

Table of Contents

| | |
|--|-----------|
| Introduction | 1 |
| Getting the Most Recent Version | 1 |
| Using the People’s Toolkit | 1 |
| Making Contributions | 1 |
| Frequently Asked Questions | 2 |
| What is the Vermont Workers’ Center? What does the Workers’ Center do? | 2 |
| What are human rights? | 2 |
| What is the Healthcare Is a Human Right campaign? | 2 |
| What does the Vermont Workers’ Center mean by “Healthcare is a human right”? | 2 |
| Does the Constitution of Vermont or the U.S. give us the right to healthcare? | 3 |
| Do other countries recognize healthcare as a basic human right? | 3 |
| Why isn’t healthcare treated as a human right in the U.S.? | 3 |
| Would treating healthcare as a human right raise my taxes? | 3 |
| How would treating healthcare as a human right reduce the total cost of healthcare? | 4 |
| Wouldn’t a government-financed healthcare system result in rationing? | 4 |
| Doesn’t Vermont already do a good job providing healthcare to those who can’t afford it, with VHAP, Dr. Dynasaur and Catamount Health? | 5 |
| Why should someone with good, reasonable health insurance support this campaign ? | 5 |
| Isn’t government-guaranteed healthcare “socialism”? | 5 |
| Isn’t the federal government taking care of healthcare reform? | 6 |
| Vermont, like all states, is facing a serious revenue crisis. Can we afford to provide healthcare to all at a time like this? | 6 |
| Human Rights Principles | 8 |
| Overviews of Current Vermont Healthcare Reform Legislation | 10 |
| H.100/S.88 | 10 |
| H.491 | 14 |
| H.510 | 17 |
| S.181 | 21 |
| H.196/H.512 | 23 |
| Side-by-Side Vermont Legislation Human Rights Analysis | 26 |
| Comments on Proposed Federal Healthcare Reform Legislation | 27 |
| Summary | 27 |
| Introduction | 27 |
| Q & A | 27 |
| Legislative Testimony (Blended Legislation Proposal), 29 January 2010 | 31 |
| Introduction | 31 |
| About the Vermont Workers’ Center and the Healthcare is a Human Right Campaign | 31 |

| | |
|--|-----------|
| Campaign Principles | 32 |
| Time Frame | 34 |
| Proposal | 34 |
| Conclusion | 37 |
| Organization/Business Endorsers of the Healthcare is a Human Right Campaign (partial list) | 37 |
| The Cost of Healthcare | 40 |
| How much does health care cost in Vermont? | 40 |
| National Health Care Costs | 40 |
| Overhead & Administrative Costs in the United States | 40 |
| Who Pays? | 40 |
| Footnotes | 41 |
| Talking Points for Conversations with Legislators | 43 |
| Questions | 43 |
| Issues | 43 |
| Guide to Vermont Representatives and Senators | 44 |
| Committee Hearing Logging Form | 45 |
| Revision History | 46 |

Introduction

The People's Toolkit is a document intended to help Healthcare is a Human Right campaign volunteers to become familiar with the campaign itself, the human rights principles that the campaign uses in evaluating proposed healthcare reform legislation, the actual proposed legislation and other information that might be of use in talking with legislators or attending legislative committee hearings.

Along with this introduction, the People's Toolkit consists of nine informational components, as follows.

- Frequently Asked Questions (FAQ)
- Human Rights Principles
- Overviews of Current Vermont Healthcare Reform Legislation
- Side-by-Side Vermont Legislation Human Rights Analysis
- Comments on Proposed Federal Healthcare Reform Legislation
- Blended Legislation Proposal, 29 January 2010
- The Cost of Healthcare
- Talking Points for Conversations with Legislators
- Guide to Vermont Representatives and Senators

The toolkit also contains a committee hearing logging form and an appendix showing the history of revisions to the Toolkit.

Getting the Most Recent Version

The People's Toolkit is a dynamic document, with information being updated, corrected and added frequently. Each page is marked with a date, in the form "rev. 2010-02-15"; and the specific changes that were made to each revision of the document are listed in an appendix labeled "Revision History."

You can check for new versions of the Toolkit by going to the Vermont Workers' Center web site, www.workerscenter.org/healthcare.

Using the People's Toolkit

Reading the components in the order listed above is a reasonable way to get started with the toolkit. Doing so will put you in a good position to explain the campaign and how we evaluate proposed healthcare reform legislation, as well as to discuss the major healthcare reform bills that have been introduced in the Vermont legislature this session.

