It's all up to you. Contact your legislators NOW!

Call the Sergeant-at-Arms's Office and leave a message: **(800) 322-5616**

Get home phone, address, and email: **http://www.leg.state.vt.us/legdir/legdir2.htm**

Myth Five: "You won't have your choice of doctor or hospital."

H.100 and S.88 give everyone free choice of doctor or hospital. This is often not the case under our present system, where private insurance often limits a patient's choice. H.100 and S.88 even have provisions for contracting with out-of-state hospitals that regularly treat large numbers of Vermont residents. The bill also provides for out-of-state specialty care, which may not be available locally, and allows for payments for emergency services incurred by Vermonters while traveling out of state.

Myth Six: "We should wait for national health care reform and not make change as a state."

The Obama administration has already made clear that its national plan will be built around private insurance subsidies. In that sense, it may look a lot like Vermont's Catamount program, which has enrolled relatively few Vermonters and has been unsuccessful in achieving universal access. Vermont's experience with Catamount, as well as the history of similar reforms in other states, shows that subsidizing individuals to buy private insurance cannot reduce the excessive administrative costs that are driving up health care costs. These reforms fail to achieve universality because many people cannot afford to buy in. Ultimately, the Catamount-type reforms cannot be sustained financially because most people are left with their present insurance and have no political interest in being taxed for a costly, piecemeal plan that benefits only a small segment of the population.

Myth Seven: "Let's give Catamount Health a chance to work before we try anything else."

To date, Vermont's Catamount has enrolled about 7,000 people. The last official estimate of the total number of uninsured in Vermont is 47,000, despite the existence of Catamount, VHAP, Medicaid, and Dr. Dynasaur. These programs do not alleviate the insecurity facing thousands of people who are underinsured or at risk of losing their present coverage if they lose their jobs. So, piecemeal solutions can never cover everyone.

While Catamount has certainly helped some people get health insurance, it has not helped to control overall health care costs. It is these costs, and especially the wasteful administration and excessive profits, that are threatening to undermine the care upon which we all depend. We cannot expect Catamount to address the underlying causes of health care inflation and inequity. It was not designed to change the system, only to offer some help around the edges. Therefore, we must act now to save our quality health care and make it available to all Vermonters, by taking public control of the financing, and applying it across the health care spectrum. H.100 and S.88 would do this.

For more information:

www.vermontforsinglepayer.org

Deb Richter, MD

802-595-2820

VTHCA@sover.net

Health Care for All Vermonters

Quick Facts on Vermont's Pending Universal Health Care Bills

What are H.100 and S.88, the Vermont Universal Health Care Bills?

There are several single payer bills in the Vermont legislature, but the most likely to move are H.100 and S.88. These bills establish a comprehensive, publicly financed, universal health care system in the state of Vermont. H.100's lead sponsor is Rep. Michael Obuchowski, (D-Rockingham) with 17 House cosponsors. Half the Senators are co-sponsors of S.88. The legislation is currently assigned to committee, where it is not expected to advance unless citizens mount a strong advocacy campaign!

H.100 and S.88 would create a publicly financed, privately delivered system of health care similar to the Medicare program, but covering all Vermont residents. If passed, the state would be on an orderly track to achieve universal access, beginning with hospital services by July 1, 2011, primary and preventive care by July 1, 2012, and all other essential health services by July 1, 2013.

The goal of H.100 and S.88 is to ensure that all Vermonters have access, guaranteed by law, to the highest quality and most cost effective health services, regardless of their employment, income, or health status.

Who Would Be Eligible?

Under H.100 and S.88, every person meeting Vermont residency requirements would be eligible to receive the same package of comprehensive health care benefits as every other Vermont resident. Health care would not be dependent on private insurance, employment, age, income status, or any criteria other than Vermont residency.

What Health Services Would Be Covered?

H.100 and S.88 would create a comprehensive benefit package known as VermontCare. A Health Care Board would be responsible for deciding the actual services to be covered, but the legislation ensures that the package would be comprehensive, would provide a choice of services and provider, and would improve quality. In developing the package, the Board would be required to consult with health care experts as well as the public.

How Would Costs Be Contained?

Because VermontCare would be publicly funded, costs would be contained through a public budgeting process and negotiations with providers. H.100 and S.88 would establish community health boards that would assess and prioritize regional health care needs and make recommendations to the Legislature, which would annually decide on overall health care spending. State funds as well as federal funds would be deposited into a trust fund earmarked for health care. Annual appropriations into this fund would ensure optimal levels of funding for the program.

How Would Reimbursements Be Made?

Various payment methodologies would be administered by the state. These could include annually adjusted reimbursement rates for physicians, global (lump sum) budgets for hospitals, and discounted bulk drug purchasing. The state Health Care Board would be involved in devising the payment methodologies and would hear appeals from affected parties.

