URGENT SCARE

The price of health care plans in Vermont has doubled in six years. The prognosis for cost containment is grim.

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The Community Health Centers of Burlington recorded 165,000 patient visits last year, 35,000 more than five years ago. One out of every 10 visits now requires translation services, and hundreds of checkups are performed not in a doctor's office but on the streets, in the woods and wherever else backpack-carrying providers can find patients of an increasingly needed homeless outreach program.

CEO Jeffrey McKee and his staff have never worked harder. Yet the center is quickly going broke, unable to cover growing expenses — starting with the cost of its own workers' health care.

The Chittenden County provider is projecting a $2 million budget gap largely driven by rising health insurance costs. Next year, it will pay 55 percent more for plans than in 2022.

"We're losing about $300,000 a month," McKee said at a meeting with state officials and local health care leaders last month. "An organization our size cannot sustain that."

Similar conclusions are being reached all across Vermont — in hushed tones at dinner tables, behind closed doors at local businesses and during budget meetings at public schools. On this, there is no debate: Health care has become unaffordable and grows more so each year.

THERE IS NO HOSPITAL IN VERMONT THAT IS NOT IN JEOPARDY.

BRUCE HAMORY

The monthly cost of a typical plan on the state's insurance marketplace has doubled over the past six years — from $474 to $948 — and ranks among the country's most expensive. Individuals qualify for subsidies, but employers do not. They must absorb the hikes or pass the costs on to their workers.

Rising costs are leading more healthy people to consider ditching insurance entirely, a dicey proposition that could deepen Vermont's problem by further shrinking the risk pool and leaving it with a larger proportion of people who need costly medical services.

State regulators have responded by targeting the main driver of insurance premium hikes: hospital costs. But efforts to limit hospitals' budget growth have jeopardized their futures. Nine of the state's 14 hospitals, all nonprofits, lost money last year, and some have less than half of the minimum recommended cash reserves.

A law passed in 2022 known as Act 167 commissioned a report on Vermont's health care system and how it can be made more sustainable. Released this fall, the report made a dire prediction: Vermont's hospital system could need massive new cash injections merely to maintain the status quo.

"There is no hospital in Vermont that is not in jeopardy," said Dr. Bruce Hamory, a former infectious disease physician who authored the report. Hamory's recommendation: Push as much care out of the hospitals as possible and regionalize Vermont's siloed hospital system.

Included in the treatment plan was a bitter pill: Four rural hospitals — Gifford Medical Center, North Country Hospital, Grace Cottage Hospital and Springfield Hospital — should prepare for the day when they can no longer sustain their inpatient units. Those hospitals must start planning now for new ways to serve the community, Hamory said, perhaps by repurposing their space and staff to other needed services, such as long-term or mental health care.

FILE: DAVID SHAW

Paramedic Stephan Bryant bringing a patient into Brattleboro Memorial Hospital's emergency room

For Vermont's largest hospital, Hamory had a different message. The University of Vermont Medical Center is too expensive, he argued, and must find ways to be more efficient.

Hamory has stressed that his recommendations are just that — recommendations, or options for hospitals to consider when bills start piling up, as he expects they will. Rather than a strict road map, the report is meant to be a starting point for future planning, state officials say. But hospital CEOs see it differently. They are waging a campaign to discredit Hamory's suggestions, which they say would do more harm than good.

Simply putting the idea of closures on the table has hurt their communities, the hospitals contend. Last week, the Vermont Association of Hospitals and Health Systems issued a statement saying frontline health care workers are due an apology.

"They have been disrespected and disrupted by this work and they need to know they are valued," the statement said.

The uproar over the Hamory report has threatened to drown out a desperately needed conversation about the future of Vermont's health care system.

That worries Mike Fisher, Vermont's health care advocate, whose office hears daily from people who are delaying tests and procedures out of fear over the expected cost.

The report, at its most basic level, is a "prognosis," Fisher said, one defined not by some consultant but by the economics of rural health care.

JAMES BUCK

Jeffrey McKee

"It can't be, 'Should we change?' We have to change," Fisher said. "There is no path forward in our current approach."