We have tried to provide enough information to help you become comfortable discussing the proposed legislation without overwhelming you with detail. If you wish to read the text of the actual bills, you can do so by going to <http://www.leg.state.vt.us/database/status/status.cfm> and entering the bill number into the form.

Making Contributions

As you use the People's Toolkit, let us know how it works for you. In particular, are there frequently-asked questions that we have not provide answers for? Or could the existing answers be improved?

Send your comments, corrections and suggestions to <david@workerscenter.org> or <peg@workerscenter.org>.

Frequently Asked Questions

What is the Vermont Workers' Center? What does the Workers' Center do?

The Vermont Workers' Center is a democratic, member-run organization dedicated to organizing for workers' rights and living wages for all Vermonters. We seek an economically just and democratic Vermont in which all residents have living wages, healthcare, childcare, housing and transportation. The Vermont Workers' Center is committed to taking action on the full range of issues of concern to working people. By organizing rallies, public hearings and forums, publicizing people's stories and taking direct action, we support workers throughout the state who are trying to improve their wages, benefits, rights on the job, working conditions and communities.

What are human rights?

Human rights are the basic rights that all people are entitled to. In 1948, the United Nations adopted the Universal Declaration of Human Rights, which includes access to medical care and other basic civil, political, economic and social rights, which are seen as the foundation of freedom and democracy.

The human right to healthcare is codified in Article 25, which states:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

What is the *Healthcare Is a Human Right* campaign?

The *Healthcare Is a Human Right* campaign is the Vermont Workers' Center's effort to help Vermonters win a system of universal healthcare that is equitable, is accountable to the people and eliminates all barriers to the enjoyment of the human right to health.

With tens of thousands of Vermonters lacking access to healthcare — and untold numbers “under-insured” — it is clear that our government has failed to fulfill its obligation of ensuring Vermonters' human right to healthcare. The Vermont Workers' Center believes this failure is the result of the influence of powerful special interests on our elected representatives. We believe the solution to this problem depends on a mass movement of Vermonters demanding a healthcare system designed to ensure public health rather than private profit. With enough Vermonters demanding meaningful reform, our elected representatives cannot justify a claim that healthcare for all is “not politically possible.” Through grassroots organizing around the state, we are creating a network of activists who are building this movement.

What does the Vermont Workers' Center mean by “Healthcare is a human right”?

We believe that the human-rights principles of *universality, equity, accountability, transparency, and participation* must be applied to the healthcare system. In short:

1. Every person is entitled to comprehensive, quality healthcare.

2. Systemic barriers must not prevent people from accessing necessary healthcare.
3. The cost of financing the healthcare system must be shared fairly.
4. The healthcare system must be transparent in design, efficient in operation and accountable to the people it serves.
5. As a human right, a healthcare system that satisfies these principles is the responsibility of government to ensure.

Does the Constitution of Vermont or the U.S. give us the right to healthcare?

Human rights exist outside of law. The United States has not ratified the covenants and treaties that would give the Universal Declaration of Human Rights the force of law. Nor does the Vermont Constitution explicitly grant the right to healthcare. But we do not depend on law for our assertion of our human rights. Every person is entitled to human rights regardless of the embodiment (or lack thereof) of those rights in law.

Do other countries recognize healthcare as a basic human right?

Healthcare is recognized as a human right in most countries around the globe. The United States is the only “industrialized” country that doesn’t provide healthcare as a right to every resident from cradle to grave. Countries across Europe, Asia, Latin America and the Middle East recognize that every citizen has the right to reach the highest attainable standard of health, has a right to appropriate treatment and to live without fear of getting sick. Humane countries recognize that in order to have a productive, happy society they must provide their citizens with the basic right to health.

Why isn’t healthcare treated as a human right in the U.S.?

We believe the failure to respect human rights is invariably the result of the corrupting influence of powerful special interests on government. In the case of healthcare policy, an examination of “reform” efforts reveals an uncanny desire on the part of elected representatives to preserve a system based on private health insurance participation despite the indisputable superiority of a public, single-payer system.

Would treating healthcare as a human right raise my taxes?

Besides reducing suffering and improving the quality of life for untold numbers of people, a system of healthcare based on human-rights principles would also greatly reduce the total cost of healthcare. If you currently pay premiums, deductibles and co-pays for healthcare, replacing those payments with an equitable financing system, such as a broad-based income tax, would probably reduce the total amount that you pay — and it would certainly help to protect you from the crippling financial burden of a catastrophic medical emergency.

