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MEMORANDUM

TO: Donald G. Milne, Clerk of the House
John Bloomer, Secretary of the Senate
Emily Bergquist, Director and Chief Counsel

FROM: Stephen Kimbell, Commissioner, Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)

RE: Three-Year Forecast of Vermont Health Care Expenditures: 2010 – 2013 (Revised Version)

DATE: February 3, 2011

CC: Representative Mark Larson, Chair, House Health Care Committee
Senator Clair Ayer, Chair, Senate Health & Welfare Committee
Anya Rader-Wallack, Special Assistant to the Governor on Health Care Reform
Susan Besio, Director, Office of Vermont Health Access
Alex MacLean, Secretary of Civil and Military Affairs
Michael Davis, Director of Hospital Regulatory Operations, BISHCA
Lori Perry, Health Policy Analyst, BISHCA

We have attached a revised copy of a *Three-Year Forecast* of Vermont health care expenditures. This report was developed to meet the requirement under 18 V.S.A. § 9406 (b)(1-4) that directs the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to annually prepare a three-year projection of health care expenditures made on behalf of Vermont residents. The statute also requires that the report be filed with the General Assembly on or before January 15th of each year. We apologize that data filings later than normal delayed our filing until today.

The information contained in this analysis will also be included in the annual *Vermont Health Care Expenditure Analysis* report that BISHCA will file with the General Assembly in February.

Please feel free to contact Michael Davis BISHCA if you have any questions or concerns regarding this forecast report.



STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE,
SECURITIES & HEALTH CARE ADMINISTRATION



LEGISLATIVE REPORT
DIVISION OF HEALTH CARE ADMINISTRATION

THREE-YEAR FORECAST of VERMONT HEALTH CARE EXPENDITURES 2010 – 2013

Revised version
February 3, 2011

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2010-2013 Forecast

Three-Year Projections of Health Care Expenditures

This Forecast report describes projected expenditures for Vermont health care providers and on behalf of Vermont residents for the period 2010-2013.

Introduction

This forecast report is prepared to meet requirements under 18 V.S.A. § 9406 (b)(1-4) that directs the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to prepare annually a three-year projection of health care expenditures made on behalf of Vermont residents. The report to the general assembly is due each January.

The forecast is built off of 2009 actual Vermont health care expenditures. Factors used to build the projections are primarily acquired from the National Health Expenditure projections completed by the federal government¹. In addition, the Vermont forecast also considers recent Vermont trends over the last three years.

In preparing the annual Expenditure Analysis reports, BISHCA relies on multiple data sources that have very different reporting taxonomies. Accordingly, BISHCA must take care in categorizing information consistently in order to evaluate year-to-year changes and trends over time. Gathering and analyzing the 2009 data reflected much of this difficulty. However, BISHCA notes that about 70 percent of the Resident data and 60 percent of the Provider data are from solid, dependable sources.

The three-year forecast does not attempt to anticipate changes in state or federal legislation that could affect projections. Also, the forecast does not try to anticipate major shifts in payer enrollment. The forecast only projects trends over the next three years based upon the best information available today.

The projections are used in the evaluation of health insurance rate and trend filings that are submitted to BISHCA, as well as with the hospital budget review process and the Certificate of Need process. The projections of Vermont health care resident expenditures are also used in the development of the Unified Health Care Budget. See Appendix A for more detail.

The information contained herein will also be reported in the annual *Vermont Health Care Expenditure Analysis* report. That report, detailing 2009 health care expenditures by Vermont residents and Vermont providers, will be filed with the General Assembly in February.

¹ National Health Expenditure (NHE) Data web site:
[www.cms.hhs.gov/NationalHealthExpendData/.http://www1.cms.gov/NationalHealthExpendData/downloads/PHCE_Growth_Factors.pdf](http://www1.cms.gov/NationalHealthExpendData/downloads/PHCE_Growth_Factors.pdf)

Two Different Analyses

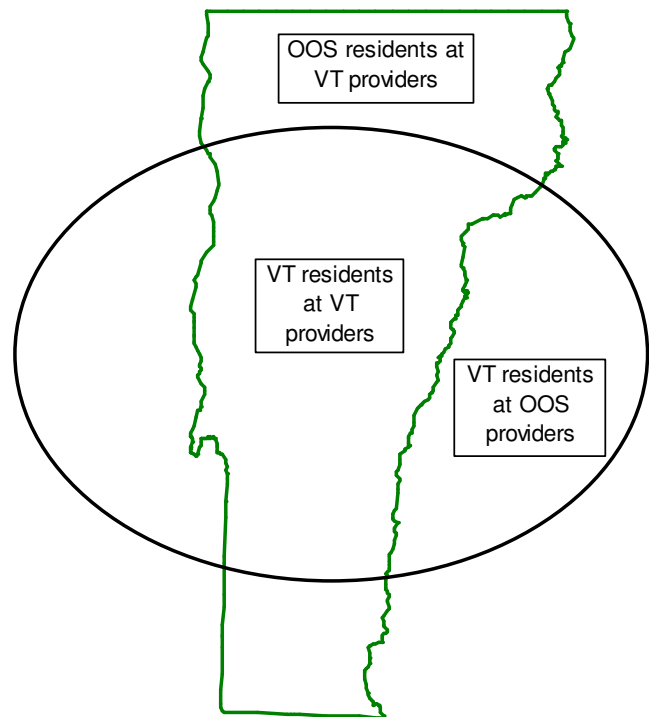
BISHCA forecasts health costs from two perspectives: the **Resident analysis**, which includes expenditures on behalf of Vermont residents, regardless of where the health care was rendered; and the **Provider analysis**, which includes all revenue received for services by Vermont providers, regardless of where the patient lives. Because some Vermonters obtain health care out-of-state (OOS) and some non-Vermonters come to Vermont for care, both of these analytical constructs are necessary to understand health care spending. In the figure below, the Vermont map represents Vermont providers and the oval represents Vermont residents.

Different populations, data sources, and estimating methods between the resident analysis and provider analysis contribute to differences in total expenditures and growth rates.²

Forecast Models

The two models use the 2009 Vermont health care expenditures as their base. In both models, most of the projected expenditures for Vermont in 2010-2013 are estimated using the provider service projections reported by the U.S. Centers for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) model³. Because the data is more current, community hospital data includes both 2010 and 2011 budget data submitted to BISHCA during the annual hospital budget review process.

