



To: Vermont Partners for Health Care Reform

From: Avalere Health

Date: December 13, 2013

Re: Response to State of Vermont Agency of Administration Comments Regarding Avalere's Evaluation of Vermont Health Care Reform Financing Plan

On November 14, 2013, Avalere Health provided the Vermont Partners for Health Care Reform an evaluation of the Vermont Health Care Reform Financing Plan. In that evaluation, we stated that we believed, based on our review of the material produced by the State, the estimated \$1.61 billion cost to implement the Green Mountain Care (GMC) in 2017 could be too low. Specifically, we noted that 1) the provider payment rates used in the State's analysis may not be sufficient to keep the current level of access to care in Vermont; and 2) the level of administrative savings used in the forecast may be overstated. Changing these two assumptions to what we believe are more reasonable levels could increase the funding cost to \$1.9 to \$2.2 billion.

The Office of the Secretary of the Agency of Administration in the State of Vermont has written a response to Avalere's evaluation of the financing plan. In that response, Robin Lunge, the Director of Health Care Reform, commented that while the State agrees with some of Avalere's findings, it did not agree with our statements regarding provider payment rates or the estimated administrative costs. In addition, Ms. Lunge has been quoted in media reports stating that, even using the higher end of the Avalere estimated cost (\$2.2 billion), the costs of GMC are still lower than the current cost of health care in Vermont. We address each of these comments in turn.

Provider Payment Rate Calculations

Ms. Lunge noted that Avalere's calculation of the current average provider payment rate in Vermont of 122 percent of Medicare did not account for the fact that "different patients have different average costs." To construct our estimated average payment rate, we used data presented in Table 13 of the financing plan, which represents the amount paid by either private insurance or Medicaid relative to what Medicare would have paid for the same patient's care. We then applied these rates to the mix of patients at Vermont hospitals. We believe this calculation, which results in the estimated 122 percent of Medicare payment ratio, accurately represents the payment levels for most hospitals and physicians in Vermont.

Ms. Lunge noted in her formal reply that "UMASS ...estimated that current payments average 107% of Medicare." In an email provided to Avalere by the University of Massachusetts consultants, the basic methodology for constructing this estimate demonstrated that this ratio should represent the blended average for every single provider in the state combined. This email also noted that, according to their calculations, estimated 2017 payments without reform will average around 110 percent of Medicare, while payments under GMC will average around 107 percent of Medicare. This email raised additional questions, notably the underlying process for converting current payments for some groups of patients into Medicare-equivalent rates. In addition, since different providers have different mixes of patients, looking at the combined statewide average will not help explain the potential impact to different constituents.

Due to the significantly different payer mixes at different types of providers, using a single number for the entire state masks the distributional effects that would occur if the GMC paid all providers "the same standard ... rates for all their patients, calculated at 105 percent of Medicare payments."¹ Since reimbursement for Medicaid patients under the GMC would see a significant increase relative to current rates, providers with an above-average share of Medicaid patients would benefit, whereas providers with a below-average share of Medicaid patients would not see a commensurate increase in payments. For providers that rely on commercial patients for most of their earnings, there may be little incentive to continue operating in the state.

Finally, the State notes that "UMASS...indicated that providers would reap administrative savings that would make up for the 2% rate reduction." As we detailed in our evaluation of the State's report, we do not believe providers will realize much, if any, administrative savings under the proposed GMC plan. Providers will still have multiple payers to send claims to, limiting their ability to reduce spending on the staff necessary to complete these tasks. In addition, no single provider will likely experience the 2 percent rate reduction, but instead face markedly different impacts depending on their mix of patients. Some providers would need to reduce operating costs well beyond what is pictured by the financing plan, raising questions about continued operational feasibility.

Since the change in provider rates is anticipated to reduce total health care expenditures in Vermont by nearly \$154 million in 2017, we believe a more transparent explanation of the analysis used to calculate the report's average payment rates would be useful, including information regarding the average payment rates in 2012 that were used as the starting point for the entire output. We continue to believe that hospitals and physicians are currently paid at approximately 122 percent of Medicare, so a shift to 105 percent for most of their patients would result in significant reductions in payments. After this step, we recommend that the State examine the distributional impact of these changes and the potential implications on different

¹ "State of Vermont Health Care Financing Plan Beginning Calendar Year 2017 Analysis", January 24, 2013. Page vii.

constituents of the Vermont health care community. This in turn will help the State meet its mandate under Act 48 to ensure that GMC is designed in a manner to support Vermont health care providers.

