

## **Responses to the Senate Health and Welfare Committee Questions on the Hsiao Report**

### **Payroll tax and employer/employee impacts**

Q: How was the calculation made that the payroll tax will decrease over time?

A: For the first several years after reforms are implemented, substantial one-time savings will reduce the annual growth rate in health spending below the projected growth rate of the state payroll. Once all initial savings have been achieved, we believe that on-going savings that result from changes in payment and organization will continue to bend the cost curve and keep spending growth below what we have seen historically

Q: Are there federal subsidies that can aid small companies that will “bear the burden” of the payroll tax?

A: Yes, to the extent that we are able to use tax subsidies that are part of federal reform

Q: Would the payroll tax be considered a deductible business expense?

A: Yes.

Q: What businesses will be affected by the payroll tax? For example, a hairdresser employing 7 people, a 10 person company paying minimum wage, etc.

A: In our model, we based the payroll tax solely on the wage level of each employee. The legislature may want to consider other approaches, such as incorporating the number of employees in a company.

Q: How do you define a low wage employer?

A: For modeling purposes, we used a cut-off of 200% of FPL (just under \$22,000 for an individual in 2011). In the report we recommend a more gradual approach, with a lower FPL for complete exemption and a partial exemption to a higher level.

Q: The report talks about a “minimum threshold wage”. Does this account for seasonal, part-time, and/or low-wage employees?

A: Our analyses and recommendations were developed at a conceptual level. The report did not address this level of detail – it is based on FAMILY income level. We believe that the specifics of how the payroll tax would operate, such as exemptions, are best decided by the legislature.

Q: Can you provide an examples and/or scenarios of how people (e.g. a state employee, household of a state employee, etc.) might pay more or less out-of-pocket (in premiums versus payroll tax, etc.) under the new system versus the current system?

A: See attached examples

Q: How will people without jobs contribute to the system? For example, wealthy people not needing employment.

A: Because we recommend a payroll tax as the sole source of NEW funding, those without wage and salary income will not contribute. We picked that approach to maximize deductibility for federal taxes. Other options for financing are certainly possible.

Q: Will undocumented workers have access to health care?

A: In our model, we assume that they wouldn't. Currently, Medicaid and the exchange require documentation under federal law.

### **Jobs**

Q: How many jobs will be created? How many jobs will be lost? By when?

A: See attached analysis.

Q: Has the unemployment cost of transitioning employees been calculated into the costs? What are the demographics of the "lost jobs" population? For example, if a segment of the population is near retirement age, will they just retire instead of reentering the workforce?

A: In response to comments that we received, the final version of the report includes an estimate of retraining costs, based on our estimate of job losses and the Annual Report required by the Vermont Workforce Investment Act. We estimate that about 1,500 workers would need retraining, at a cost of about \$6,700 per worker, or about \$10 million. We were unable to find a source of demographic information on these workers.

### **Integrated Delivery system**

Q: How will ACOs be established? Can we have a clearer example of what it will look like?

A: There is no specific model for how ACOs will develop. The organization and operation are likely to differ across the state, depending in part on how care is currently organized and delivered.

Q: Who and how are the measures for pay-for-performance determined?

A: There are a wide range of measures currently in use. Which measures are selected and who selects them will be determined as part of enacting statutes and writing rules.

### **Costs & Savings**

Q: Is there a balance sheet for the cost of setting up the new system?

A: We haven't developed one. A balance sheet can be built once a specific proposal is developed.

Q: Does the report assume savings from using a bid-process rather than a no-bid process and if so, how is that calculated?

A: Yes. Based on his experience, Professor Hsiao believes that a periodic competitive process acts as an incentive to develop more efficient systems.

## **Migrations**

Q: Will there be residency requirements for receiving health insurance. In Tennessee, in-migration strangled the TennCare program. What data source was used to rule out in-migration as a problem?

A: We were unable to find any information on the impact of in-migration on TennCare. We looked at an analysis done by the Vermont Agency of Human Services that examined the impact of changing welfare benefits on migration. We also looked at the state's experience when it created the VHAP program. Neither of these indicated in-migration as a consequence of benefit changes.

