COLORADO FOUNDATION FOR
UNIVERSAL HEALTH CARE

Colorado's proposal overcomes problems that stymied Vermont

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On December 18, 2014 Vermont Gov. Peter Shumlin made a surprise announcement that he no longer supported the Vermont universal health care proposal because he said it would be too expensive and would unfairly burden businesses and Vermonters at a time when their economy was struggling. This was a major reversal in Vermont politics. Before the announcement, the majority of voters, the majority of the legislators in both Vermont chambers, and the governor had endorsed and campaigned on universal health care. Universal health care systems work and cost less in all other industrialized countries. All previous analysis of universal health care showed it was more affordable, but the Governor's Vermont proposal did not find much savings. Is the Governor correct in saying universal health care is too expensive or did something go wrong?

Vermont approved a single payer health care system without specifying the policies that would make it work. Not surprisingly, policy issues matter. Dr. William Hsiao, who designed and guided the implementation of the successful Taiwan universal health care system in the 1990s, offers relevant commentary on a similar situation in Taiwan. He reports that before he went to Taiwan, problems arose when four technical experts tried and failed to come up with a successful universal health care proposal. He said, "It was like a wagon drawn by four horses, with each going in a different direction and nobody driving.[1]" Vermont's proposal, in which political forces and political concessions shaped a plan that did not have a driver keeping track of realistic economics, is similar to the first, unsuccessful attempt at a plan in Taiwan. Interestingly, Dr. Hsiao, who has experience designing and at times implementing health care systems around the globe, also conducted the preliminary analysis of the Vermont proposal before the political concessions, and he found that it was economically feasible.

The governor's economic proposal is a plan with too many political concessions and too little focus on what would work. Vermont adopted universal health care based primarily on a "health care is a human right" campaign without an emphasis on economics. The proposal's governing body, the Green Mountain Care (GMC) Board, which was not responsible for financing, designed a system without a focus on the economic and policy decisions needed to make it economically feasible. Its design included political concessions to insurers, hospitals, and providers. On top of that, the Governor offered financing concessions to low-income constituents, high-income constituents, and the self-employed, and as a result, the cost for the remaining payers—middle-income workers and employers—became too high.

In addition, Vermont faces a number of situational challenges. Vermont has a high per capita health care cost, limited median family income, a small population, and a workforce and medical services that intermingled with neighboring states. All of these factors decreased Vermont's ability to reduce costs. Colorado, fortunately, does not have these challenges.

How is the Colorado proposal different?
The Colorado proposal for ColoradoCare aka Colorado Health Care Cooperative is a system designed to establish universal, high-quality, and accessible health care; decrease the overall costs of health care through efficiencies; and collect premiums in an efficient and fair manner. It differs from Vermont's approach and plan in multiple ways:

- *Colorado's plan does not make an alliance with the insurance industry*. The GMC Board Chair was closely associated with the insurance industry and had been a strong advocate of the RomneyCare program in Massachusetts[2], which expanded coverage but also greatly increased costs. The Board agreed to subcontract with a large insurance company and promoted this as a public-private partnership. This partnership did not report the administrative savings that are expected to come from removing the multiple, for-profit, middle managers.

- *Colorado would obtain the benefit of savings, not pass the benefits onto hospitals for higher profits.* Vermont made a political decision to eliminate the Hospital Provider Tax, presumably because in a universal health care system such a tax only increases the cost to GMC. However, the economic analysis showed that GMC would not reap any benefit of lower cost, and the hospitals would retain the savings.
- *Colorado would pursue decreases in the cost of pharmaceutical and durable medical equipment*. Multiple analyses, as well as model programs such as the VA Hospital system, have found that a unified system can use its market power to lower the costs of pharmaceuticals and medical equipment. However, Vermont decided not to pursue lowering pharmaceutical costs.
- *The Colorado proposal decreases administrative complexity instead of increasing it*. The GMC Board decided to implement a complex transition to payment reform through Accountable Care Organizations (ACOs)[3,4] in order to pursue a theoretical cost savings later on. While ACOs are supported by health care economists and offer promise, they are still in the process of development and have not yet been shown to maintain quality care and offer savings when applied over a whole state. This expensive transition consumed natural cost savings from administrative simplification. The Colorado proposal minimizes the Cooperative's administrative expense in order to achieve a savings. Colorado's proposal phases in ACOs and other payment reforms only to the extent that they decrease cost and improve value.
- *The Vermont plan did not attempt to retain obvious savings*. It claimed there would not be any savings, which ignores potential savings from obvious factors, such as the reduction in administrative tasks when there is one primary payer, the elimination of the marketing and advertising costs in the multi-payer system, and the elimination of the need for insurer profits, among other things. When administrative costs go down, someone has more money, and it appears that Vermont allowed providers to use the administrative savings to increase income. The Colorado proposal incentivizes the system to benefit from savings. As a provider's administrative costs decrease, the payments would correspondingly decrease. Colorado's obligation would be to maintain overall provider compensation at a level that is competitive enough with other states so that Colorado would have a sufficient health care work force.
- *The Colorado proposal is less disruptive to employers.*
  While in the long run both the employer's and employee's premium payments come from the funds available for the wage/benefit package, in the short run, the Vermont proposal requires that employers who did not previously pay for health care pay a 10.5% payroll premium. Such a large increase is burdensome. The Colorado proposal:
    - Shares the 10% payroll premium between employer and employee so that the employer pays 6.67% and the employee pays 3.33%.
    - Allows employers that have previously paid for most of health care to pay employee's share if the employer agrees to do so by union contract or any other contract.
    - Covers the medical portion of workers' compensation, which decreases workers' compensation costs by 60%. This reduces the administrative and financial burden on employers.
- *The Colorado proposal has premiums that are fairer—one combined employer/employee rate for everyone without the large difference between the effective rates for low-income and high-income residents.* The Colorado proposal is modeled after the successful Social Security and Medicare insurance premium collections. Everyone pays the same percentage rate for combined employee and employer contributions (10% split between employer and employee). In addition, to be fair to working people, the same percentage rate is applied to non-payroll income. Vermont would have collected its premiums using two methods, a payroll premium tax of 11.5% paid by the employer, and a progressive income premium tax that rose to 9.5% of adjusted income. The combined employer/employee premium contribution varied greatly as the Table below shows.