OLD STORY

The reasons for Vermont's high insurance premiums are complex and intertwined, but much can be traced back to a familiar source: Vermont's aging population, now one of the country's oldest. The number of people over age 65 has nearly doubled since 2000, and one in three people will reach that age by 2040. Fewer babies are born each year, and, barring an influx of immigration, the workforce is projected to shrink in the coming decades.

All this will have major repercussions for the health care system.

Already, Vermont hospitals say they're treating more older patients, with increasingly complex and costly health-care needs, than ever before. Providing this care has become more challenging amid prolonged workforce shortages; labor costs have skyrocketed as stretched-thin staffs seek pay raises and hospitals fill shifts with expensive temporary workers.

Throw in growing drug costs, medical-supply inflation and the challenge of transferring patients into community-based facilities, and you're on your way to understanding why Vermont's hospitals are spending 50 percent more today — $3.6 billion — than five years ago.

"Old and rural is not a good model for cheap anything but especially not for cheap health care," Stephen Leffler, the president and chief operating officer of the UVM Medical Center, said at a public meeting last month.

Hospitals have raised their prices to cover their growing costs. Because Medicare and Medicaid increase rates for hospitals by limited amounts each year, these hikes fall hardest on commercial insurance companies. Vermont hospitals now have some of the highest prices in the country, according to an independent analysis from researchers at RAND.

What does this mean for Vermonters on private insurance? Again, demographics loom large.

Vermont insurance companies have been losing members as more people reach 65, leave the workforce and transition onto Medicare. The result is that a shrinking number of people are footing the bill for ballooning hospital costs.

The state has been trying to rein in hospital spending for more than a decade through ambitious reforms that seek to change the way Vermonters pay for health care. But there has been little to show for those efforts.

Former governor Peter Shumlin's yearslong pursuit of a single-payer model imploded in 2014 after he learned how much it would cost and abandoned the effort.

Four years later came the all-payer model, which sought to move Vermont away from a fee-for-service funding system to one that instead encourages preventive care by reimbursing providers a set amount per patient. But OneCare Vermont, the nonprofit that manages the system, never managed to corral enough patients and providers, and a recent analysis by state regulators found that the model may have cost more than it saved.

The task of curtailing Vermont's health care spending has instead fallen on the Green Mountain Care Board, a five-member panel appointed by the governor to regulate hospital budgets and insurance rates.

Vermont has a long-standing goal of keeping annual hospital budget growth to 3.5 percent. But hospitals routinely propose budgets that exceed this target and warn that any cuts will reduce access to health care.

The budget approval process has become a game of chicken, in which

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regulators must decide whether to grant the increases hospitals request or bear blame should, say, a birthing center be forced to shut down.

This tension plays out most publicly with the UVM Medical Center, whose $2 billion budget makes up two-thirds of hospital spending in the state. UVM Medical Center officials have repeatedly blasted the care board for trimming their proposals, but their predictions of revenue shortfalls haven't always come to pass.

When the care board cut the hospital's requested rate increase from 20 percent to about 15 percent in fiscal year 2023, for instance, the hospital called it a "severe blow" to access. In reality, though, the Burlington hospital saw far more patients than it expected that year, grossing $80 million more than projected.

Faced with an 8 percent budget increase request from the medical center this summer, regulators held their ground. Citing the hospital's recent overage, they instead ordered it to lower what it charges commercial insurers by 1 percent. It was a shot across the bow, intended to send a clear message: Vermonters cannot afford more increases.

The hospital responded by announcing plans to delay construction on a new surgical center, blaming the regulators. Then, last month, it formally appealed the care board's budget decisions, saying that unless the budget order were reversed, patient care would suffer.

No matter the ruling, health care costs will soon rise even higher for many.

That's because earlier this summer, the state's largest insurer, Blue Cross Blue Shield of Vermont, received permission from the care board to raise its premiums by roughly 20 percent next year.

The decision came after the Vermont Department of Financial Regulation, which audits insurance companies to ensure they can meet their obligations, raised the alarm over the insurer's financial outlook. Blue Cross was hurtling toward insolvency, the state watchdog said, and needed to quickly rebuild its reserves.