For the provider model, provider service expenditures are projected forward, and then allocated by payer based on the most recent payer distributions that have been reported through 2009. For the resident model, each payer's (e.g., Medicare, private insurance) provider service expenditures are also projected forward with (primarily) NHE projections from the 2009 base. Medicaid is projected independently in the resident model based on their budgeted growth rates and other information from the Agency of Human Services (AHS) since their data is more current. This includes the projections for the Global Commitment for Health (Medicaid). Aside from that, the forecast model assumes no significant changes in enrollment or significant program policy changes in Medicare or Medicaid.⁴



² For example, since an estimated 35% of the patients at the Veteran's Hospital in White River Junction, VT are not Vermont residents, the spending associated with those patients is *not* included in the Vermont resident analysis but *is* included in the Vermont provider analysis.

³ NHE web site - <http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf>

⁴ A technical documentation report with a more complete discussion of the forecast model will be available on BISHCA's web site upon completion of the full 2009 Expenditure Analysis report.

2008 & 2009 Updates and Methodology Changes

Each year, new information or updates from previous sources sometimes require us to re-state the values in a given year. For example, the original reported values in the annual Expenditure Analysis are often re-stated in the following year. This allows for more accurate trends and year-to-year comparison. There are also methodological changes that can have the same effects. For this year's reports, the following has been updated:

For 2007 - 2008, we have updated the following areas:

- 1) The Self-insured payer has been recalculated for 2007 & 2008 with a methodology using Annual Statement Supplement Report (ASSR) for the Federal, TPA/ASO, Dental and CBA lines of business. 2007 decreased by \$185 million and 2008 decreased by \$218 million respectively. The change was based upon better information as to where Vermonters were enrolled for various types of insurance coverage.
- 2) The 2008 Medicare expenditures have been updated with actual expenditures from The Dartmouth Institute for Health Policy & Clinical Practice (TDI) data provided to BISHCA. Medicare expenditures decreased from the 2008 estimate we projected last year by \$20.7 million, primarily in Hospitals and Physician. 2009 Medicare expenditures should be received sometime in the spring of 2011.

For 2009, we have an improved methodological change.

- 1) The Out of Pocket (OOP) methodology has been updated to rely more on Vermont data and less so on the census and the NHE.
 - a. First, Medicare claims expenditures reported to BISHCA from The Dartmouth Institute (TDI) now include out of pocket costs by Medicare enrollees.
 - b. Second, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) allows us to measure the insured enrollee's actual out of pocket costs for about 75% of the commercial market.
 - c. Survey and 2007 census data and the National Health Care Expenditures (NHE) is still used in certain cases to help us estimate out of pocket costs for unique provider populations and services.

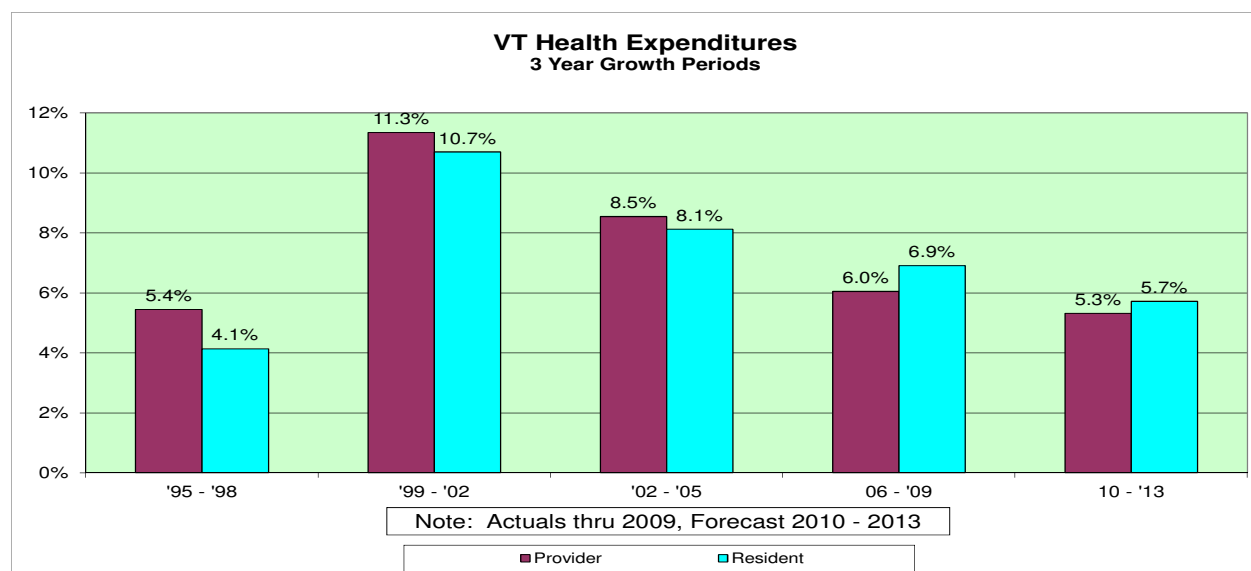
Executive Summary

In 2009, health care for Vermont residents grew 7.6 percent. This spending level for Vermont was higher than the 2008 resident growth rate of 6.6%.⁵ Nationally, health care expenditures grew 4.0 percent in 2009. Vermont has not seen the effects of the recession on health spending as strongly as the U.S., and the pace of health care growth remains a problem when examining per capita costs. This is also noted by CMS, “Despite the overall slowdown in national health spending growth, increases continue to outpace growth in the resources available to pay for it.”⁶

In 2009, even though Vermont resident health care spending grew faster than the U.S., Vermont resident per capita health care expenditures were lower than the U.S.; \$7,581 in Vermont compared to \$8,160 nationally. Nevertheless, with Vermont at almost 93% of the national level, it is closer to the national average than ever before.

Forecasting health care growth involves numerous variables as explained by the National Health Expenditure (NHE) division at CMS.⁷ Using their science, BISHCA combines the NHE growth rates with known Vermont trends and data to forecast growth for the period 2010 – 2013. The forecast for those next three years shows a growth level a little slower than the last three years, with resident spending going from 6.9% in '06 – '09 to 5.7% in '10 – '13. A number of influences explain why the forecasted growth will keep with recent trends:

- 1) NHE explains the recession will continue to hold down growth, as economy-wide prices have grown at less than 2% the last 4 years,⁸
- 2) The Vermont hospital net revenue targets in 2011 and 2012,
- 3) The limit around the growth of the Global Commitment (Medicaid) waiver, and,
- 4) Health care reform changes in Medicare as explained by NHE.



