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What Happened in Vermont: Implications of the Pullback from Single Payer

By Steffie Woolhandler, M.D., M.P.H., and David U. Himmelstein, M.D.

Gov. Peter Shumlin's Dec. 17, 2014, announcement that he would not press forward with Vermont's Green Mountain Care (GMC) reform arose from political calculus rather than fiscal necessity. GMC had veered away from a true single payer design over the past three years, forfeiting some potential cost savings. Yet even the diluted plan on the table before Shumlin's announcement would probably have lowered total health spending in Vermont, while covering all of the state's uninsured.

Background

Decades of exemplary grassroots organizing (and strong labor union support) in Vermont put single payer on the agenda. During Shumlin's 2010 gubernatorial campaign, he promised to implement a single payer reform, which was a factor in the Progressive Party's decision not to field a candidate. But the details of Shumlin's plan weren't fleshed out during the campaign.

After his victory, Shumlin and the legislature commissioned economist William Hsiao to study options for health reform in Vermont, including single payer. Rejecting a fully public single-payer plan, Hsiao instead proposed a "public-private hybrid" model and projected \$580 million in savings, including large administrative cost savings, in the program's first year.

Spurred by Hsiao's positive projections, in 2011 the legislature passed a health reform law that laid out plans for implementing the Affordable Care Act in the short term, and called for a later transition to a single payer GMC plan. But while the law gave a detailed prescription for implementing the ACA (including construction of an exchange whose final cost was about \$250 million), the sections on single payer were vague, and punted decisions on critical issues to the GMC Board to be appointed by the governor. That board would determine whether critical services like long-term care would be covered; the amount of copayments; how hospitals and doctors would be paid; and whether capital funds would be folded into operating budgets or allocated through separate capital grant (the *sine qua non* of effective health planning). Critically, the bill included no plan for funding the single payer program.

An early signal of trouble was Shumlin's appointment of Anya Rader Wallack to chair the new GMC board. Wallack had deep ties to the private insurance industry, having held key positions (including the presidency) at the Blue Cross Blue Shield of Massachusetts Foundation. That foundation played a central role in designing and pushing for Massachusetts' 2006 Romneycare reform, and subsequently issued a series of glowing evaluations of Romneycare that helped buttress the case for replicating its structure in the ACA.

From the outset, Shumlin and the GMC Board embraced an Accountable Care Organization payment strategy that would enroll most Vermonters in large hospital-based, HMO-like organizations that would be overseen by a "designated entity" – presumably Blue Cross. To-date, ACOs have shown little or no overall cost savings, have increased administrative costs, and have driven hospitals to merge and gobble up physician practices. The consolidation of ownership triggered by ACO incentives has raised concern that regionally dominant ACOs will use their market power to drive up costs. In Vermont, Dartmouth Hitchcock and the University of Vermont's Fletcher Allen system dominate the market, and have initiated a for-profit, joint venture ACO.

The GMC Board's design incorporated several other features that increased the administrative complexity, and hence administrative costs of the proposed reform. The plan never envisioned including all Vermonters in a single plan, instead retaining multiple payers. Hence, hospitals, physicians' offices, and nursing homes would still have had to contend with multiple payers, forcing them to maintain the complex cost-tracking and billing apparatus that drives up providers' administrative costs. It proposed continuing to pay hospitals and other institutional providers on a per-

patient basis, rather than through global budgets, similarly perpetuating the expensive billing apparatus that siphons funds from care. And hospitals would have continued to rely on surpluses from day-to-day operations as their main source of capital funds for modernization and expansion. This undermines health planning and raises bureaucratic costs by forcing hospital administrators to undertake the additional work needed to identify and pursue profit opportunities.

Some of this complexity was forced on Vermont by federal statutes that may preclude folding Medicare and the military's Tricare program into a state single payer plan, and restrict states' ability to outlaw private employer-provided coverage that duplicates the public plan. But the decisions to abandon lump-sum hospital payment, and separate grants for capital were the GMC Board's choices.

The End Game of Vermont's Reform

Vermont's November 2014 gubernatorial election had very low voter turnout, a circumstance that generally favors the right. Gov. Shumlin – who had hedged on health reform during the campaign – eked out a narrow plurality, leaving the state legislature to decide between him and the Republican candidate and greatly weakening Shumlin's position. A month later, while awaiting the legislature's decision (they elected him to a third term on January 9), Shumlin announced his pullback from reform.