Would H.100 and S.88 Reduce Overall Health Care Costs?

Studies have shown that publicly financed systems are less costly because they eliminate insurance overhead, complicated billing systems, and administrative waste. Another advantage is that the financial burden of paying for health care can be spread across the entire population in a way that is fair and affordable. Because society already pays for health care one way or another, one approach is to think of public financing as simply a more logical and deliberate way to raise money for the services upon which we already rely. Health insurance premiums would be replaced by broad-based taxes, so that those persons making less money would pay less.

It is the intention of sponsors of H.100 and S.88 that with passage of these bills, the majority of Vermont families would pay less for health care than they do now, and society as a whole would benefit from the administrative savings and cost controls achieved through public financing and careful budgeting.

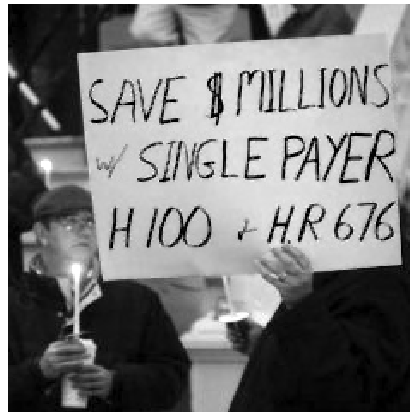
What Taxes Would Finance VermontCare?

H.100 and S.88 do not specify a financing source, except to mandate that the Legislature would decide on taxes to replace all health insurance premiums by a date certain, after which private insurance could only be offered for services not covered by VermontCare. The most likely financing source would be an employer payroll tax coupled with a progressive income tax. Under H.100 and S.88, employers would no longer be responsible for managing employees' health care insurance. This would result in savings for employers and would eliminate a source of friction between employers and employees.

Are H.100 and S.88 Politically Possible, Especially in These Difficult Economic Times?

H.100 and S.88 are designed to save Vermont's health care system from economic collapse. Families and employers need relief from sharply rising health care costs. Hospitals and other providers need assurance of reliable funding. Continuing on our present course of escalating costs and unequal access is no longer acceptable. Health care spending, if not brought under public control, has the potential to bankrupt individuals as well as businesses, schools, municipalities, and ultimately our entire economy. If this happens we lose the trusted health care institutions and quality care we now enjoy.

Publicly financed health care, as is practiced in most developed countries, can reverse this trend, and is therefore politically attractive if strong opposition from vested interests can be overcome.



The Political Struggle For Universal Health Care

Naysayers often use myths to discredit the idea of publicly financed universal health care. Among these are the following:

MYTH ONE: "Vermont can't get the necessary waivers to roll federal funds into a state sponsored health care plan."

It is true that the state may need federal waivers for H.100 and S.88 to be implemented, because much of our current health care costs are federally funded. Vermont cannot afford to lose those funds. But the state has received federal waivers for many other health care programs in the past. Dr. Dynasaur—the Medicaid program for children—required a waiver, and so did Catamount, the new program for the uninsured. Even the Bush administration gave waivers to Massachusetts for the most recent health care reforms in that state. There is no reason to think that the Obama administration would do less for Vermont.

MYTH TWO: "We can't afford to pay for everyone's health care."

Yes we can! We can afford to pay for everyone's health care, but we can't afford to pay for everyone's insurance. Huge sums are currently wasted on paperwork and insurance profits. When everyone is enrolled in one common plan, administration is greatly simplified. Providers only have to learn how to request reimbursement from one source, not from dozens of competing insurance plans. Studies have calculated administrative savings in Vermont from public financing administered through a single reimbursement system to be in the range of hundreds of millions annually.

MYTH THREE: "The government will tell your doctor what to do."

Under our present financing system doctors are under pressure from insurance and disease management companies to practice medicine according to insurance company guidelines that are often engineered to maximize profits rather than to optimize patient care. Sometimes these companies even bypass the doctor and go directly to the patient and tell them what to do without the doctor's knowledge. Under H.100 and S.88, the government would not deliver the care, it would simply pay for it. Doctors would practice medicine without having to worry if their patient's insurance was adequate.

MYTH FOUR: "Your taxes will soar."

We currently fund nearly 60 percent of the health care bill through taxes. The public pays for those over age 65 through Medicare, and for those at the bottom of the income scale through Medicaid. We pay for public employees' health insurance mostly through our property taxes, which are regressive because they are not based on income. There are also many hidden taxes and invisible cost shifts that are burdensome and unfair. Under H.100 and S.88, the taxes for Medicare and Medicaid will continue, but the balance of health care spending will be financed based on your ability to pay. In other countries, this works quite well. People pay far less in health care taxes than the average citizen here, and everyone is covered.