⁵ The expenditures for 2008 were updated from last year’s Expenditure Analysis report. As a result, the growth for 2007 -2008 changed from 7.3% to 6.6%.

⁶ Hartman, M. et al., “Health Spending Growth At A Historic Low in 2008”, Health Affairs, January 2010; 29 No. 1 (2010): 147-155.

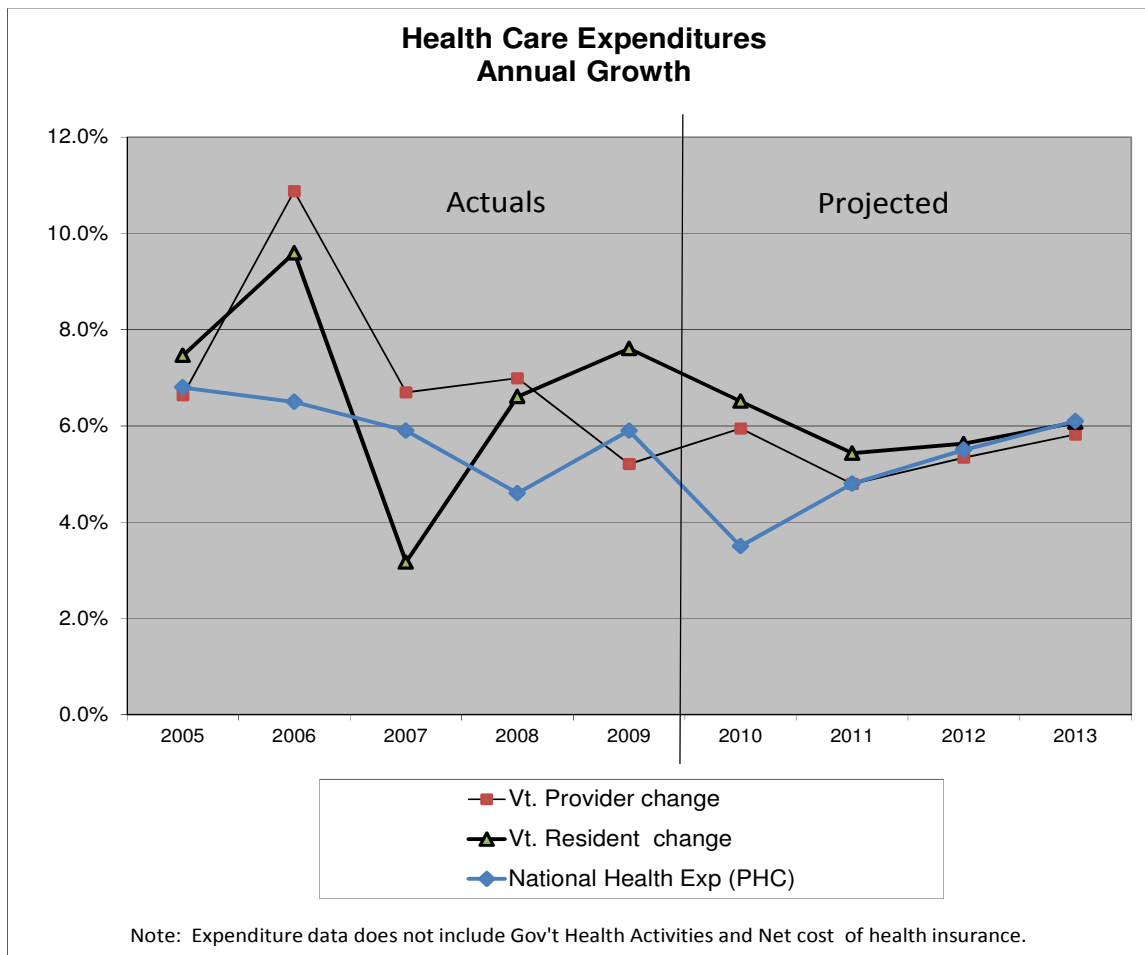
⁷ NHE web site - <http://www.cms.gov/NationalHealthExpendData/downloads/projections-methodology.pdf>

⁸ NHE web site - <http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf>

There are numerous unknowns that will influence the growth over the next several years. The NHE explains that while reform changes are taking form, many of those changes will not begin to show until 2014 and later. These changes include the expected expansion of Medicaid coverage as well as the advent of the State-level Health Insurance Exchanges. By 2019, the NHE expects that 92.7% of the nation will have coverage.⁹ Other provisions of the Affordable Care Act will result in lower Medicare payments as managed care plans will see reductions, most medicare services will see reductions in their annual payment updates, and the creation of an Independent Payment Advisory Board could effect new changes.

From the Vermont perspective, two key factors have been included in the forecast through 2013. First, we have established lower hospital growth for both 2011 and 2012. Net revenue growth is limited to 4.5% and 4.0% for 2011 and 2012 respectively. Second, the recent Global Commitment waiver at DVHA has been agreed with CMS and established growth limits that were lower than established in previous years' forecasts.

In summary, we expect growth over the next three years to average 5.7% for care provided to Vermont residents. This compares closely with the NHE projections of 5.6% over a similar period. When examined as a percentage of the GDP, Vermont expects total spending to be 18.5% of the GDP while the NHE see total spending at 17.6% of the GDP. The NHE does expect growth to increase at a higher rate beginning in 2014.