Comparison of Vermont and Colorado proposal premium rates for payroll and other income

(Employer and employee rates are combined because both come from wage and benefit package.)

Income level or source	Vermont Proposal	Colorado Proposal
Low-income (below 138% Federal Poverty Level)	Employer pays **10.5% payroll**	Employer pays **6.67% payroll**, and the 3.33% employee contribution is refunded due to Medicaid waiver.
Working people	Employer pays 10.5% of payroll and employee pays progressive income tax that rises to 9.5% so that working people pay **between 10.5% of payroll and 21% of wage benefit package** on pay increases once the top level of income is reached.	Employer pays 6.67% payroll and employee pays 3.33% payroll resulting in a **10% impact on the wage/benefit package.**
Non-payroll income usually associated with high income.	Pay 9.5% of income after deductions resulting in a rate **below 9.5%.**	Pay **10% of non-payroll income**.
Self-Employed	Pay 9.5% of income after deductions resulting in a rate **below 9.5%.**	**10% of net income** is assessed on the business, which gives self-employed the same tax advantage as employers by reducing Social Security and Medicare taxes and reducing the **impact on the self-employed to between 8.537% and 5.637** of net income depending on tax bracket.
High income	Premiums are **capped at $27,500**	Premiums are capped at 10% of $450,000 for joint filers, which is **$45,000**

Vermont has more challenges than Colorado in creating a universal health care system.

- Vermont's per capita health care costs are 26% higher than Colorado's (2009)
- The median Vermont family income is 6% lower than Colorado's (2012).
- Vermont's economic recovery has been stalled while Colorado has a robust economy. (In the Kiersz. & Holodny (2015) ranking of state economies, Colorado ranked number one for the fastest growth, and Vermont ranked 49th[5].) Premiums based on income are decreased when the economy is down.
- Vermont would have lost some tax revenue by converting to Green Mountain Care because it has a tax on insurance claims. Colorado does not have a comparable tax.
- Medical services for Vermont are often located in neighboring states (1/3 of Vermont residents have received treatment at the Manchester, NH, hospital system). Consequently, the state needed to build a more complicated provider network including negotiating and contracting with out-of-state providers. Colorado can just include all Colorado providers, simplifying the administration of a provider network as well as reducing the administrative burden in providers' offices.
- Vermont's 2014 population is 626,562 compared to Colorado's 5,355,866[6]. The small population size reduces Vermont's market power for decreasing the cost of pharmaceuticals and durable medical equipment.
- Vermont's workforce is mixed with neighboring states making the efficient, payroll-based premium collection system a difficult way to collect premiums from residents. Colorado's workforce overlaps very little with neighboring states. This allows Colorado to rely primarily on the payroll-based system similar to Social Security and Medicare.

Vermont endorsed universal health care without a plan. In the planning process, Vermont granted concessions to the insurance industry, providers, hospitals, the self-employed, and both low-income and high-income residents. These concessions in Vermont made a system that could not work. Colorado, on the other hand, is presenting a plan, ColoradoCare, that works as a coherent whole. It is not subject to the concessions that could cause it to drift

from the mission of universal, high-quality, and accessible health care. Colorado, also, is healthier and wealthier, and has geographical advantages. Although the Vermont proposal needs to be reworked, the Colorado proposal remains strong and on solid ground.

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[1] Underwood, A. (2009) Prescriptions: Making sense of the health care debate. Health Care Abroad: Taiwan. N.Y. Times, NY/NY. http://prescriptions.blogs.nytimes.com/2009/11/03/health-care-abroad-taiwan/?_r=1

[2] Woolhandler, S. & Himmelstein, D.U. (2015). What happened in Vermont: Implications of the pullback from single payer. Physicians for a National Health Program, Chicago. http://www.pnhp.org/news/2015/january/what-happened-in-vermont-implications-of-the-pullback-from-single-payer

[3] Ibid

[4] State of Vermont. (2014) Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System. State of Vermont, Montpellier. http://www.leg.state.vt.us/jfo/healthcare/Health%20Reform%20Oversight%20Committee/2015_01_06/Reports_GMC%20FINAL%20REPORT%20123014.pdf

[5] Kiersz, A. & Holodny, E. (2015). Here's how all 50 state economies are doing, ranked from slowest to fastest (3/15/15). Business Insider. http://www.businessinsider.com/state-economic-growth-rankings-2014-8#1-colorado-50

[6] http://en.wikipedia.org/wiki/List_of_U.S._states_and_territories_by_population

Additional Resources:

Friedman, G. (2015) Professor Friedman's Analysis of Shumlin's Financing Proposal. Healthcare-NOW, Washington, DC. http://www.healthcare-now.org/professor-friedmans-analysis-of-shumlins-financing-proposal

Goozner, M. (2015) Lessons from Vermont. Modern Health Care. http://www.modernhealthcare.com/article/20150103/MAGAZINE/301039984?utm_source=AltURL&utm_medium=email&utm_campaign=am%3Fmh