THE ECONOMICS OF UNIVERSAL HEALTHCARE - CASE STUDY OF VERMONT PUBLIC OPTIONS

what does REMI say? sm

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Health Care Debates

Source: NY Times, June 28, 2019

“We must pass a Medicare for All system to guarantee affordable health care for all, not just for those who can afford it.” Bernie Sanders (8/19/2019)

"Everybody who says Medicare for all and every person in politics who allows that phrase to escape their lips has a responsibility to explain how you are supposed to get from here to there” - Pete Buttigieg (6/27/2019)

“I understand the appeal of Medicare-for-all, but folks supporting it should be clear that it means getting rid of Obamacare, and I’m not for that” - Joe Biden (7/15/2019)

State Level Discussions

California rejected a state ballot measure in 1994 and Governor Schwarzenegger vetoed two bills, one in 2006 and one in 2008.

Vermont passed a law requiring universal healthcare be studied in 2011, but the reform was ultimately abandoned

Vermont Universal Healthcare – Green Mountain Care

Universal Healthcare in Vermont began in 2010 as a reaction of proponents of ACA who thought the ACA didn't go far enough.

- Progressive Democrat Peter Shumlin won the VT governorship running on a universal healthcare platform.
- Given that public dollars were used for private insurance and costs of the ACA continued to rise, Green Mountain Care was pitched as a cost saver.

Source: Cornell Policy Review, Roll Call, Politco

Vermont Universal Healthcare – Green Mountain Care

Act 128, passed on May 2010, required VT to design three plans that resulted in universal coverage.

- Act 128 allocated $300,000 for the Health Care Reform Commission to hire consultants to design the required plans.
- The legislature hired three consultants viewed as providing technical legitimacy to the policy:
  - William Hsiao,
    - Harvard Economist who advised Taiwan during their transition to universal health care;
  - Jonathan Gruber,
    - MIT Economist who worked on both the Massachusetts' healthcare reform and ACA;
  - Steven Kappel,
    - Independent Healthcare consultant from Vermont .

Source: Cornell Policy Review

Study Options

Option 1: Government-run single payer

- 1A: Comprehensive benefit package
- 1B: Standard benefit package

Option 2: Health exchanges with a public option

Option 3: Government-run single payer with board oversight

- Same as 1B but with board oversight

Source: Act 128 Health System Reform Design

Option 1 – Single Payer

Features:

- All payments channeled through a “single pipe”
- All providers would receive the same payment
  - Payments paid by Medicaid and Medicare would increase
  - Payments paid previously by private insurers would decrease
- Shift away from fee-for-service to accountable care organizations (ACOs).
- Change malpractice law to no-fault system (New Zealand, Scandinavia)

Savings:

- Consolidation of insurance functions (Admin. costs from multiple players)
- Reduced provider costs

Financing:

- Payroll contribution shared between employees and employers

Two Sub-Options:

- 1A. Comprehensive benefit package (Dental, Vision, Minimal Cost Share)
- 1B. Standard Care (Platinum ACA with cost sharing)

Source: Act 128 Health System Reform Design

Option 2 – Public Option

Features:

- Government administered option that competes on Vermont's Health Insurance Exchange.
- All payments channeled through a "single pipe" with uniform rules
  - Similar to the German system
- Shift away from fee-for-service to accountable care organizations (ACOs)
- Change malpractice law to no-fault system

Savings:

- Reduced administration costs for providers
  - Less than in the single payer option

Source: Act 128 Health System Reform Design

Option 3 – Single Payer with Board Oversight

Features:

- Identical to 1B. – Single Payer with Standard Care
  - All payments channeled through a "single pipe"
  - All providers would receive the same payment (Medicare/Medicaid ↑ and private ↓)
  - Shift away from fee-for-service to accountable care organizations (ACOs).
  - Change malpractice law to no-fault system (New Zealand, Scandinavia)
- Governed by an independent board
  - Comprised of employers, the state, and workers
  - Would annually update benefits packages and payment rates
  - Insulated from political process
  - Competitively contract out administrative and provider relations functions