State regulators anticipated that many people wouldn't be able to afford the increases. But they reluctantly approved the request anyway, knowing that a bankrupt Blue Cross could threaten the entire health care system.

"We're plugging holes by putting fingers in leaks," said Owen Foster, the care board chair.

A RISKY BET

The Family Place was contributing $666 monthly per employee for health insurance when Stephanie Slayton came on as executive director last year. The Norwich nonprofit — one of 15 parent-child centers that offer a range of family-oriented services in Vermont — increased that contribution to $890 this year and will again increase it to $1,000 next year to prevent rising premiums from eating into employees' take-home pay.

The growing expenses have forced Slayton to make tough decisions: The Family Place has stopped offering scholarships or sliding-scale fees for its small, early childhood education program, for instance. But Slayton worries it won't be enough.

While the $1,000 contribution will cover premiums for cheaper health plans, it won't fully pay for the more robust plans that most of her employees say they need. The majority have families, and the nonprofit cannot afford to contribute extra toward the more expensive family plans.

During a recent recruitment push, in which employees were offered bonuses for referring new hires, Slayton said she received a harsh truth.

"All my friends are like me, moms with young children, and I think they'd be great [for the job]," one of her employees told her. "But the benefits are so abysmal, I'd never advise them to come here."

"I was so sad," Slayton said, "because I think people genuinely like their work here. But if you're a single parent, or a young family starting out … it's just an untenable situation."

The average price of health insurance coverage for a Vermont family was $25,588 last year, according to the Kaiser Family Foundation. That's double what it was a decade ago and $1,500 higher than the national average.

Employers who wind up absorbing those increases are attempting to cope with rising health care costs by charging more for their goods and services or cutting expenses. Others have no choice but to pass the price hikes on to their employees, sometimes wiping out annual raises.

The situation has threatened the growth of Vermont's economy by forcing some businesses to downsize or reassess planned expansions. Meanwhile, people who live here with insufficient health care coverage may delay care or consider ditching insurance entirely, at the risk of landing in massive medical debt.

"Affordable health care is critical for our demographic problem," Foster, the care board chair, said.

A pandemic-era expansion of federal subsidies has blunted the impact of rising premiums for those who purchase insurance plans though Vermont's state marketplace, created as part of the federal Affordable Care Act. Roughly 90 percent of the 30,000 people with such plans now receive some form of tax credits. But businesses, many of which are staring down a third straight year of double-digit increases, have had no relief.

Vermont's nonprofit sector — which employs roughly 70,000 people and provides vital safety-net services — has been hit particularly hard by premium hikes.

Many nonprofits only began offering health insurance within the past decade or so to better compete for workers. They rely on funding sources that cannot be easily scaled to keep pace with rising costs.

At another nonprofit parent-child center, in Montpelier, co-executive director Joe Ferrada said roughly half of his 40 employees have told him that they routinely consider delaying their health care because of the cost.

"They are choosing not to take care of their health beyond preventative care because they can't afford the deductible," he said.

It's not just small employers feeling the pinch. The University of Vermont recently announced that it was raising tuition for the first time in five years to help cover the cost of its employees' health care.

Days later, the trust that manages insurance plans for some 34,000 public school employees and their dependents across the state announced premiums would jump another 12 percent next year. That will drive proposed public school budgets higher, and administrators are again bracing for voters to reject them.

