstration waiver gave Vermont a first-of-a-kind exemption from Medicaid rules, allowing DAIL to pool funds for nursing home and home- and community-based services (HCBS) that formerly were in separate “silos.” The waiver effectively eliminates the federal bias where the only Medicaid entitlement was for nursing home services. Previously, individuals with the highest level of need were entitled to direct entry into a nursing home but had to wait in line for a limited number of “slots” to open up if they opted for home- and community-based services. Now highest-need individuals are entitled to choose *either* nursing home care *or* home- and community-based services consistent with their needs and preferences. The waiver provides greater choice to beneficiaries and families, in consultation with their case managers and state nurses, to determine where an individual will receive care.

Description of Choices for Care

Goals and Objectives. The goals of Choices for Care are to increase access to home- and community-based services, reduce use of nursing home services, serve more people, and manage overall costs for long-term care spending. The basic premise is that, given the choice, more people will choose to have their long-term care needs met in their own homes and communities rather than in institutions. Expanding home- and community-based service options will serve this growing consumer preference while decreasing Vermonters’ reliance on nursing home care. The state expects to save money because HCBS services cost less on average than institutional services. Under the waiver, any savings realized as beneficiaries shift to HCBS services are to be reinvested into serving more people at home or in community settings, including persons who are at risk for Medicaid long-term care services but are not yet eligible. The hope is that, with fewer beneficiaries using high-cost nursing facility services, more funds will be available to increase HCBS services for more participants.

Gradually “Shifting the Balance.” The May 2006 report *Shaping the Future of Long-term Care and Independent Living*³ lays out DAIL’s current target for creating a more “balanced” long-term care system. For every 100 people receiving Medicaid long-term care services, no fewer than 40 individuals will be served by home- and community-

³ Available at <http://www.dad.state.vt.us/WhatsNew/ShapingTheFuture20052015May2006.pdf>

based providers, while no more than 60 will be served in nursing homes. Upon attaining this 60/40 balance statewide, the next step is to plan for a 50/50 balance. However, it is difficult to predict the eventual balance since the development of new options and changes in consumer preferences will influence the outcome.

- A chart in the *Shaping the Future* report (p. 16) illustrates how the 60/40 balance has been achieved in seven of Vermont's 14 counties.
- Another chart (p. 15) tracks the progressive shift in Vermont's Medicaid long-term care spending in favor of HCBS services. In FY 2005, one-third of Medicaid long-term care spending (about \$50 million) supported services in home- and community-based programs while the other two-thirds (about \$100 million) went to nursing facilities.

Participants Categorized by Level of Need. Under Choices for Care, eligible individuals are assigned to one of three groups based on their level of need for long-term care services. The "Independent Living Assessment" is used to assess an individual's level of need (or "clinical eligibility") for long-term care services.⁴ The three categories of need are "highest needs," "high needs," and "moderate needs," as follows:

- The "*highest needs*" group consists of frail seniors and adults with physical disabilities who are determined through the detailed clinical assessment process to require "extensive or total assistance." If they meet Medicaid long-term care financial eligibility, these individuals are automatically entitled to:
 1. Receive long-term care services in a home- and community-based setting (without having to wait for funding to become available); or
 2. Choose care in a nursing facility.
- The "*high needs*" group consists of individuals who meet Medicaid LTC financial eligibility but whose long-term care needs do not require the highest level of assistance. For example, these individuals may have less significant functional impairments or may be able to regain some lost function with appropriate therapy or training. Persons in this category are still eligible for HCBS or nursing home services but may be placed on a waiting list if funds are not available.
- The "*moderate needs*" group is a waiver "expansion" population. It consists of individuals who previously may not have qualified for LTC Medicaid but whose long-term care needs put them at risk of institutional placement. This group is eligible to receive "preventive and supportive" services only. The purpose is to help stabilize or improve these participants' conditions and thereby prevent or forestall the need for more costly care.
 - Benefits for "moderate needs" individuals are limited to three services that offer preventive and supportive care—namely, adult day, homemaker, and case management services.

⁴ Available at [http://www.dad.state.vt.us/dail/Forms/IndependentLivingAssessmentForm\(Oct-2006\).pdf](http://www.dad.state.vt.us/dail/Forms/IndependentLivingAssessmentForm(Oct-2006).pdf)

- Individuals in this expansion group are served with a specific set-aside of funding. The federal waiver provided the flexibility to create this set-aside for preventive and supportive services by effectively converting some funds from previous General Fund-only programs into waiver programs that can be funded with federal Medicaid dollars (i.e., the 60-percent federal match).
- Individuals in this group may also be eligible for other state and federally funded programs such as Older Americans Act services (though the area agencies on aging) or Medicaid State Plan services such as skilled nursing services from home health agencies.

Evaluation and Monitoring Design. The waiver requires that the state conduct an independent evaluation of the waiver demonstration's impact on applicants and participants. The evaluation will examine such things as participant satisfaction, impact on the array and amount of services available in the community, effectiveness in delaying the need for nursing facility care, and overall cost-effectiveness. The evaluation findings are important to quality improvement and possible modifications to the waiver that may better serve beneficiaries. DAIL brought an advance copy of the RFP to select an independent evaluator before the DAIL Advisory Board in October. At its October 2006 meeting, the Committee requested that DAIL share a draft of the RFP with HAOC members as well, which DAIL provided following the meeting.

Highlights from DAIL testimony and reports on first year implementation

1. Person-Centered Assessment and Options Counseling. Vermont has established a team of 12 nurses (Long-term Care Clinical Coordinators) across the state to work with candidates for Medicaid long-term care. When older Vermonters or adults with physical disabilities are admitted to a hospital or become too frail or disabled to live on their own, the clinical coordinators conduct an "independent living assessment" to determine the level of care needed, and they counsel the individual on available options to ascertain the individual's preferences.

- DAIL reported that the department's Long-Term Care Clinical Coordinators determined clinical eligibility for over 2,700 individuals applying for services during the first year of implementation.
- The new process for the assessment of clinical eligibility using LTC Clinical Coordinators is proving to be a more cohesive and consistent process for determining level of need than the previous system.

2. Increase in Consumer Direction. Choices for Care has enhanced the role of consumer choice, control, and direction in home- and community-based care. In the home based setting, the program offers three services that may be directed by the participant (consumer-directed) or a surrogate (surrogate-directed)-i.e., personal care, respite care, and companion services. If participants are willing to be the employer and able to direct their own care, or if they have a surrogate who can be the employer, they recruit, train, and supervise their own attendants. Payroll services are provided by a fiscal intermediary under contract with the state.

- DAIL reported that the percentage of services being managed under consumer-directed or surrogate-directed arrangements increased from 50 percent to 65 percent in the first year of the waiver.

3. *More Beneficiaries Receiving Home- and Community-Based Services (HCBS).* DAIL provided regular updates on its continued efforts to improve and expand home- and community-based services and decrease the use of nursing facility care.

- First-year results as of October 2006 showed an incremental increase in individuals receiving home- and community-based services (146 more persons). This was almost equal to the decrease in number of nursing home residents (155 fewer residents):

Care Setting	Persons Served—Oct. 2006	Compared to Oct. 2005
Nursing Facility	2,131 residents	155 fewer
Home-based Care	1,134 individuals	146 more
Enhanced Residential Care	232 residents	59 more

- The above table also shows that there were 205 more people who were receiving either home-based care or Enhanced Residential Care (ERC) over the year before. DAIL estimated that this increase in persons served in noninstitutional settings was twice as large as would have occurred under the previous system, which had experienced relatively constant increases of only 80-90 new people a year. The 34-percent increase in Enhanced Residential Care enrollment was significant because enrollment had remained flat in previous years.
- Overall, the number of people participating in the Choices for Care waiver increased by 557 individuals—from 3,447 individuals at the start of the waiver to 4,004 individuals as of October 2006. Most of these individuals were in the “moderate needs” group.
- 509 participants were served in the “moderate needs” group—about 100 more individuals than DAIL projected would be served under the fixed set-aside of funds. According to DAIL, it was possible to serve 25 percent more people than projected because many participants needed some but not all three types of services available (i.e., adult day, homemaker, and case management services).

4. *Waiting List for “High Needs” Participants.* DAIL also reported that, as of November 15, 2006, the waiting list for Medicaid long-term care services decreased to 73 individuals who are in the “high needs” category.

A year ago, under the old system of “slots” for HCBS services that preceded Choices for Care, there were 241 individuals on the waiting list. Since October 1, 2005, 258 “high needs” individuals have been admitted to Choices for Care.

The anticipated size of the waiting list in the future years of the waiver was a concern of the committee. DAIL officials expressed “confidence” that the waiting list will not

exceed more than a small percentage of people in the high needs group. DAIL has developed a prioritization strategy to ensure that persons on the waiting list are served in order of greatest need—for example, if their condition deteriorates or if there is the loss of a spouse acting as caregiver. This year 35 individuals were moved from the “high needs” to “highest needs” list because of such “special circumstances.”⁵ The waiting list is discussed at the “waiver team” meetings held monthly in each county with the relevant stakeholders in Medicaid long-term care (e.g., providers, clinical coordinators, case managers, area discharge planners). In August 2006, DAIL determined there was sufficient funding to take 12 individuals off the waiting list. As of December 2006, DAIL anticipates that another 12-15 individuals will be removed from the waiting list.

5. *“Savings” and the Financial Health of Nursing Homes.* As reflected in the table above, nursing homes are serving 155 fewer Vermonters in October 2006 than a year ago, a decline from 2,286 to 2,131 Medicaid-funded residents. DAIL estimated that this decreased usage and thus a reduced trend in reimbursements paid to nursing homes translate into a Medicaid “savings” of \$1.6 million for FY 06.

These “savings” remain in the LTC system and may be used to serve more people, to help stabilize the system through reimbursement increases, or to develop/expand additional options. For example, in FY 06, the first year of the waiver, the Choices for Care budget had \$1.6 million to reinvest, after covering the 205 new individuals admitted to the program. This \$1.6 million was carried over into FY 07. The DAIL spending plan for FY 07 projects that the \$1.6 million will be needed to cover services for additional program participants. However, looking forward to FY 08, DAIL is examining whether it would be prudent to use a portion of these funds to increase reimbursements for providers. The final recommendation on this question will come in the FY 08 budget as part of the recommendations from the Long Term Care Sustainability Study.

The committee asked about the impact of declining reimbursements on the financial condition of nursing facilities. DAIL responded that the situation remains “in flux” as the nursing home industry adjusts to the new reality of Vermont’s increasingly available home- and community-based alternatives. As of October 2006, at least five nursing homes were exempted from the standard nursing home payment rules and were being paid under the provisions for “extraordinary financial relief.” At its October meeting, the committee requested that, for future updates, DAIL provide a concise summary of nursing home industry impact, including:

- Information concerning which individual nursing homes are being paid under “extraordinary financial relief,” have newly applied for such relief, or are otherwise at serious financial risk
- Occupancy census statistics by geographic area or county and reports of beds that have come off line

⁵ The Department shall enroll an individual in the Highest Need group when the Department determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual’s safety. *Choices for Care Regulations.*

6. *Managing Funding under the Five-Year Budget Neutrality Cap.* A critical issue in Choices for Care is the state's capacity to manage a fixed amount of funding under the waiver's five-year aggregate spending limit. The waiver imposes a "budget neutrality" cap that will close off federal matching funds once total expenditures exceed \$1.236 billion for the five-year demonstration. This spending cap places the state at financial risk if growth trends in either of two areas (or both) run higher than projected:

1. Increases in enrollment—e.g., if pent-up demand for home-based services were to produce a "woodwork" effect
2. Per member per month (PMPM) costs—e.g., if HCBS settings were to attract a much higher proportion of high acuity patients than previously.

Accordingly, the committee asked DAIL about trends in these two areas. DAIL officials sought to allay concerns about both the woodwork effect ("it hasn't happened and we don't see it happening") and increasing acuity trends in HCBS participants ("average plan of care costs for HCBS services are lower than a year ago").

7. *Concern about Financial Pressures.* According to the May 2006 *Shaping the Future* report (p. 15), Choices for Care "allows Vermont to serve more people . . . while managing the system within the available funds so as to avoid creating a 'runaway' entitlement." The committee sought DAIL's assurances that expanding services to new people at the current rate will not risk exacerbating financial pressures that down the road could over-commit state and federal funding. Comments from committee members revolved around the following policy concerns:

- Nursing home "savings" will diminish as the decline in nursing home beds levels off ("saturation point"). As that happens, expanding services to more people will become a growing expense. How will serving more people be managed to avoid putting the state at financial risk?
- Using nursing home "savings" to serve more beneficiaries must be balanced against the first priority of ensuring that the system as a whole is supported. Greater demand on a fragile system of community providers could undermine planning efforts aimed at improving reimbursement methodologies and using some nursing home savings to increase reimbursement for HCBS providers. How is DAIL planning to create the right balance?
- How will DAIL ensure that sufficient funds will also be available to meet the continued need of some of the state's nursing homes for "extraordinary financial relief" to maintain their viability and, where appropriate, to support those facilities in downsizing to adjust to declines in occupancy?

DAIL officials agreed on the overriding importance of addressing the pressures contributing to financial instability within the long-term care system. DAIL pointed to two studies due to the legislature in mid-January 2007 that will provide a comprehensive analysis of the long-term care system in Vermont and offer recommendations for strengthening the financial viability of the system:

- Long-term Care Sustainability Report
- Nursing Home Reimbursement Study

A. Long-Term Care Sustainability Report—January 15, 2007

Sec. 149a of No. 215 of the Acts of the 2005 Adj. Sess. (2006) directed DAIL to collaborate with nursing homes, residential care homes, assisted living residences, home health agencies, area agencies on aging, and adult day providers to address the sustainability of Vermont's long-term care system. The Long-Term Care Sustainability Task Force convened by DAIL has met monthly since June 2006 and is required to issue a report by January 15, 2007. The report will:

- Describe Vermont's rapidly changing long-term care "system"
- Set forth a vision for the system over the next five years
- Make projections of the provider and program capacity needed (including nursing home beds)
- Discuss nursing home occupancy levels and strategies for reducing "overbedding"
- Recommend a framework for creating more systematic reimbursement for all providers of long-term care services

The hope is that this study will provide the cornerstone of a reimbursement system that actively promotes home- and community-based services and adequately funds community-based providers, yet assures that a reconfigured nursing home industry has the resources to continue providing high quality care to the frailest members of Vermont's population.

B. Nursing Home Reimbursement Study

The task force studying nursing home reimbursements consists of six nursing facility administrators, the executive director of the Vermont Health Care Association (VHCA), two CPAs who work with the nursing facilities, the AHS business office (Allen Merritt), the Division of Rate Setting (Kathleen Denette and Patricia Elias), Patrick Flood (commissioner of DAIL), and Joan Senecal (deputy commissioner of DAIL). DAIL issued an RFP and selected Pacific Health Policy Group as the consultants to support the task force. The task force completed an assessment of the pros and cons of the current system, identified key areas of interest, and reviewed various models at its November meeting. The key areas that the models address are: inflation factors, occupancy adjustment, cost center ceilings, and cost allocation rules.

This report on nursing home reimbursement will assist the legislature in its review of rules for setting Medicaid rates for nursing home services that in FY 2006 increased financial pressures on nursing facilities with low occupancy. As required by the 2005 appropriations bill (Sec. 302 of No. 71 of the Acts of the 2005 Adj. Sess. (2006)), the minimum occupancy standard used in setting a nursing facility's per diem Medicaid payment for nursing, residential care, indirect, and property costs increased from 90 percent to 93 percent occupancy effective July 1, 2005. This means that if a facility's occupancy is below 93 percent when "re-basing" occurs (a process of rate adjustments to reflect current costs), the per diem payment rate will be lower than under the 90 percent occupancy standard. The effect is to reduce the rates of those nursing homes that are running below the minimum occupancy level, providing a financial incentive to reduce

unnneeded bed capacity. The 2006 appropriations bill (Act 215, Sec. 272) lowered the minimum occupancy standard back to 90 percent “effective for FY 2007 only.” The minimum occupancy standard will thus revert back to 93 percent on July 1, 2007 unless addressed during the upcoming legislative session.

Last, the committee requested the department to include information about nursing homes and the financial status of nursing homes in future reports about the Choices for Care waiver as both the home and community based services and nursing homes are vital parts of Vermont’s long-term care system.

Recommendation

The committee recommends that the standing committees review the two reports due to the legislature in mid-January 2007 that will offer recommendations for strengthening the overall financial viability of the long-term care system in Vermont:

- Long-Term Care Sustainability Report
- Nursing Home Reimbursement Study

In addition, the committee recommends routine reporting from DAIL providing information on Medicaid long-term care, the sustainability of nursing homes, and the home- and community-based care network.

Part XIII. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Implementation of the VPharm Program

Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has had significant effects on Vermont’s Medicare beneficiaries, including those who also receive coverage under Medicaid and Vermont’s pharmacy programs. The act has had a substantial effect on the financing of the Medicaid program. Sections 314–316 of Act No. 71 (2005) created the VPharm program in Title 33, chapter 19, subchapter 8 to wrap around the Medicare Part D pharmacy benefit and modified the current pharmacy programs. This section of the report provides a very general overview of the Medicare drug benefit, the impact on Vermont pharmacy program beneficiaries, and the implementation issues presented by the Medicare drug benefit and the VPharm program considered by the committee.

Overview

The most well-known aspect of the act is to provide pharmacy coverage to all Medicare beneficiaries. The following table summarizes coverage and costs at different income levels. When comparing coverage, it is important to recognize the different effects of premiums and cost-sharing. Premiums affect all members of each eligibility group equally. Cost-sharing (co-pays and deductibles) affects sicker individuals more and healthier individuals less. The VPharm program provides wraparound coverage for eligible beneficiaries to limit the premium and cost-sharing of these individuals.

Comparison of New Medicare Pharmacy Benefits with Current Vermont Pharmacy Assistance Programs

Income	2005 Vt. Program	Medicare Part D Premium	Medicare Part D Cost Sharing	VPharm
Dual-eligibles (usually under 100% of poverty)	Traditional Medicaid – no premium	None	\$1 (generic) / \$3 brand co-pay	Covers excluded drug categories and cost-sharing for EPSDT and pregnant women
Up to 135% of poverty, \$6,000/\$9,000 assets	VHAP Pharmacy; \$13/month (no cost-sharing)	None	\$2 (generic)/\$5 (brand) co-pay	Covers excluded drug categories; \$15/month (no cost-sharing)
135% to 150% of poverty, \$10,000/\$20,000 assets	VHAP Pharmacy; \$13/month (no cost-sharing)	Sliding scale (\$0 to \$35 per month)	\$50 deductible 15% coinsur. up to \$3,600, then \$2/\$5	Covers excluded drug categories, Part D premiums, and cost-sharing; has a \$15/month state premium (no cost-sharing)
150% to 175% of poverty	VScript – maintenance drugs only; \$17 / month (no cost-sharing)	\$ varies by plan	\$265 deductible 25% coinsur. to \$2,400, no benefits to \$3,850, then 5% coinsurance (details below)	Covers excluded drug categories, Part D premiums, and cost-sharing for maintenance meds; has a \$20/month state premium (no cost-sharing)
175% to 225% of poverty	VScript Expanded – maintenance meds only; \$35/month (no cost-sharing)	Same as above	Same as above	Covers excluded drug categories, Part D premiums, and cost-sharing for maintenance meds; has a \$42/month state premium (no cost-sharing)
225% to 400% of poverty	Healthy Vermonters Program	Same as above	Same as above	No coverage
Above 400% of poverty	None	Same as above	Same as above	No coverage

Medicare drug benefits are offered by private insurance entities—either as part of comprehensive managed care coverage (Medicare Advantage) or as a stand-alone prescription drug plan. For 2007, there are 51 stand-alone prescription drug plans (PDPs) in Vermont, an increase from 44 plans offered in 2006. 14 of the plans qualify for Medicare's premium subsidy for persons with limited incomes. Not all 11 of the qualifying plans from 2006 have stayed in Vermont. Premiums in 2007 range from \$13.40 to \$87.40 per month, increasing from a range between \$7.32 and \$65.58 per month in 2006. Because some of the PDPs have left or have increased their premiums above the qualifying benchmark, some beneficiaries currently enrolled in Medicaid or VPharm will be automatically enrolled into a new PDP. The federal law requires that the automatic enrollment be random, so beneficiaries are being encouraged to review the plan assignment to ensure it meets their needs. In fact, because plans have changed cost-sharing and other coverage, all beneficiaries should be encouraged to check their coverage to make sure the plan is still the best option for them.

As of June 11, 2006, according to the Centers on Medicare and Medicaid Services (CMS), 74,238 of approximately 90,000 eligible Vermonters had enrolled in Medicare Part D coverage. Between November 15, 2006 and December 31, 2006, Medicare beneficiaries can sign up for prescription drug plans or switch PDPs. However, in order to have coverage in effect by January 1, 2007, beneficiaries must enroll by December 8, 2006. Information and assistance is being provided through the area agency on aging organizations and the Health Care Ombudsman's Office.

During the 2006 session, the legislature authorized emergency coverage provisions and an additional expenditure of \$11 million to ensure that beneficiaries received adequate coverage, because there were tremendous difficulties with the federal implementation. Nos. 84, 91, 95, and 109 of the 2005 Adj. Sess (2006). The committee heard testimony from the Office of Vermont Health Access, the Department of Disabilities, Aging, and Independent Living, and the Health Care Ombudsman's Office about ongoing challenges. The testimony was that there continue to be difficulties for beneficiaries, especially when a beneficiary changes plans. Although the number of problems has decreased, however, the complexity of the problems has increased. One frequent issue is coverage of the six special drugs that people should be able to access without prior approval. These include psychiatric and cancer drugs. In addition, there have been problems with the timely processing of exceptions and appeals. The CMS Boston office has assisted in resolving complaints and problems. In addition, BISHCA has followed up on several complaints about marketing and sales. There were three poorly performing plans which have merged with other companies that were doing fairly well, so it is hoped these plans will improve.

OVHA also testified that the agency had submitted a request to CMS to be reimbursed for drug claims paid for by the state that should have been paid for by the Part D plans. OVHA is requesting reimbursement for claims from 1/1/06 to 3/31/06, totaling \$6.2 million for Medicaid eligibility individuals and \$2.9 million for low income subsidy (LIS) eligible individuals enrolled in VPharm. For claims after March 31, OVHA will pursue collection from the insurance companies. There will be an additional claim for administrative expenses incurred due to the operational problems at the federal level.

Recommendation

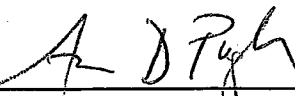
The committee recommends that the standing committees continue to monitor the progress of the Office of Vermont Health Access in seeking reimbursement from CMS and from the Medicare Part D Prescription Drug Plans for state expenditures during 2006 resulting from operational problems at the federal and PDP levels.

In addition, in last year's report, the committee recommended that the standing committees consider whether the VPharm program should cover cost-sharing for individuals in home- and community-based care through the Choices for Care waiver in order to ensure that these individuals have the same pharmacy coverage as individuals in nursing homes. The standing committees should consider this issue this year as this committee did not receive an update.

