

Vermont's Great Experiment in "Single Payer" Healthcare

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Vermont, which politically veers to socialism, has a long history of healthcare reform efforts. Tinkering with healthcare delivery has been a favorite pastime for governors past and present. However, now for the first time vast amounts of federal money are being sunk into this effort. Although Vermont has a population of only 630,000 residents, our small state has to date received more than \$400 million in federal funds, and the spigot is still flowing.

Vermont has become a Petri dish for "ObamaCare." President Obama initially wanted something closer to single payer, but had to compromise, setting up healthcare "Exchanges" instead. Still, his administration has been pouring funds into Vermont so that Governor Peter Shumlin can try to do what President Obama hasn't been able to do on a national basis.

Stated Goals

In his 2011 inaugural address Gov. Shumlin declared, "We must create a single-payer healthcare system that provides universal, affordable health insurance for all Vermonters that brings these skyrocketing costs under control. Let Vermont be the first state in the nation to treat healthcare as a right and not a privilege." Gov. Shumlin's theories about economics and justice are as well grounded as his medical theories, such as his assertion that "Americans born today live less long than their parents" and that "American health care costs are three to four hundred times [*sic*] the spending of other developed countries" while they "live longer and healthier than we do."¹

Two recent reports commissioned by the governor have estimated single-payer system cost savings. In 2011, the first report estimated a \$580 million savings in Year 1.² In 2013, the second report lowered the estimate to \$34 million in Year 1.³ But whatever the number, nearly all the purported savings would come from reducing provider payments by \$155 million.

The great goals of this Canadian-style single-payer health care system are to:

- Abolish health insurance;
- Guarantee that all Vermont residents will get "affordable and appropriate care at the appropriate time in the appropriate setting" (as determined by a five-member government board);
- Enforce cost-saving efficiencies, "payment reforms," and "global budgets" on medical providers;

- Finance the annual \$6 billion single-payer system with tax dollars from one source or another.

Note, however, that Vermont's entire 2012 state budget is only \$5 billion, of which \$2 billion is Medicaid.

Implementation

According to the plan, the following will occur in 2017: Vermont will close Vermont Health Connect (Vermont's Exchange). All Vermont residents will be forced to accept healthcare provided through a publicly financed, government-run system supported by a combination of a 14% to 18% payroll tax and other taxes. Everyone will pay according to his ability. This will be the largest tax increase in Vermont's history. There is to be universal coverage and access. Additional reforms needed by 2017 include physician payment reform, rate reform, and global budgeting for hospitals.

Vermont is one of five states to receive a \$45 million State Innovation Model (SIM) federal grant.⁴ This grant will fund activities inside and outside state government over the next 4 years to address two core aims: (1) to expand and integrate innovative healthcare provider payment and (2) to expand and integrate health information technology that supports more effective and efficient care delivery.

When Gov. Shumlin was state senate leader in 2008, HIT (Health Information Technology) was passed as Act 192. This created a new tax of 0.199% on all health insurance claims to pay for implementing the plan. Three years later HIT required even more money, so in 2011 the legislature quadrupled the tax rate on claims, and Gov. Shumlin signed the law.

To oversee all aspects of reform to a single-payer scheme, the governor hand-picked a five-member board: three healthcare professionals, a restaurateur, and as Chair, Anya Rader-Wallack, formerly Gov. Howard Dean's special assistant for health policy, who left Vermont in 1994 to get a Ph.D. in "social policy" at Brandeis University.

The Green Mountain Care Board states: "The most unique thing about Vermont's Board is that the Legislature assigned it unprecedented responsibility for all the major factors influencing the cost of health care."⁵ The board is to guarantee that all Vermont residents will get "affordable and appropriate care at the appropriate time in the appropriate setting."

The amount of money available will inevitably define what care is "appropriate," what timing is "appropriate," and

what setting is “appropriate.” This board will decide how much coverage Vermonters are entitled to receive, when they will get it, who will provide it, and how much providers will be paid for providing it, all in light of available funds. This is otherwise known as healthcare rationing.

From Vermont’s Exchange, we are to get to a “single-payer” system, which ironically will still be a multi-payer system regardless of its name, in this manner: People with Medicare will keep their Medicare coverage. Medicare wraparound plans will probably be included in the single-payer system, as will Medicaid recipients. Self-funded ERISA plans such as IBM do not have to comply with state laws. But in Vermont they will either have to put their employees into the single-payer system or pay the state a per-employee tax for not doing so.

Effects

Access to Care under Green Mountain Care

Patients will find fewer doctors available, with long waits and likely denial of access to care. Physicians won’t be able to afford to practice in Vermont because of reduced payments, on top of the already low payments from Medicare. With “everybody in,” single payer brings increased utilization demands that can’t be met. More care will be delivered by less qualified personnel such as physician assistants.

Confidentiality under Green Mountain Care

Under Green Mountain Care, patients will not have control of their own medical information. Act 48 assumes that federal regulations will govern the use of medical records. The State Medicaid Health Information Technology Plan, submitted Sep 3, 2011, envisions a “statewide clinical data repository, decision support, and clinical messaging system.”⁶ Vermont law does not give citizens the right to opt out of this database.

The patient’s chart will be linked to information from the Health Insurance Exchange. Electronic medical records at individual practice locations will be linked with one central clearinghouse managed by the state. Patients will get to authorize which physicians have access, but the patient does not choose whether or not to be in the clearinghouse. The only information excluded is psychotherapy notes, but the rest of a psychiatric record, including diagnosis and medications prescribed, will be included.

