Issues Paper #3:

Vermont and Hawaii discuss getting from Exchanges to Universal Coverage

A note from Vermont:

Vermont is exploring how to design an Exchange infrastructure that could be used for Green Mountain Care (the single payer) when the state is able to get a waiver from the Exchange. This involves determining which functions and business operations of an Exchange could be reused. Vermont is also looking at achieving administrative savings in advance of the single payer by sharing Exchange infrastructure with other payers who are self-insured or insured in the large group market, as well as other coverage programs. The options and analysis will be made available to interested states and others outside of Vermont as it develops.

Many of the same functions are needed for state employees, Medicaid, the Exchange, and a single system. Each must enroll residents, each must pay claims, each must collect funds. For example, Vermont is currently planning the enrollment functions needed for the Exchange - which includes a web portal for individuals, employers, and employees. There is no reason that others couldn't use the same portal, even if the insurance product or self-insured plan was outside of the individual and small group markets (which are the markets in the Exchange in 2014).

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A note from Hawaii:

As I see it, one of the key messages that single-payer advocates must get across to both potential allies and to the general public is that competition in health care financing is counterproductive because of the nature of the health care market. A high percentage of the population has known health risks, and this means that in a competitive insurance market, plans succeed not by offering a better, more cost-effective product, but by avoiding covering or paying for sick people. When individuals choose their plan and a high percentage of them have known health risks, then there will be a severe adverse selection problem, leading to the "adverse selection death spiral" and the demise of any plan stuck with the sicker segments of the population.

[If a state considers a Public Option] the only way I can see a "public option" working as a stepping stone to single payer is if it starts out with a large, broad, captive risk pool (that is not open to competition from private insurance within that captive pool), and is then offered to the rest of the insured population where competition is allowed. An example is the Connecticut SustiNet proposal, which starts by taking all state-funded health plans - state, county, and municipal employees and retirees, Medicaid, and the "HUSKY" plan for low income uninsured not eligible for Medicaid, and forms their plan with that captive population. Then they will offer it first to small businesses in competition with private plans, and then to large businesses. The problem with this proposal is that it leaves the various components in the SustiNet plan as separate plans (retirees, current employees, Medicaid, and HUSKY), albeit with a single administrative structure, with the intention of gradually equalizing fees among these plans and merging then sometime down the road.

I believe it would work better to actually combine all these publicly funded plans in a single plan with the same benefits, fees, drug formulary, etc. in one plan from the start. This is similar to what Rocky Mountain Health Plans in Colorado did - combining Medicare (via a Medicare Advantage plan they set up), employer based insurance, and Medicaid in a single plan with blended fees and a vigorous, physician directed quality improvement program. They achieved among the lowest Medicare and Medicaid costs in the country, with no access problems for Medicaid beneficiaries, and with high quality outcomes.

The other issue is how to handle setting up an insurance exchange as required under PPACA. If this is run by insurance companies that assume competition is beneficial, then it will run into serious adverse selection problems and high administrative costs. The alternative is what Vermont is doing, in setting up a rudimentary exchange designed to be minimally competitive, with just two or even one plan (if a waiver can be obtained). Then, as soon as they can get the necessary waivers, they will fold this into a full single-payer plan.

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