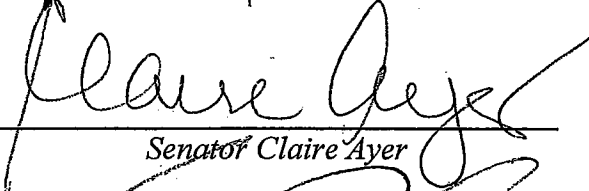
2006 Report of the Health Access Oversight Committee to the Vermont
General Assembly and the Governor of the State of Vermont



Senator Jeanette White, Chair



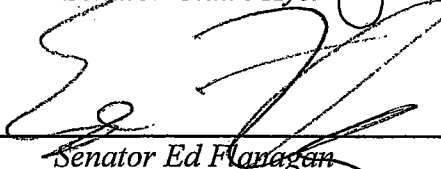
Representative Ann Pugh, Chair



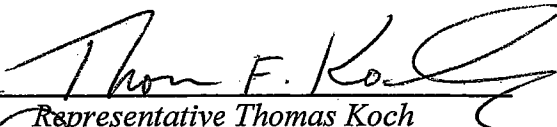
Senator Claire Ayer



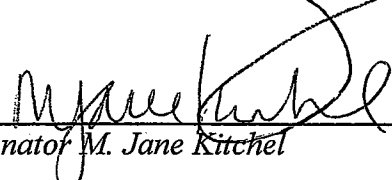
Representative Michael Fisher



Senator Ed Flanagan



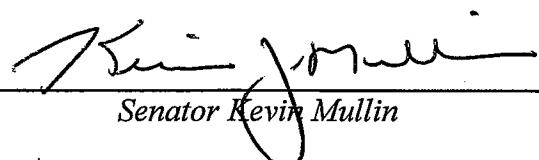
Representative Thomas Koch



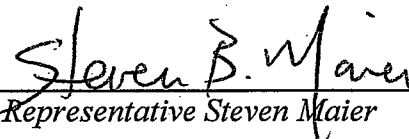
Senator M. Jane Kitchel



Representative Mark Larson



Senator Kevin Mullin



Representative Steven Maier

Appendices

Appendix	Title
1	Health Access Oversight Committee – Statutory Authority
2	2006 Witness List
3	Medicaid and Medicaid-expansion Chronology
4	Family Income by Size and Federal Poverty Level Chart
5	Overview of Health Coverage Programs
6	Medicaid Reimbursement Increases: Statutory Language
7	Medicaid Citizenship Documentation: Committee Comments on Interim Final Rule
8	Medicaid Citizenship Documentation: APHSA/NASMD Comments on Interim Final Rule
9	Medicaid Citizenship Documentation: Memo to LCAR
10	Medicaid Citizenship: Letter to Congressional Delegation
11	Health Care Financing Reports: Recommended Reporting Format
12	Health Care Financing Reports: Preliminary Database Design
13	Health Care Financing Reports: Database Design Document
14	Employer Sponsored Insurance: JFO Report re: other states
15	ESI: Agency of Human Services Report
16	ESI: Staff Analysis
17	ESI: Motion

the 1990s, the number of people in the UK who are aged 65 and over has increased from 10.5 million to 13.5 million (13.5% of the population).

There is a growing awareness of the need to address the needs of older people, and the Government has set out a strategy for the 21st century in the White Paper on *Ageing Better: The Government's Strategy for Older People* (Department of Health 2000). This strategy is based on the following principles:

- Older people should be able to live independently and actively in their own homes.
- Older people should be able to live in their own communities.
- Older people should be able to live in their own homes and communities for as long as possible.

These principles are reflected in the following objectives of the strategy:

- To ensure that older people are able to live independently and actively in their own homes.
- To ensure that older people are able to live in their own communities.
- To ensure that older people are able to live in their own homes and communities for as long as possible.

The strategy also sets out a number of key actions to be taken to achieve these objectives:

- To ensure that older people are able to live independently and actively in their own homes.
- To ensure that older people are able to live in their own communities.
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**Appendix 1. Health Access Oversight Committee:
Statutory Authority 2 V.S.A. Chapter 24**

CHAPTER 24. HEALTH ACCESS OVERSIGHT COMMITTEE

§ 851. CREATION OF COMMITTEE

(a) A legislative health access oversight committee is created. The committee shall be appointed biennially and consist of ten members: five members of the house appointed by the speaker, not all from the same political party, and five members of the senate appointed by the senate committee on committees, not all from the same political party. The house appointees shall include two members from the house committee on human services, two members from the house committee on health care, and one member from the house committee on appropriations. The senate appointees shall include three members from the senate committee on health and welfare, one member from the senate committee on finance, and one member from the senate committee on appropriations.

(b) The committee may adopt rules of procedure to carry out its duties.

§ 852. FUNCTIONS AND DUTIES

(a) The health access oversight committee shall carry on a continuing review of the operation of the Medicaid program and all Medicaid waiver programs that may affect the administration and beneficiaries of these programs.

(b) In conducting its review and in order to fulfill its duties, the committee shall consult the following:

- (1) Consumers and advocacy groups regarding their satisfaction and complaints.
- (2) Health care providers regarding their satisfaction and complaints.
- (3) The office of Vermont health access.
- (4) The department of banking, insurance, securities, and health care administration.
- (5) The agency of human services.
- (6) The attorney general.
- (7) The health care ombudsman.
- (8) The Vermont program for quality in health care.
- (9) Any other person or entity as determined by the committee.

(c) The committee shall work with, assist, and advise other committees of the general assembly, members of the executive branch, and the public on matters relating to the state Medicaid program and other state health care programs. Annually, no later than January 15, the committee shall report to the governor and the general assembly.

§ 853. MEETINGS AND STAFF SUPPORT

(a) The committee may meet during a session of the general assembly at the call of the chair or by a majority of the members of the committee. The committee may meet during adjournment subject to the approval of the speaker of the house and the president pro tempore of the senate.

(b) For attendance at meetings which are held when the general assembly is not in session, the members of the committee shall be entitled to the same per diem compensation and reimbursement for necessary expenses as those provided to members of standing committees under section 406 of this title.

(c) The staff of the legislative council and the joint fiscal office shall provide professional and administrative support to the committee. The department of banking, insurance, securities, and health care administration, the agency of human services, and other agencies of the state shall provide information, assistance, and support upon request of the committee.

Appendix 2. 2006 Witness List

Sharon Moffatt, Interim Commissioner, VDH
Joshua Slen, Director, OVHA
Paul Harrington, Vermont Medical Society
Marybeth McCaffrey, Esq., Health Care Policy Analyst, AHS Economic Services Division
Don Dickey, Medicaid Policy Analyst, JFO,
Donna Sutton Fay, Health Care Ombudsman
Steve Kappel, JFO
Cassandra Edson, Legislative Counsel
Robin Lunge, Legislative Counsel,
Susan Besio, Director of Health Care Reform Implementation
Steve Gold, Deputy Secretary, AHS
Les Birnbaum, Esq., Health Policy Analyst, Planning, Policy and Regulations Unit,
Economic Services Division
Trinka Kerr, Staff Attorney, Office of Health Care Ombudsman
Carrie Hathaway, Administrative Services Director, OVHA
Sarah Clarke, Assistant Agency Finance Operations Manager
Mary Day, Agency of Human Services Managed Care Organization Administrator
Betsy Forrest, Health Care Affordability Project Coordinator, AHS
Randy Brock, State Auditor
Brendan Hogan, Director, Health Programs Integration Unit, OVHA
John Klesch, Vermont Retail Association
Jackie Flanagan, VPIRG
Hunt Blair, Bi-State Primary Care
Lila Richardson, VCDR
Ann Rugg, Deputy Director, OVHA
Anthony Otis, Vermont Pharmacy Retail Association
Greg Farnum, President, VITL
Theresa Wood, Deputy Commissioner, DAIL
Theo Kennedy, Director, Planning, Policy and Regulations, DCF
Peter Taylor, Vermont Dental Society
Patrick Flood, Commissioner, DAIL
Michael Benvenuto, Senior Citizens Law Project
Jackie Majoros, LTC Ombudsman

Appendix 3. Medicaid and Medicaid-Expansion Chronology

1967

- ✓ Vermont's Medicaid program begins.

1987

- ✓ Protected Income Levels raised to federal maximum.
- ✓ Income test for pregnant women and children raised to 100% of FPL.
- ✓ Coverage for Katie Beckett children.
- ✓ Home- and Community-Based Services waiver implemented.

1988

- ✓ Income test for pregnant women and infants (under age 1) raised to 185% of FPL.
- ✓ Income test for children (over age 1 and born after 9/30/83) raised to 100% FPL.

1989

- ✓ Dr. Dynasaur created as a state-funded program with no resource test for pregnant women to 200% of FPL and children under age 7 to 225% of FPL.
- ✓ Medicaid resource test eliminated for pregnant women and children born after 9/20/83.
- ✓ Qualified Medicare beneficiaries are covered by Medicaid for the out-of-pocket costs of Medicare-covered services (100% FPL and resource test).
- ✓ VScript created as a state-funded program for elderly and disabled to 175% of FPL.

1990

- ✓ Medicaid income test increased for children (ages 1-5) to 133% of FPL.

1992

- ✓ Dr. Dynasaur incorporated into Medicaid program by increasing Medicaid income test for children (under age 18) to 225% of FPL; by eliminating resource test for children (under age 18); and by increasing the income test for pregnant women to 200% FPL.
- ✓ HIV/AIDS Insurance Assistance Program created.

1995

- ✓ Act 14 authorizes VHAP, a Section 1115 Medicaid waiver permitting coverage of low income uninsured Vermonters and a pharmacy program for low income elderly and disabled. No resource test. Financed with increase in cigarette tax.
- ✓ Home- and Community-Based Services waiver approved for Traumatic Brain Injury patients.

1996

- ✓ VHAP and VHAP-Rx implemented for qualified individuals to 100% FPL.
- ✓ Income test for VHAP and VHAP-Rx increased to 150% of FPL.
- ✓ VHAP Trust Fund transfer of \$3.3 million for Medicaid purposes.

1997

- ✓ Mandatory managed care enrollment begins.
- ✓ VHAP Trust Fund transfer of \$3.3 million for Medicaid purposes.

1998

- ✓ Increased income test for underinsured children to 300% of FPL under Medicaid and uninsured children to 300% of FPL under SCHIP.
- ✓ VHAP Trust Fund transfer of \$0.772 million to general fund.

1999

- ✓ Increased VHAP income test to 185% of FPL for parents and caretakers of eligible children.
- ✓ State-funded VScript incorporated into VHAP-Rx and cost-sharing reduced from 50% coinsurance to \$1 or \$2 co-payment.
- ✓ Community Rehabilitation and Treatment Program created as a Section 1115 waiver expanding coverage through community mental health centers to adults to 150% of FPL.
- ✓ VHAP-Limited covers emergency hospital care.
- ✓ General fund transfer of \$1.948 million to VHAP Trust Fund.
- ✓ Beneficiaries enrolled in HMOs transferred to the Primary Care Case Management program.
- ✓ Adult dentures added as a covered benefit.

2000

- ✓ General fund supplemental budget transfer of \$1.9 million to VHAP Trust Fund. All tobacco products revenue allocated to VHAP Trust Fund. Tobacco Settlement Fund transfer of \$2.883 million to VHAP Trust Fund.
- ✓ VHAP-Rx eligibles covered for eyeglasses and vision services.

2001

- ✓ VHAP adult dental coverage is restricted.
- ✓ Co-payments increase for VHAP-Rx and VScript.
- ✓ Increased provider reimbursement by \$1.338 million with commitment to increase Medicaid reimbursements to Medicare level in 4 years.

2002

- ✓ Creation of a single state fund for Medicaid, VHAP, VScript, and SCHIP.
- ✓ 5-year Medicaid budgeting.
- ✓ 49-cent cig. tax increase in FY03.

- ✓ 26-cent cig. tax increase in FY04.
- ✓ Increased VHAP and Rx program cost-sharing.
- ✓ Enrollment cap in Rx programs.
- ✓ Suspension of vision care for one year.
- ✓ Changes in long-term care asset rules.
- ✓ Clarification of “uninsured” VHAP eligibility.
- ✓ Rescissions: dentures, chiropractic, elective surgery.

2003

- ✓ Adult eyewear coverage suspended indefinitely.
- ✓ 6-month period of guaranteed eligibility for individuals enrolled in managed care eliminated.
- ✓ Coinsurance and co-payments eliminated in VHAP program, except in regard to medically necessary emergency room visits, and premiums established.
- ✓ Deductibles and co-payment requirements eliminated in VHAP-Rx, VScript, and VScript expanded premiums established.
- ✓ Monthly premiums established for Dr. Dynasaur and SCHIP beneficiaries.
- ✓ Increased reimbursement for dentists, residential care facilities, and hospitals.
- ✓ Co-payments for hospital visits applied to some Medicaid recipients.

2004

- ✓ Pharmacists must disclose prices.
- ✓ Pharmaceutical marketers must disclose name of gift recipients and average wholesale price (AWP) of drugs marketed; reports made to the office of the Attorney General (no longer board of pharmacy).
- ✓ Public programs must cover OTC drugs.
- ✓ Retail and mail-order pharmacies treated similarly.
- ✓ Evidence-based research education program established.
- ✓ Study on 340B programs.
- ✓ Sunset extension for mental health drugs.
- ✓ Pilot program for prior authorization exemption established.
- ✓ Private health insurance plans must cover drugs purchased in Canada.
- ✓ DCF to design website on reimportation.
- ✓ Healthy Vermonters Plus established.
- ✓ Mental Health Oversight Committee created.
- ✓ VSH no longer exempt from state licensing.
- ✓ Program for the therapeutic use of cannabis established.
- ✓ Long-term care partnership program established pending federal approval.
- ✓ Legislative approval for Section 1115 Medicaid waiver for home- and community-based services.

2005

- ✓ VPharm created to provide wrap around coverage to the Medicare Part D benefit.
- ✓ Current Rx programs now called Vermont Rx.
- ✓ Behavioral Health Drugs added to the preferred drug list.
- ✓ Choices for Care long-term care Section 1115 Medicaid waiver approved and implemented.
- ✓ Global Commitment for Health Section 1115 Medicaid waiver approved and

implemented.

- ✓ Vermont Information Technology Leaders group established; to include OVHA.
- ✓ DCF & OVHA to provide disenrollment reports for any program with a premium.
- ✓ 24-hour nurse line to be established in OVHA.
- ✓ Chronic care coordination program to be developed.
- ✓ Hospital discharge planning program to be developed.
- ✓ Chiropractic trial to be designed for implementation in 2007.
- ✓ Opiate dependency program developed.
- ✓ Tightened eligibility rules for long-term care Medicaid.
- ✓ Removed asset test for QMB, SLMB, and QI populations.

2006

- ✓ Catamount Health and Catamount Health Assistance Program created, to be implemented Oct. 1, 2007
- ✓ Employer-sponsored insurance premium assistance program created, to be implemented Oct. 1, 2007, with review and approval by Joint Fiscal Committee and Health Access Oversight in December 2006
- ✓ VHAP and Dr. Dynasaur beneficiary premiums reduced effective July 1, 2007
- ✓ Medicaid Chronic Care Management program created to be implemented by Oct. 1, 2007

Appendix 4. Family Income by Size and Federal Poverty Level Chart (2006)

MONTHLY

Family Size	100%	150%	175%	185%	200%	225%	300%
1	\$817	\$1,225	\$1,429	\$1,511	\$1,633	\$1,838	\$2,450
2	\$1,100	\$1,650	\$1,925	\$2,035	\$2,200	\$2,475	\$3,300
3	\$1,383	\$2,075	\$2,421	\$2,559	\$2,767	\$3,113	\$4,150
4	\$1,667	\$2,500	\$2,917	\$3,083	\$3,333	\$3,750	\$5,000
5	\$1,950	\$2,925	\$3,413	\$3,608	\$3,900	\$4,388	\$5,850
6	\$2,233	\$3,350	\$3,908	\$4,132	\$4,467	\$5,025	\$6,700
7	\$2,517	\$3,775	\$4,404	\$4,656	\$5,033	\$5,663	\$7,550
8	\$2,800	\$4,200	\$4,900	\$5,180	\$5,600	\$6,300	\$8,400

YEARLY

Family Size	100%	150%	175%	185%	200%	225%	300%
1	\$9,800	\$14,700	\$17,150	\$18,130	\$19,600	\$22,050	\$29,400
2	\$13,200	\$19,800	\$23,100	\$24,420	\$26,400	\$29,700	\$39,600
3	\$16,600	\$24,900	\$29,050	\$30,710	\$33,200	\$37,350	\$49,800
4	\$20,000	\$30,000	\$35,000	\$37,000	\$40,000	\$45,000	\$60,000
5	\$23,400	\$35,100	\$40,950	\$43,290	\$46,800	\$52,650	\$70,200
6	\$26,800	\$40,200	\$46,900	\$49,580	\$53,600	\$60,300	\$80,400
7	\$30,200	\$45,300	\$52,850	\$55,870	\$60,400	\$67,950	\$90,600
8	\$33,600	\$50,400	\$58,800	\$62,160	\$67,200	\$75,600	\$100,800

Appendix 5.

Overview Vermont State Health Care Programs as of 8/30/2006

Program	WHO IS ELIGIBLE	BENEFITS	COST SHARING
Medicaid PIL Medicaid Working Disabled up to 250% FPL	<ul style="list-style-type: none"> · Aged, Blind, Disabled, · Parents or Caretaker Relatives of a Dependent Child · Disabled working adults 	<ul style="list-style-type: none"> · Covers: physical and mental health, dental (\$475-yearly cap), prescriptions. · Not covered: dentures, eyeglasses, or chiropractic · Covers excluded classes of Medicare Part D drugs for dual eligible individuals. 	<ul style="list-style-type: none"> · no program fee · \$1/\$2/\$3 prescription co-pay if no Medicare Part D coverage. · \$1 to \$5 co-pays if have Medicare Part D. Medicare Part D is primary rx coverage for Medicaid/Medicare recipients. · \$3 dental co-pay · \$3/ outpatient hospital visit · \$75 per inpatient admission
Dr. Dynasaur 200% FPL	Pregnant Women	<ul style="list-style-type: none"> · same as Medicaid 	<ul style="list-style-type: none"> · up to 185% FPL: No fee · up to 200% FPL: 30.00/family/month · No co-payments required
Dr. Dynasaur 300% FPL	Children up to age 18	<ul style="list-style-type: none"> · same as Medicaid but covers eyeglasses 	<ul style="list-style-type: none"> · up to 185% FPL: no fee · up to 225% FPL: \$30/family per month · up to 300% FPL: \$40/family per month w/other insurance · \$80/family per month w/out other insurance · No co-payments required
VHAP (Vermont Health Access Plan) 150% FPL	Uninsured Adults Without Dependent Children	<ul style="list-style-type: none"> · same as Medicaid except: no inpatient elective hospital coverage. 	<ul style="list-style-type: none"> · up to 50%FPL: \$0.00 · up to 75% FPL: \$11 per person/ month · up to 100% FPL: \$39 per person/ month · up to 150% FPL: \$50 per person/ month · No cost sharing except: · \$25 emergency room visit/ \$60 if not medically necessary
VHAP 185% FPL	Uninsured Adults With Dependent Children	<ul style="list-style-type: none"> · same as Medicaid except: no inpatient elective hospital coverage 	<ul style="list-style-type: none"> · \$80 per month, otherwise same as VHAP without dependent children
VHAP Pharmacy 150% FPL	Elderly or disabled ind. not eligible for Medicare part A or B and has no insurance that covers any portion of prescription cost	<ul style="list-style-type: none"> · same prescriptions covered by Medicaid · diabetic supplies · eye exams 	<ul style="list-style-type: none"> · \$15 per person per month no co-payments
Vscript 175% FPL Vscript Expanded 225% FPL	<p>Same as listed directly above</p> <p>Same as listed directly above</p>	<ul style="list-style-type: none"> · Maintenance medication, · diabetic supplies · Maintenance medication, · diabetic supplies 	<ul style="list-style-type: none"> · \$20 per person per month · no co-payments · \$42 per person per month · no co-payments · Manufacturer has to sign supplemental rebate agreement with the state
Vpharm 150% FPL	Medicare Part D beneficiaries	<ul style="list-style-type: none"> · covers excluded classes of Medicare Part D meds. · Medicare Part D premium 	<ul style="list-style-type: none"> · \$15.00 per person premium paid to the State. · *Must apply for the low income subsidy* · No Medicare Part D co-payments

**Overview Vermont State Health Care Programs
as of 8/30/2006**

Vpharm 175% FPL	Medicare Part D beneficiaries	· covers excluded classes of Part D maintenance meds · Medicare part d premium	· \$20.00 per person premium paid to the State · no Medicare Part D co-payments for maintenance medications
Vpharm 225% FPL	Medicare Part D beneficiaries	· Same as listed directly above	· \$42.00 per person premium paid to the State. No Medicare Part D co-payments maintenance medications.
Healthy Vermonters discount drug program 300% FPL	Anyone who has no or has exhausted prescription coverage	· discount on medications	· Beneficiary pays the Medicaid rate for prescriptions
Healthy Vermonters discount drug program 400% FPL	· Aged (65 or older) · Disabled has no or has exhausted prescription coverage	· discount on medications.	· Beneficiary pays the Medicaid rate for all prescriptions. Medicare Part D is primary. HV is secondary.