⁹ NHE web site - <http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf>

Vermont Resident Forecast

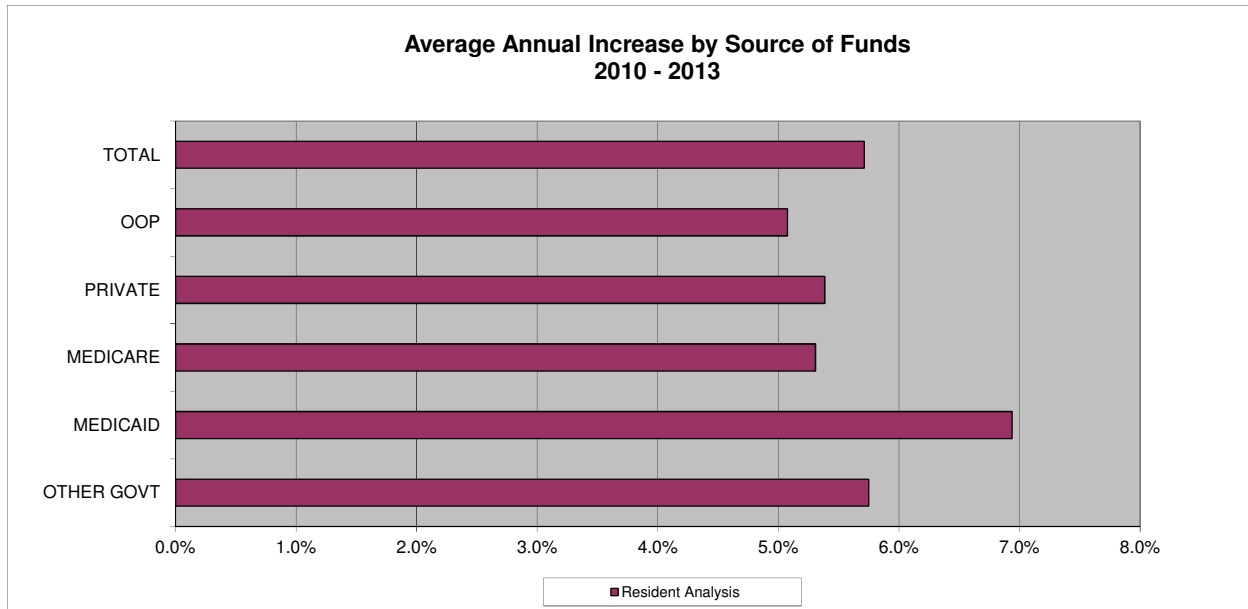


Figure 1

Resident Analysis – how much payer funds will grow to fund health care services

- Total health care expenditures for Vermont residents are \$5.0 billion in 2010 and are projected to be \$5.9 billion by 2013. This calculates to an average annual increase of 5.7%.
- Of the \$910 million increase, \$434 million (48%) will be paid by Commercial insurance and out of pocket funds.
- Medicaid will need to pay \$282 million (31%) of the \$910 million increase.
- The balance of \$194 million (21%) will be paid by Medicare and other government funds.
- Vermont per capita health care expenditures (based on the resident analysis) are projected to be \$9,218 in 2013.¹⁰ This compares to \$7,051 per capita in 2008 (5.5% annual increase).¹¹
- The average annual increase in Vermont per capita health care expenditures over 2010-2013 is projected to be 5.7 percent. National per capita health care spending is projected to grow at an average annual rate of 4.2 percent during the same period. There are a number of reasons that may explain Vermont's per capita difference with national data, including sources of data, definitions, methodologies, timing, and adjustments. More discussion on per capita health care costs will occur in the full *2009 Expenditure Analysis* report.

¹⁰ <http://crs.uvm.edu/census/projections/state/>; Vt. population of 621,710 in 2009, projected to be 643,394 in 2013.

¹¹ This reflects the updated 2008 spending data. Note that per capita costs include all health care expenditures, including medical care, long-term care, and government health care spending.