Administrative Savings from Shift to GMC Single Payer

Ms. Lunge also writes in her formal reply, "...the Administration is concerned that the current administrative costs set forth by the [Avalere] report are too low," and that "it is not clear that the administrative costs listed in Table 5 of the [Avalere] report offer an apples to apples comparison to the administrative costs set forth in the UMASS report."

The UMass report used a paper from December 2009 that relied on data from Vermont insurers in 2008. In that report, the authors wrote "for purposes of this report, administrative expenses include only claim adjustment expenses and general administrative expenses." The 2009 paper then used the 2008 data filed by each insurer with the State to calculate administrative cost ratios.

Avalere instead relied on data submitted by each insurer to the State in 2013 that represented the actual cost experience from 2011 and the proposed cost experience for 2013. The administrative costs listed in the more recent data include "general administrative expense," "cost containment expense" and "other claim adjustment expense." We believe this data is comparable to the 2008 data used in the financing plan.

In addition, officials from Blue Cross Blue Shield of Vermont (BCBS) informed us that the company had seen below-average growth in administrative costs over the past several years. The company had a consolidated administrative cost ratio of 6.7 percent in 2013, and has budgeted for a 6.4 percent ratio in 2014. They also noted that this ratio represented the combined experience of BCBS-VT and its subsidiary The Vermont Health Plan (TVHP).

Ms. Lunge also writes in her reply, "Even if the BCBS administrative cost number is accurate, the higher administrative costs of MVP and BCBS subsidiary TVHP demonstrate opportunities for additional savings." We agree that it may be possible to lower the administrative cost ratio related to the individuals currently enrolled in these two plans. However, unless GMC is able to maintain the lower administrative ratio of BCBS, the increase in spending for current BCBS enrollees in GMC will negate any savings from the reduced spending related to the other plans.

Finally, local press has quoted Ms. Lunge saying that Avalere's prediction that the switch to a single payer wouldn't create savings "intuitively doesn't make sense." We understand her sentiment, since in theory a single payer system should result in less administrative complexity and therefore lower costs. However, as noted above as well as in our evaluation, providers will

still need to submit claims to multiple different payers, suggesting the administrative complexity for providers will not decrease by much, if at all. Likewise, the efforts by BCBS over the last several years to restrain growth in administrative costs while increasing enrollment suggests there may be little opportunity for the State to find additional efficiencies simply by shifting Vermonters into the GMC.

Since the financing plan assumes \$126 million in savings in 2017 due to lower administrative costs, we believe the State would be well served to reexamine the administrative cost assumptions used in the financing plan, especially given that they are now nearly six years old.

Estimated Costs of GMC Compared to Current Spending on Vermont Health Care

Ms. Lunge was cited in several press accounts saying, "Even using their numbers, quite frankly, it shows we can move to Green Mountain Care, cover all Vermonters with a better benefit, on average, than what people have today for the same or lower cost."

While we are unclear as to what total cost Ms. Lunge is referring to in her statement, we note adding \$300-\$500 million to the \$1.61 billion in new spending required would result in higher costs with GMC than without GMC. Table 7 in the financing plan shows that 2017 health care spending in Vermont would be \$5.952 billion without GMC and \$5.916 billion with GMC, for a total savings of \$35 million (-0.5%). The same table highlights that \$1.611 billion would need to be financed for the GMC. We believe this amount could instead be \$1.900-\$2.200 billion, which would in turn mean the total cost under the GMC could be \$6.216 billion to \$6.416 billion, an increase of \$264 million (+4.4%) to \$464 million (+7.8%) relative to expected spending without GMC.

Conclusion

As we noted in our evaluation, and as we took care to emphasize in our testimony before the Vermont Legislature's Health Care Oversight Committee, Avalere does not believe that GMC cannot succeed. We simply caution that there are a wide range of variables that need to be fully considered when evaluating the appropriate course of action, and a more comprehensive review of the distributional effects of the proposed financing plan would help all parties understand the expected effects of GMC.

We encourage the State to work closely with the Vermont health care community to ensure that the full range of outcomes are sufficiently explored and understood, in order to preserve the quality of care that Vermonters have come to expect.