Coverage Groups	Premium	FPL	household size			
			1	2	3	4
Medicaid PIL outside Chittenden Cty		NA	\$841.00	\$841.00	\$1008.00	\$1141.00
Medicaid PIL inside Chittenden Cty		NA	\$908.00	\$908.00	\$1075.00	\$1208.00
VHAP	No Fee	50%	\$411.00	\$553.00	\$694.00	\$836.00
VHAP	\$11/ person/month	75%	\$616.00	\$829.00	\$1041.00	\$1254.00
VHAP	\$39/person/month	100%	\$821.00	\$1015.00	\$1388.00	\$1671.00
VHAP	\$50/person/month	150%	\$1232.00	\$1657.00	\$2082.00	\$2507.00
VHAP (families with dependent children only)	\$75/person/month	185%	\$1519.00	\$2043.00	\$2567.00	\$3092.00
VHAP Pharmacy	\$15/person/month	150%	\$1232.00	\$1657.00	\$2082.00	\$2507.00
Vscript	\$20/person/month	175%	\$1437.00	\$1933.00	\$2429.00	\$2924.00
Vscript Expanded	\$42/person/month	225%	\$1847.00	\$2485.00	\$3122.00	\$3760.00
Vpharm	\$15/person/month	150%	\$1232.00	\$1657.00	\$2082.00	\$2507.00
Vpharm	\$20/person/month	175%	\$1437.00	\$1933.00	\$2429.00	\$2924.00
Vpharm	\$42/person/month	225%	\$1847.00	\$2485.00	\$3122.00	\$3760.00
Dr. Dynasaur Children up to 18	No Fee	185%	\$1519.00	\$2043.00	\$2567.00	\$3092.00
Dr. Dynasaur (pregnant women & children up to 18)	\$30/family/month	200%	\$1642.00	\$2209.00	\$2775.00	\$3342.00
Dr. Dynasaur Children up to 18	\$30/family/month	225%	\$1847.00	\$2485.00	\$3122.00	\$3760.00

**Overview Vermont State Health Care Programs
as of 8/30/2006**

Dr.Dynasaur Children up to 18 · \$40/family/month · \$80/family/month if uninsured Healthy Vermonters (any age)	300%	\$2463.00	\$3313.00	\$4163.00	\$5013.00
Healthy Vermonters (aged, disabled)	400%	\$3284.00	\$4417.00	\$5550.00	\$6684.00

- * Income calculation is based on Gross Income less some deductions. Taxes and FICA are not deductions.
- * ONLY Medicaid has resource limits. Medicaid Resource Limits: \$2000 Individual \$3000 per Couple.
- * PIL: Protected Income Limit
- * FPL: Federal Poverty Level
- * Long Term Care Medicaid (nursing home care, waiver services) is **NOT** included in this chart

Created by the Office of Health Care Ombudsman

**Appendix 6. Medicaid Reimbursement Increases: Statutory Authority
Sec. 9 of No. 191 of the Acts of 2005 Adj. Sess. (2006)**

Sec. 9. MEDICAID REIMBURSEMENT

(a)(1) The office of Vermont health access shall adjust Medicaid and the Vermont health access plan reimbursement to reflect the following priorities in the following order:

(A) an increase in base rates for evaluation and management procedure codes to enhance payment to a level equivalent to the 2006 rates in the Medicare program;

(B) incentives and payment restructuring for health care professionals participating in the care coordination program;

(C) an increase in base rates for current procedural terminology (CPT) codes which are significantly lower than the 2006 Medicare reimbursement levels starting with the lowest first; and

(D) an increase in dental reimbursement by, first, restoring the reductions in adult dental rates which were effective February 1, 2006 and, second, by splitting the remaining amount approximately in half to increase rates for dental services and to increase the dental cap for adults in such a manner as to offset any loss in benefit level due to the rate increases.

(2) The Medicaid reimbursement rate increases in subdivision (1) of this subsection shall be effective on January 1, 2007 for fiscal year 2007 and July 1 for fiscal years 2008 through 2010.

(b) To the extent permitted by the appropriation in Sec. 107 of H.881 of the 2005 Adj. Sess. (2006), the office of Vermont health access shall increase Medicaid reimbursements to hospitals effective January 1, 2007. In fiscal year 2008 and thereafter, the office shall increase Medicaid reimbursement rates as provided for in this subsection annually on July 1 until the federal upper limit is reached.

(c) In fiscal years subsequent to 2007, it is the intent of the general assembly that Medicaid reimbursement increases to health care professionals and hospitals under Medicaid, the Vermont health access plan, and Dr. Dynasaur should be tied to the standards and quality or performance measures developed under the Vermont blueprint for health strategic plan established in section 702 of Title 18. Prior to implementation, these standards shall be approved by the general assembly through the appropriations process.

(d) No later than October 31, 2006, the office shall report to the health access oversight committee with a plan for allocation of the appropriated amounts for fiscal year 2007 among the priorities established in subsection (a) of this section and among hospital reimbursements as provided for in subsection (b) of this section. Prior to the implementation of the reimbursement adjustments in this section, the health access oversight committee shall review and determine if the allocation among the priorities is equitable and reflects legislative intent.

Appendix 7. Medicaid Citizenship Documentation: Committee Comments on Interim Final Rule

115 STATE STREET
MONTPELIER, VT 05633
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FAX: (802) 828-2424



STATE OF VERMONT
GENERAL ASSEMBLY

REP. ANN PUGH, CO-CHAIR
SEN. JEANETTE WHITE, CO-CHAIR
SEN. CLAIRE AYER
SEN. ED FLANAGAN
SEN. M. JANE KITCHEL
REP. THOMAS KOCH
REP. MARK LARSON
REP. STEVEN MAIER
SEN. KEVIN MULLIN
REP. JOHN PATRICK TRACY

HEALTH ACCESS OVERSIGHT COMMITTEE

August 8, 2006

Centers for Medicare and Medicaid Services
Submitted electronically to:
<http://www.cms.hhs.gov/eRulemaking>

RE: File Code CMS-2257-IFC

We are writing on behalf of the Health Access Oversight Committee, a bicameral, bipartisan committee of the Vermont legislature, which focuses on issues relating to Medicaid and access to health care. The committee is concerned that the new federal documentation of U.S. citizenship requirements contained in the Deficit Reduction Act (DRA) will result in Vermonters having difficulty accessing Medicaid and the Vermont-specific health care programs funded with Medicaid dollars, which are operated under a Section 1115 Waiver of federal Medicaid law. The committee is also very concerned about the increase in administrative costs and burden on Vermont's Office of Vermont Health Access and Department for Children and Families resulting from the DRA requirements.

We endorse the comments submitted by the American Public Services Association (APHSA) and the National Association of State Medicaid Directors (NASMD) as well as having several specific suggestions.

First, the July 1, 2006 implementation date required by the DRA is unreasonable, especially considering that the regulations will not be finalized until later this summer, at the earliest. The additional administrative burdens on the state will require changes to the eligibility screening process, including additional funding. These changes are extremely difficult to achieve by the implementation date required. The funding is especially difficult, since Vermont has a part-time legislature, which will not be in session until January 2007 and, therefore, cannot authorize any changes to the funding until well after

the implementation requirement. At minimum, additional time for verifying Vermonters currently receiving Medicaid or Vermont's Health Access Program should be allowed.

Second, Vermont is operating under a unique Section 1115 Waiver, which establishes a spending cap on most of Vermont's Medicaid and waiver programs. It is unreasonable to impose an additional, costly administrative burden on a state which has waiver-capping expenditures. Any administrative costs for verifying citizenship should not be considered as spending under Vermont's Global Commitment Waiver.

Comments on Provisions of the Interim Final Rule with Comment Period

435.407 Types of Documentary Evidence

Third, we request that the exemption extended to individuals receiving Supplemental Security Income (SSI) and Medicare be extended to additional populations, such as foster care children, subsidized adoption Medicaid recipients, independent living youth and individuals receiving Social Security Disability Income (SSDI). States are currently required to verify citizenship for all children receiving federal foster care maintenance payments, adoption assistance payments or independent living services. For children entering foster care, it is unlikely that documentation of citizenship would be readily available and unlikely that the parent(s) would be willing or able to provide the identification given the contentious nature of removing children. For individuals receiving SSDI, the federal law requires the same application process and documentation requirements as for SSI, thus these groups of people should be treated that same.

Fourth, we are very pleased that the state is able to accept verification from other agencies, such as Medicare or vital records. This type of verification should be allowable for any applicant who has proven citizenship and identity to another government agency, including matches with the public assistance recipient information system, the U.S. Department of Veterans Affairs, Social Security, and the U.S. Citizenship and Immigration Services database. In addition, when Medicaid has paid claim forms for a child's birth, this should be adequate proof that the child was born in this country and thus is a citizen. In addition, interstate data matches with state agencies which have received proof of citizenship or identity would reduce administrative burdens and decrease duplicative verification requirements.

Fifth, applicants and recipients should be treated equally and the state should have the option of providing coverage to an applicant, as well as a recipient, during a reasonable period pending proof of citizenship. States are mandated to provide a legal immigrant who has been in the U.S. for over 5 years coverage for Medicaid for a reasonable period pending receipt of the documentation. 42 U.S.C. §1320b-7(d)(4)(A). Citizens should be treated equally with legal immigrants. At minimum, the state should have the option to provide Medicaid coverage while an applicant has a pending passport application or a pending request for a certified copy of a birth certificate. In both of these instances, there is likely to be strong evidence that an applicant is a citizen. Allowing an individual to become eligible for coverage based on a pending application is consistent with the "reasonable opportunity" required by the statute, which allows an individual time to present evidence of citizenship.

Sixth, for the third and fourth levels of documentation, there is a requirement that the document be made 5 years prior to the date of application. This requirement should be deleted. At a minimum, for an individual who has been receiving Medicaid, it should be clarified that the 5-year period runs before the date of the reapplication and not the initial application.

Seventh, in subsection (h)(1), there is a requirement for original or certified copies of documents. This is more stringent than the evidentiary rules used in court. In circumstances where there is a reasonable explanation why an original or certified copy cannot be produced, the state should be able to accept other forms of reliable verification, as determined by the state through state regulation.

Seventh, in subsection (h)(6), the regulations may require the state to verify electronically citizenship or identity if the individual uses third or fourth tier documentation. If electronic verification is available, the state should be able to use this type of verification in lieu of documentary evidence as this method simplifies the process for applicants and for the state. The electronic verification has sufficient reliability to provide quality assurance in Medicaid. Access to health care is a priority in Vermont and other states. When a reliable and simple verification process is available, the state should be allowed by CMS to use that process in lieu of physical paper documentation as it increases the legitimate state interest in maximizing access to health care for its citizens.

Eighth, we support the expansion of acceptable documentation to prove citizenship or identity detailed in the APhSA/NASMD comments.

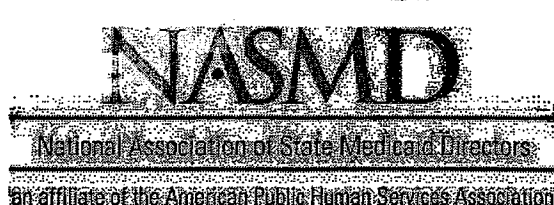
Thank you for the opportunity to comment on the interim regulations.

Sincerely,

Ann Pugh, Co-Chair
Health Access Oversight Committee

Jeanette White, Co-Chair

Appendix 8. Medicaid Citizenship: APHSA/NASMD Comments



August 7, 2006

Mark B. McClellan, M.D., Ph.D
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS 2257-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicaid Citizenship Documentation Provisions of the Interim Final Rule with Comment Period, Regulatory Impact Statement 71 Federal Register 39214 (July 12, 2006); File Code CMS-2257-IFC

Dear Dr. McClellan:

The American Public Human Services Association (APHSA) and its affiliate, the National Association of State Medicaid Directors (NASMD), respectfully submit this comment letter on Medicaid; Citizenship Documentation Requirements. APHSA is commenting on the interim final rule that was published on July 12, 2006, in the *Federal Register* (71 FR 39214) for the Centers for Medicare and Medicaid Services (CMS).

APHSA appreciates the opportunity to work with CMS in the initial phase of implementation of this important provision as required by the Deficit Reduction Act of 2005. States have and will continue to make a good faith effort to comply with the statute in a timely fashion. As discussed in greater detail in our comments below, states believe that there are several steps CMS can take to clarify its guidance and minimize the burden on both states and current and potential Medicaid consumers while still fulfilling the intent of the law. We further believe the regulation should more closely follow the statute.

States request that CMS exempt foster care youth, independent living youth, subsidized adoption Medicaid recipients, and individuals receiving Social Security Disability Income (SSDI) from this requirement. In addition, there are several recommendations that APHSA believes will streamline the documentation process while more closely following the statute. Such recommendations include: remove the "tiered" approach to the acceptable documents list, amending the types of documents currently accepted, and addressing the resource burden this mandate imposes on states.

Amending Requirements for Special Population Groups

APHSA commends CMS for determining that there was a scrivener's error and that Supplemental Security Income (SSI) and Medicare recipients are exempt from both the citizenship and identity requirements. In addition, we request that the exemption be extended to additional population groups: foster care children, subsidized adoption Medicaid recipients, and independent living youth and individuals receiving Social Security Disability Income (SSDI).

Foster Care Children

Through their child welfare agencies, States routinely determine citizenship for all children in foster care, regardless of Title IV-E eligibility. After the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (PL 104-193), the Administration for Children and Families (ACF) issued a Policy Interpretation Question (PIQ) on January 14, 1999 which, explicitly indicates that states are required to verify the citizenship of all children receiving federal foster care maintenance payments, adoption assistance payments or independent living services. Because a state does not know if a child is eligible for Title IV-E at the time the child enters the system, the child welfare agency must verify citizenship of all children entering the foster care system.

With regard to identity, most children in foster care simply do not have access to the documents outlined in the interim final rule. Given the contentious nature of the removal of a child, it is unlikely that the parent(s) will be willing or able to provide the necessary identification documents to the state. Therefore, APHSA strongly recommends that this population be exempt from these requirements.

Applicant and Recipient Status

In addition, in previous forums CMS has verbally communicated that children in foster care, children receiving adoption assistance, and independent living youth who are categorically eligible for Medicaid, are to be treated as recipients, not applicants, for purposes of citizenship documentation. APHSA appreciates this statement. However, states believe they currently lack the legal standing to apply this distinction. As such, APHSA requests that CMS provide official written guidance explicitly indicating that these categorically eligible children are to be treated as recipients. In order to expedite this request, we are asking that a Dear State Medicaid Director letter be issued in the immediate future. We also request that the language regarding recipient versus applicant be clarified in the final regulation.

Newborn Children

In accordance with the Social Security Act §1902, §1903(v), and 42 U.S.C. §1396(e), an infant born to a non-citizen pregnant mother whose labor and delivery are covered by Medicaid is born to a woman eligible for and receiving medical assistance (emergency services) under a State plan. Therefore, we request that these infants be deemed eligible for Medicaid for a period of one year.

Supplemental Security Income and Social Security Disability Income Beneficiaries

We also ask that individuals who are receiving Supplemental Security Income (SSI), but have not yet been entered into the database system, be permitted to provide SSI check stubs to document that they are in fact SSI recipients. SSI recipients in all states should be treated the same regardless of whether they live in a 209-B state or a 1634 state because Social Security Administration (SSA) has established citizenship and identity for all recipients of SSI. In addition, we request that CMS clarify that former Medicare and SSI recipients are exempt from this requirement.

We further contend that the application process and documentation requirements for SSI are identical to that for Social Security Disability Income (SSDI). As such, SSDI recipients should be treated similarly and therefore be exempt from the requirement to document citizenship and identity.

Tribal Members

States also are concerned that the interim final rule does not allow for the acceptance of tribal enrollment cards as proof of citizenship. APHSA and the states have worked closely with tribes on this issue, and we believe the processes for obtaining a tribal enrollment card go well beyond the burden of proof for documenting citizenship for the Medicaid program and should therefore be acceptable as proof of citizenship.

Although the process may differ between tribes, all tribes base the tribal enrollment card process on ancestry. Specifically, many base it on being able to prove that an ancestor's name was part of a tribal enrollment treaty such as the Dawes Commission rolls for enrollment between 1899 and 1906; the Grande Ronde Restoration Act and subsequent *Federal Register* announcement on June 24, 1984 that listed tribal members; the Alaska Native Claims Settlement Act of 1971; the Annuity Rolls of April 14, 1941 for the Minnesota Chippewa Tribe; and others. APHSA also has learned that many processes require a birth certificate, affidavit of paternity, documentation of blood line, and other similar ancestry documentation.

In addition, APHSA recognizes that there are concerns with individuals who may be members of tribes located in States having an international border. However, we believe it would be more reasonable for CMS to provide additional guidance specifically directed towards such tribes.

Expanding Acceptable Documentation

APHSa appreciates CMS's efforts to approve a range of documents as acceptable for meeting the citizenship and identity requirements. States have reviewed the types of information collection, records, and current systems and believe there are additional forms and methods for documentation that should be accepted as proof of both citizenship and identity. The documents listed below would strengthen states' ability to accurately document proof of citizenship and identity. We also recommend that CMS develop a process by which states can submit requests for additional documents that also meet these requirements but have not yet been identified or are subsequently developed.

Citizenship

Specifically, on citizenship documentation we request that CMS allow states to accept the following documents:

- Copies of birth records, or souvenir birth certificates, submitted by hospitals to States' Vital Records Bureau for registering births.
- States' Medicaid paid claim forms for births.
- Birth records from child support agencies.
- Tribal enrollment cards. Enrollment in a federally recognized tribe should also be acceptable to document citizenship. The Native American Tribal documents listed as documentation of identity should also be accepted for citizenship.
- State identification cards.
- The "preponderance of evidence." This should be allowable in rare situations where exhaustive research has been done and everything points to citizenship, but none of the listed documents exist. APHSa has heard that states have done this in the past, and it has not later been proven to result in erroneous citizenship documentation.

In addition, the following records are currently permissible forms of secondary evidence for citizenship verification from the SSA Programs Operation Manual System (POMS). As such we request that CMS also allow these records for purposes of meeting the Medicaid citizenship documentation requirement.

- A religious record established in the U.S. within 3 months of birth, showing a U.S. place of birth and either a date of birth or the individual's age when the record was made.

- An early school record for the applicant showing a U.S. place of birth, the date of admission to school, the date of birth, or the age of the individual at the time the record was made, and the names and places of birth for the applicant's parents.

Identity

For purposes of identity, we request that the following additional items be allowed:

- Birth certificates. These certificates specifically identify all necessary information that other identity documents contain.
- Voter registration cards. These are government issued cards that meet the necessary requirements to reliably prove identity.
- A child's removal court order and court documents for individuals of any age.
- Verification of identity by Child Welfare agencies for children under their care.
- Birth records from child support agencies.
- Immunization records. These records contain identifying information, specifically for children. States have found that parents are more likely to retain immunization records than other types of documentation.
- Private agency identification cards for children. Most of these, such as I-Dent-A-Kid and Life Touch, work with school systems.
- Photos in school yearbooks should be permitted as they identify children under 18 who are enrolled in school.
- School records for children under 18.
- Identity affidavits or facility medical records for any institutionalized individuals who are not receiving SSI or Medicare.
- Social Security (NUMIDENT) System.
- Checks issued by the U.S. Department of Veteran Affairs.
- Affidavits. These should be permitted to prove identity for individuals of all ages.

Data Matches

APHSA appreciates the opportunity to recommend additional data match sources that should be permissible for citizenship and identity. States request that CMS make the following data match sources acceptable:

- Matches with the Public Assistance Recipient Information System (PARIS).
- Matches with NUMIDENT.
- Matches with the U.S. Department of Veterans Affairs.
- Medicaid paid claim forms that show that Medicaid paid for the birth.
- Matches with the Social Security Administration's SS5 database.
- Matches with the U.S. Citizenship and Immigration Services (CIS) database, Systematic Alien Verification for Entitlements (SAVE).
- Matches with Indian Health Services.
- Matches with State Attorney General offices.

Interstate Transfer of Information

APHSA requests that CMS clarify that an inter-agency data match is sufficient and no additional documentation is necessary. Specifically, we ask that CMS permit as sufficient proof an intra-state data match with the department of motor vehicles or vital statistics offices. Also, in light of the fact that many states are moving to paperless case files, we ask that you accept an indicator on an electronic case file rather than require states to keep "paper" case files.

In addition, states are concerned with the treatment of inter-state transfers in the interim final rule since such transfers will be critical components of the processes states establish to meet the documentation requirements. To meet this requirement, APHSA recommends that states be allowed to request copies of documentation from another state's Medicaid agency. Additionally, APHSA requests that if one state has verified the citizenship or legal status of a Medicaid client, then that documentation should be acceptable in all states without holding any states liable for federal penalty for failure to document citizenship a second time. That is, if the client moves from state A and applies for Medicaid in state B, the documentation from state A should suffice and state B should be held harmless for disallowances made by CMS for any subsequently identified eligibility errors based on information from state A.

States will utilize a range of databases to comply with this regulation. Further, states are continuously upgrading their systems and new databases are periodically developed. As such, we recommend that CMS provide additional information regarding acceptable database sources. APHSA also requests that CMS work with states to identify a process for determining the reliability of new databases as they become available and when they can be used to document citizenship and identity in accordance with this regulation.

Reducing the States' Burden of Administering Large Federal Mandates

APHSA is concerned that CMS has vastly underestimated the burden to states. States have received limited outreach guidance from CMS, yet they have had to provide training for eligibility workers and other staff, and even other state agencies, whose responsibilities require them to be knowledgeable of this new requirement. They also have had to develop new materials and systems. To this end, we recommend that the agency consult with states to develop an accurate estimate of the additional costs and requirements of this new mandate to states. States also request that they receive a higher FMAP to accommodate this significant new responsibility.

In addition, states believe CMS has failed to provide an accurate estimate of the time and resources that states are and will continue to invest in obtaining, documenting, and, in some cases paying for, the required documents. Several states have estimated their time frame to be between twenty and twenty-five minutes per recipient, clearly much longer than the five minute estimate in the regulation. States are further reporting that the time it takes an individual to acquire and provide the state with acceptable documentary evidence and to review the declaration is considerably longer than the ten minutes allocated in the interim final rule.

Implementation Considerations

APHSA requests that CMS alter the language to treat applicants and recipients equally. We request during the reasonable period, CMS allow the applicants who have declared they are citizens to qualify for Medicaid services.

Further, APHSA requests that citizens be given the same rights as applicants who declare they are immigrants. States are mandated to provide a person who declares that they are a legal immigrant (who has been in the U.S. over 5 years) eligibility for Medicaid without their documentation. According to 42 U.S.C. §1320b-7(d)(4)(A), states also are mandated to make immigrants eligible for Medicaid and to provide them with a reasonable opportunity period to submit satisfactory immigration information. We ask that states be permitted to provide individuals who declare they are citizens with eligibility during the reasonable opportunity period while they obtain the documentation. Further, we request that states be eligible to receive Federal Financial Participation (FFP) for providing services to such individuals during this time period.

Most states define a minor as an individual under the age of 18 or 21. We request that states be afforded the option to apply the criteria for youths age 17 that they would apply for those aged 16 and under.

Federal Financial Participation for Administrative Expenditures

APHSA respectfully requests an expansion of the definition of administrative expenditures for which states can receive FFP. APHSA recommends that CMS revise the definition for administrative expenditures to include personnel, costs to obtain records for those clients who are impoverished, and costs for the development of database interfaces.

Further, we ask for clarification for individuals found to be presumptively eligible who subsequently are unable to meet the documentation requirements. We ask that states be permitted to collect FFP for the period of presumptive eligibility. States also are working with CMS to comply with the new Payment Error Rate Measurement (PERM) requirements. APHSA strongly recommends that states be held harmless from PERM as long as they can outline the steps taken to obtain proof of citizenship and identity.

We ask that states be reimbursed for Medicaid claims, retroactive to the date of application, for administrative and health services provided to Medicaid applicants whose eligibility determination was delayed due to barriers in obtaining citizenship and/or identification documents.

Compliance

As previously noted, states are currently working with CMS to comply with the new PERM requirements. With regard to compliance for this program, states believe it is critical for the Center for Medicaid State Operations to consult with the PERM staff in the Office of Financial Management regarding the overlap and implementation of both new requirements and mandates to states. We ask that CMS work with the PERM staff to outline the PERM requirements and standards as they relate to this provision.

Provisions of the Interim Final Rule with Comment Period

APHSA respectfully requests that CMS remove the requirement for a hierarchy of reliability of citizenship documents since this was not included in the statute of the Deficit Reduction Act of 2005.

Secondary Evidence of Citizenship

We ask for further clarification for children born overseas who are adopted by U.S. citizens. These children and their adoptive parents may not have immediate access to a

certificate of naturalization or a certificate of citizenship. We therefore request that these children be made eligible immediately upon adoption.