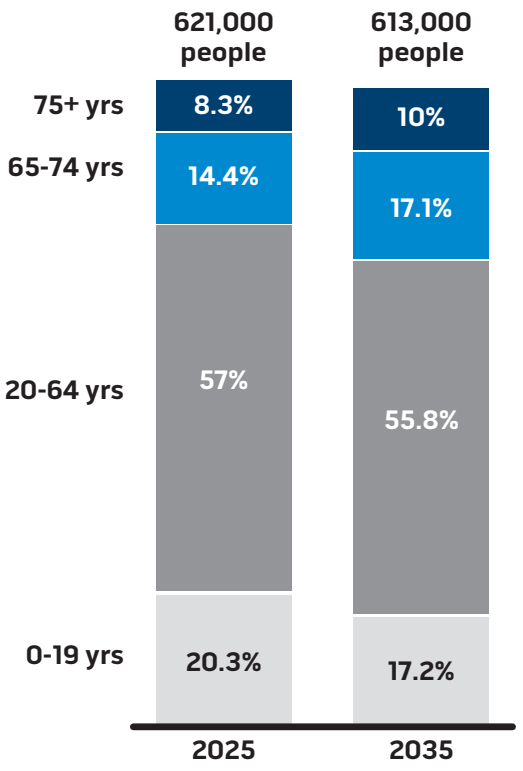
Rising premium costs worry Fisher, the health care advocate, because when health insurance markets are squeezed by high prices, a predictable trend occurs.

"Healthy people leave," he said. "Sick people? They've got to stay" — and pay even more.

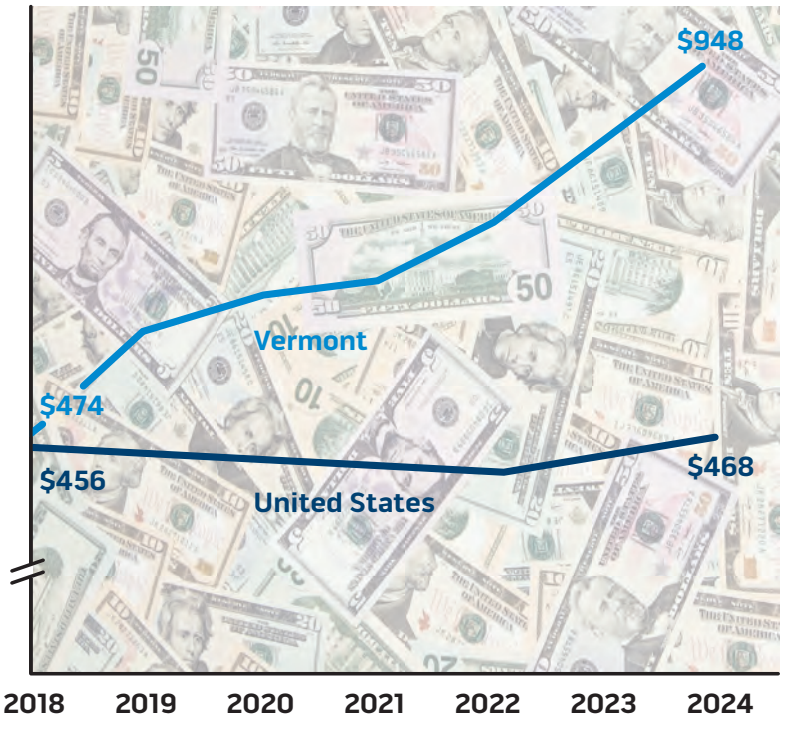
Insurance companies recognize the impact of high premiums and say they've tried to curb cost growth wherever possible. But that has its own ripple effects.

Small health care organizations, including independent physicians' offices, say private insurances companies don't pay them enough for the medical services they provide — and they have little leverage to

Projected Vermont population by age group



Average monthly premium for lowest-cost Silver marketplace premium



SOURCE: OLIVER WYMAN/GREEN MOUNTAIN CARE BOARD

A SHRINKING NUMBER OF PEOPLE ARE FOOTING THE BILL FOR BALLOONING HOSPITAL COSTS.

negotiate higher reimbursement rates. Some can go years without any increases, making it harder to cover their own increasing expenses, including recruiting and retaining employees.

The Community Health Centers of Burlington increased pay for its providers by a combined $1 million last year, "and we're still far behind the hospital," McKee said. Several providers have left over the past two years to work for other organizations "where the salaries are substantially higher and the work substantially easier."

The affordability gap could widen for Vermont workers over the next few years, even if insurers managed to keep premiums level.