Vermont Resident Forecast

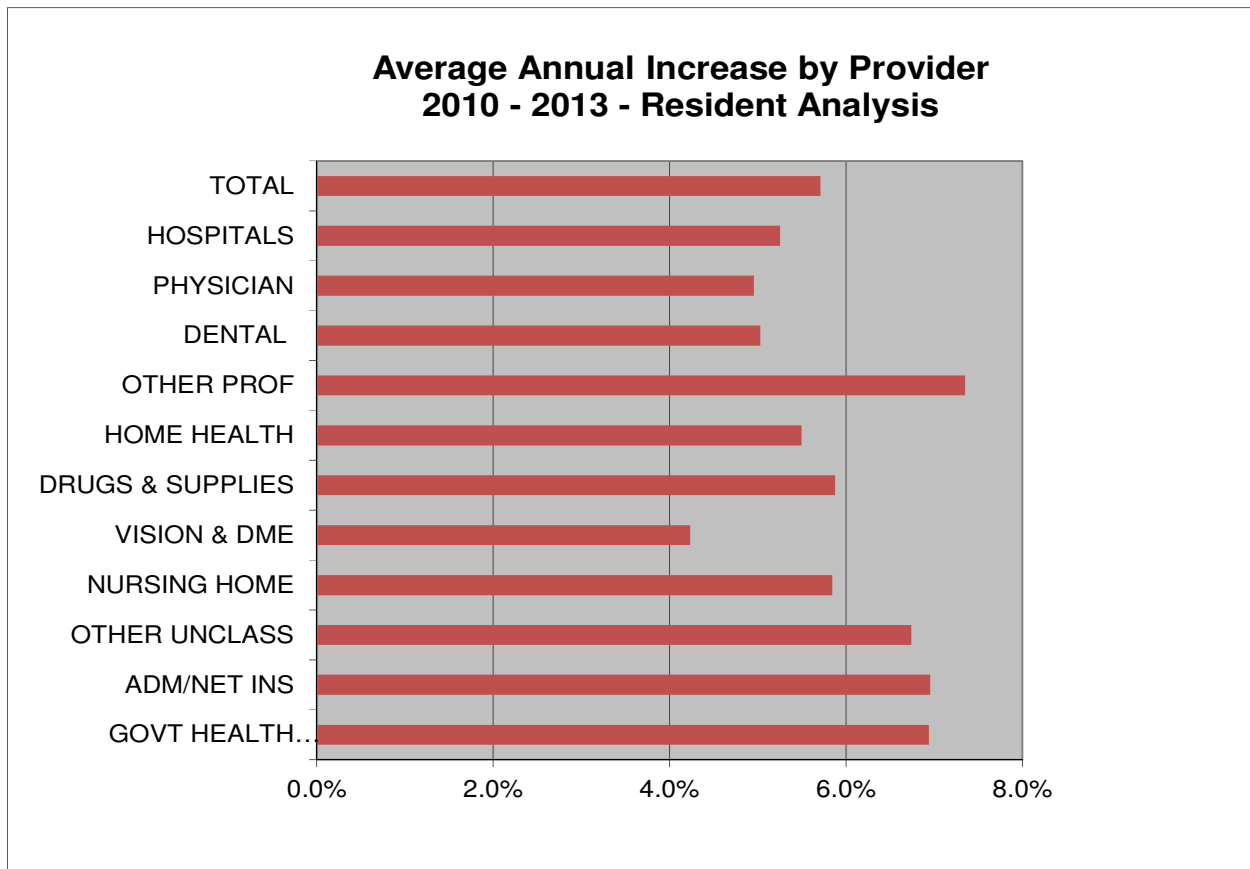


Figure 2

What payer information projects

- Vermont provider services are projected to experience an average annual increase of 5.9 percent in the 2010-2013 time period. This growth will total \$910 million over the 3 years.
- It is important to keep in mind that hospital and physician expenditures represent over 45% of the total. While their growth is projected lower than the total, they will require over \$413 million of the total \$910 million in growth through 2013.
- Other Professional Services shows the highest annual increase at 7.4% and Administration/Net cost of health insurance is 2nd highest at 7%.
- The 3rd highest growing category is government health activities; it shows an average annual growth of 6.9 percent. Most of the expenditures here are funded by Medicaid and support an array of Agency of Human Services programs. The full 2009 *Expenditure Analysis* report will have more detail on government health activities.
- Expenditures for Vision and Durable Medical Equipment are projected to grow the least among the providers at 4.2 percent annually from 2010 to 2013.
- The increases in Vermont *resident* expenditures by provider are about 0.4% higher than the increases measured in the Vermont *provider* expenditures in the figure above. The increases in the totals of the two models (resident and provider) can be different because the populations are not the same and therefore could have a different service mix.

How do previous forecasts compare with actual results?

Dollars in millions

Vermont Expenditures									
Resident	2006	2007	2008	2009	Provider	2006	2007	2008	2009
Jan '06 Forecast	\$ 3,774.6	\$ 4,054.4	\$ 4,360.0	\$ 4,687.4	Jan '06 Forecast	\$ 3,737.0	\$ 4,012.3	\$ 4,306.3	\$ 4,617.3
Jan '07 Forecast	na	\$ 4,248.8	\$ 4,622.1	\$ 4,949.6	Jan '07 Forecast	na	\$ 4,110.4	\$ 4,442.1	\$ 4,751.7
Jan '08 Forecast	na	na	\$ 4,426.0	\$ 4,798.5	Jan '08 Forecast	na	na	\$ 4,408.9	\$ 4,753.9
Jan '09 Forecast	na	na	na	\$ 4,936.1	Jan '09 Forecast	na	na	na	\$ 4,696.5
Actual	\$ 3,982.6	\$ 4,108.8	\$ 4,380.4	\$ 4,713.5	Actual	\$ 3,882.2	\$ 4,142.2	\$ 4,431.9	\$ 4,662.7
Differences - Forecast from Actual									
Resident	2006	2007	2008	2009	Provider	2006	2007	2008	2009
Jan '06 Forecast	\$ (208.03)	\$ (54.45)	\$ (20.35)	\$ (26.08)	Jan '06 Forecast	\$ (145.23)	\$ (129.93)	\$ (125.57)	\$ (45.43)
Jan '07 Forecast	na	\$ 139.93	\$ 241.72	\$ 236.09	Jan '07 Forecast	na	\$ (31.80)	\$ 10.21	\$ 88.98
Jan '08 Forecast	na	na	\$ 45.61	\$ 84.99	Jan '08 Forecast	na	na	\$ (22.97)	\$ 91.22
Jan '09 Forecast	na	na	na	\$ 222.58	Jan '09 Forecast	na	na	na	\$ 33.84
Differences - Forecast from Actual									
Resident	2006	2007	2008	2009	Provider	2006	2007	2008	2009
Jan '06 Forecast	-5.5%	-1.3%	-0.5%	-0.6%	Jan '06 Forecast	-3.9%	-3.2%	-2.9%	-1.0%
Jan '07 Forecast	na	3.3%	5.2%	4.8%	Jan '07 Forecast	na	-0.8%	0.2%	1.9%
Jan '08 Forecast	na	na	1.0%	1.8%	Jan '08 Forecast	na	na	-0.5%	1.9%

Figure 3

- The figures above show resident and provider expenditures from the January 2006, January 2007, and January 2008 forecasts compared to actual data. The middle chart shows the differences in dollars. For example, the 2006 Forecast shows that 2009 was \$26.08 million lower than the actual spending.
- The variability across individual payers and providers may very well be greater than the aggregate total variability.
- 2006 actual data reflected the start of the Medicare Part D Prescription Drug Program and the beginning of Vermont's Global Commitment for Health Waiver. These programs resulted in higher actual expenditures compared to the forecasts. Because BISHCA does not attempt to project changes in policy, these programs and their associated spending were not included in the forecasts done in January 2007.
- Further detail will be provided in the *2009 Expenditure Analysis* report when it is published.

Note: The differences between the resident and provider analyses are due to different populations, accounting techniques, reporting definitions, and fiscal year considerations.

2006-2013 Vermont Resident Health Care Expenditures

(\$ in thousands)

PAYERS	2006	2007	2008	2009	Projected				2006-2013	2010-2013
					2010	2011	2012	2013	Average Annual Change	Average Annual Change
Out-of-Pocket	\$493,986	\$579,321	\$595,542	\$693,932	\$729,532	\$763,754	\$801,855	\$846,371	8.0%	5.1%
Private Insurance	\$1,633,371	\$1,600,787	\$1,686,526	\$1,765,562	\$1,868,054	\$1,965,674	\$2,067,300	\$2,186,395	4.3%	5.4%
Medicare	\$730,539	\$795,103	\$842,766	\$907,921	\$959,516	\$1,006,661	\$1,057,416	\$1,116,596	6.2%	5.2%
Medicaid	\$950,774	\$963,730	\$1,060,444	\$1,155,724	\$1,261,368	\$1,343,953	\$1,439,555	\$1,542,574	7.2%	6.9%
Other Government	\$173,952	\$169,878	\$195,086	\$190,379	\$201,993	\$213,168	\$225,084	\$238,880	4.6%	5.8%
TOTAL RESIDENT EXPENDITURES	\$3,982,622	\$4,108,819	\$4,380,364	\$4,713,518	\$5,020,462	\$5,293,211	\$5,591,209	\$5,930,816	5.9%	5.7%
Annual Percent Change	9.6%	3.2%	6.6%	7.6%	6.5%	5.4%	5.6%	6.1%		