Approximately 60% of total healthcare costs already come from our tax money. These costs include public employees (police, firefighters, federal employees, state employees, municipal employees, teachers, postal workers, the military and elected officials) and the many public federal and state programs (Medicare, Medicaid, VHAP, Dr. Dynasaur etc).

How would treating healthcare as a human right reduce the total cost of healthcare?

- If everyone had preventive and primary care, the use of much more expensive critical and emergency care would be greatly reduced.
- Public healthcare systems tend to have dramatically lower administrative costs than private systems (5% vs. 30%). Eliminating multiple systems with different rules and exclusions would also reduce the administrative burden on healthcare providers. And, of course, eliminating private health insurance companies would eliminate money spent on profits and on corrupting the political system.
- With a single “risk pool,” the healthcare system administrator would have more power in negotiating the price of pharmaceuticals and medical equipment. And public governance boards could better allocate healthcare resources.
- With universal healthcare, medical malpractice insurance would not have to cover the cost of future medical care that might result from a judgment against a provider.
- Under the current business model of health insurance, not only is there a tremendous amount of waste by the duplicity of multiple insurers, there is the whole apparatus of red tape in a system set up to pocket insurance premiums and deny payment for care. By eliminating the needless overhead of gatekeepers and profits of insurance companies, shareholders and medical debt collection agency sharks, we will be able to use our money on providing healthcare to all and still save money.

Wouldn't a government-financed healthcare system result in rationing?

Every possible healthcare system has some form of rationing. A more useful way of framing the question is: *Does the healthcare system allocate its resources in an efficient, effective and humane manner?*

The United States currently spends far more *per capita* on healthcare than the rest of the “developed” world, yet the healthcare system in the United States provides relatively poor care. We believe that treating healthcare as a human right would result in less rationing — not more — because, for the same amount of money, we could buy a healthcare system that is more universal, more affordable and of higher quality.

In the United States, we currently ration healthcare in many ways. For example, we ration healthcare according to employment status, according to age, according to gender, according to geographic or political location, according to social relationships, according to health history and according to willingness (and ability) to battle against health insurance company bureaucracies. These forms of rationing are both inhumane and illogical.

Instead of providing relatively inexpensive preventive care, we treat people who lack access to primary care in expensive hospital emergency rooms, and we almost always do so after their health conditions have advanced and become more expensive and more difficult to treat successfully. Those of us who can still manage to buy health insurance are subsidizing this illogical and increasingly unaffordable system, so all of us are either directly subject to some form of rationing or increasingly at risk.

So, yes, a government-financed healthcare system would result in rationing, just like any other healthcare system. But it would undoubtedly result in much less rationing than our current system.

Doesn't Vermont already do a good job providing healthcare to those who can't afford it, with VHAP, Dr. Dynasaur and Catamount Health?

Though Vermont does more than most other states, and these programs provide quality care for some who would not otherwise have coverage, there are more than 60,000 Vermonters still uninsured and hundreds of thousands more are under-insured. And, because these programs do not effectively address the need to control healthcare costs, they are unsustainable. Each day, healthcare becomes more unavailable to more Vermonters.

Why should someone with good, reasonable health insurance support this campaign ?

We believe that every person deserves comprehensive, quality healthcare simply by virtue of being human. Don't you? If not, then ask yourself: which of your neighbors, friends or family members do you believe should be denied healthcare?

Public healthcare systems like Medicare — which provides universal coverage for senior citizens — do a good job of providing quality healthcare with little money wasted on administrative overhead. We simply want to include everyone and cover all medically necessary care and medication.

If you have a private health insurance plan, perhaps provided to you as a benefit of employment, consider the fact that good, reasonable private health insurance is disappearing. Fewer employers are offering this benefit at all, and, among those that do, rising costs are increasingly being shifted onto employees. Your healthcare premiums, deductibles and copays are paying for a system that provides expensive critical and emergency care to people who lack the basic primary and preventive care that might have made their expensive care unnecessary. You are also paying for administrative overhead that wastes much more of your healthcare dollar than any public system. And you are participating in a system that has no way of controlling the ever-rising cost of healthcare. What is your strategy for dealing with the rising cost of your "reasonable" health insurance plan? Is it better than our strategy?

Oh, by the way, are you sure you have the coverage that you will need? Have you ever heard the term "rescission"? Rescission is the private insurance industry's evil practice of dropping people who have been paying their health insurance premiums for years, once those people need healthcare that the insurance company would have to pay for.