The expanded tax subsidies are set to expire at the end of 2025 barring an extension from Congress, where Republicans and Democrats have long been at odds over health care initiatives. That could raise the cost on individuals by hundreds of dollars overnight and lead more to question whether insurance is worth the investment.

Elizabeth Courtney, a marketing professional from Wolcott, is already considering that question.

Courtney is enrolled in a Blue Cross Blue Shield family plan that also covers her husband and their two children. A subsidy has lowered the cost of their monthly premium by nearly $2,000, Courtney said, but they still have a nearly $13,000 deductible before the plan kicks in.

"My kids get to see the doctor once a year for free. Everything after that, we pay for out of pocket," Courtney said.

The only real benefit of the plan is that it provides a safety net in the event of a costly catastrophic medical event, Courtney said. Should the subsidies expire, however, she'd consider opening up a health savings account, into which she could deposit the money she'd otherwise pay toward premiums and use it to pay her family's medical bills.

"And hope for the best," she said.

TAKING THE MEDICINE

Bruce Hamory spent more than a decade as an executive at Geisinger, a rural Pennsylvania hospital system, where he confronted some of the same headwinds that have battered rural hospitals all across the U.S.

Now a partner and chief medical officer at the New York City-based consulting firm Oliver Wyman, Hamory spends his time helping health care systems become more sustainable before they run into trouble.

He spent a year in Vermont meeting with hospital leaders, state officials, health insurers and patients. He reviewed budget documents, data submissions and demographic trends.

His takeaway: A storm is forming over the Green Mountains.

Vermont hospitals will need $700 million to $2.4 billion in additional revenue over the next five years to break even, according to his analysis. Another $700 million dollars will be required to achieve the margins typically needed to borrow money to fix up aging buildings and equipment.

Vermont faces a choice, Hamory said. It could allow hospitals to go under and hope that the market fills the void. It could cling to the status quo and put yet more pressure on commercial insurers. Or it could change the system in a way that prevents unplanned closures and preserves access to care.

He called for big-picture items that the state has been working on for years: more housing, a stronger emergency medical system, including first responders in rural areas. But his most substantive and controversial recommendations involve hospitals themselves, which he said must prepare now for an unavoidable financial crunch.

He singled out four of the smallest, most rural hospitals — Gifford Medical Center, North Country Hospital, Grace Cottage and Springfield Hospital — that he said face the direst financial forecasts.

"Every prediction I can make, with every trick I know to pull, says that within three to five years, your bank will call the bill and close you," Hamory said during a presentation to the care board in August. "You need to be prepared."

In addition to closing their inpatient units, those hospitals should consider converting their emergency departments into less expensive urgent care centers, Hamory said.

He recommended that Vermont's other hospitals ditch low-volume procedures and look to jointly employ physicians as a first step toward a more regional approach.

Finally, Hamory had specific recommendations for the UVM Medical Center. He cited a pair of analyses provided to the care board that suggest the hospital is among the more expensive in the country and has one of the highest administrative-to-clinical costs.

UVM Health Network officials have said those findings rely on flawed data and that their own internal analyses show they perform well compared to peer hospitals. Hamory said it doesn't matter.

Vermont's biggest hospital "is too expensive," he said.

Hamory believes his recommendations could save Vermont upwards of $400 million over the next five years, if fully implemented. That money could be reinvested in the infrastructure that's needed to care for more patients in cheaper settings, including at home.

Lawmakers and health care regulators involved in the passage of Act 167 have given Hamory's work mostly positive reviews. They didn't agree with all of his recommendations — several were wary, for instance, of the idea that Vermont could afford to lose North Country Hospital, which serves the most rural part of the state. But they said the report offered a solid foundation for planning the system's future.

Hospital leaders disagree.

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Mike Fisher

They accused Hamory of failing to recognize their importance to local communities and said the bulk of his recommendations have no basis in reality. They have also dismissed Hamory's financial projections as unreliable doomsday thinking.

Some suggest Hamory devised his analysis to reach a foregone conclusion.

"If I were a pessimist, I would think the consultant designed the report exactly to create a burning political platform to change the system, rather than try to work through the existing problems that we have," said Michael Costa, the recently-hired CEO and president at Gifford Medical Center in Randolph. "It feels like a political document more than a policy document."