PROVIDERS	2006	2007	2008	2009	Projected				2006-2013	2010-2013
					2010	2011	2012	2013	Average Annual Change	Average Annual Change
Hospitals	\$1,351,601	\$1,361,322	\$1,517,122	\$1,739,497	\$1,848,869	\$1,936,865	\$2,037,710	\$2,155,762	6.9%	5.3%
Physician Services	\$601,545	\$615,694	\$642,458	\$638,416	\$678,655	\$707,448	\$743,511	\$784,615	3.9%	5.0%
Dental Services	\$124,531	\$191,607	\$201,372	\$209,458	\$218,921	\$228,257	\$239,588	\$253,611	10.7%	5.0%
Other Professional Services	\$157,762	\$144,570	\$148,609	\$153,021	\$161,803	\$172,050	\$186,238	\$200,168	3.5%	7.4%
Home Health Care	\$87,949	\$94,895	\$102,553	\$101,538	\$107,213	\$112,925	\$119,132	\$125,881	5.3%	5.5%
Drugs & Supplies	\$561,870	\$510,746	\$530,779	\$566,076	\$602,326	\$638,933	\$674,237	\$714,838	3.5%	5.9%
Vision Products & DME	\$70,102	\$87,594	\$90,629	\$94,063	\$97,342	\$101,059	\$105,446	\$110,235	6.7%	4.2%
Nursing Home Care	\$216,337	\$239,902	\$255,318	\$265,753	\$283,036	\$299,022	\$316,347	\$335,622	6.5%	5.8%
Other/Unclassified Health Services	\$37,364	\$34,101	\$33,971	\$43,339	\$46,485	\$49,657	\$52,889	\$56,530	6.1%	6.7%
Admin/Net Cost of Health Insurance	\$320,484	\$379,695	\$347,516	\$367,042	\$391,566	\$424,496	\$449,332	\$479,057	5.9%	7.0%
Government Health Care Activities	\$453,075	\$448,693	\$510,037	\$535,315	\$584,246	\$622,498	\$666,779	\$714,496	6.7%	6.9%
TOTAL RESIDENT EXPENDITURES	\$3,982,622	\$4,108,819	\$4,380,364	\$4,713,518	\$5,020,462	\$5,293,210	\$5,591,209	\$5,930,815	5.9%	5.7%
Annual Percent Change	9.6%	3.2%	6.6%	7.6%	6.5%	5.4%	5.6%	6.1%		

2006-2013 Vermont Provider Health Care Expenditures

(\$ in thousands)

PAYERS	2006	2007	2008	2009	Projected				2006-2013	2010-2013
					2010	2011	2012	2013	Average Annual Change	Average Annual Change
Out-of-Pocket	\$538,686	\$590,953	\$612,581	\$717,659	\$755,036	\$790,144	\$830,225	\$877,091	7.2%	5.1%
Private Insurance	\$1,470,286	\$1,556,606	\$1,704,162	\$1,685,380	\$1,782,545	\$1,862,442	\$1,958,874	\$2,070,348	5.0%	5.1%
Medicare	\$735,045	\$850,144	\$870,462	\$941,513	\$994,841	\$1,039,065	\$1,091,209	\$1,151,802	6.6%	5.0%
Medicaid	\$922,722	\$926,767	\$995,428	\$1,074,208	\$1,149,937	\$1,213,704	\$1,287,040	\$1,368,425	5.8%	6.0%
Other Government	\$215,498	\$217,744	\$249,228	\$243,926	\$257,743	\$271,499	\$286,071	\$303,172	5.0%	5.6%
TOTAL PROVIDER EXPENDITURES	\$3,882,238	\$4,142,214	\$4,431,861	\$4,662,685	\$4,940,102	\$5,176,855	\$5,453,418	\$5,770,838	5.8%	5.3%
Annual Percent Change	10.9%	6.7%	7.0%	5.2%	5.9%	4.8%	5.3%	5.8%		

PROVIDERS	2006	2007	2008	2009	Projected				2006-2013	2010-2013
					2010	2011	2012	2013	Average Annual Change	Average Annual Change
Hospitals	\$1,607,094	\$1,748,089	\$1,872,379	\$2,000,218	\$2,117,557	\$2,205,224	\$2,314,086	\$2,443,614	6.2%	4.9%
Physician Services	\$521,826	\$571,072	\$586,728	\$561,643	\$594,075	\$616,649	\$645,632	\$679,205	3.8%	4.6%
Dental Services	\$214,537	\$226,151	\$237,685	\$246,564	\$256,488	\$266,770	\$279,356	\$295,280	4.7%	4.8%
Other Professional Services	\$166,814	\$175,786	\$185,630	\$205,546	\$215,758	\$229,312	\$248,837	\$267,636	7.0%	7.4%
Home Health Care	\$96,280	\$97,632	\$100,440	\$102,802	\$107,434	\$112,741	\$118,349	\$124,471	3.7%	5.0%
Drugs & Supplies	\$504,254	\$543,165	\$584,477	\$646,021	\$684,547	\$725,619	\$763,794	\$808,319	7.0%	5.7%
Vision Products & DME	\$72,904	\$73,179	\$78,778	\$80,154	\$82,488	\$85,396	\$88,840	\$92,611	3.5%	3.9%
Nursing Home Care	\$218,373	\$228,356	\$244,732	\$252,566	\$263,403	\$276,201	\$288,952	\$303,753	4.8%	4.9%
Other/Unclassified Health Services	\$27,080	\$30,092	\$30,976	\$31,856	\$34,108	\$36,445	\$38,794	\$41,454	6.3%	6.7%
Admin/Net Cost of Health Insurance	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Government Health Care Activities	\$453,075	\$448,693	\$510,037	\$535,315	\$584,246	\$622,498	\$666,779	\$714,496	6.7%	6.9%
TOTAL PROVIDER EXPENDITURES	\$3,882,238	\$4,142,214	\$4,431,861	\$4,662,685	\$4,940,102	\$5,176,855	\$5,453,418	\$5,770,838	5.8%	5.3%
Annual Percent Change	10.9%	6.7%	7.0%	5.2%	5.9%	4.8%	5.3%	5.8%		

Appendix A

Use of the Three-Year Forecast

The *Three-Year Forecast*, the *Expenditure Analysis* and the *Unified Health Care Budget* are distinct products used by BISHCA in administering its statutory obligations. The following outlines the purposes currently planned for the *Three-Year Forecast* and how they interrelate with different BISHCA tasks.