Finally, it is indisputable that a healthcare system based on human-rights principles would cost dramatically less than the current system. Less money wasted on healthcare would strengthen our economy, which would benefit everyone.

Isn't government-guaranteed healthcare "socialism"?

Public policy that recognizes healthcare as a human right is not a radical idea. After all, except for the U.S., all of the developed world provides healthcare to all of its citizens, and only a few of those countries (e.g. Cuba, Sweden) could be called "socialist." Healthcare systems around the world demonstrate that there are many ways of accomplishing universal healthcare. We do not believe it is necessary for healthcare providers to work for the government or for government to manage hospitals or other medical institutions. We believe, simply, that it is government's responsibility to ensure the human rights of its people. Put another way: since a market-based system is designed for profit, rather than human rights, we believe that healthcare should not be a market-based system.

Here in the U.S., we currently finance many public services such as police, fire departments, armies and schools the way we are proposing to finance healthcare. We doubt that anyone calls the Vermont State Police “socialists.”

Imagine if we treated other public goods the way we treat healthcare. When you call 911, the dispatcher would ask if your situation is covered by your insurance policy, before sending help. Imagine having to decide which 911 policy you will need and then having to pay a deductible and copays when an emergency arises. Or, worse, imagine having to decide whether you could afford to pay for the “help” provided by the police, before dialing 911.

Isn't the federal government taking care of healthcare reform?

On December 24th, 2009, the Senate passed H.R. 3590, the “Patient Protection And Affordable Care Act.” This bill and the corresponding House bill, H.R. 3962, which was passed November 7, will now go to a conference committee, where the differences between the House and Senate bills will be worked out -- a process that will probably take until early February.

Though the effects on Vermont of the federal legislation that will eventually emerge from conference committee are unclear, what is clear is that neither federal bill satisfies the human rights standards of universality, equity, accountability, transparency and participation.

The federal reform proposals each include a few positive elements, such as expanding access to healthcare for the poor and increasing regulation of health insurers. But because each is based on the principle of a health insurance mandate, the proposals entrench the treatment of healthcare as a commodity rather than a human right.

The federal reform proposals do far too little to address the fundamental problem of the United States' healthcare system: the rising costs of healthcare. Without addressing this fundamental problem, the proposals will leave many millions underinsured — stuck with the same inadequate private health insurance plans that have failed to protect people from financial ruin brought on by serious illness or injury.

In excluding undocumented workers, women seeking reproductive healthcare and many of the working poor, the federal reform proposals simply fail to satisfy the goal of establishing universal healthcare.

It is hard to explain or justify a healthcare reform approach based on a health insurance mandate and lacking in comprehensive cost controls by any logic other than that of treating healthcare as a source of profit for the health insurance, pharmaceutical and other medical industries. In fact, the federal legislative process has from the start been co-opted by economic interests that make the satisfaction of human rights principles impossible.

With the federal “reform” efforts so corrupted by the influence of industries profiting from the current healthcare system -- and with the resulting legislation so frustratingly inadequate to the task of creating a system of healthcare that is universal, is equitable, is accountable to the people and eliminates all barriers to healthcare -- we must continue to work for meaningful healthcare reform in the Vermont Statehouse.

Vermont, like all states, is facing a serious revenue crisis. Can we afford to provide healthcare to all at a time like this?

The lack of affordable universal healthcare presents us with not just a humanitarian crisis but also an economic crisis. The high cost of our current healthcare “system” is responsible for many of the

economic problems that we now face, and the rapid rise of healthcare costs creates an economic situation that is unsustainable. The current healthcare “system” has no way of controlling these costs other than by denying the care that people need. There are ways of controlling healthcare costs without reducing the quality of care, but implementing effective cost controls requires a real healthcare system not merely a collection of insurance plans.

Rather than seeing healthcare reform as an added burden on our economy, we should see it as a form of economic development. With healthcare as a human right, we could eliminate the single largest cause of personal bankruptcy. We could eliminate the single largest barrier dissuading would-be entrepreneurs from starting new businesses. We could reduce the cost of local government and schools. And, of course, we could live longer, healthier, more productive lives.

Human Rights Principles

The Healthcare is a Human Right campaign's support of any healthcare reform legislation depends on our assessment of whether the legislation satisfies human rights standards. It is as simple as that. We wish to see the human right to healthcare embodied in law.

In evaluating a specific bill, we apply the human-rights principles of *universality*, *equity*, *accountability*, *transparency* and *participation*.