Mike Del Trecco, the president and CEO of the hospital association, said the suggestion that Vermont should restrict hospital growth even as facilities are seeing more patients than ever is dangerous and misguided. The only path forward must be an all-out effort to reverse the demographic trends at the heart of the problem, Del Trecco said, so that the state can keep investing in hospitals.

"We can't cut our way to prosperity here," he said.

The fact is, however, that Vermont has been trying to attract more young families for three decades with little success.

Time is running out, according to Hamory. Maintaining the status quo over the coming years would lead to only one outcome, he said: People will go bankrupt — and hospitals will soon follow.

WHO WILL LEAD?

The Vermont Agency of Human Services successfully lobbied lawmakers to amend Act 167 last year so that the agency, rather than the Green Mountain Care Board, would be in charge of vetting Hamory's recommendations. A transformation of the health care system, legislators reasoned, would require the participation of those beyond the care board's reach.

That means the job of leading Vermont through this thorny conversation is now the responsibility of Gov. Phil Scott and his administration.

Some lawmakers wonder whether the governor's up for it.

"The administration has shown very little willingness to take this sort of role in the schools conversation, leaving a lot of that up to the local decision makers," said Rep. Lori Houghton (D-Essex Junction), chair of the House Health Care Committee. "We cannot go through the same process here with hospitals because of how interconnected they all are."

"I'm skeptical," Sen. Ruth Hardy (D-Addison) said. The governor is "pounding Democrats on affordability right now, and one of the least affordable systems in our state is our health care system. If he's not willing to lead on this, then that will be frustrating and telling and will make it harder for us to move forward."

Amanda Wheeler, a Scott spokesperson, responded that the governor has offered proposals for making schools more cost-effective — most of which the legislature has not acted on — and believes similarly in the need for Vermont to "rethink" how it delivers health care.

"We are in the early phases of our policy development process, so next steps on what healthcare policy changes the Governor may put forward in January, if reelected, are still to be determined," Wheeler wrote in an email.

AHS officials say they're approaching the work with an open mind. The state's role will be to "help these communities make the right decision for themselves," said Brendan Krause, the director of health care reform at AHS.

"I don't think we're at a phase yet where we're talking about mandating," he said.

The conversation will be unavoidable, however, if the state concludes that Hamory's projections have merit. After all, it is hard to imagine any of Vermont's hospitals willingly deciding to shutter their inpatient beds.

A more likely scenario is that hospitals will hold on for as long as they can — then scream for help. "The question for the legislature then," Hamory said, "as each of these hospitals goes belly up: How much money are they willing to provide?"

A BANKRUPT BLUE CROSS COULD THREATEN THE ENTIRE HEALTH CARE SYSTEM.

The threat of inaction is what most worries Fisher, the health care advocate. "I just hope that the Hamory report doesn't represent an opportunity for many of us to look back and say, 'We told you so,'" he said.

The Scott administration says the next phase of the sustainability planning could take a year or more.

In the meantime, businesses are wondering whether they will be able to afford next year's premium hikes.

Ironically there's no better illustration of the breadth and complexity of the problem than what McKee faces at the Community Health Centers of Burlington. He has been advocating for increased reimbursement rates from Medicaid, which covers roughly one-third of its patients, and Blue Cross. But he said he's received no assurances.

At last month's meeting with state officials, he said he would need to sign off on service cuts in the next few months. The programs most at risk are those that lose money, he said, including outreach clinics for the homeless, elderly and people who don't speak English.

"It pains us all to even be thinking about that," he said, "but if we don't do that as an organization, we will not survive."

Sitting across from McKee was Leffler, UVM Medical Center's president, who had already spoken at length about how his hospital needs much more financial support. He listened intently, nodded his head, then told the room he had heard the same warning from McKee two weeks earlier, at a meeting that left him feeling "scared."

The hospital is already filled with people who could have their needs better met in other settings, Leffler said. Every program McKee closes, he warned, "will just make our ER busier." ⑦