Fourth Level Evidence of Citizenship

APHSA appreciates CMS' allowance of affidavits, however we request clarification as to whether the affidavits attesting to the person's citizenship can also be used to document identity. The affiants are attesting to the person's citizenship, therefore it should be reasonable to assume that the individual attesting to the person's citizenship can also attest to the person's identity.

We are asking that the language regarding affidavits be modified to provide the state flexibility to accept a declaration attesting to the facts and given under penalty of perjury. This will allow states that have different requirements for what should be included in an affidavit to obtain the necessary information without changing their statute.

Additionally, we ask for an exception for those individuals that are not incapacitated and have made their best efforts to locate such documents but such documents have been lost or destroyed due to a natural disaster.

States also believe there are alternatives for programs that currently operate on a mail-in basis. States and the federal government have worked together to streamline the process for applying for public assistance program. As a result, many programs have mail-in application processes which do not require a face-to-face interview. We request that if the state can assure that the information received about the identity and citizenship is accurate, copies will be sufficient.

Regulatory Impact Statement

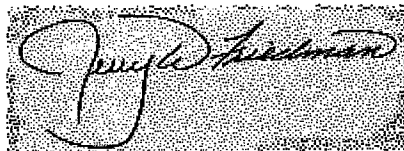
APHSA asks for clarification on the cost to states, and the way in which it has been determined that this provision will yield savings to the states. The regulation specifically states, "state savings under \$50 million per year over the next 5 years." Given the significant new requirements for states discussed above in the section on burden estimates, we do not anticipate that states will recognize any savings. Instead, states currently report that they will likely incur significant new costs.

In the Regulatory Impact Statement, a Certificate of Naturalization is listed as an acceptable form of documentation. It has come to the attention of the states that the copying of a Certificate of Naturalization is a felony. Thus, we would request further clarification as to how an agency can appropriately document that such agency has seen the document.

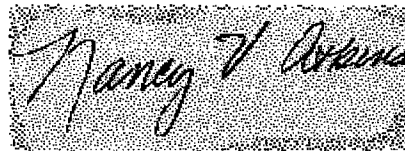
Also included within the regulatory requirements section of the interim final rule are a number of indications that a five-year rule applies. We ask that this requirement be removed.

We would be pleased to meet with you at any time on these matters. Thank you for considering our comments. If you have any questions, please do not hesitate to contact me or Elaine Ryan at (202) 682-0100, ext. 235.

Sincerely,



Jerry W. Friedman
Executive Director
American Public Human
Services Association



Nancy Atkins
Chair
National Association of State
Medicaid Directors

cc: Melissa Musotto, Office of Strategic Operations and Regulatory Affairs
Katherine T. Astrich, Office of Information & Regulatory Affairs

Appendix 9. Medicaid Citizenship Documentation: Memo to LCAR

Vermont Legislative Council

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MEMORANDUM

To: Senator Mark MacDonald, Chair
Legislative Committee on Administrative Rules

From: Representative Ann Pugh,
Chair, House Committee on Human Services
Co-Chair, Health Access Oversight Committee

Date: October 17, 2006

Subject: Medicaid Citizenship and Identity - Emergency Rule

The Health Access Oversight Committee (HAOC) has been following the federal Medicaid changes regarding documenting citizenship and identity. In August 2006, the committee submitted comments on the interim final rule to the Centers for Medicare and Medicaid Services supporting several practical changes to the rule. The federal change has not been considered by a standing committee at this time due to the timing of the federal change, so the HAOC comments represent the sole legislative consideration to date.

The committee did not consider the issue of whether emergency rulemaking was the appropriate vehicle, so I will not comment on that issue. My comments address the substance of the rule and if the committee decides to approve the emergency rule, would be appropriately addressed as the rule progress through the regular rulemaking process.

In general, the comments by HAOC urged CMS to ensure that the federal rules were not overly burdensome and created a barrier to eligible individuals accessing health care coverage.

First, HAOC commented that the exemption extended to individuals receiving Supplemental Security Income (SSI) and Medicare be extended to additional populations, such as foster care children, subsidized adoption Medicaid recipients, independent living youth and individuals receiving Social Security Disability Income (SSDI). In the rule offered by the Agency of Human Services, if CMS were to expand the exemptions, the rule would have to go through the rulemaking process again. It would be further the legislative goals to add a "catch-all" provision to M170.1(e) to allow the exemption to be applied more broadly if the federal exemptions change or pursuant to a court interpretation.

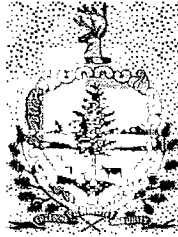
Second, several comments of the HAOC urged CMS to expand the acceptable list of documents and allowable data matches to other reliable sources. Again, the rules provide an exclusive list which would require changes should CMS expand the federal rules or interpretations and could incorporate any federal or court-required changes through a general provision.

Third, the Agency has indicated that it will provide financial assistance to individuals who are unable to pay the fees necessary to collect the required documentation. The rule is silent on this issue. The HAOC is very concerned that Vermonters' access to health care coverage would be limited by the documentation requirements and supports financial assistance for this purpose. Because the Agency is seeking federal financial support for this assistance, there should be rules or, at minimum, policy guidance explaining the requirements and parameters of this assistance.

Thank you very much for your attention to this matter. If these issues are unable to be addressed as part of the emergency rulemaking, I sincerely hope that the Agency will address these issues in the final rule, or if necessary, that the committee will follow-up on these issues during the regular rulemaking process.

**Appendix 10. Medicaid Citizenship:
Committee Letter to Congressional Delegation**

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**STATE OF VERMONT
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HEALTH ACCESS OVERSIGHT COMMITTEE

January 10, 2007

The Honorable Patrick Leahy
United States Senator
Post Office Box 933
Montpelier, Vermont 05602

The Honorable Bernard Sanders
United States Senator
1 Church Street, 2nd floor
Burlington, Vermont 05401

The Honorable Peter Welch
Representative in Congress
30 Main Street, 3rd floor, Suite 350
Burlington, Vermont 05401

Re: Citizenship and Identity Verification Requirements

Dear Senator Leahy, Senator Sanders, and Representative Welch:

We are writing on behalf of the Health Access Oversight Committee (HAOC) to express concern about the new federal documentation of U.S. citizenship and identity requirements contained in the Deficit Reduction Act (DRA). We were pleased to learn of Congress's action just prior to adjournment to exempt foster children and individuals receiving Social Security Disability Income (SSDI).

Given the HAOC's responsibility for oversight of Vermont's Medicaid programs and Vermonters' access to health care, we are particularly concerned that the documentation requirements will result in Vermonters having difficulty accessing Medicaid and the Vermont-specific health care programs funded with Medicaid dollars. The committee is

also very concerned about the increase in administrative costs and burden on Vermont's Office of Vermont Health Access and Department for Children and Families resulting from the DRA requirements.

While our state Medicaid agency has made an effort to maximize data-matching for individuals to minimize the burdens of the requirements, our state would benefit from several small changes at the federal level. These changes include:

- Expand the list of documents and data matches allowed by CMS to prove identity and citizenship or allow states to choose the sources.
- Extend the exemption provided to individuals receiving Supplemental Security Income (SSI) and Medicare to additional populations who already prove identity and citizenship or who are vulnerable populations, including:
 - families receiving Food Stamps; and
 - youth living independently.
- Clearly authorize states to extend eligibility to applicants immediately, pending verification, in order to assist individuals in accessing health care in emergency situations, such as urgent pharmacy requests.
- Remove the requirement that third- and fourth-level documentation be made five years prior to the date of application.
- Modify the requirement that the agency see the original or certified copy to allow the state to accept other forms of reliable verification.
- Extend the implementation time frame to allow states additional time to implement the requirements.
- Provide financial assistance or, at minimum, the higher administrative federal financial participation match rate to address the financial burden of implementing the requirements, which have cost Vermont at least \$400,000 in additional funds.

We have attached our comments to the federal regulations to provide more detail on each of these issues. We would welcome the opportunity to discuss these issues with you.

Sincerely,

Ann Pugh, Co-Chair

Jeanette White, Co-Chair

Appendix 11. Health Care Financing Reports: Recommended Reporting Format

Report 1 – Enrollment		Most Recent	One Year Ago	Percent Change
Aged, Blind, & Disabled	Children Adults Duals			
Reach-Up	Children Adults			
VHAP (Global Expansion)				
Other Children	Underinsured SCHIP			
Pharmacy	VPharm 1 (<151%) VPharm 2 (151-175%) VPharm 3 (176-225%) Other Medicaid Other Healthy Vermonters			
Total				

Future versions of this report may include additional details such as age or geographic region.

Table 2 – Financial Overview

Global Commitment	Year to Date			Budget		
	Program	Investments	Total	Program	Investments	Total
OVHA	\$999	\$999	\$999	\$999	\$999	\$999
VDH	\$999	\$999	\$999	\$999	\$999	\$999
DAIL	\$999	\$999	\$999	\$999	\$999	\$999
DCF	\$999	\$999	\$999	\$999	\$999	\$999
Education	\$999	\$999	\$999	\$999	\$999	\$999
All Other	\$999	\$999	\$999	\$999	\$999	\$999
TOTAL	\$999	\$999	\$999	\$999	\$999	\$999
Premium			\$999			
BUDGET NEUTRALITY			\$999			
Choices For Care			\$999			\$999
OTHER Buy-In			\$999			\$999
Claw-back			\$999			\$999
DSH			\$999			\$999

Table 3 – Spending by Program		<u>Year to</u>	<u>One</u>	<u>Percent</u>
		<u>Date</u>	<u>Year</u>	<u>Change</u>
			<u>Ago</u>	
Aged, Blind, & Disabled	Children Adults Duals			
Reach-Up	Children Adults			
VHAP (Global Expansion)				
Other Children	Underinsured SCHIP			
Pharmacy	VPharm 1 (<151%)			
	VPharm 2 (151-175%)			
	VPharm 3 (176-225%)			
	Other Medicaid			
	Other Healthy Vermonters			
Other	Buy-In Claw-back DSH			
<hr/>				
Total				

Table 4 – Spending by Sector

	<u>Year to</u>	<u>One Year</u>	<u>Percent</u>
	<u>Date</u>	<u>Ago</u>	<u>Change</u>
Pharmacy			
Hospital			
Nursing Home			
Physician			
Buy-In			
Claw-back			
DSH			

Additional sectors will be included in Table 4.

Appendix 12. Health Care Financing Reports: Preliminary Database Design

Table 1 – Enrollment (SFY 2002 to SFY 2006)

Month / Year

Program

Age cohort

Enrollment

Table 2 – Paid Claims (SFY 2001 to SFY 2006)

State Fiscal Year

Enrollment Category

Type of Service

Amount Paid

Service Count

Table 3 – Lump Sum Payments (SFY 2005 to SFY 2006)

State Fiscal Year

Type of Payment (e.g. DSH, cost settlement)

Amount Paid

Appendix 13. Health Care Financing Reports: Database Design Document

EXPENDITURES

Type of Payment	<ol style="list-style-type: none">1 Fee for service2 Capitation3 Allocated FFS (e.g. TPL, pharmacy rebate)4 Lump Sum (e.g. DSH)
Spending Category	<ol style="list-style-type: none">1 Global Commitment (excludes MCO investment)2 MCO Investment3 Choices for Care waiver4 Other waiver (historical)5 SCHIP6 DSH7 Clawback8 Pharmacy wrap9 QI-1 (federal dollars only)10 Other
Department	Who ultimately spends money / funding source
Eligibility	AID Codes
Paid Year	State fiscal year, 4 digits
Paid Quarter	1-4
Service Type	COS
Primary Payer	<ol style="list-style-type: none">1 Medicaid (default)2 Medicare (dual)3 Other insurance
Units of Service	To be investigated. Days for inpatient, visits for outpatient, visits for physician, days of supply for drugs?
Age	To be investigated. Current standards, 5 year cohorts?
Allowed Amount	Blank if other than claim payment
Cost Sharing	Blank if other than claim payment
Other Insurance	Blank if other than claim payment
Actual Paid	

Appendix 14. Employer-Sponsored Insurance: JFO Report

Vermont Legislative Joint Fiscal Office

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ISSUE BRIEF

October 15, 2006

Prepared by Don Dickey

Premium Assistance for Employer-Sponsored Insurance (ESI) Enrollment Experience in Other States

Summary

Premium assistance programs use Medicaid funds to help beneficiaries purchase private health insurance, rather than to pay directly for care. There are several potential benefits to premium assistance programs, including cost savings for the state¹, increased enrollment, and reduction in cost shifting.

As part of Act 191, “Health Care Affordability for Vermonters,” the state was directed to explore one type of premium assistance – subsidizing the employee share of employer-sponsored health insurance (ESI). An analysis of the costs and benefits of a Vermont ESI premium assistance program is underway, using Vermont survey and Medicaid data. This issue brief is intended to provide context for that analysis, by examining the experience of other state Medicaid programs, with a focus on enrollment.

Several conclusions can be drawn from the experiences of other states:

- Complex administrative challenges have constrained enrollment in state premium assistance programs
- Only a handful of premium assistance programs have achieved enrollment levels above 1 percent of the eligible populations
- Enrollment of low-income adults in premium assistance programs is especially challenging
- Initial enrollment estimates have been overly optimistic, both in the number who ultimately enroll and the time it takes to achieve ultimate enrollment
- Federal efforts to promote state premium assistance programs under the recent HIFA waiver initiative (2001) have yet to bear fruit.

¹ Total cost savings is a function of the number of Medicaid beneficiaries who enroll in the premium assistance program, their historical costs to the Medicaid program, and their future costs under premium assistance, including direct premium subsidy and any additional costs, such as “wrap around” costs for benefits and cost sharing.

Introduction

Section 1974 of Title 33² directs the Agency of Human Services (AHS) to implement a mandatory premium assistance program by October 1, 2007 to assist current Vermont Health Access Plan (VHAP) enrollees who have access to employer-sponsored insurance (ESI) coverage. Premium assistance entails using state and federal Medicaid funds to subsidize insurance premiums on behalf of Medicaid beneficiaries for the purchase of private insurance coverage. A premium assistance program that will move current VHAP enrollees from direct VHAP coverage to ESI coverage has been viewed as a way to generate Medicaid “savings.”³

During the legislative session, consultants and staff from the administration and legislature settled on a preliminary working estimate of “savings” that could be generated by ESI premium assistance for VHAP enrollees.⁴ To put the working estimate on stronger footing, 33 V.S.A. § 1974(g) directed the Agency of Human Services to conduct a survey of current VHAP enrollees, which is expected in October 2006. The AHS survey will provide more precise information concerning the number of VHAP enrollees who are potentially eligible for ESI premium assistance and the budgetary “savings” projected to result by requiring those individuals to enroll in such a program.

This issue brief serves as a companion document to the AHS survey by reviewing the enrollment experience of premium assistance programs in other states. Enrollment is a critical variable along with the change in per-member-per-month cost in estimating the potential budget “savings” on current VHAP enrollees who are eligible for ESI premium assistance. Examining those state premium assistance programs most successful in building enrollment will help inform the assumptions that underlie projections for potential enrollment of VHAP enrollees in ESI premium assistance in Vermont.

Discussion

1. Complex challenges have constrained enrollment in ESI premium assistance over the past 15 years

Despite recent federal efforts to expand ESI premium assistance, state programs continue to wrestle with common administrative and operational challenges that have historically limited efforts to build enrollment. These program challenges are not new. States began operating premium assistance under Medicaid over 15 years ago, and the major program challenges were identified early on. Federal cost reduction legislation in 1990 mandated that states implement “premium payment” programs for Medicaid beneficiaries with access to employer-based health insurance.⁵ Congress made this provision voluntary seven years later following a report by the

² As enacted by Sec. 13 of Act 191 - An Act Relating to Health Care Affordability for Vermonters, 2005 Vt. Acts & Resolves No. 191 (Adj. Sess. 2006).

³ 33 V.S.A. § 1974 also requires *future* enrollees in both VHAP and Catamount Health to enroll in available ESI coverage via premium assistance if determined to be less costly than direct coverage. However, this paper focuses only on current Medicaid program eligibles because of their potential to generate “savings” off the currently budgeted Medicaid expenditures.

⁴ See “H.861 Balance Sheet,” Committee of Conference, May 5, 2006 (reflecting net “savings” from shifting current VHAP enrollees to ESI coverage), available at <http://www.leg.state.vt.us/HealthCare/BALANCE%20SHEET%20FINAL.pdf>

⁵ 42 USC 1396e (1991).

federal General Accounting Office (GAO) indicating that many states had not been effective in implementing premium assistance programs.

In its 1997 report, the GAO delineated the chief administrative “barriers” that are inherent in operating premium assistance programs, including:

- Difficulty of identifying and investigating individual employee eligibility
- Complexity of coordinating coverage with employers
- Shifting nature of beneficiaries’ Medicaid eligibility status and employment status
- Dynamic nature of employer-sponsored insurance.

The GAO predicted that, because of those barriers, even successful programs would have at best a “modest” impact in terms of enrollment and savings when compared with the total Medicaid populations and expenditures in those states.⁶

The implementation barriers identified by the GAO in 1997 continue to prevent widespread enrollment in premium assistance programs. Rhode Island’s January 2006 annual report on its premium assistance program identified a virtually identical list of obstacles that have hindered its highly regarded program from realizing greater enrollment⁷. In addition, the same set of challenges has been examined in extensive detail in the web-enabled “Premium Assistance Toolbox,” released as a technical assistance resource in 2004 to assist states in surmounting the complexities of ESI premium assistance.⁸

Because of these administrative barriers, most premium assistance programs operated by states for their Medicaid populations have very low enrollment.⁹ The existing Medicaid “health insurance premium payment (HIPP)” programs in Vermont, New Hampshire, and Maine provide apt examples in this region. The number of individuals enrolled in Medicaid premium assistance for ESI coverage as of January 2006 represents a very small percentage of overall Medicaid enrollees, as follows:

- Vermont - 57 individuals
- Maine - 207 individuals
- New Hampshire - 50 individuals.

Similar to the other two states, Vermont’s program does not require beneficiaries to enroll in premium assistance unless they are already enrolled in ESI coverage. The program pays premiums for Medicaid beneficiaries who have existing health insurance coverage, but can no longer afford the coverage for one reason or another.¹⁰ In New Hampshire, most enrollees in

⁶ U. S. General Accounting Office, “MEDICAID: Three States’ Experiences in Buying Employer-Based Health Insurance,” Report to the Chairman, Committee on Commerce, House of Representatives, July 1997, GAO/HEHS-97-159, pp. 16-17, available at <http://www.gao.gov/archive/1997/he97159.pdf#search=%22Three%20States'%20Experiences%20in%20Buying%20Employer-based%20Health%20Insurance%22>

⁷ “Rite Share Premium Assistance Program: Estimated Savings for State Fiscal Year 2005,” Rhode Island Department of Human Services, January 2006, p. 11, available at http://www.riteshare.ri.gov/documents/reports_publications/RS%20Savings%20Report%20SFY04%20with%20admin%201-12-06.pdf#search=%22Rite%20Share%20Premium%20Assistance%20Program%22

⁸ “The Premium Assistance Toolbox for States,” National Academy for State Health Policy, October 2004, available at www.patoolbox.org

“A Snapshot of State Experience Implementing Premium Assistance Programs,” National Academy for State Health Policy, April 2003, available at <http://www.nashp.org/Files/snapshot.pdf#search=%22Premium%20Assistance%20Snapshot%22>

⁹ “These same factors are thought to underlie the very low enrollment in the premium assistance programs established prior to HIFA.” “Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity,” Kaiser Commission on Medicaid and the Uninsured, October 2003, p.1, available at <http://www.kff.org/medicaid/kcmu4143brief.cfm>

¹⁰ Lori Collins, OVHA, June 2006.

Medicaid premium assistance are disabled children (Children with Special Health Care Needs - Katie Beckett program) whose families have access to ESI.¹¹ As with Medicaid premium assistance programs in other states, enrollment in these programs is very small.

2. Only a handful of state premium assistance programs have achieved significant enrollment

Only a handful of premium assistance programs have achieved enrollment levels of more than 1% of the state's Medicaid eligible populations – namely, Rhode Island, Massachusetts, Oregon, Pennsylvania, and Iowa. The following table shows the number of individuals receiving premium assistance for ESI group coverage in the 13 states with active programs. Only five of these states had enrollment in ESI premium assistance of more than 1% of the nondisabled adults and children eligible for Medicaid and SCHIP.

Enrollment in ESI premium assistance programs operational as of July 2006¹²

State	Year Implemented	Medicaid eligible individuals enrolled in ESI*	Total of Medicaid children/adults (nondisabled)	Percent of Medicaid children/adults
Rhode Island	2001	5,500	117,000	4.7%
Massachusetts	1998	18,973	552,000	3.4%
Pennsylvania	1994	22,600	1.16 million	1.9%
Iowa	1991	4,400	275,000	1.6%
Oregon	1998	5,300	502,000	1.05%
Idaho	2004	456	Less than 1% of Medicaid children/adults	
Illinois	1998	4,922	Less than 1%	
Maine	2005	200	Less than 1%	
New Jersey	2001	770	Less than 1%	
Texas	1996	11,912	Less than 1%	
Utah	2003	75	Less than 1%	
Virginia	1991	1,600	Less than 1%	
Wisconsin	1999	1,691	Less than 1%	

* "Medicaid-eligible individuals enrolled in ESI" does not include individuals who lack access to ESI coverage, but receive Medicaid premium assistance to purchase insurance in the individual (nongroup) market. Nor does it include family members who are ineligible for Medicaid/SCHIP benefits but who receive subsidized coverage incidental to family coverage purchased to cover Medicaid-eligible children.

The table above enables a general comparison of ESI premium assistance enrollment across different state Medicaid programs, but its usefulness is limited. Apples-to-apples comparisons across programs are difficult because the Medicaid population groups eligible for premium

¹¹ John Bonds, Office of Medicaid Business and Policy, NH Department of Health and Human Services, July 2006.

¹² For the top five states, the number of Medicaid eligible individuals enrolled in ESI premium assistance is based on direct personal communications with the program directors administering those programs. Enrollment numbers for the lower eight states are based on personal contact or recent issue briefs on state premium assistance programs, including, e.g.,

a) "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?", National Health Policy Forum, July 2006, available at <http://www.nhpf.org/index.cfm?fuseaction=Details&key=608>

b) "Premium Assistance Programs for Low Income Families: How Well Does it Work in Rural Areas?" North Carolina Rural Health Research and Policy Analysis Center, January 2006, available at http://www.shepscenter.unc.edu/research_programs/rural_program/wp.html

c) "Premium Assistance Programs: How Are They Financed and Do States Save Money?" Kaiser Commission on Medicaid and the Uninsured, October 2005, available at: <http://www.kff.org/medicaid/upload/Premium-Assistance-Programs-How-are-they-Financed-and-do-States-Save-Money-Issue-Brief.pdf>

assistance vary from state to state as a reflection of different state environments and program goals. Generally, the different covered groups targeted for premium assistance include one or more of the following three groups:

- Children and parents eligible for Medicaid
- Children and pregnant women eligible for SCHIP
- Children and adults eligible under a Medicaid 1115 waiver coverage “expansion.”¹³

Because premium assistance for the VHAP program would target adults in the income eligibility range of 0-185% of poverty, it is more useful to examine the states with effective programs that target a similar population of adults. The states with programs that meet that criterion include Rhode Island, Massachusetts, and Oregon.¹⁴

3. Enrollment of adults at the VHAP income eligibility range has remained very low

In Massachusetts, Oregon, and Rhode Island, enrollment of adults in premium assistance at the VHAP income eligibility range (0-185% FPL) has remained very low. These states have many more adults enrolled in their Medicaid, SCHIP, and Medicaid expansion programs than does Vermont. In Rhode Island, for example, adults comprise about one-third (39,000) of the 117,000 nondisabled adults and children enrolled in its Medicaid and SCHIP program, yet only 1,500 adults are enrolled in premium assistance. The following table shows the enrollment of adults at the VHAP income eligibility range (0-185% FPL) in these three states. None of the three states is predicting anything more than very gradual enrollment increases for adults in this eligibility range.