Universality is the principle that human rights must be afforded to everyone, without exception. It is by virtue of being human, alone, that every person is entitled to human rights.

Equity is the principle that every person is entitled to the same ability to enjoy human rights. Healthcare resources and services must be distributed and accessed according to people's needs, not according to payment, privilege or any other factor. Disparities and discrimination in healthcare must be eliminated, as must any barriers resulting from policies or practices.

Accountability is the principle that mechanisms must exist to enable enforcement of human rights. It is not enough merely to recognize human rights. There must be means of holding the government accountable for failing to meet human rights standards.

Transparency is the principle that government must be open with regard to information and decision-making processes. People must be able to know how public institutions needed to protect human rights are managed and run.

Participation is the principle that government must engage people and support their participation in decisions about how their human rights are ensured.

In other words:

1. Every person is entitled to comprehensive, quality healthcare.
2. Systemic barriers must not prevent people from accessing necessary healthcare.
3. The cost of financing the healthcare system must be shared fairly.
4. The healthcare system must be transparent in design, efficient in operation and accountable to the people it serves.
5. As a human right, a healthcare system that satisfies these principles is the responsibility of government to ensure.

Another way to apply these principles is by means of a set of questions, such as these:

- *Does the system provide healthcare to all? Or are some groups of people excluded, as if they are not entitled to a human right?*
- *Does the system provide equal access to comprehensive healthcare services? Or does it separate people into different tiers of access or coverage, thus producing inequities, increasing administrative costs and weakening the system itself?*

- *Does the system treat healthcare as a public good? Or does the system treat healthcare as a source of profit for powerful vested interests?*
- *Does the system eliminate barriers to use of needed healthcare services? Or do “co-payments” and other out-of-pocket costs discourage people from accessing the care that they need?*
- *Is the system financed equitably? Or do people pay for healthcare based on conditions that are unrelated to their ability to pay, such as age, health status, gender or employment status?*
- *Does the system use money effectively and efficiently? Or do numerous “payers” with numerous administrative systems introduce unnecessary costs that add nothing to the quality of the healthcare provided?*
- *Does the system allocate resources equitably, according to health needs? Or are some communities better served than others?*
- *Does the system improve the quality of healthcare, by rewarding providers who utilize best practices and provide excellent outcomes? Or does the system simply pay providers for performing medical procedures?*
- *Does the system enable meaningful community participation? Or are decisions made far from the people affected by the decisions that are made?*
- *Is the system accountable to the people it serves? Or is it complex, mysterious and impervious to influence?*

Overviews of Current Vermont Healthcare Reform Legislation

H.100/S.88

OUTLINE

H.100/S.88 “proposes to establish the goal of universal access to essential health care services in Vermont through a publicly financed, integrated, regional health care delivery system; provide mechanism for cost containment in the system; and provide a framework, schedule and process to achieve that goal.”

The bill begins with findings, in five parts, as follows.

1. The healthcare infrastructure (and services) are public goods that are threatened in the current healthcare system. In particular, economic incentives distort the provision of quality care, and multiple payers create excessive administrative waste.
2. The current healthcare system cannot contain costs and is therefore unsustainable.
3. The costs of the current healthcare system are unfairly distributed.
4. The current healthcare system is not accessible to all who need care.
5. The quality of healthcare in Vermont could be improved by a better system.

The bill creates a new plan, VermontCare, to pay for essential healthcare services in Vermont. It would utilize the existing network of healthcare providers (doctors & hospitals) but would eliminate private insurance for essential healthcare services and replace the current multiple payers with a single public fund financed by a system of broad-based taxes. Insurance premiums (and, therefore, deductibles) and out-of-pocket payments (“co-pays”) would be eliminated. All residents of Vermont would be eligible for VermontCare, simply by virtue of residence.

The bill would merge three existing government divisions into a new department, Health Care Administration, and create a new three-member board, the Vermont Health Care Board, each with specific mandates, guidelines and timelines for designing, implementing and managing the services included in VermontCare. (Specifically: the Board would propose [to the general assembly] a package of essential health services to be covered by VermontCare and subsequently act in a quasi-judicial capacity to hear complaints and amend established reimbursement rates. The Department of Health Care Administration would administer payments and establish a drug formulary, which would be used to negotiate discounts from manufacturers and establish uniform state-wide prescription practices, along with several other administrative duties related to VermontCare.)

The bill also calls on the general assembly to create regional community health boards to assess, prioritize and define community health needs, as well as to develop budget recommendations and provide regional oversight and evaluation regarding the delivery of care in their regions.