## **Actuarial**

Q: Can you explain what is meant by "risk adjustment mechanisms" (as mentioned on page 13 of the report)?

A: Risk adjustment is a tool to compensate providers and carriers that take responsibility for sicker patients. Risk adjustment mechanisms may include patient age, presence of chronic illnesses, and utilization of care. For example, a provider whose patients are estimated to require 10% more care than the average patient will receive a capitation rate that is 10% higher than average.

Q: Is the Medicare RBRVS fees schedule the same as what we generally refer to in broader terms as Medicare rates or is it something different? For instance, on page 89, when it says Specialists would be paid on the Medicare RBRVS-based fee schedule, does that essentially mean they would be paid at the same rate they would have for the same service under Medicare?

A: RBRVS is a reimbursement mechanism that defines reimbursement in relative terms, rather than in absolute dollars. For example, under RBRVS, the most complex office visit (99215) is reimbursed 6.92 times higher than the simplest (99211). It is up to individual payers to translate these ratios into actual payment amounts. Currently, Medicare and many commercial payers use RBRVS and reimburse providers at different levels.

## **Other**

Q: Could supplemental insurance cause incentive to whittle away at the essential benefit package?

A: It is possible, but our study did not look at this possibility.

Q: Are we setting up a multi-tier system instead of a single payer system? For example, tier 1) Medicare, 2) Medicaid, 3) Essential Benefit Package, 4) Supplemental Insurance

A: There will be some unavoidable differences in benefits, as a result of federal law, but under our proposal, coverage will be universal and claims processing and reimbursement rates will be standardized.

Q: Why should any provider expect adequate payment after receiving the Government's budget cuts?

A: We believe that the negotiation model that is proposed under Option 3 will provide an effective mechanism to balance demand and cost containment pressures.

## Imaginary Company, Inc.

### Standard Wages, Standard Benefits

Employee	Salary	Insurance	Premium		Payroll Tax	
			75% Employer	25% Employee	10.9% Employer	3.6% Employee
1	\$90,000	2	\$11,578	\$3,859	\$9,810	\$3,240
2	\$80,000	F	\$15,919	\$5,306	\$8,720	\$2,880
3	\$60,000	1	\$5,789	\$1,930	\$6,540	\$2,160
4	\$45,000	2	\$11,578	\$3,859	\$4,905	\$1,620
5	\$44,000	F	\$15,919	\$5,306	\$4,796	\$1,584
6	\$41,000	2	\$11,578	\$3,859	\$4,469	\$1,476
7	\$32,000	N	\$0	\$0	\$3,488	\$1,152
8	\$27,000	1	\$5,789	\$1,930	\$2,943	\$972
9	\$25,000	N	\$0	\$0	\$2,725	\$900
10	\$8,000	N	\$0	\$0	\$872	\$288
<b>Total</b>	<b>\$452,000</b>		<b>\$78,149</b>	<b>\$26,050</b>	<b>\$49,268</b>	<b>\$16,272</b>
<b>Average</b>	<b>\$45,200</b>					

**Difference---->**      **(\$28,881)**    **(\$9,778)**

Premium Factor (1 = SOV Select Care)      1  
 Wage Factor (1=average)      1

### Standard Wages, Lower Benefits

Employee	Salary	Insurance	Premium		Payroll Tax	
			75% Employer	25% Employee	10.9% Employer	3.6% Employee
1	\$90,000	2	\$9,262	\$3,087	\$9,810	\$3,240
2	\$80,000	F	\$12,735	\$4,245	\$8,720	\$2,880
3	\$60,000	1	\$4,631	\$1,544	\$6,540	\$2,160
4	\$45,000	2	\$9,262	\$3,087	\$4,905	\$1,620
5	\$44,000	F	\$12,735	\$4,245	\$4,796	\$1,584
6	\$41,000	2	\$9,262	\$3,087	\$4,469	\$1,476
7	\$32,000	N	\$0	\$0	\$3,488	\$1,152
8	\$27,000	1	\$4,631	\$1,544	\$2,943	\$972
9	\$25,000	N	\$0	\$0	\$2,725	\$900
10	\$8,000	N	\$0	\$0	\$872	\$288
<b>Total</b>	<b>\$452,000</b>		<b>\$62,519</b>	<b>\$20,840</b>	<b>\$49,268</b>	<b>\$16,272</b>
<b>Average</b>	<b>\$45,200</b>					