Shortly thereafter, he released the GMC Board's detailed cost projections which he said had convinced him not to go ahead. The Board estimated zero administrative savings from its proposed plan. It also projected zero savings on drugs and medical devices, tacitly acknowledging that GMC wouldn't use bargaining clout to rein in prices, and ignoring the fact that Quebec, its neighbor to the North, has gotten big discounts.

The Board's cost estimates also incorporated an old (too high) estimate of the number of uninsured Vermonters, inflating the projected increase in utilization and cost. Finally, it assumed that doctors would expand their work hours (and incomes) to care for the newly insured, rather than maintaining their current work hours by seeing their other patients a little less frequently – as happened with the implementation of single payer coverage in Quebec.

But even the GMC Board's inflated cost estimates indicate that universal coverage under its quasi-single payer plan would cost somewhat less overall than the current system. The voluminous Board report includes detailed tabulations of new costs to the state treasury under the proposed reform. But the report scrupulously avoids providing any figures for the impact of reform on the total cost of health care (public and private) in the state. Economist Gerald Friedman has estimated these overall impacts using the report's data, previous estimates of health expenditures in Vermont, and CMS figures on Medicare spending and expected health care inflation under the ACA. He estimates that even the diluted reform proposed by the GMC Board would cut overall health spending in Vermont by about \$500 million annually.

So why did Gov. Shumlin declare the reform unaffordable? Many have noted that the \$2.5 billion in new state expenditures required under the reform would nearly double the state's previous budget. But these numbers are meaningless absent an accounting of the savings Vermont households would realize by avoiding private insurance premiums and out-of-pocket costs. As detailed above, these savings would more than offset the new taxes.

But although the total costs of care would have fallen even under the GMC plan, some – mostly higher-income, healthy Vermonters whose taxes would go up the most – would have paid more. Although the GMC tax plan was far from progressive, it was far less regressive than the current pattern of health care funding in the state. The GMC Board estimated that most of the 340,214 families earning less than \$150,000 annually would have gained, while most of the 24,102 families above that income level would have lost. Overall, employers' costs would have risen by \$109 million – with many small businesses experiencing cost increases, a political sore point.

Conclusion

It's a misnomer to label Vermont's Green Mountain Care plan "single payer." It was hemmed in by federal restrictions that precluded including 100 percent of Vermonters in one plan, and its designers further compromised on features needed to maximize administrative savings and bargaining clout with drug firms, and improve health planning.

But even the watered-down plan that emerged could have covered the uninsured, improved coverage for many who currently face high out-of-pocket costs, and actually reduced total health spending in the state – albeit far less than under a true single payer plan. A true single payer plan would have made covering long-term care affordable, and allowed the elimination of all copayments and deductibles.

Vermont's experience holds important lessons for single payer advocates.

1. Effective grassroots organizing makes a difference. It got real health care reform on the political radar screen in Vermont, and can get it back on the radar there and elsewhere. Indeed, single payer forces in Vermont are already rallying to reverse Shumlin's decision. The virtues, value, and simplicity of a single payer approach have broad popular appeal.
2. Federal restrictions impose significant compromises on state-level single payer plans. For this, as well as other reasons, organizing for single-payer state plans and organizing for national legislation are not competing strategies, but complementary ones. The ultimate goal for both is a single, inclusive program for the entire nation.

3. As single payer work advances, we need to anticipate that corporate opposition will mobilize – often behind the scenes. The only effective antidote is continued grassroots mobilization. Delayed implementation and punting key decision to the future opens the door for corporate influence and smear campaigns.
4. Beware of “experts” with a track record unsympathetic to single payer. Economic projections are always based on assumptions, which are often highly political.
5. Even when we don’t get the whole pie, demanding it often yields a significant piece. Although a major single payer effort was stymied in Vermont, it achieved substantial progress. It’s no accident that Vermont’s uninsurance rate has come down to 3 percent; that virtually all children in that state are covered; that its Medicaid program is among the best; that its hospitals have come under tighter fiscal regulation; and that single payer remains in the limelight there. Even as he backed off from single payer for now, the governor promised to press for future health reform.

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