Under VermontCare, providers would be compensated based on best practices and healthcare outcomes rather than for individual services. Hospitals would negotiate annual “global” budgets instead of being paid for individual services.

HUMAN RIGHTS ANALYSIS

The *universality* standard is largely met by VermontCare’s simple eligibility standard, which is that of residency. The bill explicitly states that all Vermont residents will be covered “regardless of their age, employment, economic status or their town of residency”. Yet it remains to be resolved who may be excluded by the “reasonable residency requirements.” It must be ensured that all immigrants are included. Also, it is not fully clear what healthcare services people will be covered for, as the package of “essential” healthcare services is left entirely for the Board to propose. Though the final package must be approved by the legislature, which provides a process for improving the proposal, the legislation could be improved by referencing, as a minimum standard, the services specified by the international human rights framework.

The *equity* standard could be met, depending on the details of funding. The bill suggests that financing will be derived primarily from “broad-based taxes,” which is a key element of a universal and equitable health system, and a clear improvement over a less equitable insurance-premium-based funding scheme. Yet the provision remains somewhat vague and includes loopholes, for example for “corporate donations.” Importantly, the bill eliminates out-of-pocket expenses and deductibles for medical services, which is a big improvement over the current system.

The *participation* standard is met by the bill’s emphasis on community-based health services, which enable communities to assess their needs jointly, take part in planning and decision-making and build strong relationships with providers in their communities.

The *accountability* and *transparency* standards are addressed by means of the public processes specified in the operation of the Vermont Health Care Board, the Department of Health Care Administration and the regional community health care boards. The bill requires that governance follows mandated accountability guidelines and furthers the public good. Annual reports and evaluations must be provided to elected officials. The community health boards are required by the bill to solicit public input, presumably in all of their operations. Made up of community members, providers and health care institutions, the community health boards exercise oversight, carry out evaluations, and receive complaints and appeals.

FAQ

What are House 100 and Senate 88, the Vermont Universal Healthcare Bills?

H.100 and S.88 one of two bills (the other is H.491) currently before the Legislature that would establish a comprehensive, publicly financed, universal healthcare system in the state of Vermont. H.100’s lead sponsor is Rep. Michael Obuchowski (D-Rockingham), and the bill has 17 co-sponsors. Half of all 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 VermontCare, a publicly-financed, privately-delivered system of healthcare covering all Vermont residents. If passed, these bills would put the state on track to achieve universal access, beginning with hospital services by July 2011, primary and preventive care by July 2012 and all other essential healthcare services by July 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 employment, income or health status.

Will everyone in Vermont have access to healthcare?

Yes, every Vermont resident will have access to the healthcare they need, regardless of their ability to pay. VermontCare will ensure that Vermonters get free healthcare at the point of use, which means that their doctors and hospitals will not charge them. Vermonters who are covered by federal programs, such as Medicare or the Veterans Administration, will continue to receive their care from these sources. Private insurance companies, which currently do much to undermine our right to healthcare, will no longer have control over our access to care.

Will all healthcare services be covered by this universal plan?

VermontCare will cover all essential health services. A Health Care Board will specify, in consultation with the public, precisely which services will be included.

Will we be able to choose our doctors and hospitals?

Yes, H.100 and S.88 will give everyone free choice of doctors and hospitals. Vermonters will no longer be limited to “in-network” providers assigned by private insurers. VermontCare will also pay for out-of-state specialty care, in case such care is not available locally.

Will a universal plan be responsive to the needs of all Vermonters?

Communities will take part in identifying their health needs and matching health services to those needs. Patients and providers will sit on community health boards that assess and prioritize local needs and recommend how resources should be allocated. Vermonters will also have input into the implementation of VermontCare as a whole, because healthcare is treated as a public good for all. Participation and accountability of this kind can ensure that health services meet the distinct needs of all Vermont communities — or can make amends if something goes wrong.

Will everyone be able to afford healthcare?

Yes, healthcare will become affordable to all Vermonters, because the costs of VermontCare will be shared fairly by all Vermonters. The plan will be financed mainly through broad-based state taxes, including employer payroll and income taxes. Such collective financing means that those who have higher incomes contribute at a level that helps support the whole system, including those with low incomes.

How would doctors and hospitals be paid?