**Difference---->**      **(\$13,251)**    **(\$4,568)**

Premium Factor (1 = SOV Select Care)      0.8  
 Wage Factor (1=average)      1

### Standard Wages, Doesn't Offer

Employee	Salary	Insurance	Premium		Payroll Tax	
			75% Employer	25% Employee	10.9% Employer	3.6% Employee
1	\$90,000	2	\$0	\$0	\$9,810	\$3,240
2	\$80,000	F	\$0	\$0	\$8,720	\$2,880
3	\$60,000	1	\$0	\$0	\$6,540	\$2,160
4	\$45,000	2	\$0	\$0	\$4,905	\$1,620
5	\$44,000	F	\$0	\$0	\$4,796	\$1,584
6	\$41,000	2	\$0	\$0	\$4,469	\$1,476
7	\$32,000	N	\$0	\$0	\$3,488	\$1,152
8	\$27,000	1	\$0	\$0	\$2,943	\$972
9	\$25,000	N	\$0	\$0	\$2,725	\$900
10	\$8,000	N	\$0	\$0	\$872	\$288
<b>Total</b>	<b>\$452,000</b>		<b>\$0</b>	<b>\$0</b>	<b>\$49,268</b>	<b>\$16,272</b>
<b>Average</b>	<b>\$45,200</b>					

**Difference---->**      **\$49,268**    **\$16,272**

Premium Factor (1 = SOV Select Care)      0  
 Wage Factor (1=average)      1

### Higher Wages, Lower Benefits

Employee	Salary	Insurance	Premium		Payroll Tax	
			75% Employer	25% Employee	10.9% Employer	3.6% Employee
1	\$117,000	2	\$9,262	\$3,087	\$12,753	\$4,212
2	\$104,000	F	\$12,735	\$4,245	\$11,336	\$3,744
3	\$78,000	1	\$4,631	\$1,544	\$8,502	\$2,808
4	\$58,500	2	\$9,262	\$3,087	\$6,377	\$2,106
5	\$57,200	F	\$12,735	\$4,245	\$6,235	\$2,059
6	\$53,300	2	\$9,262	\$3,087	\$5,810	\$1,919
7	\$41,600	N	\$0	\$0	\$4,534	\$1,498
8	\$35,100	1	\$4,631	\$1,544	\$3,826	\$1,264
9	\$32,500	N	\$0	\$0	\$3,543	\$1,170
10	\$10,400	N	\$0	\$0	\$1,134	\$374
<b>Total</b>	<b>\$587,600</b>		<b>\$62,519</b>	<b>\$20,840</b>	<b>\$64,048</b>	<b>\$21,154</b>
<b>Average</b>	<b>\$58,760</b>					

**Difference---->**      **\$1,529**    **\$314**

Premium Factor (1 = SOV Select Care)      0.8  
 Wage Factor (1=average)      1.3

### IMPORTANT NOTES

This is from the employer's perspective - impacts on families will be different, depending on family composition.  
 This does not include any exclusions from the tax.  
 This is based on report recommendations - it does not reflect any proposed legislation.

1 = Single      F = Family  
 2 = Two-person      N = doesn't purchase

Estimated Employment Impacts of Single Payer Option 3, 2015-2024

Industry	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Health	3.9	3.4	3.2	2.9	2.7	2.0	1.8	1.7	1.5	1.4
Insurance	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.6	-0.6
All Other	1.7	2.4	2.6	2.7	2.7	1.9	1.8	1.7	1.6	1.5
Total	5.1	5.4	5.4	5.1	4.9	3.4	3.1	2.8	2.5	2.3

Change is in thousands of employees, compared to current law (not PPACA).

Source: Kavet Rockler analysis, using REMI