1. Expenditure Analysis

The *Vermont Health Care Expenditure Analysis* is an annual publication that provides a description of the dollars that were spent for health care on behalf of Vermonters. The analysis is broken out to show how dollars were spent from both a payer and provider perspective. The *Expenditure Analysis* enables BISHCA to examine the system on a number of levels. Some examples of its use as an analytical tool include identifying the fastest growing sectors and shifts in Vermont's health system, and demonstrating the relative contributions of private health insurance and government programs such as Medicaid and Medicare. The *Expenditure Analysis* helps in understanding cause and effect within the system and facilitates more effective and meaningful debate for public policy development.

The *Expenditure Analysis* also serves as the base from which projections of future health care expenditures are developed. It provides the definitional guideline for recording health care expenditures and provides trend data, which, along with the forecast, supports ongoing analysis of health care expenditures.

2. Unified Health Care Budget¹²

BISHCA is required by law to establish a *Unified Health Care Budget* (UHCB) each year. The budget is intended to serve as the basic guideline within which Vermont can control health care costs, direct resources, and ensure that Vermonters have access to high-quality services. Development of the *Unified Health Care Budget* is based upon the annual *Expenditure Analysis* along with the formal hospital budget reviews.

A draft UHCB and *Three-Year Forecast* is presented through a public comment process, which takes place concurrently with the hospital budget review process. Interested parties, provider bargaining groups, and hospitals are asked to provide input. The final UHCB is then established once the Commissioner of BISHCA approves the hospital budgets. The final UHCB for each year is comprised of the total amount of money approved for hospital budgets through the hospital budget review process, together with the expenditure forecasts for other sectors of the health care system.

The development of the UHCB, including discussions with health care plans regarding forecasted costs, should help improve the process and projections of future health care expenditures. Understanding trends and changes in costs from the perspective of the payers should improve forecast accuracy.

¹² See 18 V.S.A. § 9406(a) for a complete description.

The *Three-Year Forecast* includes a certain dependence on growth trends experienced at the national level that may not be similar to what occurs in Vermont. BISHCA recognizes that the forecast needs more current Vermont-specific data to replace the dependence on national data in order to reflect trends that are unique to the state. Our strong reporting system for the Vermont community hospitals allows BISHCA to modify the report to be more Vermont-specific. Additional Vermont-specific data would improve the model.

3. Uses with Insurance Rate Filings

Vermont law provides that insurance rates shall not be unjust, unfair, inequitable, excessive, inadequate, unfairly discriminatory, or otherwise contrary to the law.¹³ BISHCA analyzes utilization and cost trends as well as the historical financial performance of each insurance product when it reviews proposed insurance premiums. A key issue in establishing a future rate is making a projection of future trends based upon current cost and utilization data. Traditionally, this prediction relies heavily on historical patterns. National factors can also play a large role in this prediction, especially for businesses that write insurance outside of Vermont.

The Department and its contracted actuaries consult the data contained in the forecast when reviewing health insurance rate filings. This data also aids BISHCA and its actuaries when analyzing the relationship between hospital rate increases and increases in insurance premiums.

The Cost Shift Task Force Report¹⁴ discusses some current limitations in analyzing the reporting from hospitals and insurance companies. This report was filed in December 2006 with The Commission on Health Care Reform and was updated in 2008, 2009, and 2010. The Task Force acknowledged that the reporting taxonomies used to support insurance and budget regulatory systems are not currently compatible. It was expressed that additional work will need to be completed to better understand how to make regulatory and reporting requirements more consistent.

¹³ See e.g., 8 V.S.A. §§ 4062, 4513, 4584 and 5104.

¹⁴ See “Act 191 Cost Shift Task Force Report” under “Legislative Initiatives/Reports” on the Health Care Administration page of BISHCA’s web site, http://www.bishca.state.vt.us/HcaDiv/Data_Reports/a_data_reports_index.htm

4. Act 53

The passage of Act 53 in 2003 required BISHCA to prepare a four-year capital budget and a health resource allocation plan. The *Three-Year Forecast* served as a contextual framework in developing the *Health Resource Allocation Plan* (HRAP), which was adopted by the Governor in August 2005. It also informed the update to the HRAP, which was adopted by the Commissioner of BISHCA in July 2009. The forecast can also be used in the Certificate of Need (CON) process that BISHCA administers. BISHCA continues to review how these projects should be coordinated as part of the overall health care planning envisioned in Act 53.

Appendix B Definitions and Data Sources: Resident (Payer)

Expenditure Categories	Definition	Data Sources for Payer Matrix	Allocation to Provider Services
<u>Out-of-Pocket</u>	Includes expenditures made directly by consumers to purchase health care services and supplies; includes deductibles and coinsurance. Excludes payments for insurance premiums that are included in the insurance expenditure category.	Medicare and VHCURES data includes out of pocket costs for enrollees. Also, average of NHE per capita data and data from Market Decisions (from the 2009 VT Household Health Insurance Survey).	Allocation based on NHE distributions, line item data from Market Decisions, and other Resident expenditures.
<u>Private Insurance</u>	Includes expenditures made by BCBSVT, MVP, CIGNA and other private commercial payers that sell benefit plans regulated by BISHCA. Includes comprehensive major medical insurance, Medicare supplement insurance, long-term care, and dental insurance. Excludes accident only and disability insurance.	BCBSVT, CIGNA, and MVP reported 2009 data by provider service category. Other private commercial insurance expenditures were calculated from the 2009 Annual Statement Supplement filed with BISHCA.	Actuals as reported by BCBSVT, CIGNA, and MVP. Other private allocation based on BCBSVT and MVP distribution.
- Commercial			
- Self-Insured	Includes expenditures by companies that assume financial risk and directly pay for health services for their employees. These plans are exempt from state regulation under ERISA.	Calculated from the 2009 Annual Statement Supplement filed with BISHCA.	Allocation based on BCBSVT and MVP distribution.
- Workers' Compensation	Includes the medical component of workers' compensation claims. Some of these claims are self-insured and some are private insurance.	Calculated with data from A.M. Best, the National Council on Compensation Ins., and the National Academy of Social Ins.	Allocation based on 2009 workers' compensation medical payments in Oregon.
<u>Medicare</u>	Includes expenditures made by the federal government on behalf of beneficiaries of the national Medicare program, including the elderly and disabled.	2008 claims data for Medicare beneficiaries who are VT residents regardless of location of covered services received, and inflated by a 3-year average increase, with adjustments for drugs and admin.	Actual reported 2008 claims data for VT beneficiaries.
<u>Medicaid</u>	Includes health expenditures for beneficiaries of VT's medical assistance program, a federal-state health insurance program for certain low-income and medically needy people and aged, blind, and disabled residents. The program provides medical and prescription drug coverage.	2009 Medicaid expenditure claims data prepared by AHS. Global Commitment, Long-Term Care, SCHIP, and MCO Investments are included in the data.	Actual reported claims data and input from AHS.
<u>Other Government Federal</u>	Includes federal expenditures to operate the V.A. Hospital, grants administered by the VT Dept. of Health for health care services not covered through the Medicare or Medicaid program, and expenditures on federally qualified health centers.	2009 data from the V.A. Hospital, AHS, and the Bi-State Primary Care Association.	Allocation based on input from AHS.
<u>Other Government State & Local</u>	Includes public health activities and payments made by the state government for health care services that are not covered through the Medicare or Medicaid program.	2009 data from AHS, the VT State Hospital, the V.A. Hospital, and DHCA.	Allocation based on input from AHS.