Doctors will be paid from public funds while continuing their private practices. Under H.100 and S.88, the government will not deliver the care; it will simply pay for it. Doctors will practice medicine without having to worry about whether their patients' insurance is adequate or if a particular treatment is profitable. Each hospital will receive an annual lump-sum budget to provide for the health needs of its community, rather than being paid for individual treatments. This reimbursement mechanism will eliminate the incentive for hospitals to use expensive equipment as a means to make money and will instead enable them to focus on what is best for their patients.

Can H.100 and S.88 reduce our healthcare costs while guaranteeing healthcare for all?

Yes, costs will be reduced because a publicly financed and administered system eliminates the waste of multiple “risk pools.” A universal public plan also eliminates complicated billing systems, administrative waste and, of course, profit. Equitable public financing will ensure that no one in Vermont pays more than they can afford for the care they need. The majority of Vermont families will pay less for healthcare

than they do now, and society as a whole will benefit from investing in the healthcare we need rather than in a parasitic insurance industry that we do not need.

How can Vermont practically implement H.100 and S.88?

Vermont will need to get federal waivers for implementing a universal healthcare plan, because programs such as Medicaid are currently federally funded. We could do it without the waivers, but it would be more difficult and less efficient — although still much better than what currently exists. The state received federal waivers for other healthcare programs, such as Dr. Dynasaur and Catamount. Moreover, Senator Bernie Sanders has introduced a bill in Congress that would allow up to five states to pilot universal healthcare programs with automatic waivers, which would make the implementation of H.100 and S.88 much easier.

Doesn't Catamount offer health insurance for uninsured Vermonters?

To date, Catamount has enrolled only about 7,000 people, which leaves at least 53,000 Vermonters uninsured — and many more under-insured. Moreover, all of us, whether insured or not, suffer in an unequal system that puts barriers between us and the healthcare we need. Subsidizing individuals to buy private insurance does not improve access to comprehensive, quality care for all. Programs such as Catamount were not designed to address the underlying causes of healthcare inequity and cost inflation, so they cannot lead us to a system that ensures our right to healthcare. They offer only some unsustainable, temporary help around the edges of the crisis.

Isn't the Obama administration about to implement the right to healthcare?

No. As a candidate, Obama said we should all have the right to healthcare, but he has not put forward reform proposals that would guarantee healthcare for all. The “reform” we are likely to get maintains the market-based healthcare system, in which healthcare is a commodity sold by insurance companies. Market-based reforms like this fail to meet any of the three main human rights standards. They fail to achieve universality, because many people cannot afford to buy in. They fail to achieve equity, because people have unequal access to care, due to the type of coverage they get, where they live or how old they are. And the reforms are neither transparent nor accountable to the people they are supposed to serve, because private companies remain in control of access to care.

Are H.100 and S.88 politically possible, especially during these difficult economic times?

The obligation to ensure everyone's human rights does not go away during difficult economic or political times. In fact, in difficult times, when our needs are greatest, is when we most need to have our rights protected. History shows that significant human rights gains can be won during the most difficult of times. Social Security and the minimum wage are but two examples.

Vermonters will no longer accept the ongoing violation of their right to healthcare. The fight for universal healthcare is a human rights struggle that we can — and will — win.

H.491

H.491: Sponsored by Rep. Davis of Washington and co-sponsored by Reps. Burke Edwards of Brattleboro, Haas of Rochester, and Zuckerman of Burlington

OUTLINE

H.491 is a single-payer bill with many similarities to H.100/S.88 but with more detail in a number of areas and a number of additional features. One of its focuses is on the coordination of care.

H.491 creates a new plan, Ethan Allen Health, to pay for medically necessary health care services. It would utilize the existing network of health care providers (doctors & hospitals) but would eliminate private insurance for covered services and replace the current multiple payers with a single public fund financed by a combination of an income tax, an employer payroll tax, a progressive sliding-scale premium structure and federal (Medicare & Medicaid) waivers. The principal out-of-pocket health care costs -- deductibles, co-payments and coinsurance -- would be eliminated. All residents of Vermont would be eligible for Ethan Allen Health, simply by virtue of residence, with enrollment available at the point of service.

Coverage would apply when an individual was temporarily absent from Vermont. Visitors to Vermont who use services would be billed. Coverage could be extended to nonresidents who work in Vermont, using a sliding scale.

Ethan Allen Health would be administered by a board, in this case comprised of fifteen members, five of which would be appointed by five elected regional health planning boards, the rest of which would be appointed by the five appointed regional members, with a requirement that the following roles be filled: two consumers, one employer, one union member and six providers, the last group as follows: primary care, registered nurse, mental-health provider, dentist, nursing home director and hospital director.