Savings:

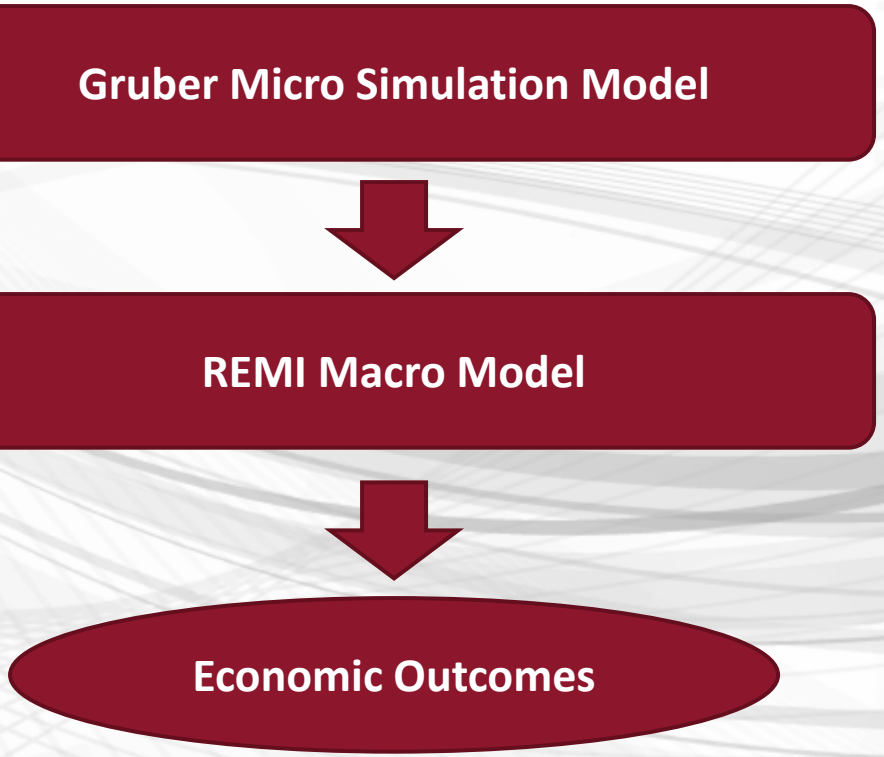
- Consolidation of insurance functions (Admin. costs from multiple players)
- Reduced provider costs

Financing:

- Payroll contribution shared between employees and employers

Source: Act 128 Health System Reform Design

Methodology



GMSIM

Gruber Micro-Simulation Model (GMSIM) was developed with funding from the Kaiser Family Foundation and has been used in California, Delaware, Kansas, Wisconsin and Wyoming, among others.

Inputs:

- Data from the Current Population Survey and Medical Expenditure Panel Survey-Insurance Component
- Policy Parameters

Key Model Aspects:

- Aggregates individual level data to synthetic firms
  - Evaluates policy impact on employers, which is a function worker average.
- Policy rules are translated into price changes

Outputs:

- population movements across types of insurance,
- changes in government spending and tax revenues,
- changes in firm wages and health insurance spending, and
- changes in household budgets.

Source: Act 128 Health System Reform Design

Savings Assumptions

Table 2. Accumulated Savings by Source as a Percentage of Total Health Expenditure, 2015-2024.