AHS	Agency of Human Services	BCBSVT	Blue Cross Blue Shield of Vermont
BISHCA	Department of Banking, Insurance, Securities and Health Care Administration	CIGNA	Connecticut General Life Ins Co of Amer.
DME	Durable medical equipment	DHCA	Division of Health Care Administration
NHE	National Health Expenditures model	ERISA	Employment Retirement Income Security (1974)
VPQHC	Vermont Program for Quality in Health Care	V.A.	Veterans' Administration
		SCHIP	State Children's Health Insurance Program

Appendix B

Definitions and Data Sources: Provider

Expenditure Categories	Definition	Data Sources for Provider Matrix	Allocation to Payers of Services	Forecast Method
<u>Hospitals</u>	Includes net revenues from all inpatient and outpatient acute care services and paid physician salaries and expenses at VT community hospitals, Brattleboro Retreat, VT State Hospital, and V.A. Hospital.	2009 data from all VT non-profit community hospitals, VT State Hospital, V.A. Hospital, and Brattleboro Retreat.	Payer as reported by hospitals. Unspecified expenditures allocated based on resident matrix.	NHE blend of hospital % projection increases and Community Hospital 2011 and 2012 budget limits, and Brattleboro Retreat 3-year moving average.
<u>Physician Services</u>	Includes revenue for all physicians (including osteopathic physicians), rural health clinics, federally qualified health centers, nurse practitioners, and physician assistants. Salaries and expenses paid for Vermont hospital-owned physician practices are excluded (see Hospitals).	2007U.S. Economic Census, inflated to 2009 with NHE data.	Allocation based on resident matrix. Represents total net practice revenue, not physician net income.	NHE physician % projections.
<u>Dental Services</u>	Includes revenue for dental and oral surgery services.	2007U.S. Economic Census, inflated to 2009 with NHE data	Allocation based on resident matrix.	NHE dental % projections.
<u>Other Professional Services</u>	Includes all revenue for services provided by licensed health care professionals who are not physicians or dentists and who directly bill for their services. Includes: chiropractic services, physical therapy services, podiatrist services, psychological services, and all other expenditures for services provided by health professionals that are not specifically identified.	Chiropractic, physical therapy, psychological, podiatrist, and other professional services data from 2007U.S. Economic Census, inflated to 2009 with NHE data	Allocation based on resident matrix.	NHE other professional % projections and VT 3- year moving average.
<u>Home Health Care</u>	Includes revenue from all services provided by home health agencies.	2009data from the VT Assembly of Home Health Agencies (non-profit agencies), Bayada and Associates in Physical & Occupational Therapy.	Payer expenditures as reported by VT Assembly of Home Health Agencies and Bayada.	VT 3- year moving average and NHE home health % projections.
<u>Drugs and Supplies</u>	Includes all revenue for prescription drugs and non-durable supplies that are purchased by prescription. Non-prescription drugs are included.	2009 Verispan, L.L.C. data (Henry J. Kaiser Family Foundation, State Health Facts Online) averaged with 2009 NHE drugs growth rate. Estimate for supplies added.	Allocation based on resident matrix.	Weighted average of NHE prescription drugs and non-durable medical supplies % projections.
<u>Vision Products & DME</u>	Includes all revenue for products that aid sight and for all services provided by optometrists and opticians. Also includes expenditures for durable medical equipment purchased from independent vendors.	2007U.S. Economic Census, inflated to 2009 with NHE data	Allocation based on resident matrix.	Weighted average of NHE other professional and durable medical equipment % projections.
<u>Nursing Home Care</u>	Includes all revenues received by nursing homes, including intermediate care facilities and skilled nursing facilities.	Expenditure data reported to AHS Division of Rate Setting for 2009. Estimates added for non-Medicaid homes.	Government expenditures allocated as reported by nursing homes to AHS. Private expenditures distributed based on resident matrix.	VT 3- year moving average and NHE nursing home % projections.
<u>Other / Unclassified Health Services</u>	Includes all services not specified elsewhere, including college health fees, office-based business health spending, and some public school health spending.	University of Vermont, Vermont Department of Education, others.	Payer as reported by provider.	NHE other personal health care % projections.
<u>Admin/Net Cost of Health Insurance</u>	Includes the administrative costs of health care programs. Net cost is the difference of premiums earned and benefits incurred and includes administrative costs, as well as, additions to reserves, rate credits and dividends, premium taxes, and plan profits or losses and is estimated separately.	2009 data by provider service category. Other private commercial insurance expenditures were calculated from the 2009 Annual Statement Supplement filed with BISHCA	Reported directly by Payer.	N/A
<u>Government Health Activities</u>	Includes all expenditures for health activities through AHS, public mental health funding, case management services, and VT Department of Corrections health-related spending. State and Federal grants and DHCA expenditures are also included.	AHS and DHCA.	Allocated as reported by AHS. AHS does not include employee or operating costs, only grant programs. DHCA includes employee and operating costs and contract with VPQHC.	Medicaid annual increases projected separately based on Global Commitment upper limits.