State	Eligibility Group	Enrollment
Massachusetts	Parents 133–200% FPL	4,725
	Childless adults 0–200% FPL	
Oregon	Parents/Adults 0-185% FPL	2,998
Rhode Island	Parents/Adults 0-185% FPL	1,500

The very low enrollment of adults at the VHAP income eligibility range is relevant to making assumptions about the potential ESI enrollment of VHAP beneficiaries. These states’ experience raises concerns about the preliminary working estimate of enrollment that the legislature and administration agreed to and included on the H.861 Committee of Conference “Balance Sheet.”¹⁵ The Balance Sheet projected that 3,180 current VHAP beneficiaries would be enrolled in ESI premium assistance by the second year. This would be more than twice the number of adults enrolled in ESI by Rhode Island, even though Rhode Island has over 1½ times as many adults in Medicaid — 39,000 in RI compared to less than 24,000 in VHAP. The Balance Sheet projection appears especially optimistic given the income eligibility distribution of VHAP enrollees. As reflected in the table below, only 8,618 individuals of the 23,286 individuals enrolled in VHAP had incomes over 100% of poverty in July 2006. While the survey will provide empirical evidence, it is likely that access to ESI declines at lower income, especially below poverty.

¹³ See “The Premium Assistance Toolbox for States,” National Academy for State Health Policy, October 2004, available at www.patoolbox.org

¹⁴ Neither Iowa nor Pennsylvania has comparable experience with Medicaid premium assistance programs for adults up to 185% of poverty.

¹⁵ See the “H.861 Balance Sheet” accompanying the Report of Committee of Conference on H.861, available at <http://www.leg.state.vt.us/HealthCare/BALANCE%20SHEET%20FINAL.pdf>

VHAP Enrollment, July 2006¹⁶

% FPL	Persons Enrolled
0-50%	9,271
50-75%	2,479
75-100%	2,918
100-150%	6,891
150-185% (caretakers)	1,727
	23,286

Vermont is in the process of reexamining its working estimate of enrollment of adults in ESI premium assistance. Pursuant to 33 V.S.A. § 1974(g), the Agency of Human Services (AHS) is conducting a survey of current VHAP enrollees to provide a sounder foundation for estimating the number of individuals who are potentially eligible for ESI premium assistance. However, based on the experience of other states, those estimates are likely to be lower than the preliminary working estimates included during the legislative session on the H.861 Balance Sheet.

4. Enrollment has taken longer and been lower than anticipated

The experience of other states suggests not only that the preliminary working estimate of enrollment may be too high, but also that the rapid increase of enrollment over FY08 and FY09 projected on the H.861 Balance Sheet may be too fast. Close examination of the programs in Rhode Island, Massachusetts, and Oregon reveals that ESI premium assistance enrollment in these states has remained lower than anticipated and far lower than originally estimated, and it has increased more slowly than anticipated. For each of the three states, this section will discuss:

- Enrollment estimates at the time of premium assistance implementation
- Actual enrollment experience since implementation
- Current enrollment in 2006.

A. Rhode Island

Enrollment estimate at the time of implementation. When Rhode Island's program was implemented in 2001, it was estimated that about one-half of all working families enrolled in its Medicaid/SCHIP program would have access to employer-sponsored health insurance, which was to amount to some 20,000 persons by July 2002.¹⁷

Actual enrollment experience, 2001-2006. In February 2001, Rhode Island implemented a voluntary premium assistance program. During the first year, the program worked on developing program infrastructure and building relationships with employers, but achieved negligible enrollment.¹⁸ Upon becoming mandatory in January 2002, the program succeeded in shifting some 2,800 individuals from traditional Medicaid into ESI premium assistance during 2002, and then another 2,000 individuals during 2003. ESI enrollment slowed down after that and has remained in the same range for the past two years, fluctuating between 5,500 – 6,000 individuals since June 2004.¹⁹

¹⁶ Source: http://www.path.state.vt.us/premium/Enrollment_Report_2006.pdf

¹⁷ "FY 2003 State Budget - Part II Medicaid Expenditures and the Rite Care Program," Rhode Island Public Expenditure Council, p. 17, available at <http://www.ripec.com/matriarch/d.asp?PageID=66&PageName2=pdfsdoc&p=&PageName=medicaid%2Epdf>

¹⁸ Id.

¹⁹ Personal communication with Lisa Dimauro, Rite Share Program Director, July 2006.

Actual enrollment (children and adults) in Rite Share 2002-2006

Jan. 2002	Jan. 2003	Jan. 2004	Jan. 2005	Jan. 2006	July 2006
111	2,905	5,006	5,876	6,012	5,500

Current enrollment in Rite Share, June 2006

Eligible Population	Eligibles Enrolled
Children and pregnant women up to 250% FPL	Children: 4,000
Adults up to 185% FPL	Adults: 1,500

B. Oregon

Enrollment estimate at the time of implementation. Oregon's program was designed to provide premium subsidies not only for ESI coverage, but also for coverage in the individual (nongroup) market. When implemented in 1998, Oregon's program was expected to serve approximately 15,000 individuals after the phase-in period ending in 2001. This goal became fiscally "impracticable" when less than one-quarter of program applicants enrolled in ESI premium assistance, while three-quarters of applicants enrolled in the far more costly individual market (with about one-half of those individual market enrollees ending up in the high risk pool).²⁰

Actual enrollment experience, 1998-2006. From its start in 1998, Oregon's program operated with low ESI enrollment (about 940 individuals at its peak²¹) until it was refinanced with federal matching funds under an 1115 waiver (HIFA) in October 2002. Throughout most of 2003, the program "focused on maximizing new enrollments in the employer-sponsored insurance market" and "engaged in aggressive marketing efforts" for ESI enrollment, while closing down individual market enrollment.²² According to the program director, these efforts to build ESI enrollment had limited success because, for most low-income working individuals, either employer coverage was not available or the employer did not contribute toward the premium.²³ Because of the limited access to ESI, only about 20% of all premium assistance enrollees were covered by ESI while some 80% were covered by individual policies. Today ESI group coverage represents a slightly higher proportion of enrollment (about one-third), but ESI enrollment has grown slowly and currently remains much lower than the state anticipated – at around 5,500 individuals.²⁴ The program director predicts that enrollment in ESI coverage will continue at the current pace.²⁵

²⁰ See "Agency Overview, Oregon Insurance Pool Governing Board," March 2005, p.28, available at http://www.oregon.gov/OPHP/docs/ways_means_report.pdf

²¹ "Evaluation of the Family Health Insurance Assistance Program," Oregon Department of Administrative Services, June 1999, available at <http://www.statecoverage.net/statereports/or7.pdf>

²² See "Agency Overview, Oregon Insurance Pool Governing Board," pp. 5, 7, 33, available at http://www.oregon.gov/OPHP/docs/ways_means_report.pdf

²³ Personal communication with Craig Kuhn, Program Manager, Family Health Insurance Assistance Program (FHIAP), July 2006. See also "A Snapshot of State Experience Implementing Premium Assistance Programs," National Academy for State Health Policy, April 2003, p. 23 (Although almost 50 percent of the children enrolled in premium assistance had parents who worked full time, many of these parents either lacked access to ESI or had employers who did not make contributions to dependent coverage.), available at

<http://www.nashp.org/Files/snapshot.pdf#search=%22Premium%20Assistance%20Snapshot%22>

²⁴ As of early September 2006, 37% of enrollees (5,390 individuals) received premium assistance for ESI coverage, and 63% of enrollees (9,171 individuals) received assistance for individual market coverage. Individual market enrollment is closed, with a waiting list of over 24,000 applicants. (Several years ago, Vermont policy makers explored the possibility of subsidizing individual market coverage for high-cost Medicaid/VHAP enrollees without access to ESI coverage, but this was determined not to be a viable policy option. Personal communication with Lori Collins, OVHA, June 2006.)

²⁵ Personal communication with Craig Kuhn, July 2006.

*Actual ESI enrollment (children and adults) in FHIAP 2002-2006*²⁶

July 2002	July 2003	July 2004	July 2005	July 2006
800	1,967	3,655	4,450	5,536

Current ESI enrollment in FHIAP, July 2006

Eligible Population	Eligibles Enrolled
Children & pregnant women up to 185% FPL	Children – 2,538
Parents/adults up to 185% FPL	Adults – 2,998

C. Massachusetts

Enrollment estimate at the time of implementation. At the onset of its premium assistance program, Massachusetts identified the target population as the approximately 70,000 – 100,000 individuals (with and without children) who worked for small employers and had incomes less than 200 percent of FPL.²⁷

Actual enrollment experience, 1998-2006. Massachusetts operates three separate ESI premium assistance programs for its Medicaid, SCHIP, and expansion populations, respectively. The program director for Massachusetts' premium assistance programs reports that annual enrollment data are not readily available because, until last year, the state did not break down enrollment by program or separate out individuals who received ESI premium assistance but were not eligible for Medicaid or SCHIP. However, she stated that, from 1998 to 2004, the program relied on referrals from eligibility workers, and enrollment in premium assistance for Medicaid and SCHIP was significantly less than what it is today. Beginning in March 2004, the state began an aggressive program to increase premium assistance enrollment for Medicaid and SCHIP. This effort began after the state made substantial investments in staff and information resources and selected an outside contractor to manage investigations of employee eligibility. As a result of these enhancements, Medicaid premium assistance enrollment has grown substantially during the past two years, and the program director indicates that combined Medicaid and SCHIP enrollment is continuing to grow steadily.²⁸

Analyzing Medicaid and SCHIP premium assistance enrollment in Massachusetts is complicated by the Insurance Partnership (IP) program. The Insurance Partnership is designed to encourage small employers to offer health insurance to uninsured low-income workers *not eligible for direct coverage under Medicaid or SCHIP*. However, the Insurance Partnership has attracted a significant number of eligible-but-not-enrolled Medicaid and SCHIP beneficiaries (mostly children) who did not apply directly to those programs but were determined to be eligible after applying for the IP program. About two-thirds of IP participants are self-employed individuals and their families,²⁹ and many of these families have modest incomes that enable their children to qualify for Medicaid or SCHIP eligibility. Whereas the IP had enrolled 13,285 individuals in ESI premium assistance as of April 2006, a substantial number of those individuals (mostly children)

²⁶ Source: http://www.oregon.gov/OPHP/docs/ways_means_report.pdf
http://egov.oregon.gov/OPHP/docs/fhiap_stat_pack.pdf
<http://www.statecoverage.net/statereports/or7.pdf>

²⁷ "Premium Assistance Programs under SCHIP: Not for the Faint of Heart?" The Urban Institute 2003, p. 9, available at http://www.urban.org/UploadedPDF/310794_OP-65.pdf

²⁸ Personal communication with Nancy Keeley, Premium Assistance Programs, July 2006.

²⁹ Self-employed individuals find the IP attractive because they qualify for a double benefit – both the subsidy paid to the employer (up to \$1000 per employee) and the premium assistance payment available to employees with incomes up to 200% FPL. See "Employer Subsidies for Health Insurance Premiums: Massachusetts' Unique Experiment," RTI International, September 30, 2004.

have premium assistance payments made under Medicaid and SCHIP premium assistance, rather than the Insurance Partnership.³⁰

The following table reflects the complicated picture of Massachusetts' premium assistance enrollment, with enrollment counts for each program provided by the program director. Current enrollment of Medicaid and SCHIP eligible beneficiaries was 18,973 individuals, as of April 2006. The table shows that Massachusetts (unlike Rhode Island) includes in its premium assistance count many family members who are ineligible for Medicaid/SCHIP benefits but receive state-subsidized coverage incidental to the purchase of ESI family coverage.

Current enrollment in premium assistance in Massachusetts, April 2006

Program Authority	Eligible Population	Eligibles Enrolled³¹	Non-Eligible Enrollment³²
Medicaid section 1906 (1994)	Children to 150% FPL Parents to 133% FPL	13,073 Medicaid children and parents*	1,800 non-eligible family members
SCHIP (1998)	Children 150-200% FPL	5,900 SCHIP children**	3,000 non-eligible family members
Section 1115 demonstration (1995)	Parents (133-200% FPL) Childless adults (0-200% FPL) working for small employer participating in Insurance Partnership	4,725 qualifying adults***	1,740 non-eligible spouses

* The Medicaid-eligible group includes 7,753 individuals enrolled through Medicaid premium assistance and 5,320 individuals enrolled through the Insurance Partnership.

** The SCHIP-eligible group includes 4,400 children enrolled through SCHIP and 1,500 children enrolled through the Insurance Partnership.

*** The Insurance Partnership has enrollment of 13,285 individuals when the enrollees who are eligible for premium assistance under Medicaid and SCHIP are counted in the IP total.

In summary, enrollment in ESI premium assistance in Rhode Island, Massachusetts, and Oregon has developed more slowly than anticipated and remained substantially lower than anticipated.

5. Even in successful states, enrollment tends to level off at lower-than-expected participation

The experience of three of the five leading states – Rhode Island, Pennsylvania, and Iowa – suggests that enrollment in ESI premium assistance tends to level off at lower-than-expected participation. In each of these states, premium assistance enrollment has remained in the same range in recent years. As discussed later, premium assistance programs must contend with high monthly turnover in participation as enrollees experience changes in Medicaid eligibility, employment, or the health coverage offered by their employer. Although the premium assistance programs in Rhode Island, Pennsylvania, and Iowa have been constantly adding new enrollees, overall enrollment has not grown because an equal number of individuals fall off the rolls each month. Total enrollment in Rhode Island's program has not grown since June of 2004, and the program director acknowledged that enrollment appears to have stabilized at the current level.³³

³⁰ Personal communication with Nancy Keeley. For example, in a family of four, an IP-eligible father and non-eligible mother may both qualify for monthly IP premium assistance of \$150, whereas the SCHIP-eligible child and Medicaid-eligible infant may qualify for the more generous premium assistance payments available under each of those programs.

³¹ Massachusetts does not break down Medicaid premium assistance enrollees by children and adults.

³² Employer-sponsored insurance normally covers children through family coverage. Consequently, family members who would otherwise not be eligible often receive coverage as an incidental benefit when a state provides premium assistance for a Medicaid- and SCHIP-eligible child.

³³ Personal communication with Lisa Dimauro, Rite Share Program Director, July 2006.

Pennsylvania's enrollment has been relatively stable for over 3½ years (since December 2003).³⁴ Iowa's program has remained at its current level for the past four years (since August 2002).³⁵

State	Enrollment	Percent of Medicaid children/adults
Rhode Island	~ 5,500-6,000 eligibles since June 2004	4.7%
Pennsylvania	~ 22,000 eligibles since December 2003	1.9%
Iowa	~ 4,500 eligibles since August 2002	1.6%

The implication is that ESI premium assistance enrollment tends to level off in time and that, in each of the three states, it has stabilized at lower-than-anticipated participation. While enrollment in ESI coverage continues to grow slowly in Oregon and Massachusetts, the general pattern evidenced by the three states above, as well as the majority of the other states with active premium assistance programs, is that enrollment tends to level off at lower-than-expected participation.

6. Federal efforts to promote state premium assistance programs under the HIFA waiver initiative during the last five years have yet to bear fruit

Since 2001, the federal government has vigorously promoted ESI premium assistance as a mechanism to reduce Medicaid costs and support private employer-based health insurance. All states that have applied for 1115 demonstration waivers to expand coverage to uninsured residents have been strongly encouraged to consider employer-sponsored insurance (ESI) as a mechanism for health coverage expansion.³⁶ In fact, this has been a specific *requirement* of the federal Health Insurance Flexibility and Accountability (HIFA) initiative launched in August 2001.³⁷ The HIFA initiative offers states fast-track federal approval of Section 1115 waivers that meet the criteria prescribed in the streamlined HIFA waiver application, and exploring premium assistance and related approaches for coordinating private insurance represents a central criterion in the HIFA template.³⁸ Moreover, to create a more favorable climate for states to pursue premium assistance, the HIFA initiative relaxed the federal standards governing cost-effectiveness, cost-sharing, and benefits that have complicated states' adoption of premium assistance under Medicaid and SCHIP.³⁹ Given the strong push provided by the HIFA initiative, states considering premium assistance should naturally look for guidance to the experience of states with approved HIFA waivers.

³⁴ "Eligibility and Point-in-Time Enrollment in Premium Assistance Programs," National Academy for State Health Policy, October 2004, available at http://www.patoolbox.org/docdisp_page.cfm?LID=2912C479-42E3-4A8E-AE1A427C42A35938

³⁵ "A Snapshot of State Experience Implementing Premium Assistance Programs," National Academy for State Health Policy, April 2003, p.7, available at

<http://www.nashp.org/Files/snapshot.pdf#search=%22Premium%20Assistance%20Snapshot%22>

³⁶ Personal communication with Ed Hutton, Center for Medicare and Medicaid Services (CMS), August 2006.

³⁷ "Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity," Kaiser Commission on Medicaid and the Uninsured, October 2003, p. 3, available at

<http://www.kff.org/medicaid/kcmu4143brief.cfm> States whose plans did not initially propose to build on private coverage—such as Arizona and California—were required to explore the role of ESI in their expansions. See "1115 Ways to Waive Medicaid and SCHIP Rules," National Health Policy Forum, June 2002, p. 7, available at http://www.nhpf.org/pdfs_ib/IB777_1115Waivers_6-13-02.pdf

³⁸ *CMS Guidelines for States Interested in Applying for a Health Insurance Flexibility and Accountability (HIFA) Demonstration*, accessed in June 2006 at

http://www.cms.hhs.gov/HIFA/02_Guidelines.asp#TopOfPage

³⁹ E.g., "Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States," Gretchen Engquist and Peter Burns, State Coverage Initiatives Program, August 2001, available at <http://www.statecoverage.net/pdf/issuebrief802.pdf>

Taken as a whole, however, the HIFA experience does not support optimistic assumptions concerning the potential for either quick start-up or robust enrollment. The premium assistance programs required under HIFA waivers have been slow to get off the ground. None of the 12 HIFA waiver states⁴⁰ has yet to achieve significant enrollment in an ESI premium assistance program. The two programs with the largest enrollment of Medicaid eligibles in ESI premium assistance – Oregon (5,347 individuals) and Illinois (4,922 individuals) – had preexisting state-funded programs that began in 1998, three years prior to the HIFA initiative. Each of those states converted its program to HIFA 1115 waivers for purposes of gaining federal match (both did so in the fall of 2002). Both programs have small enrollment compared to the number of eligibles in the state – i.e., no more than 1% of Medicaid-eligible nondisabled adults and children. Illinois' enrollment has remained in the same range for the past four years. Current enrollment in its voluntary program has fluctuated around 5,000 individuals, which is actually lower than August 2002 (one month prior to the HIFA waiver) when enrollment in its then mandatory program was at 5,600 children.⁴¹

Of the remaining 10 HIFA waiver states, five states have programs with very low enrollment, and the other five states have never implemented a premium assistance program. Three of those states – California, Arizona, and Colorado – did not proceed to implement ESI premium assistance after conducting feasibility studies.⁴² The disappointing experience to date of the 12 HIFA waiver states is summarized here as follows:

Four states with greatest enrollment in ESI premium assistance

- Oregon (10/02)* 5,535 (3,000 adults / 2,535 children)
- Illinois (9/02) 4,925 (fewer enrollees today than prior to HIFA waiver)
- New Jersey (1/03) 770 (280 adults / 490 children)
- Utah (2/02) 75

⁴⁰ This analysis of HIFA waiver states focuses on premium assistance programs that target *individuals who are eligible for direct state coverage – i.e., Medicaid and SCHIP programs*. As with premium assistance for VHAP enrollees, these programs seek to create “savings” by requiring that beneficiaries enroll in ESI coverage whenever it represents a lower cost alternative to direct Medicaid/SCHIP coverage. Not included in this analysis are premium assistance initiatives that *subsidize private coverage for currently uninsured persons not eligible for Medicaid/SCHIP*. Those programs are not designed to generate “savings” on the current Medicaid budget, but rather to reduce the future costs of subsidizing private coverage for a population that is not eligible for direct state coverage. Such programs are akin to premium assistance for future Catamount Health enrollees, rather than premium assistance for current VHAP enrollees. Examples of such programs are found in the recently implemented HIFA waivers for New Mexico and Oklahoma (*both of which have very low enrollment*) and the newly approved HIFA waiver for Arkansas. See “Medicaid HIFA Waiver Comparison: Arkansas, New Mexico and Oklahoma,” State Coverage Initiatives Program, AcademyHealth, June 2006, available at <http://news.statecoverage.net/ahstsd/issues/2006-06-20/3.html>

⁴¹ The early enrollment history of Illinois' program is described in an analysis of Maryland's failed premium assistance program. “Maryland Children's Health Program (MCHP) Premium Private Option: The Employer Sponsored Insurance Premium Assistance Program, November 2003, p. 17, available at http://12.109.133.237/Files/7-Maryland_report_on_ESI_11.03.pdf

⁴² Feasibility studies for premium assistance in both Colorado and Arizona concluded that enrollment would be small and cost savings minimal. CMS required Arizona to submit a new ESI premium assistance proposal as part of its March 2006 waiver renewal, which is pending CMS review. However, 2006 state legislation to authorize Arizona's program failed to pass. Personal communication with Arizona program director, July 2006. See “Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity,” Kaiser Commission on Medicaid and the Uninsured, October 2003, p.1, 8-9, available at <http://www.kff.org/medicaid/kcmu4143brief.cfm>
 “Final Report of the Child Health Plan Plus Employer Buy-In Feasibility Study,” Colorado, December 2001, <http://www.statecoverage.net/statereports/co5.pdf>

Three states still too early in implementation, but anticipate small enrollment

- Idaho (11/04) 456 (predict fewer than 1,400 children; capped at 1,000 adults)
- Virginia (8/05) 1,600 (mostly from previous SCHIP premium assistance program)
- Michigan (1/04) Anticipate low enrollment

Five states have not implemented premium assistance program under state's HIFA waiver

- California (1/02) Completed feasibility study
- Arizona (12/01) Completed feasibility study
- Colorado (9/02) Completed feasibility study
- Maine (9/02) Report to legislature on premium assistance in 2006. No action taken.
- New Mexico (8/02) Concluded premium assistance models would not be viable.