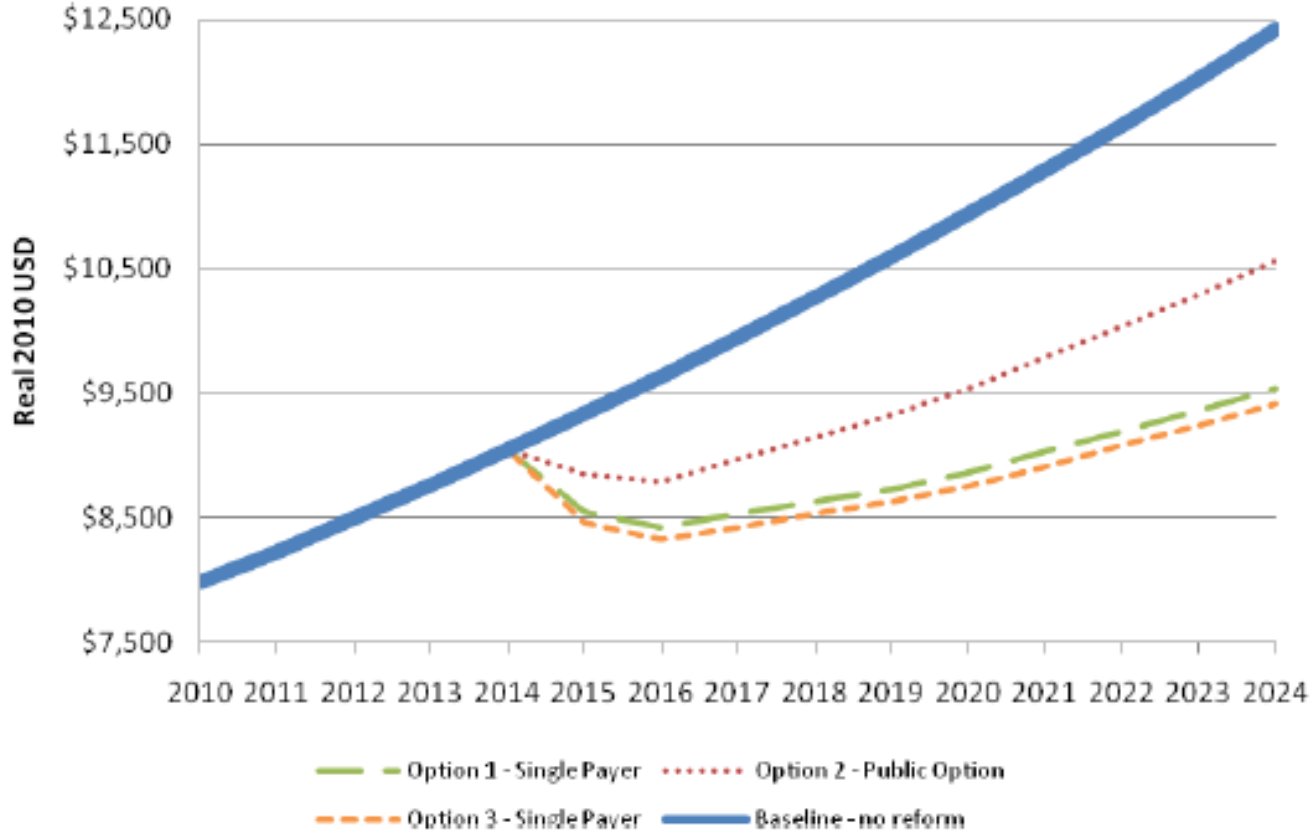
	Option 1	Option 2	Option 3
Administrative - Insurer & Provider	7.3%	3.6%	7.8%[1]
Reduced Fraud and Abuse	5%	5%	5%
Shift to Integrated Delivery System	10%	5.5%	10%
Medical Malpractice Reform	2%	2%	2%
Public-Private Management Structure	-	-	0.5%[1]
Total Savings	**24.3%**	**16.1%**	**25.3%**

[1]Note: Option 3 assumes slightly greater administrative savings through the competitive bid process for claims administration, which provides incentives to innovate and develop more efficient systems. Option 3 furthermore assumes an additional 0.5 percent savings over the 10 year period reflecting the more modest updates to benefits and payments expected under the independent board compared to those decided through a political process.

