Public Comments On the Draft "Hsiao" Report

Feb. 3, 2011

Dear Dr. Hsiao and team members:

The Healthcare Is a Human Right Campaign thanks you for preparing this encouraging and immensely helpful report, which we see as a crucial milestone in Vermont's movement toward universal healthcare. We greatly welcome your valuable contribution to establishing a healthcare system in Vermont that works for everyone.

As with all important pieces of research, your report raises many questions for us, which we respectfully submit below. We thank you for your consideration and are looking forward to your answers, which will serve to strengthen our efforts to achieve universal healthcare in Vermont.

Respectfully,
Cassandra Edson, Policy Committee Member
Healthcare Is a Human Right Campaign
Vermont Workers' Center

Questions and Comments to Dr. Hsiao Concerning the Draft Report

1. **Human Rights Principles - generally:**
   Please include information in the report showing how the three reform options meet the principles of universality, equity, participation, transparency and accountability, as well as making healthcare a public good. This is required by Act 128, Sections 2.1, 2.2, 2.6, and 8(a).

2. **Human Rights Principles - timeframe:**
   Why did you propose to begin universal coverage as late as 2015? Given the human rights crisis - people are dying due to lack of healthcare - is there some way to begin universal coverage earlier? Please explain in detail what the government has to do over the next two years to start implementing your recommended option, and what factors could contribute to accelerating this process.

3. **Human Rights Principles - economic modeling:**
   a. Could you include additional questions or variables in your macro-economic model - questions that quantify the human rights benefits of health care reform? Please try to estimate the

economic effects resulting from a healthier population (e.g. increased productivity) and increased numbers of primary care providers (e.g. increased economic activity in rural locations). For example, the Institute of Medicine's 2004 report on the consequences of not having health insurance includes a discussion of cost savings that can be found when individual are able to get the care they need, when they need it, instead of waiting to get care until they are unnecessarily sicker, and when individuals are not victims of job lock. These potential savings do not appear to be addressed in the proposal; please provide estimates of these cost savings.

   b. Did the GMSIM accurately predict the economic situation Massachusetts found itself in? Where it was wrong? Were any errors corrected and the GMSIM made more effective?
   c. Can you please provide the empirical evidence to support the assumption that employer savings will be passed to workers as increased wages?

4. **Universality - access:**
   a. A system that excludes undocumented residents cannot be considered universal. Please include Vermont's undocumented residents in your modeling of cost and savings.
   b. It appears that Medicare recipients are excluded from all design options. Yet many Medicare recipients do not have access to the care they need, as they are unable to obtain secondary plans (even through the state of Vermont) due to the monthly cost. Would this population then be covered by Vermont's new system, to the extent that Medicare does not offer sufficient benefits to meet their health needs, or would the new system only provide wrap-around coverage for those Medicare recipients who are income-eligible for Medicaid? Will working Medicare recipients be subject to the payroll tax? Would employer and individual Medicare Supplement plans remain in existence under these designs?
   c. Please explain whether your proposal includes access to healthcare for workers injured on the job, so that injured workers would no longer have to navigate the workers' compensation process to get the healthcare they need?
5. **Universality - comprehensiveness:**
   a. Act 128 requires that each option contain two benefit packages, but the report only includes information and cost estimates for an essential benefit package in Option 3. Please add the comprehensive benefit package to Option 3 in your report.
   b. The principle of universality requires that everyone has coverage for all needed healthcare, including home- and community-based services, services in nursing homes, payment for transportation related to health services, and dental, hearing, and vision care. Can you please provide cost estimates for including all these benefits? In particular, please include full coverage of dental care in one of the plans and provide a cost calculation.
   c. Please clarify whether under the essential benefit plan dental care is only available for children. If so, why is dental care for adults not classified as preventive care? Please explain your rationale for excluding adults from dental care.
6. **Equity - access:**
   a. How did you estimate at what level co-pays and co-insurance would deter lowincome people from getting needed healthcare? It seems that co-insurance of 20% for a hospital stay (plus Medicare deductible), or any payment for receiving emergency care, or 25% co-insurance for brand prescription drugs (all proposed in the essential benefits package) may deter the use of needed care and/or threaten a family's financial health. How were the proposed amounts for out-of-pocket costs decided? What is the quantitative difference between the out-of-pocket costs you propose and the costs born by an under-insured Vermonter today? How do you guarantee that out-of-pocket expenses do not lead to people foregoing necessary care?
   b. Please explain how you calculated the cost-sharing limit of 10-12% of income. As cost-sharing is in addition to the payroll tax, this amount seems unreasonably high.