* *Month/year when HIFA waiver was approved by CMS*

7. Enrollment assumptions need to take into account the administrative complexity of implementing ESI premium assistance and the time needed to build infrastructure

Assumptions on VHAP enrollment in ESI premium assistance that underlie projected VHAP “savings” need to account for the administrative challenges of implementing premium assistance programs that can impede and delay enrollment. States with experience in operating premium assistance programs have found that they need to allow as much as 1½ years for the up-front planning and coordination that must be done prior to implementing their programs.⁴³ Furthermore, states caution that a significant up-front investment is needed, and that savings will not accrue to the program immediately.⁴⁴

What has enabled the five leading states (Rhode Island, Massachusetts, Oregon, Pennsylvania, and Iowa) to be more successful than others is that they devoted substantial time and resources to develop the staff and infrastructure to meet the complex administrative challenges. The infrastructure needed to support enrollment takes time to develop and cannot be rushed. The three most critical areas of development are as follows:

- Staff capacity
- Information systems
- Coordination with employers.

A. Hire and Train Capable Staff

Because premium assistance programs are highly staff intensive, large investments in staff have been necessary to build and maintain enrollment in premium assistance programs. As reflected in the table below, Massachusetts has 33 FTE staff, including contracted staff. Pennsylvania has a program staff of 48 FTEs in five regional offices for its premium assistance program. Iowa has 14 staff administering the program, including five intake workers and seven case managers. Rhode Island has seven FTEs. Hiring and training necessary program staff takes time, and the ongoing personnel cost is substantial.

⁴³ See discussion in “Premium Assistance Toolbox” at

http://www.patoolbox.org/docdisp_page.cfm?LID=746C7A4B-530D-4C24-AA22960A928D67FB

⁴⁴ See “Premium Assistance Toolbox” at http://www.patoolbox.org/docdisp_page.cfm?LID=F3FEE0F8-71BE-4420-AC920C621B6FBAE5

State	Number of FTE Staff
Pennsylvania	48
Massachusetts	33
Iowa	14
Rhode Island	7

B. Information Systems

Another critical task to support program enrollment is to compile and maintain information in a program database on a large number of employer benefits plans, including up-to-date information on scope of benefits, employee contributions, and deductibles/coinsurance. For example, Rhode Island's program maintains information on about 1,000 employers in the database, and Massachusetts maintains information on some 2,000 employers. Program staff in both states indicated that the database is essential to the process of reviewing employer coverage and investigating cost-effectiveness – which is performed in both states by outside contractors.⁴⁵ While it would be most efficient to collect information directly from employers, Rhode Island found that employers were not returning the forms. The program had to switch to having the employee obtain the information from the employer, which is a more time-consuming process.

The database improves a state's ability to identify up-front both whether the employer may have coverage that is sufficiently comprehensive to meet benefit standards and whether the employer contribution is high enough to keep down the subsidy cost. Rhode Island categorizes employers as "approved," "non-approved," and "unknown." In response to changing employer health plans, this employer information must be continually modified to take into account changes in tier structure, prescription co-pay structure, and member cost-sharing (deductibles, coinsurance). The state's eligibility systems generate daily referrals of applicants or families who have been recertified and who also work for approved employers so that program staff is daily reviewing a constant stream of cases.

Recently, Massachusetts developed key "markers" for staff to identify individuals with greater probability of meeting cost-effectiveness. For example, if a Medicaid applicant is a wage earner working more than 100 hours per month and has 2 or more children, this increases the likelihood that the individual will have access to health insurance, and that premium assistance (for the adult and children) would be cost-effective. Rhode Island is currently in the process of reconfiguring its data system to obtain better information to support its investigation process. Previously, Rhode Island imposed a requirement on small group employers to submit data quarterly on all their covered lives so that Medicaid could perform a data match, but the data was not sufficiently timely to be of much use.

⁴⁵ The classic example of the need for an information database is Wisconsin's experience in implementing premium assistance under SCHIP in 2001. After over 64,128 employer coverage forms for premium assistance eligibility were screened, only a very small percent of the applicants were enrolled in the program -- 47 families, working for roughly 27 employers. "Premium Assistance Programs under SCHIP: Not for the Faint of Heart?" The Urban Institute 2003, p.17, available at http://www.urban.org/UploadedPDF/310794_OP-65.pdf The pioneering work of Pennsylvania in building its information system for premium assistance was profiled in a state health policy newsletter in April 2004. "Profiles in Coverage: Pennsylvania's HIPP program," State Coverage Initiatives, April 2004, available at <http://www.statecoverage.net/pennsylvaniaprofile.htm>

C. Outreach to Employers

Initiating a premium assistance program also requires considerable start-up time to build relationships with employers and information on the ESI coverage they offer. Effective coordination with employers is critical due to the continuously changing circumstances that make it an unending challenge to maintain enrollment. Premium assistance programs experience high monthly turnover, primarily because enrollees experience changes in Medicaid eligibility, employment, or the health coverage offered by their employer⁴⁶, as shown by the following examples:

State	Monthly Turnover
Massachusetts	In Medicaid, 1,080 new enrollees, but 908 dropped off In SCHIP, 895 new enrollees, but 856 dropped off (April 2006)
Rhode Island	About 280 new enrollees each month, but an equal number fall off
Oregon	About 250 new enrollees each month, but about 180 fall off

In addition, more than one-half of the individuals investigated for premium assistance are not found to be cost-effective. Rhode Island has found that, after accounting for those families who have lost Medicaid eligibility or left employment, approximately 45% of cases are cost-effective by the time they are reviewed.⁴⁷ This is similar to Oregon's experience where a December 2005 report found that more than one-half of those approved for premium assistance could not be enrolled.⁴⁸

Because employer cooperation with premium assistance programs is essentially voluntary, programs need to engage in extensive outreach and one-on-one communication. Rhode Island and Massachusetts both emphasized that an enormous amount of time and resources was required to gain credibility and to build effective working relationships with employers. For example, Rhode Island had to send letters manually to employers and employees requesting information about employer-based insurance. Rhode Island started out trying to collect information directly from employers, but after the forms were not returned, the state switched to having the employee obtain the information from the employer. The state identified approximately 6,000 employers for its Medicaid/SCHIP enrollees and determined that 69% (4,410 employers) offered coverage. Eventually, the state whittled the group down to over 1,000 employers that were approved for premium assistance based on factors such as benefit design and premium cost.⁴⁹ In addition, Rhode Island found that it had to revamp completely how it made premium subsidies to employees to remove administrative burdens that were found to hinder employer participation.

In summary, these three critical areas of planning and infrastructure development — staff capacity, information systems, and coordination with employers — take considerable time and effort to put in place. Assumptions on VHAP enrollment in ESI premium assistance must account for the impact of these challenges that can impede and delay the ramp-up of enrollment in a new premium assistance program.

⁴⁶ Vermont's group market is also subject to changes in employer coverage. Early in 2006, Vermont's small existing Medicaid premium assistance program lost almost one-quarter of its enrollment due to changes in employer coverage that made ESI no longer cost-effective (OVHA, Lori Collins, April 2006).

⁴⁷ "Rite Share Premium Assistance Program: Then and Now," Rhode Island Department of Human Services, June 2004, available at <http://www.statecoverage.net/statereports/ri30.ppt#1>

⁴⁸ See "Agency Overview, Oregon Insurance Pool Governing Board," p.19, available at http://www.oregon.gov/OPHP/docs/ways_means_report.pdf

⁴⁹ "Rite Share Premium Assistance Program: Then and Now," Rhode Island Department of Human Services, June 2004, available at <http://www.statecoverage.net/statereports/ri30.ppt#1>

Conclusion

The message from other states' experience with premium assistance is that careful analysis of data and cautious assumptions concerning potential enrollment are warranted. Premium assistance programs are highly complex to establish, and they face many ongoing challenges to success. Even the state programs considered most successful have enrollment levels that are substantially lower than originally expected. While shifting current VHAP enrollees into premium assistance may produce net savings for the State of Vermont, the enrollment assumptions that underlie projected VHAP "savings" need to account for the administrative complexity and related challenges that have consistently prevented premium assistance programs in other states from meeting expectations for enrollment, and thus expectations for savings.

Report to
Health Access Oversight Committee
and
Joint Fiscal Committee

**Employer-Sponsored Insurance
Premium Assistance**

The Office of Vermont Health Access
Agency of Human Services

November 22, 2006

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Executive Summary

An analysis of a recently-conducted survey of beneficiaries of the Vermont Health Access Plan (VHAP) yielded an estimate that an Employer-sponsored Insurance (ESI) premium assistance program could produce gross savings and cost avoidance of \$12-13 million after administrative and development costs for the three-year period of SFY08 through SFY10. The state share of those savings and avoided costs would be approximately \$4.9-5.4 million.

The lower cost of ESI premium assistance would allow the state to provide assistance to more uninsured Vermonters. In addition to saving money, insuring the uninsured by maximizing their enrollment in ESI plans would bolster the commercial market on which most Vermonters depend for their health care coverage. Although other states' experience shows that premium assistance programs are challenging to administer, the resulting savings more than offset the administrative costs.

This report recommends that the State of Vermont move forward to implement an ESI premium assistance program for the VHAP and Catamount Health populations, and analyze whether to include other populations at a future time.

Thanks to everyone who has contributed to this report, including members of Joint Fiscal Office, Office of Vermont Health Access (OVHA), Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), the Agency of Human Services' fiscal office, and the Department for Children and Families' Economic Services Division.

Section 1: Background

Section 13 of Act 191, An Act Relating to the Health Care Affordability for Vermonters, passed during the 2006 legislative session, requires the Agency of Human Services to submit a report to the Joint Fiscal and Health Access Oversight Committees prior to November 15, 2006, containing specific information related to the development and implementation of the ESI premium assistance program. The report must contain the following:

- A plan for additional expenditures beyond the first \$250,000 of the \$1 million appropriated in H.881 for start-up and initial administrative expenses associated with ESI planning and development,
- Results of a survey to determine whether and how many individuals currently enrolled in the Vermont Health Access Plan (VHAP) are potentially eligible for ESI premium assistance,
- The sliding-scale premium and cost-sharing assistance amounts provided under the ESI premium assistance program to individuals,
- A description and estimate of benefits offered by VHAP that are likely to be provided as supplemental benefits for the ESI premium assistance enrollees,
- A plan for covering dependent children through the premium assistance program, and
- The anticipated budgetary impact of an ESI premium assistance program for fiscal year 2008.¹

The Office of Vermont Health Access (OVHA) and the Department for Children and Families' Economic Services Division (ESD) formed a work group in June 2006 for the planning and implementation of the ESI and Catamount Health premium assistance programs. Representatives from the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) have participated in the work group as needed, as have representatives from private firms under contract with the Agency: MAXIMUS (Member Services Unit), Electronic Data Systems (Medicaid Management Information System), and Policy Studies, Inc. (system development).

¹ 33 VSA § 1974(g)(2)

Section 2: Description of ESI Premium Assistance

Overview

ESI premium assistance is a key feature of Vermont's health care reform plan. Because of employers' contributions to ESI premiums, the lower cost of providing ESI premium assistance (as compared to the cost of providing premium assistance to people enrolled in Catamount Health plans) will allow the state to assist more Vermonters in obtaining coverage.

Who is eligible

There are three groups of uninsured individuals eligible for premium assistance:

- Individuals with income under 150 percent of the Federal Poverty Level (FPL) and parents under 185 percent of FPL who are eligible for VHAP and have access to ESI plans
- Individuals with income between 150 percent and 300 percent of FPL who have access to ESI plans²
- Individuals with income between 150 and 300 percent of FPL without access to ESI but who wish to enroll in Catamount Health with premium assistance.

To be eligible for premium assistance in the latter two categories, individuals must have been uninsured for at least 12 months, with some exceptions.³

Uninsured adults with income greater than 300 percent of FPL may purchase a Catamount Health plan but will receive no premium assistance.

The first two groups described above are the focus of this report.

Benefits

For individuals who are eligible for VHAP and have access to ESI, the ESI plan must offer benefits "substantially similar to the benefits covered under the certificates of coverage offered by the typical benefit plans issued by the four health insurers with the greatest number of covered lives in the small group and association market in this state."⁴

²300 percent of FPL is \$2463 per month or \$29,556 per year; for a household with two adults, 300 percent of FPL is \$3313 per month or \$39,756 per year.

³ Individuals do not have to wait 12 months for premium assistance if they lost coverage due to one of the following reasons: loss of employment; death of the principal insurance policyholder; divorce or dissolution of a civil union; no longer qualified as a dependent under the plan of a parent or caretaker relative; no longer qualifying for COBRA, VIPER, or other state continuation coverage; or a college-sponsored insurance plan became unavailable because the individual graduated, took a leave of absence, or otherwise terminated studies.

⁴ 33 VSA § 1974(b)(2)(A)

Who is Eligible	Type of Coverage	Benefits
VHAP adults 0-150% FPL; or parents under 185% FPL	Employer Sponsored Insurance	The benefits covered by the plan must be substantially similar to the benefits offered by the typical benefit plans issued by the four health insurers with the greatest number of covered lives in the small group.
Uninsured Adults 151–300% FPL not eligible for any OVHA program.	Employer Sponsored Insurance	The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance.
	Catamount Health Plan	The benefits provided under Catamount Health.

In addition, OVHA will “wrap around” the ESI plan to ensure the adult receives the same benefits as would be available through VHAP. The cost of the coverage to the beneficiary under ESI will not be higher than VHAP coverage; therefore, the adult would not pay a monthly premium that is higher than the VHAP premium and would not be responsible for any cost-sharing (deductibles, co-insurance, and co-pays) above VHAP cost-sharing requirements.

For those up to 300 percent FPL who are not eligible for existing state programs, the ESI benefits must be substantially similar to the benefits offered by Catamount Health and provide appropriate coverage of chronic conditions. In addition, any cost -sharing for chronic care under ESI will be covered by the wrap-around benefit.

Those without access to ESI may enroll in Catamount Health.

Plan Approval & Cost Effectiveness

For OVHA to provide premium assistance it must determine the individual is enrolling in an approved health plan that is “cost-effective.” A plan is cost-effective if it is less expensive for the state to pay premium assistance and wrap-around costs for an individual in an ESI plan than to provide full coverage under the VHAP program.

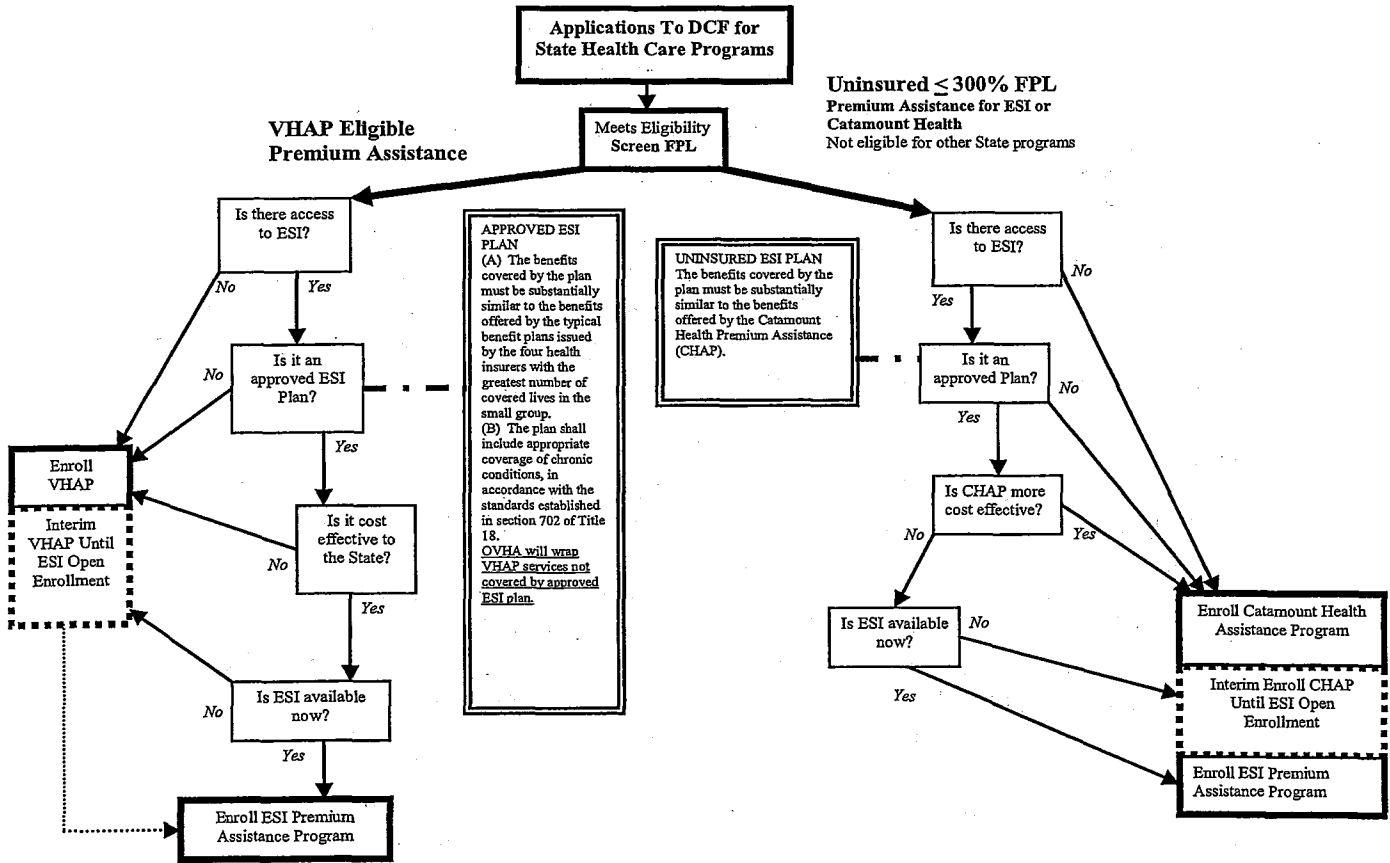
For those on VHAP, OVHA will perform a cost-effectiveness test comparing VHAP costs and ESI premium assistance costs. If a VHAP-eligible adult is required to enroll in ESI, VHAP will “wrap around” the ESI plan to ensure that the adult receives the same benefits as would be available through VHAP.

If an adult is not eligible for VHAP but is under 300 percent FPL, OVHA will perform a cost-effectiveness test comparing ESI premium assistance costs and Catamount Health premium assistance costs. If the adult receives premium

assistance in the ESI plan, the state will pay for any cost-sharing associated with the treatment of chronic conditions.

Uninsured adults with income greater than 300 percent FPL may purchase a Catamount Health plan but will receive no premium assistance.

The following flowchart shows the three groups eligible for premium assistance (VHAP/ESI, ESI, and Catamount Health), a description of the benefit, and the process flow for each group.



Section 3: VHAP Survey Results

Survey Results

The health care reform bill required the Agency of Human Services to conduct a survey to determine how many individuals currently enrolled in VHAP, including those eligible as caretakers, are potentially eligible for ESI premium assistance. In August 2006 OVHA signed an interagency agreement with BISHCA that allowed BISHCA to extend its contract with Market Decisions L.L.C. to include the VHAP survey. OVHA, BISHCA, and Department for Children and Families' Economic Services Division collaborated with Market Decisions on the content of the survey questionnaire. The survey was conducted in August and early September of 2006.

Extrapolating the results of the survey to the VHAP population as a whole, 63 percent of VHAP beneficiaries have some earned income; however, only 10 percent of VHAP beneficiaries are eligible to enroll in an ESI plan, either because their employers do not offer health insurance or because the employees do not work enough hours to qualify for their employer plans.

Methodology for simulating cost-effectiveness test and cost savings

Those VHAP respondents who said they had access to and were eligible for ESI plans were matched against the Medicaid claims database to determine actual claims cost for the twelve months in SFY06. Actual claims costs for these VHAP beneficiaries ranged from zero to \$25,986 for the 12-month period.

An algorithm was developed to match actual claims cost for each person against estimated ESI costs using the premium, deductible, co-insurance, and out-of-pocket maximum for several product offerings, including Catamount Health and various plans from Vermont's small group and association market. Also used was a hypothetical plan with average single-person cost-sharing according to the 2006 Kaiser Family Foundation survey. This analysis determined that approximately half of VHAP beneficiaries with access to and eligible for ESI would have cost-effective ESI plans. The 1068 beneficiaries falling into this category represent five percent of the VHAP population as a whole.

For the beneficiaries for whom it would be cost-effective to enroll in ESI plans with premium assistance, the difference between their actual claims cost and the estimated cost of their ESI premium plus wrap costs (deductible and cost-sharing up to the out-of-pocket maximum) becomes the estimated cost savings. Cost savings from the sample may then be applied to the VHAP population as a whole to determine total cost savings to the program. See Section 7 for the budgetary impacts of ESI.

Section 4: Sliding Scale Premiums and Cost-sharing Amounts

Statute requires that “the premium assistance program . . . provide a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual, with greater amounts of financial assistance provided to eligible individuals with lower household income and lesser amounts of assistance provided to eligible individuals with higher household income.”⁵

Since the law states that VHAP-eligible individuals enrolled in ESI should not have out-of-pocket expenditures greater than the premium and cost-sharing obligations under VHAP, the Agency is proposing to set the ESI individual contributions for VHAP-eligible ESI enrollees at the same level as VHAP premiums as of July 1, 2007.

For individuals who are not eligible for VHAP, the Agency is proposing that ESI individual contribution levels be the same as contribution levels for Catamount Health. Using the same contribution levels for both ESI and Catamount Health would ensure equity for individuals participating in premium assistance and having income above the VHAP income maximum.

Below is a chart that shows the comparison of proposed individual contributions in the VHAP, ESI, and Catamount Health premium assistance programs.

COMPARISON OF BENEFICIARY'S SHARE OF PREMIUM									
VHAP=Vermont Health Access Plan									
VHAP ESI=Premium assistance for people eligible for VHAP and enrolled in an ESI plan									
ESI=Premium assistance for people not eligible for VHAP & enrolled in an ESI plan & income <300% FPL									
CHAP=Catamount Health Assistance Program (assistance for people in Catamount Health & <300% FPL)									
% FPL	Monthly income	VHAP \$ ¹	VHAP % ²	VHAP ESI \$	VHAP ESI %	ESI \$ ³	ESI %	CHAP \$	CHAP %
50-75%	\$513	\$7	1.36%	\$7	1.36%				
75-100%	\$718	\$25	3.48%	\$25	3.48%				
100-150%	\$1,026	\$33	3.22%	\$33	3.22%				
150-185%	\$1,375	\$49	3.56%	\$49	3.56%	\$60	4.36%	\$60	4.36%
185-200%	\$1,580					\$60	3.80%	\$60	3.80%
200-225%	\$1,744					\$90	5.16%	\$90	5.16%
225-250%	\$1,950					\$110	5.64%	\$110	5.64%
250-275%	\$2,155					\$125	5.80%	\$125	5.80%
275-300%	\$2,360					\$135	5.72%	\$135	5.72%
¹ Beneficiary's share of premium									
² Beneficiary's share of premium as a percentage of income									
³ Proposed beneficiary's share of ESI premium									

⁵ VSA 33 § 1974(c)(3)

Section 5: Description of and Cost Estimate for the VHAP “Wrap”

Act 191 requires the Agency of Human Services through OVHA to provide “wrap-around” benefits to beneficiaries who are enrolled in ESI and eligible for VHAP. The wrap-around, or “wrap,” ensures that any provider of a service not covered under the ESI plan, but covered under VHAP, would be reimbursed. In addition, the wrap would cover cost-sharing under the ESI plan to the extent the cost-sharing exceeds VHAP cost-sharing (the only co-pay requirement in VHAP is a \$25 emergency room fee). In essence the ESI plan becomes the primary payer, with VHAP as secondary payer.

