Misinformed Reasons for Opposing Universal Primary (UPC)

We need to get costs down before offering care to everyone. This excuse has been around for decades. First, the best way to lower costs is to eliminate the excess administrative expense in our current non-system of care. Second, most attempts to lower costs in the absence of public financing have failed. The list of disappointments includes managed care, Medicare privatization, and Vermont's All Payer/ACO model. It is also said that Vermonters need to shop around for the cheapest care, but we know this to be unrealistic for most services, where high quality and geographic proximity are the prime factors that patients consider when choosing providers.

Vermont is too small; a larger, multi-state risk pool is necessary. False. Public financing for universal health care can be done for populations even smaller than Vermont's, as evidenced by the more than 30 countries worldwide that are smaller than Vermont and yet have universal health care. It is unfortunately common to mistake how large a population is needed for universal primary care with the number required for:

> An efficient commercial insurance market**.** Those markets function best when multiple insurers share the risk among a population of a million or more. Public financing is vastly different. It draws its revenue not from subscribers but from general taxation, and its purpose is to cover everyone's health care needs, rather than to compete for market share.
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> Providing high-tech, expensive medical services used by small numbers of patients. Primary care is fundamentally different from services such as burn units, transplant programs, or other highly specialized capabilities. Those services are expensive and require specialized expertise and equipment, yet the number of patients requiring these services may be extremely small. It makes sense to spread such high-cost services across a larger population. But everyone needs primary care and it is relatively inexpensive to provide—it accounts for only 6% of all medical costs.

The question is therefore not whether Vermont has enough people to "justify" publicly funding primary care, but whether we choose to fund a basic service that every Vermonter needs. Publicly funded primary care in Vermont does not need a population of one million people to be economically feasible. All it needs is a financing system that recognizes primary care as essential infrastructure—like education or public safety—and spreads its costs across the population rather than relying on each individual to pay at the point of care.

Vermont borders three other states and this makes public financing of health care too complicated. False. It is true that some Vermont residents work out-of-state, and some out-of-state residents commute to jobs in Vermont. A payroll tax would need to be adjusted to account for this. Also, some Vermonters obtain health care services out-of-state, while some out-of-state residents visit Vermont health care providers. This too can be reconciled. Vermont can contract with the commonly used out-of-state providers, and Vermont providers can bill out-of-staters' insurance the same as always. These cross-border issues were extensively analyzed and resolved by the Shumlin administration after passage of Act 48 in 2011.

Vermont will never get waivers from the Trump administration. Vermont has plenty of experience obtaining federal waivers. For instance, we have a Section 1115(a) waiver for Medicaid (the Global Commitment) that is periodically renewed and amended without federal opposition. Waivers are desirable, but not necessary, to fold the primary care portion of two other federal programs into a system of state-administered universal primary care. However, it is not necessary to obtain all three waivers simultaneously.

Affordable Care Act (ACA): Section 1332 innovation waivers are given to states that can show savings while maintaining ACA coverage requirements. UPC saves money, both in administrative costs and in prevention, making a 1332 innovation waiver attractive to the federal government.

Medicare: A Medicare waiver would be a first-in-the-nation long shot. In its absence, UPC could wrap around Medicare, providing publicly financed coverage for all primary care services that are subject to patient cost sharing.

Failure to obtain any or all of the above waivers should not preclude UPC implementation. It may become cost effective to leave some federal money on the table, in other words to fund some services with state revenue only, foregoing the minimal federal assistance for primary care, such as in high-deductible ACA plans.

The governor will veto it, and so why bother? Since opinion polls around the country show broad public support for publicly financed universal health care, a governor would risk the public's wrath by vetoing UPC. Also, a veto threat has not prevented the legislature from passing any number of bills that fail to get the governor's signature. A veto can sharpen the contrast between the executive and legislative branches and can energize advocacy and future political campaigns.

The shortage of primary care practitioners must be eliminated before implementing UPC. Not true. There is indeed a primary care clinician shortage, which is exacerbated by burnout, moral injury, and relatively low compensation. Some people worry that the situation will get worse when access to primary care is increased with UPC. While this might be true in the short term, there is every reason to believe that relieving primary care practices of the massive burden of insurance billing and collections would attract more clinicians to Vermont and encourage those already here to stay, as happened in Saskatchewan when universal health care was first implemented. In addition, with the elimination of copays and deductibles for primary care, doctors and other primary care professionals would be able to practice in accordance with their training, because patients' insurance status would no longer be a major factor in their care.