7. **Equity - financing:**
   a. As the report acknowledges, a payroll tax (proposed to retain the federal tax exemption for health insurance) is more regressive than an income tax. Why was the payroll tax designed as a flat tax (rather than progressive with different brackets), so that high earners pay a much smaller percentage of their income? Why was the payroll tax designed with a cap - a further benefit for high earners? These elements of the proposed financing mechanism do not confirm to the principle in Act 128, which mandates financing to be equitable. To make this proposal more equitable, can you please revise the design of the payroll tax and also include a tax on unearned income and an increase in corporation taxes? Please provide a calculation for making the financing more equitable.
   b. Would a payroll tax exemption for low-wage employers encourage businesses to pay lower wages? Human rights principles do not permit us to reward businesses - e.g. international fast food chains operating in Vermont - for using exploitative practices. Rather than exempting low-wage employers, could you please provide alternative cost estimates about, firstly, exempting small employers (5 employees or less) and, secondly, taxing businesses on their profitability?
   c. Can you explain why your recommended proposal shifts a sizable portion of the system's costs onto sick people (via co-pays and co-insurance)? What is the reason for placing a greater burden on sick people rather than sharing the costs among all of us? Doesn't this discriminate on the basis of health status? How sustainable is a system that bases its financial viability on sick people paying for it?
8. **Public Good & Accountability:**
   a. A health system that serves Vermonters should be accountable to Vermonters, yet it is unclear what accountability would look like under the report's three options. Could you please be more specific with regard to how each option will make the system more accountable to the people?
   b. Option 3 proposes to outsource and subcontract key elements of the healthcare system, even though Act 128 recognizes healthcare as a public good. We have overwhelming evidence that outsourcing and subcontracting reduces transparency and limits oversight by the people. Where internationally have you encountered any advantages of outsourcing and subcontracting? Isn't Taiwan's system publicly administered? Why does Option 3 propose contracting out the administration of the system? How will Option 3 guarantee that no contractor will be in a position to deny access to care or to mismanage funds?
   Specific questions concerning the contractor's role:

      i. Will the contractor make coverage decisions for individual patients? In other words, who decides whether a particular patient gets a service/claim covered?
      ii. If the contractor decides claims, is there an incentive for it to deny claims?
      iii. Would the contractor control the appeals process?
      iv. Would the governance procedures allow the contractor to be overridden or would the contractor's decisions be final?
   c. How will ACOs satisfy the principle of accountability? Can you please explain how the system will ensure that all Act 128 principles are satisfied if ACOs are used?
   d. Please explain what role community health centers (FQHCs) will have in the new system, given that they already deliver healthcare as a public good, especially to those who most need it, and have thus helped protect people's human right to healthcare.
9. **Accountability & Transparency - effective and efficient use of funds:**
   a. What is the evidence for the additional savings produced by Option 3 over Option 1? We understand that "streamlined management" is supposed to produce a small amount (0.5% more

than Option 1) in additional savings, but we do not understand how involving additional entities combined with potentially complex bidding and oversight procedures, could be seen as "streamlined" procedures that produce savings. Where are the projected savings supposed to come from? Could a streamlined management structure "that is able to reduce costs through administrative efficiencies and greater leverage in negotiating payment rates and benefit package levels" be transferable to option #1? Please explain.

b. We did not see any proposals for controlling the prices of prescription drugs charged by the pharmaceutical industry. How are you proposing to control costs and avoid that having increased drug costs shifted to patients?
c. How would a no-fault medical-malpractice system be funded? Would it continue to use private malpractice insurers?
d. Have you estimated the cost of providing a "just transition" (such as employment counseling, re-training and other transition costs) for displaced workers?

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