Since the VHAP covered services package was designed to resemble closely the covered services provided by the typical private insurance plan, there will not be many service categories covered under the wrap that are not covered by the private insurance plan. The vast majority of wrap expenditures, therefore, will be charges falling under deductibles. However, after conducting a review of some of the top plans in the small group and association market, the following services covered by VHAP are not covered in some of the private plans:

- Outpatient physical therapy, occupational therapy, and speech therapy
- Skilled nursing facility (up to 30 days)
- Nurse practitioner services
- Eye exams
- Family planning services
- Mammograms
- Home health nursing
- Vasectomies/tubal ligations

Cost estimate of the VHAP wrap

To estimate the costs of the wrap, OVHA reviewed claims from the Medicaid Management Information System (MMIS) for adults on Medicaid who are not eligible for SSI or Medicare and who have other insurance on the assumption that these adults are similar to adults on VHAP with access to ESI. For these currently eligible Medicaid adults, Medicaid is the secondary payer. This exercise, however, did not yield a large enough number of beneficiaries from which to draw sound conclusions. In addition, the types of claims represented in this small sample raised questions about whether the sample was a valid “proxy” for the VHAP working population.

Instead, an estimate of the wrap was derived from the working VHAP survey respondents who have cost-effective ESI plans by using actual claims for these

individuals over the prior fiscal year period and estimating the cost-sharing of the typical health insurance plan in the small group and association market. Using the simulation described above, the average annual wrap cost per individual would be \$28.58 per month or \$342.96 per year.⁶ The average VHAP per-member-per-month (PMPM) cost for these individuals was \$481.27, which is higher than the PMPM of \$256.41 for the VHAP population as a whole in SFY06. This finding makes sense in that a determination of cost-effectiveness would occur more often for higher-cost beneficiaries.

Cost estimate of the ESI chronic care cost-sharing wrap

Individuals who are not eligible for VHAP but are under 300 percent FPL are eligible for premium assistance for their ESI plans. The state must also provide a wrap for any cost-sharing for treatment of chronic conditions. Since 50 percent of the actual claims for the VHAP survey respondents with cost-effective ESI plans appeared to be chronic care cost-sharing claims, that percentage was used to estimate a wrap cost of \$18.29 per month or \$219.48 per year.⁷

Although by looking at each claim on the VHAP survey respondents it was possible to determine which claims were likely to have been chronic care claims, it will be very difficult to automate a process that accurately makes the distinction between chronic care claims and primary acute care claims.

Premium assistance plus wrap costs

The following table summarizes the cost of providing premium assistance, including the wrap, for VHAP/ESI and non-VHAP ESI. Since this chart is offered for comparison purposes only, the beneficiary's contribution has not been included.

Category	Premium assistance	Wrap	Total monthly cost	Total annualized cost
VHAP/ESI	\$91.21	\$28.58	\$119.79	\$1437
ESI	\$91.21	\$18.58	\$109.50	\$1314

⁶ An additional \$10 per month was added to the PMPM to account for services covered by VHAP but not covered by the ESI plan, as listed in the prior section.

⁷ \$5 per month was added for state-mandated services not covered by the ESI plan. Another \$4 per month was added should the decision be made to include ESI plans with deductibles somewhat higher than the Catamount Health deductible of \$250, in which case the state would provide a wrap down to the Catamount Health cost-sharing level.

Section 6: Should children be included in ESI plans?

Act 191 requires the Agency as part of this report to develop a plan for covering dependent children through the premium assistance program. Language earlier in Section 13 states “the agency shall determine whether to include children who are eligible for Medicaid or Dr. Dynasaur in the premium assistance program at their parent’s option.”⁸ This section of the report was to include the Agency’s decision on whether or not to include children and the justification for that decision.

In September the Agency concluded that it could not do justice to this very important analysis prior to the due date for this report. The Agency sought and received the approval of the Health Access Oversight Committee and the Health Care Reform Commission to postpone this analysis to a later date. No child will be prevented from receiving health care coverage or in any way be harmed by this postponement, since children in families below 300 percent FPL are eligible for Dr. Dynasaur, which has a richer benefit package than most ESI plans would provide.

An additional reason for this postponement is the Agency’s desire to implement premium assistance programs for adults and ensure their smooth operation before adding children. Because the implementation of premium assistance programs is a difficult challenge, and because the October 1, 2007, deadline is an ambitious deadline, the additional complexity of including children carries the risk of a delayed or flawed implementation. Since children in general are less expensive than adults to cover under state-funded programs, this is yet one more reason for not moving precipitously in this area.

⁸ 33 V.S.A. § 1974(a)

Section 7: Estimated Budgetary Impact of ESI Premium Assistance for SFY08 through SFY10 and One-time Development Costs for SFY07

Background

The SFY08 budgetary impact of ESI premium assistance is the cost savings of moving current VHAP beneficiaries into ESI, the costs avoided by moving new VHAP beneficiaries into ESI, and the costs avoided by new non-VHAP ESI premium assistance beneficiaries who would otherwise be enrolled in Catamount Health premium assistance at a higher cost.

The budgetary impact of the Catamount Health premium assistance beneficiaries and the anticipated increase in the number of VHAP beneficiaries without access to ESI have not been included in this report, but will be included in the new Global Commitment balance sheet and the Governor's recommended budget.

For the estimates of how many new VHAP beneficiaries will be on the rolls as a result of lower premiums and the outreach campaign, and the number of ESI premium assistance beneficiaries, the BISHCA Household Health Insurance Survey of 2005 was used to develop the base population estimates of Vermonters potentially eligible for assistance. Dr. Sherry Glied, an economist at Columbia University and a national expert on the issue of take-up rates, estimated how many of the potentially eligible Vermonters for VHAP and ESI would actually apply and enroll.

Population estimates and take-up rates

According to the results of the BISHCA survey, there are 17,017 adult Vermonters who are eligible for VHAP but not enrolled. Dr. Glied estimated that VHAP enrollment would grow by approximately five percent⁹ based on the premium reductions and the aggressive outreach campaign required in the legislation. This five percent gross increase would result in an additional 1316 individuals enrolling in VHAP, of which 85 would have cost-effective ESI plans.

The BISHCA survey results show that 4830 uninsured Vermonters who are over the VHAP income limit but under 300 percent FPL have access to ESI plans but have not enrolled. Dr. Glied estimates that 290 of these individuals would enroll in ESI premium assistance.

The number of people expected to enroll in non-VHAP ESI is low for several reasons. Because ESI plans are a relatively inexpensive way for people to obtain coverage, most people who have access to ESI already enroll in ESI. In fact, according to national studies, over 80 percent of employees take up their employer's ESI offer. Since Vermont's premium assistance program for ESI requires individuals to contribute toward the cost of their premiums, the difference between the total premium cost to the employee and the subsidized

⁹ The growth would be only three percent for the 0-150 percent FPL category, since there is no VHAP premium for this group, and so lower premiums would not attract additional applicants. The three percent growth is estimated to result from the outreach campaign.

premium cost is not great enough to entice many people to enroll. In fact, in the higher income categories, where most eligible beneficiaries are, the beneficiary's contribution is about equal to the average employee share of the ESI premium.

Based on the literature it is estimated that every 10 percent decline in employee required contributions toward insurance leads to a .05 percent increase in enrollment. Dr. Glied is using a somewhat higher take-up rate than these figures would imply. This take-up estimate reflects the fact that an individual who has not already enrolled in a relatively inexpensive ESI plan is likely to be fairly healthy and have a low demand for health insurance. This group is less likely than average to apply for ESI premium assistance for what might be perceived as a small monetary gain. People who have access to ESI and do not take it up are less likely to participate in premium assistance programs than are people who have no employer offers at all.

Even though the number of people who will enroll in ESI is low, it would still be less expensive to provide premium assistance to these individuals in ESI plans than in Catamount Health plans. The average ESI premium assistance cost would be an estimated \$109.50 per month (including the chronic care cost-sharing wrap), whereas the average premium assistance for Catamount Health would be approximately \$362.

Although a higher number of people could be expected to enroll in ESI if the expected employee contribution were established at a lower level,¹⁰ Dr. Glied warns that is important to be cautious about expanding these subsidies because heavily subsidizing employee premium shares for ESI could lead employers to change behavior and increase the required premium shares over time. Moreover, many people who are currently taking up employer-offered health insurance and paying the full employee share of premiums for this coverage would tend to move toward jobs where they would become eligible for subsidized premiums. The crowd-out potential of subsidizing employee premium shares at ever-increasing levels is large because such a significant portion of the potentially eligible population is already insured.

As a result of the take-up analysis, the following table summarizes the numbers of new enrollees in the various eligibility categories:

Eligibility category	New enrollees
Current VHAP to ESI	1068
New VHAP with no ESI	1231
New VHAP/ESI	85
New ESI only	290

¹⁰ Dr. Glied estimates that 1687 people would enroll in ESI premium assistance if the employee contribution were decreased to one percent of income.

Estimates of Catamount Health premium assistance participation are being developed and will be included in the new Global Commitment balance sheet and the Governor's recommended budget.

Plan for SFY07 Expenditures beyond \$250,000

H.881, the 2007 appropriations bill, added \$1 million to OVHA's budget to implement ESI assistance programs within the state Medicaid program. Section 13 of Act 191 requires the submission of this report before additional expenditures beyond \$250,000 of this \$1 million appropriation may be spent. The following table estimates expenditures for planning and development for SFY07 for both ESI *and* Catamount Health premium assistance.

ONE-TIME DEVELOPMENT COSTS FOR PREMIUM ASSISTANCE IN SFY07: CATAMOUNT & ESI		
Function	Cost	
Policy Studies, Inc. contract	\$700,000	ACCESS sys development in SFY07
Dr. Sherry Glied contract	\$11,500	Take-up rate estimates
Market Decisions contract	\$45,000	VHAP survey
Postage	\$15,000	Bulk mailing to VHAP
Rule making	\$5,400	Printing, mailing, advertising
Brochure	\$2,000	Premium assistance
Training	\$5,000	Internal staff
EDS contract costs	\$125,513	MMIS development, 50% of total cost
TOTAL for SFY07	\$909,413	

As of November 15, 2006, expenditures have been \$56,500 for the contracts with Dr. Glied and Market Decisions.

Should a decision be made to delay implementation of ESI premium assistance, the costs above would be reduced by approximately \$221,300. The remaining expenditures of \$688,113 would be necessary to proceed with development and implementation of Catamount Health premium assistance. Below is a table that estimates the marginal costs in SFY07 for the development of ESI beyond the \$56,500 that has already been spent for the two contracts described above.

ONE-TIME DEVELOPMENT COSTS IN SFY07 FOR ESI		
Function	Cost	
Policy Studies, Inc. contract	\$175,000	ACCESS sys development in SFY07 (ESI design)
EDS contract costs	\$31,300	MMIS development; 50% of total for ESI
Postage	\$15,000	Bulk mailing to VHAP
TOTAL for SFY07	\$221,300	

No expenditures have been included for outreach to uninsured Vermonters or to employers. Bi-State Primary Care Association has just issued a report that makes recommendations on how Vermont should outreach to uninsured Vermonters, and the Administration is pursuing grant money for these efforts.

Impact of ESI Premium Assistance to Program Budget for SFY 08-10

The following spreadsheet estimates the budgetary impact of the new enrollees in each category, including cost savings, cost avoidance, and administrative costs. Actual cost savings would occur by moving VHAP beneficiaries with cost-effective ESI plans into ESI with premium assistance. "Cost savings" means a direct reduction to current and future VHAP costs. The term "cost avoidance" is used to refer to new VHAP beneficiaries who would enroll in ESI and new non-VHAP ESI premium assistance beneficiaries. Both of these latter groups would reduce future costs, since without an ESI component, the state would have to pay the full cost of covering new VHAP beneficiaries under VHAP or, for the non-VHAP ESI group, under Catamount Health premium assistance.

	FFY '08	FFY '09	FFY '10	Total
Current VHAP Enrollee				
Estimated Enrollment: Current VHAP to ESI	972	1068	1068	
Estimated Cost per Enrollee (Annualized): VHAP	\$5,775	\$6,169	\$6,589	
Estimated Cost per Enrollee (Annualized): VHAP ~ ESI	\$1,437	\$1,535	\$1,640	
Annual Savings per Enrollee (Annualized):	\$4,338	\$4,633	\$4,949	
Expenditures: VHAP	\$2,019,890	\$6,587,994	\$7,036,637	
Expenditures: VHAP ~ ESI	\$502,759	\$1,639,778	\$1,751,447	
Gross Savings	\$1,517,132	\$4,948,216	\$5,285,190	\$11,750,538
State Share Savings Estimate	\$627,182	\$2,045,593	\$2,184,898	\$4,857,672
New VHAP ~ ESI Enrollee				
Estimated Enrollment: VHAP ~ ESI	85	85	85	
Estimated Cost per Enrollee (Annualized): VHAP	\$5,775	\$6,169	\$6,589	
Estimated Cost per Enrollee (Annualized): VHAP ~ ESI	\$1,437	\$1,535	\$1,640	
Annual Cost Avoidance per Enrollee (Annualized):	\$4,338	\$4,633	\$4,949	
Expenditures: VHAP	\$208,871	\$524,325	\$560,032	
Expenditures: VHAP ~ ESI	\$51,989	\$130,507	\$139,394	
Gross Cost Avoidance	\$156,882	\$393,819	\$420,638	\$971,339
State Share Cost Avoidance Estimate	\$64,855	\$162,805	\$173,892	\$401,551
New ESI Enrollee				
Estimated Enrollment: ESI	242	290	290	
Estimated Cost per Enrollee (Annualized): Catamount Health	\$4,344	\$4,640	\$4,956	
Estimated Cost per Enrollee (Annualized): ESI	\$1,314	\$1,403	\$1,499	
Annual Cost Avoidance per Enrollee (Annualized):	\$3,030	\$3,236	\$3,457	
Expenditures: Catamount	\$406,526	\$1,345,550	\$1,437,182	
Expenditures: ESI	\$122,969	\$407,010	\$434,728	
Gross Cost Avoidance	\$283,558	\$938,539	\$1,002,454	\$2,224,551
State Share Cost Avoidance Estimate	\$117,223	\$387,992	\$414,414	\$919,629
Gross Savings: VHAP	\$1,517,132	\$4,948,216	\$5,285,190	\$11,750,538
Gross Avoided Costs: VHAP ~ ESI & ESI	\$440,440	\$1,332,358	\$1,423,092	\$3,195,890
Total Gross Savings & Avoided Costs	\$1,957,571	\$6,280,575	\$6,708,282	\$14,946,428
One-time Administrative Costs	\$381,300			\$381,300
Ongoing Administrative Costs	\$428,614	\$554,298	\$570,927	\$1,553,839
Total Savings/Avoided Costs Net of Administrative Costs	\$1,147,657	\$5,726,277	\$6,137,355	\$13,011,289
State Share of Total Savings	\$474,442	\$2,367,243	\$2,537,182	\$5,378,867

Impact to Administrative Budget

The marginal administrative costs of developing and maintaining the ESI assistance program are considerably lower than the total administrative costs of developing and maintaining premium assistance programs as a whole, including the Catamount Health premium assistance program.

The administrative costs included in the budget sheet on the prior page do not include the costs of developing and operating the Catamount Health premium assistance program or increased access due to lower VHAP premiums and the aggressive outreach campaign as required in Act 191. Those costs will be included in the new Global Commitment balance sheet and the Governor's recommended budget.

Total ESI development costs for SFY07 and SFY08 are estimated to be \$645,000, the bulk of which are costs for system development in ACCESS, the Agency's Medicaid eligibility system, and the MMIS operated by Electronic Data Systems (EDS). Remaining one-time costs are for work stations for additional staff, rule-making, brochure development, postage, and staff training.

Total ongoing administrative costs for ESI are estimated to be \$554,298 in SFY09 (assuming a three percent annual growth), including six additional staff at OVHA to perform cost-effectiveness tests and coordinate benefits between Medicaid and private insurance plans, a contract to do annual maintenance on the employer database, and additional EDS costs for issuing premium assistance payments to beneficiaries. Ongoing administrative costs in SFY08 are estimated to be \$428,614 because new positions will be phased in during the course of the year.

Assumptions for budget impacts

- Premium assistance will be in operation for the second, third, and fourth quarters of SFY08.
- Current VHAP beneficiaries will be reviewed for cost-effectiveness over the second and third quarters of SFY08.
- Only 80% of current VHAP beneficiaries with cost-effective plans will be able to enroll in those plans in SFY08. Most employers have an annual open enrollment period during which current employees are able to enroll in ESI; some employers offer open enrollment twice per year. The administration is recommending legislation in the coming session that would make application for, or enrollment in, VHAP or Catamount Health premium assistance a "qualifying event" that would allow employees to enroll in ESI outside the open enrollment period; however, state law and regulations do not govern self-insured plans. Since approximately 40 percent of covered Vermonters are in self-insured plans, the 80 percent

estimate assumes that 20 percent of self-insured plans will not offer enrollment outside open enrollment periods.

- New VHAP applicants will enroll gradually over the 12-month period following the July 1, 2007, effective date of the premium reductions. New ESI applicants will enroll gradually beginning with the October 1, 2007, start date for ESI and Catamount Health premium assistance programs.
- Variable administrative costs, which are primarily staff costs, will increase gradually over the first 12 months of the program until full enrollment is reached.
- Only those administrative costs directly related to ESI implementation and ongoing administration have been used to offset ESI savings. Administrative costs necessary for Catamount Health premium assistance, with or without the ESI component, are not true ESI costs.
- In estimating cost savings, administrative barriers to enrollment have not been factored into the calculation. Administrative barriers could include employer lack of responsiveness to information requests, individuals' failure to follow through on verification requirements, and delay in enrollment in ESI due to job instability.
- Cost savings were estimated using actual claims for SFY06 for the individuals in the VHAP survey. Once the program is implemented, claims histories will not be available on new applicants, in which case an estimated PMPM will have to be used in the cost-effectiveness test. The estimated PMPM may result in less perfect predictions on individual cost-effectiveness than were obtained in the simulation completed for this report.

Section 8: Impact on Employers

As requested by the Health Access Oversight Committee, a section on the impact to employers is added to this report.

Based on an average monthly premium cost of \$456.03 (derived from national statistics and a sampling of plans available in Vermont's small group and association market), and using an average employer contribution of 80 percent, the average monthly cost to employers is \$364.82 per enrolled employee.

Section 8 above estimates that a total of 1443 Vermonters would enroll in ESI plans as a result of the premium assistance program. The total annual cost to employers, therefore, is estimated to be \$6,317,223 using current premium costs. However, if these employees were not enrolled in their ESI plans, employers would be required to pay an annual assessment of \$365 per year per full-time equivalent, or \$526,695 for all 1443 employees assuming they work full time, potentially bringing total employer costs for ESI down to \$5,790,528.

According to a recent article published in *Health Affairs*, two thirds of employers surveyed either strongly agreed or somewhat agreed that “all employers should share in the cost of health insurance for employees, either by covering their own workers or by contributing to a fund to cover the uninsured.”¹¹ In addition, 95 percent of firms offering health insurance indicated that health benefits were very or somewhat important in improving employees’ health, and most employers answered that health benefits were important in recruiting and retaining qualified employees.

Section 10: Conclusions

Implementation of an ESI premium assistance program in Vermont would save money. Using even the most conservative estimates, approximately \$3 million gross per year would be saved in the SFY08-10 time period after accounting for one-time and ongoing administrative costs, and additional future costs of approximately \$1 million per year could be avoided. Although the challenges of operating premium assistance programs are great, other states have been operating such programs for years and report they are saving money as a result of those programs.

Because of the employer contribution to premium costs, it is generally less costly for the state to provide premium assistance to people in ESI plans than in Catamount Health plans. To the extent that premium assistance can be provided at a lower cost, and savings can be realized through enrolling VHAP beneficiaries in ESI, more people will be able to participate in premium assistance programs.

In addition, supporting people in ESI plans will benefit the commercial market.

For these reasons, Vermont should move forward with the implementation of ESI premium assistance.

¹¹“Employers’ Views on Incremental Measures to Expand Health Care Coverage,” by Heidi Whitmore, Sara R. Collins, Jon Gabel, and Jeremy Pickreign, *Health Affairs*, November/December 2006

Appendix 16. ESI: Staff Analysis

Employer-Sponsored Insurance Legislative Staff Review of Administration Report

12/11/2006

Introduction and Summary

Act 191, "Health Care Affordability for Vermonters," included the creation of a program to provide premium subsidies for certain VHAP and Catamount Health beneficiaries who will be required to enroll in their employer-sponsored health insurance (ESI) plans. Act 215, which made FY 2007 appropriations for state government, included an appropriation of \$1 million to the Office of Vermont Health Access (OVHA) for development of this program. Section 13(g) of Act 191 permitted OVHA to spend \$250,000 of the appropriation immediately. Spending of the balance is contingent on a vote of the combined Joint Fiscal and Health Access Oversight Committees. To help inform that vote, the administration was required to submit a report that included an analysis of the costs and benefits of ESI.

That report was presented to the two committees on November 27, 2006. During the presentation of that report, several questions were raised by committee members. This document is intended to answer those questions, and to provide a general review of the findings of the report.

To enable this review, the administration provided all data and analyses used in the development of their report. There have been on-going discussions between legislative and administrative staff, and findings in this review have been shared with the administration, but opinions or conclusions are entirely those of legislative staff.

In its report, the administration recommended that the legislature proceed with implementation of the ESI program. The analysis upon which this recommendation was based was well done, using the best available information and appropriate methodologies. The estimate of cost savings appears accurate, given the assumptions that were made.

However, there are some questions about those assumptions, and thus the savings that ESI would generate. Additional questions have been raised, particularly during the presentation of the administration's report to the legislative committees about the broader effects of the initiative on Vermont's health care system.

Major questions include:

- By how much would actual savings differ from those calculated under assumptions of perfect information about enrollees and an ideal process?
- Exactly how will the cost-effectiveness test operate? Accuracy of this test is critical to maximizing savings.
- How will providers be reimbursed for cost-sharing liabilities incurred by beneficiaries? A substantial portion of savings comes from an assumption that Medicaid liability will be limited by Medicaid allowed charges.
- What effects will this program have on employers, especially public sector employers, and how will they react?

Background Information

There are a number of policy goals which can be achieved through an ESI program. From a financial point of view, the key goal is to save money (or reduce potential costs) by enrolling beneficiaries in their employer-sponsored health insurance. For VHAP beneficiaries, savings occur when the total costs to the state of enrollment in the employer plan, including premium subsidy, cost-sharing and benefit wrap, and administrative costs are less than the costs of paying directly for care. For Catamount Health beneficiaries, savings occur when total costs of enrollment in an ESI plan are less than the cost of the premium subsidy for Catamount Health. This comparison is called the cost-effectiveness test.