Source: Act 128 Health System Reform Design Achieving Affordable Universal Health Care in Vermont

Results: Savings

Figure A: Comparison of Vermont Health Expenditure per person under different Options in real dollar terms 2010 – 2024.



Source: Act 128 Health System Reform Design Achieving Affordable Universal Health Care in Vermont

Results: Savings

Table A. Comparison of Savings Estimates among the Three Reform Options.

	Percent of Total Health Spending from 2015 to 2024	Absolute Savings in 2010 Dollars[1]			
		2015	2016	2019	2024
Option 1	24.3%	$530 million	$720 million	$1,050 million	$1,550 million
Option 2	16.1%	$320 million	$470 million	$690 million	$980 million
Option 3	25.3%	$580 million	$770 million	$1,100 million	$1,600 million

Note: [1]Excluding savings accrued to Medicare, Veterans' Administration, Workers' Compensation plans, and Medicaid for the over 65 population.

REMI

REMI model was used to estimate the impacts of reform options on Vermont's economy

- GMSIM only models the impacts of the policy changes on the health care system
- Outputs from the GMSIM were input into the REMI model to estimate economic impacts (employment, gdp, migration).

REMI

Inputs into REMI:

- Changes in public health care spending
  - Addressed by disaggregating spending changes by industrial components: hospital care, ambulatory care, pharmaceuticals, nursing/home care, and administrative services;
- Changes in employer and employee health care spending
  - Addressed through change in wages;
- Changes in household health care spending (non-group and out-of-pocket spending)
  - Addressed through changes composition of household consumption.

Sources: REMI, Act 128 Health System Reform Design

Results: Economic Impacts

Table C. Estimated Incremental Impacts of the Three Reform Options.

		Option 1		Option 2	Option 3
Benefits package:		Standard	Comprehensive	Multiple	Standard
Number of remaining uninsured individuals	2016	0	0	28,000	0
	2019	0	0	28,000	0
Total employer spending	2016	-$80 million	$410 million	-$120 million	-$100 million
	2019	-$220 million	$290 million	-$150 million	-$240 million
Per employee health spending	2016	-$200	$1,000	-$300	-$260
	2019	-$550	$725	-$385	-$600
Number of jobs created	2016	3,800	8,200	-2,300	3,600
	2019	3,200	7,100	-3,100	2,900
Number of individuals migrating into Vermont	2016	1,600	4,000	-1000	1,500
	2019	2,900	8,000	-2,400	2,600
Gross State Domestic Product Change	2016	$100 million	$320 million	-$170 million	$90 million
	2019	$50 million	$250 million	-$250 million	$33 million

Note: All dollar figures are expressed in real 2010 dollars.

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Outcome: Selection

Consultants Recommended Option 3

A modified version of Option 3 was passed as Act 48 and signed into law by Governor Shumlin on May 26, 2011.

Key differences between Option 3 and Act 48:

- Green Mountain Care Board had more centralized control
  - Done for expediting policy changes
- Did not include a financing plan
  - Politically difficult

Source: Bennington Banner, Cornell Policy Review

Final Outcome: Withdrawn

Political Mismanagement:

- No serious public education effort
- Poor launch of Vermont Health Connect (VT ACA Exchange)
  - Reduced the state's credibility to manage healthcare

Costs:

- Shumlin couldn't guarantee that later tax increases wouldn't be needed to pay for any increases in costs

Shumlin withdrew the reform December 17th, 2014

However, Vermont recently introduced another universal healthcare bill with an operational plan possible in 2020

Source: WAMC, Roll Call, Cornell Policy Review

Model Demonstration

Following closely the original study, input three components:

1) Changes in public health care spending by disaggregating spending changes by industrial components
   - hospital care, ambulatory care, pharmaceuticals, nursing/home care, and administrative services;

2) Changes in employer and employee health care spending
   - Addressed through change in wages;

3) Changes in household health care spending (non-group and out-of-pocket spending)
   - Addressed through changes composition of household consumption.