The Health Information Exchange will be used to provide support for the Provider Incentive Program (PIE), which is part of the Payment Reform Plan described further below. In addition, selected patients will be placed into the Chronic Care Information System. The registry will contain clinical data; no distinction is made between individual information and de-identified data. Patients will be assigned to case managers to help manage their chronic illnesses; the patient cannot decline this help. Patients and doctors alike will have their

performance tracked, thanks to the electronic health record (EHR).

Payment Reform under Green Mountain Care

Gov. Shumlin speaks of reimbursing “providers” for quality, not volume, and for keeping people healthy rather than for catastrophic care.¹ In practice, this means an elaborate system of financial rewards and punishments will be used to shape the everyday clinical decision-making of physicians.⁷ Fee-for-service payment is viewed as the etiology of unsustainable increases in expenditures on medical care, so that method of payment is scheduled to be phased out. Vermont’s plan for payment reform relies heavily on the use of capitated payment and bonus schemes to influence physician behavior, a carryover of techniques from managed care, the discredited system of cost containment that single payer is ostensibly intended to replace.

But Vermont’s plan for payment reform goes far beyond managed care as we know it today. The ultimate plan is for Accountable Care Organizations to assume part of the insurance risk, and the ACOs will surely shift that financial risk to individual physicians. If patients are sicker than projected, physicians will personally bear part of the cost.

A system that links pay to clinical outcomes is incompatible with more than one published code of medical ethics. The Association of American Physicians and Surgeons Principles of Medical Ethics, Provision 4, states: “The physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration in quality of care.”⁸ The AMA Council on Ethical and Judicial Affairs makes this principle more specific in its Opinion 6.01: “A physician’s fee shall not be made contingent upon the successful outcome of medical treatment. Such arrangements are unethical because they imply that successful outcomes from treatment are guaranteed, thus creating unrealistic expectations of medicine and false promises to consumers.”⁹ In the Green Mountain Care system, physicians will be incentivized to withhold beneficial treatment from patients, and the only recourse for injured patients will be to take legal or administrative action against their personal physicians, rather than the architects of the flawed incentive plan.

Vermont’s Economy under Green Mountain Care

The governor clearly sees single payer as a boon to Vermont’s economy (“a real jobs creator for us”) with technology that will create a “smarter and more affordable health care system.” Many thoughtful Vermonters, however, do not share his views.

Businesses will flee Vermont, owing to \$2 billion in new taxes in 2017. The size of state government will be nearly doubled. Vermont will become the most heavily taxed state in

America—as its health system deteriorates. The only new jobs may be for state employees to adjudicate all the healthcare claims for the government.

Gov. Shumlin agrees that the tax increase will be the largest in history. But he claims it will be offset by a decrease in premiums. He calls the 18% of revenue that a small business spends on health benefits equivalent to a payroll tax, but he acknowledges that this will not be enough. He states that for single payer to succeed, Vermont has to “find a way to ensure that you contain costs and that we don’t continue to see our costs go up.”¹ Note that a 5% difference in the cost forecast would diminish Vermont’s fund balance by an additional \$300 million.

Act 48—Vermont’s single-payer law—was passed in an atmosphere of euphoria, based on a report that said we would save \$580 million the first year. It became apparent soon afterward that those savings could not be achieved. The governor and legislators have been scrambling ever since to patch it up and make it happen anyway. At last, only the funding for “ObamaCare” apparently saved the day. But has it really, and for how long?

Fixing Flawed Legislation Once It Is Enacted

Act 48 gives the Green Mountain Care Board unlimited authority to set fees for all healthcare professionals, and balance billing is completely banned, presumably to take effect when the state’s single-payer plan is fully implemented, if not sooner. In a system designed to eliminate cost-shifting, if the fee for a specific medical service is set below the actual cost of providing care, then that service will not be offered to patients. If fees are set too low across the board for a particular medical specialty, then those physicians are apt to leave practice in Vermont. Anya Rader-Wallack testified before the House Health Care Committee on May 5, 2013, that the board reserved the right to set fees in direct-pay practices, which would give the Green Mountain Care Board the effective authority to abolish the practice of private medicine in Vermont. When a physician’s fee is set by a third party, it opens the door to use of financial incentives to direct everyday clinical practice, and thus the relationship between patient and physician is no longer private.

As a fix for this problem, Rep. Cynthia Browning (Democrat, Arlington) introduced an amendment in 2013 that would guarantee Vermont residents the right to enter into voluntary financial arrangements with their physicians and other medical professionals. The amendment did not change the authority of third-party payers to cap their reimbursements for the purpose of cost containment, but it did permit medical professionals to offer care at the fees necessary to keep offering services and to preserve independent judgment. The Vermont House of Representatives rejected the amendment on a vote of 94-44. Rep. Sarah Copeland Hanzas (Democrat, Bradford) explained

her “no” vote as follows: “Mr. Speaker: What this amendment is suggesting is, let’s establish a high-profit, high-cost niche in our health care economy and see if we can sink the system by killing all rational efforts to rein in health care inflation.”¹⁰

Conclusion

The Vermont experience can teach all states how easily political decisions can be made without legislators and politicians actually understanding the true financial cost or future economic liabilities. The supposed benefits of Vermont’s single-payer law are based on many false assumptions. Once passed, such a law may be impossible to reverse.

Other states need to monitor carefully the adverse effects on patients, physicians, and the economy. Individual physicians are well advised to watch carefully all bills pertaining to medicine because state officials, legislators, and non-physician lobbyists in the employ of state medical societies do not make the necessary links between broad public policy decisions and their impacts on the care of individual patients.

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