The cost-effectiveness test will be discussed in detail below, but in order to understand the importance of the cost-effectiveness test, it is essential to understand how health care costs are distributed in a population. A small number of individuals almost always account for most of health care spending. Typically, 10 percent of a population accounts for between 60 and 75 percent of health care spending. These are the individuals for whom movement from state to insurer liability will produce the greatest savings for the state. In other words, the bulk of savings in an ESI program such as the one proposed by the administration will accrue from movement of a very small number of people.

The challenge is identifying these individuals in advance. For current VHAP enrollees (the basis of most analysis in the administration report), actual claims experience is available. While this is valuable, it does not provide a perfectly accurate prediction. For people with chronic conditions, prior year costs can be a fairly good predictor, but for those with acute conditions, there is less predictive value in prior year costs. For example, someone with high costs last year from an acute illness may have very low costs in the next year.

Act 191 includes a number of requirements for the ESI program. For current and new VHAP enrollees, an individual's premium and cost-sharing obligations under an employer plan must be substantially the same as what the individual would pay if enrolled in VHAP. For Catamount Health beneficiaries, the benchmark against which ESI plans are compared is Catamount Health itself.

In cases where ESI coverage is not as comprehensive as VHAP or Catamount Health, the state will "wrap" the ESI plan, reimbursing for beneficiary cost sharing and paying for services covered under the benchmark (VHAP or CH) but not under ESI.

The state will pay any employee share of premiums above what the beneficiary would pay under VHAP or CH.

Administration Analysis

Overview

In conducting its analysis, the administration had to answer many questions, outlined below:

- Current VHAP beneficiaries
 - How many are eligible for an ESI plan?
 - How much do each those individuals cost currently?
 - How much would each cost component under ESI be?
 - Premium (employee share)
 - Wrap of cost sharing to current VHAP level
 - Wrap of services covered under VHAP but not under employer's plan
- New VHAP enrollees
 - How many new beneficiaries will enroll as a consequence of reduced premiums and increased outreach?
 - How many of them would be eligible for ESI
 - How much would each of those individuals cost on VHAP?
 - How much would each cost component under ESI be?
 - Premium (employee share)
 - Wrap of cost sharing to current VHAP level
 - Wrap of services covered under VHAP but not under employer's plan
- New Catamount Health enrollees
 - How many people will enroll in Catamount Health?
 - How many of them would be eligible for ESI?
 - How much will the premium subsidy be?
 - How much would each cost component under ESI be?
 - Premium (employee share)
 - Wrap of cost sharing to Catamount Health level
 - Wrap of services covered under Catamount Health but not under employer's plan
 - Wrap of all cost-sharing for services associated with management of a chronic condition.

To answer these questions, the administration gathered information from a wide variety of sources. Much of this information was combined into an analytical model, which was used to estimate cost savings under a variety of assumptions about employer plans (premium, employee share, cost-sharing, etc.). While this model provided much of the necessary information, additional estimates were necessary to answer some specific questions.

Source Data

Overview

Most of the data for the analyses presented in the administration report comes from two sources – the Vermont Household Health Insurance Survey (VHHIS) and the VHAP beneficiary survey. VHHIS is conducted periodically by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). The survey is designed to provide information about health insurance coverage, socioeconomic characteristics, and general health care knowledge and concerns in Vermont. The most recent VHHIS was conducted in 2005.

VHAP Beneficiaries

A requirement to conduct a survey of VHAP beneficiaries was included in the Act 191 ESI language. This one-time survey was designed to estimate the number of VHAP beneficiaries who are eligible for ESI and to link that information with their actual claim costs.

The VHAP survey was administered by Market Decisions, a Maine firm with extensive Medicaid and health insurance survey experience. Participants in this survey were identified from the current beneficiary list. This enabled analysts at the Agency of Human Services to attach actual enrollment and claims information to nearly every survey response⁵⁰. To validate this survey, enrollment and claims estimates from the survey were compared to actual program information.

Other Enrollees

Information on all other enrollees, including likely new VHAP enrollees and Catamount Health enrollees, came from the VHHIS. The survey script and methodology received extensive review by both legislative staff and others. For validation purposes, VHHIS results have been compared with results from the Census Bureau's Current Population Survey (CPS).

Other Information

Additional information came from a number of sources, including the Vermont Department of Labor's fringe benefit survey, premium and benefit information from BISHCA.

Assumptions about cost and coverage of ESI plans are critical to the accuracy of the analysis, but information about the average employer-sponsored health insurance premium in Vermont is quite limited. The only information on employer premiums that is available from BISHCA is the small group market, under which very few employees are covered. There is no public information on premiums for specific large employers, regardless of whether they are insured or self-insured, but some information from national surveys is available. A third source of information is from those associations that publish their rates. The administration included premium and benefit information from Business Resource Services' website⁵¹. BRS is an association that is the source of health insurance for many small businesses in Vermont

⁵⁰ In a very small number of cases, OVHA was unable to match respondents to claims

⁵¹ http://www.brsvt.com/bcbs_plans.html

Discussion

It is important to understand that estimates from any survey, no matter how well done, have a range of uncertainty around them. This uncertainty is a function of several factors including sample size, survey design, and survey implementation. Because of the complexity of both surveys, each individual estimate will have a different uncertainty, often referred to as margin of error, but this should be 5 percent or less in most cases.

Analytical Model

Overview

The analytical model was designed to answer most of the questions listed above. It operates by applying specific parameters, such as deductible and coinsurance percentage to the claims experience of actual VHAP beneficiaries. Use of parameters provides flexibility in the model. For example, savings under a high deductible plan can be compared to savings under a more traditional health insurance plan.

Note that while claims and eligibility information is based on actual information, parameters are assumptions. Results will vary depending on what assumptions are made. Sensitivity analysis, discussed later in this review, provides a tool to explore how much estimations will change as different assumptions are varied.

The model is built from information obtained by the VHAP survey and the claims match. For each individual in the survey, information includes:

- Employment status (working or not)
- If working, does employer offer health insurance at all?
- If employer offers, is individual eligible?
- Number of months enrolled in VHAP in the last year
- Total claims paid by VHAP in the last year

Several parameters are supplied to the model, including:

- Total insurance premium
- Employee share of premium
- Deductible
- Coinsurance
- Out-of-pocket maximum
- Percentage of cost-sharing to be paid by Medicaid

For each beneficiary, the specific insurance parameters were used to calculate the cost-sharing component of state's "wrap" liability – the amount that the state would spend to ensure that beneficiary cost sharing liability was no greater than it would be under VHAP.

While this model was designed to provide information on current VHAP beneficiaries, some of the findings were also used to generate estimates of cost-avoidance for new VHAP enrollees (discussed below).

Parameters

After looking at a number of sources, the administration chose to base its estimates on a product available through Business Resource Services, an exempt association in Vermont⁵². This product has a deductible and coinsurance that are similar to Catamount Health, and a somewhat higher out-of-pocket maximum. The 2006 single rate for this product is \$456 per month, similar to the starting point for estimates of the Catamount Health premium (prior to reductions for reimbursement and selection).

Note that in most cases there is a strong relationship between premium and out of pocket costs. Insurance products with higher premiums will have lower cost sharing and vice versa. Because of this relationship, the results of the analysis are less dependent on specific choice of product than might be expected because total costs (premium plus cost sharing wrap) do not vary substantially.

Similarly, a number of sources were considered for the employee share of premium. The national Kaiser Family Foundation employer insurance survey reported an average employee share of 15 percent for single coverage, while the federal Medical Expenditure Panel Survey (MEPS) had an average of 18 percent for single coverage. According to the 2005 Fringe Benefit Survey, conducted by the Vermont Department of Labor, employers with 20 or more employees who offer health insurance require the employee to pay 20 percent of the premium. According to the survey, smaller employers require employees to pay an even lower proportion, but this finding is inconsistent with all other sources. The administration chose to assume a 20 percent employee share, which seems like a reasonable figure.

The last parameter in the list is the percentage of cost sharing paid by Medicaid. This is used to evaluate the effects of two alternatives – limiting Medicaid reimbursement for cost-sharing to Medicaid's allowed price or paying the full cost sharing amount. This is a complex issue, the implications of which will be discussed below, but here is an example:

A beneficiary's ESI plan has a \$500 deductible.

The first claim of the year is for a service for which the insurer pays \$200.

Medicaid normally pays \$150 for that service.

If Medicaid's liability is limited to its allowed price, it will spend \$150 and the provider will write off \$50. If Medicaid's liability is not limited to its allowed price, it will pay the full \$200. Clearly, this will have an effect on program savings (see sensitivity analysis, below), and on the impact of the ESI program on cost-shifting to providers.

To simplify the comparison of costs between VHAP coverage and ESI, the beneficiary premium was not included on either side. This will make costs on both sides of the comparison higher than they would actually be, but will have no effect on the savings estimate.

⁵² Exempt associations are organizations that, among other functions, purchase health insurance on behalf of their member entities. Additional information on exempt associations can be found in BISHCA's "Shopping for Individual or Small Group health Insurance," http://www.bishca.state.vt.us/HcaDiv/consumerpubs_healthcare/tips_ind_smallgroup_shop_july06.pdf

Results

The table below shows the savings estimate using the BRS \$200 deductible product described above, a 20 percent employee contribution to the premium, and the two different assumptions about how Medicaid would reimburse cost sharing. Note that these are full year savings estimates. No adjustment has been made yet for the gradual enrollment process.

	Enrollees	Savings (Gross)
Cap at Medicaid allowed	1,068	\$4.8 million
Full payment of cost sharing	992	\$3.8 million

Discussion

While this model provides estimates that are probably as good as possible, there are a number of issues that should be kept in mind. These issues are of two types – those that could potentially either raise or lower the estimate of savings and those that could only lower the estimate.

The first issue is the lack of reliable information on what insurance plans VHAP enrollees will have access to. The general lack of information about employer plans in Vermont poses an analytical challenge, but there is an additional wrinkle – the possibility that plans to which VHAP enrollees have access differ from the “typical” plan in any of the parameters discussed above. For example, VHAP enrollees may be more likely to work in employment settings where the employee share of premiums is higher than the state average. If the actual employee share of premiums is higher than estimated, savings will be lower.

A second major issue is the assumed accuracy of the cost-effectiveness test. In the model, the determination of who is cost-effective to enroll and who isn't was based on the prior year's claims. It is unlikely that future claims costs will be perfectly predicted by prior year costs. As determination of cost-effectiveness becomes less perfect, savings will be reduced, both because some lower-cost individuals will be enrolled in their employers' plans and because some higher-cost individuals will remain on VHAP.

The third issue is the assumption of enrollment of every beneficiary who appears eligible for ESI (and for whom enrollment is cost-effective). In the base estimate, there is no estimate made of the effects of all the process factors that may interfere with enrollment in an employer plan, such as job changes, open enrollment periods, and difficulties in collecting information on the employer plan. These barriers to enrollment are discussed in JFO's October 15 report, “Premium Assistance for Employer-Sponsored Insurance (ESI) – Enrollment Experience in Other States.”⁵³ In other states, these barriers appear to have reduced enrollments substantially from initial estimates.

⁵³ <http://www.leg.state.vt.us/jfo/Healthcare/Premium%20Assistance%20for%20ESI%2010-15-2006.pdf>

When converting model results to actual budget impacts, the administration report does partially address this issue by assuming a phased-in enrollment. One component of the phase-in is the need to wait for open enrollment periods.

While the first issue may produce estimates that could be either too low or too high, adjustment for the second and third would require a reduction in the estimated savings.

Additional Estimates

While the analytical model provided a mechanism to estimate the costs of the cost-sharing component of the wrap, it does not provide an estimate of the other component of the wrap cost – non-covered services. There are a small number of specific services where this is the case, such as eye exams or home health nursing, identified in the administration's report. In addition to these services, there may be other instances where the state will need to pay, such as if there are benefit limits (e.g. a self-insured plan with a cap on mental health services) or possibly in cases where the employer's coverage determines a service to not be medically necessary, but it would be medically necessary under Medicaid rules.

Because of the many factors that influence it, the true cost of the wrap is extremely difficult to estimate. The report uses a figure of \$10 per member per month for VHAP enrollees and \$9 for CH, including \$4 for cost sharing wrap (to Catamount Health benefits, rather than to VHAP) and \$5 for the wrap of chronic care services. These figures seem reasonable.

Other Analysis

New VHAP Enrollees

The discussion to this point has focused on the movement of current VHAP enrollees to employer-sponsored plans. As a result of lower premiums and enhanced outreach, a number of new beneficiaries are expected to enroll in VHAP. The total number of beneficiaries who enroll was estimated by Dr. Sherry Glied, under contract with the administration, using information from the VHHIS.

The administration report uses this information as a starting point, and makes two additional assumptions:

- 1) The proportion of new enrollees for whom ESI is available and cost-effective is the same as in the current VHAP population.
- 2) Claims for the new enrollees will be similar in cost and distribution to the current VHAP population.

Both of these assumptions are reasonable.

Cost-Effectiveness Test

The cost-effectiveness test is critical to the financial consequences of the ESI program. The basic idea of the cost-effectiveness test is to compare the estimated costs of directly funding an individual's health care to the estimated costs associated with enrolling that individual in an employer-sponsored insurance plan. Individuals for whom direct funding is estimated to cost less would remain on the state program, while individuals for whom enrollment in the employer plan would cost less would be required to enroll in that plan. The accuracy of both estimates is key to the financial success of an ESI program.

The first step in doing the cost-effectiveness test is to predict the individual's health care costs in the coming year. There are probably 3 main approaches to this prediction. The first would be to use an estimate based on individuals of the same gender and similar age. For example, the actual claims costs for all VHAP beneficiaries who are males between 30 and 39 could be calculated for the previous year and trended forward one year. This figure could be used for any individual in that age-sex category.

The second approach, applicable only to individuals who are currently enrolled in VHAP, would be to use their own claims experience. As mentioned above, this approach is likely to be fairly accurate if costs are primarily attributable to chronic conditions, but less likely if costs are primarily attributable to acute conditions.

The third approach would be to use a health risk appraisal or medical history questionnaire to identify individuals who either have or have a high probability of developing a chronic illness. This is similar to medical underwriting, used by health insurers in other states.

It is also possible to combine these tools.

As has been discussed at several meetings, the cost-effectiveness test is designed to create a selection dynamic between the state program and private coverage. Cost savings accrue to the state because costs of higher-risk beneficiaries are moved from the state to the employers and insurers.

The relationship between the cost-effectiveness test and the distribution of health care costs is also critical. While the analytical model indicated that about half of current VHAP beneficiaries who are eligible for their employer's health insurance would meet the cost-effectiveness test, the vast majority of cost savings comes from a small portion of those individuals. More than half of the estimated savings are attributable to less than 10 percent of the cost-effective beneficiaries. Successfully identifying these extremely high-cost individuals is critical to the financial success of the program.

Sensitivity Analysis

Overview

One of the most useful tools for evaluating and understanding a financial model, particularly one that relies on many assumptions, is called sensitivity analysis. The basic concept is simple – change assumptions and see how much results change. This analysis is particularly useful in identifying which assumptions have the most influence and which are less important.

JFO staff performed sensitivity analyses in the following areas:

- Different levels of accuracy in the cost-effectiveness test
- Different insurance products
- Different assumptions about employee share of premium
- The two alternative proposals for how the cost sharing wrap would operate

Cost-Effectiveness Test

Sensitivity to accuracy of the cost effectiveness test was examined by assuming different levels of accuracy and that errors were random (there was no association between beneficiary claim cost and likelihood of error). At four different levels of assumed accuracy, errors were assigned randomly ten times. The table below shows the percentage of savings that would occur as compared to perfect accuracy. As can be seen, savings percentages are fairly well correlated with test accuracy rate.

Assumed accuracy of test	Estimated percent of possible savings
95%	98.3%
90%	92.1%
80%	79.4%
75%	83.6%

Benefits

In order to examine sensitivity to benefits, we compared the BRS product that was used in the analysis to a high deductible plan, also offered by BRS. Other than the difference in benefits, all other assumptions were kept constant. The table below compares the estimated savings (excluding wrap for non-covered services).

	BRS Plan C	BRS HSA I
Deductible	\$200	\$2,250
Coinsurance	20%	None
Out-of-pocket max.	\$2,000	\$2,250
Premium (total, per month)	\$456.03	\$239.00
Enrollees	992	704
Savings (gross dollars)	\$3.8 million	\$3.5 million
Savings (state dollars)	\$1.6 million	\$1.4 million

Employee Share of Premium

To test sensitivity to the assumed employee share of total premium, savings under the BRS C plan described above were compared at 20 percent and 50 percent employee contribution. There is a substantial reduction in both the number of enrollees and savings. Estimated enrollees declines from 992 to 603 and estimated savings would be reduced from \$3.8 million (\$1.6 million state funds) to \$2.6 million (1.1 million state funds).

Medicaid Cost Sharing Liability

Savings are also strongly influenced by the policy choice of how Medicaid will calculate its liability for cost sharing (cap at Medicaid allowed amount or payment in full). This is a difficult analysis because of the variability in the ratio of Medicaid reimbursement to commercial reimbursement for different services and how the choice affects payments under the deductible and under coinsurance differently. In consultation with administration staff, we created a scenario of a series of claims, and assumed that Medicaid paid an average of 70 percent of commercial rates.

If Medicaid liability is capped at its allowed charge, we estimate that Medicaid will pay about 70 percent of the full deductible, and little, if anything, toward coinsurance. Medicaid liability as a percent of the full value of the cost sharing will thus decline as total claims increase, because of the lack of coinsurance liability. Using the same standard product (BRS C), Medicaid payments as a percent of total cost sharing liability are below 10 percent for an individual at out-of-pocket maximum.

To conduct the sensitivity analysis, we used a value of 20 percent of actual cost sharing liability (a blend of the approximately 70 percent of actual deductible liability and none of coinsurance). This will obviously increase the number of people for whom ESI is cost-effective and increase savings. Under this scenario, enrollment increases from 992 in the base case to 1,068. Savings increase substantially, from \$3.8 million (\$1.6 million state funds) to \$4.8 million (\$2 million state funds). Note that the increased savings are obtained by requiring providers to accept Medicaid as payment in full. However, reimbursement during the coinsurance period will likely be higher than Medicaid and once the out-of-pocket maximum is reached, providers will receive full commercial reimbursement. Clearly, this is an important policy decision.

Administrative Costs

Administrative costs for the ESI program are of two types – direct costs, those that can be specifically associated with this program (e.g. developing information on employer plans, cost-effectiveness tests, or coordination of benefits) and indirect costs, those that impose additional burdens on existing resources.

The administration report includes what appear to be credible estimates of direct costs. However, it is unclear what assumptions have been made about indirect costs. For example, suppose this program requires a substantial portion of the Medical Director's time to review medical histories as part of the cost-effectiveness test. Either this will mean that additional expert medical resources will be needed (adding to the cost of the program) or that other current activities will have to be deferred.

Other Financial Issues / Questions

Three other areas have generated several questions. The first is the application to the federal government to amend the Global Commitment waiver. Approval from the Centers for Medicare and Medicaid Services (CMS) is needed to implement “any of the innovative features” proposed in the state’s initial waiver application. This would include any ESI program. The state also needs federal approval in order to receive Medicaid match for the premium assistance component of Catamount Health (whether ESI or direct subsidy).

While the state has requested approval for both initiatives in its recent request to amend the Global Commitment waiver, the expectations of the federal government are not clear. For example, there has been some discussion about whether, in the absence of an ESI program, CMS would approve the use of Medicaid funds for the Catamount Health premium subsidy.

The second area of concern is the cost to state and local government for the employer share of premiums under ESI. It is likely that a number of the individuals who would move from VHAP to ESI or who would be covered under Catamount ESI are currently employed by state or local government. While it is clear that this would be a new cost for public entities, it is impossible to estimate the magnitude of this cost in the absence of information about the number of VHAP beneficiaries who are public employees. The new cost to the state would directly offset a portion of ESI savings.

The third issue area is pre-existing conditions. Private health coverage typically has an exclusion for conditions that were identified prior to the beginning of coverage, unless the beneficiary had previous coverage of some sort. This issue would not present any difficulties for individuals moving from existing VHAP coverage to ESI, but could be a problem for those people who are new enrollees in either VHAP or Catamount Health who are otherwise eligible for ESI.

For example, suppose a currently uninsured individual has asthma, for which she has paid for treatment out of pocket. If she is enrolled in her employer plan, and costs associated with asthma would not be covered for several months. The state has two options in this case – incorporate this into the cost-effectiveness test or include these costs as part of the wrap.

Non-Financial Considerations

Overview

Beyond the financial considerations that are the focus of this review, there are several other aspects of an ESI plan that should receive consideration. These include the impacts on beneficiaries, providers, and employers.

Beneficiaries

VHAP beneficiaries who are enrolled in their employer plans will be faced with some additional complexity. They will be required to carry and present two identification cards – one for their employer plan and one for VHAP. This is necessary to ensure that

providers know that they will, in most cases, need to submit a claim to Medicaid after receiving a remittance advice from the primary insurer or self-insured employer's administrator.

The appeals process may also become more complex, especially in cases where a claim was denied by both the primary insurer and Medicaid.

A third potential issue for beneficiaries is continuity of care. This is primarily an issue for VHAP beneficiaries with chronic illnesses. In addition to being switched from VHAP to their employer plans, care for these individuals may also be affected if employers change insurers, if beneficiaries change jobs, or if beneficiaries lose eligibility for their employer plans.

Providers

As mentioned above, providers will be required to submit a second claim to Medicaid for any outstanding balances until beneficiaries exceed their out-of-pocket maximums. This is nothing new for providers, but the new program will add a small amount to their administrative processes.

Employers

For large employers, the addition of a small number of new enrollees to their health plans should not be of any consequence, but for small employers, even the addition of one or two new enrollees may cause them to change their insurance benefits or drop coverage.

Budget Implications

The administration report includes a three-year overview of the budgetary impacts of ESI. This analysis takes the information developed above and makes a series of assumptions about how the actual enrollment process would proceed. These assumptions include the typical ramp-up of a public program and the likely timing of employer open enrollment periods. After discussion with administration staff, these assumptions seem reasonable.

Conclusion

The underlying analytical work was well-done, but there are several major areas of uncertainty, resolution of which can affect the magnitude of savings under ESI and have broader consequences for Vermont's health care system. Most of these questions can be answered, but answers to the rest may not be known until the program is implemented.

Appendix 17. ESI: Motion

Health Access Oversight Committee
Joint Fiscal Committee
December 12, 2006

Joint Meeting regarding the
Employer-Sponsored Insurance Program
33 V.S.A. § 1974

MOTION

Representative Larson moves that the combined membership of the committees:

- 1) approves the Office of Vermont Health Access' expenditure of the remainder of the amount appropriated in H.881 for the initial implementation of the employer-sponsored insurance (ESI) program and Catamount Health premium assistance program; and
- 2) recommends to the appropriate standing committees of jurisdiction that the committees continue to consider the outstanding policy and implementation issues and assess the advisability of further pursuit of the ESI program.