The board would be responsible for overseeing, implementing and reporting on Ethan Allen Health. Other specific responsibilities include health resource planning and information (through an Office of Health Quality and Planning), hospital budget reviews, technical assistance to the regional boards, receiving public input about the Ethan Allen Health plan, developing conflict-of-interest standards, designing support for workers dislocated by Ethan Allen Health, developing additional cost containment strategies and proposing consolidation of public health care administration. The Board would also be responsible for making an initial proposal to the legislature on the aggregate costs of Ethan Allen Health, and a proposal for funding which may include any of the following or a combination thereof: an equitable, affordable, progressive sliding scale premium structure, a payroll tax (and what rate/percentage) and an income tax.

H.491 explicitly defines the benefits provided by the Ethan Allen Health plan. These include comprehensive primary care, preventive care, chronic care, acute episodic care and hospital services. These benefits include mental-health and dental care and pharmaceuticals. The suite of benefits included in the plan may be expanded by the board.

H.491 requires that each patient have a primary care provider, to coordinate care, though referrals (to specialists) would not be necessary.

Under Ethan Allen Health, providers would be compensated by means of negotiated rates, in the case of individual providers, and operating and capital budgets, in the case of institutional providers. Regional operating and capital budgets would be proposed by the regional boards.

HUMAN RIGHTS ANALYSIS

Universality: Ethan Allen Health would be available to all Vermont residents, with enrollment available at the point of service. The plan may even be extended to those non-residents who work in Vermont. If the bill is financed in part with premiums, this may present obstacles to having everyone covered. If not, or if the premium structure is sufficiently progressive, it would meet the universality principle.

Equity: Ethan Allen Health would provide all medically necessary care to any resident of Vermont. By its nature, H.491 would eliminate a great deal of administrative waste, and it provides the Ethan Allen Health Board with a strategy for cost containment that focuses on the improvement of health care quality.

The combination of a progressive personal income tax, an employer payroll tax, progressive sliding-scale premiums and federal funds, combined with the absence of cost sharing (deductibles, co-payments and coinsurance) from a human-right perspective amount to a highly satisfactory financing strategy. We consider the requirement of having a primary care provider to be a positive way of satisfying the public policy goal of minimizing the use of critical care facilities for non-emergency health care.

H.491 also recognizes and attempts to address the issue of workers displaced by the transition to a single-payer system.

Accountability: Ethan Allen Health would be governed by the Ethan Allen Health Board, a public entity, with member appointments made by geographical regional boards. The regional board members are elected. The bill requires that the Ethan Allen Board include two consumers, one employer, one union member and six providers, including a primary care provider, a registered nurse, a mental-health provider, a dentist, a nursing home director, and a hospital director. This governance structure provides accountability.

Transparency: The regional boards provide for good transparency. The Ethan Allen Board would make recommendations to the legislature for funding would enable transparency of that report and the resulting legislative decisions.

Participation: The regional boards and reserved seats on the Ethan Allen Board for consumers and various providers enables participation. However, beyond this, there are no provisions that explicitly require these governing entities to actively engage the public.

H.491 would create elected (rather than appointed -- as in H.100) regional health planning boards. These boards, in turn, would appoint the initial members of the statewide board.

COMPARISON TO H.100/S.88

H.491 defines the health care services that will initially be made available (this list may be expanded by the board), whereas H.100/S.88 instructs the board that it creates to develop a "package" of services by means of a public process using various considerations.

H.491 calls upon the board that it creates to submit a revenue report proposing revenue sources, including an income tax, progressive sliding-scale premiums, a business payroll tax and federal monies. H.100/S.88 leaves revenue issues for a future legislature to decide.

H.491 emphasizes the coordination of health care at the individual level, whereas H.100/S.88 focuses on integration at the regional level.

The regional boards created by H.491 are elected, and the state-wide board is defined with an explicit role constitution, whereas H.100/S.88's regional boards are left to the general assembly to define, and its statewide board consists of just three appointed members.

H.491 calls for the creation of an office of health quality and planning to make recommendations to the Ethan Allen Board about the quality, access and funding adequacy of Ethan Allen Health.

H.491 calls for the creation of a conflict-of-interest committee, whereas H.100 just prohibits individuals with certain interests from serving on its board.

H.491 contains "just transition" provisions for workers whose jobs are eliminated by the change to a single payer.

H.510

H.510 has Rep. Poirier of Barre City, Rep. Hooper of Montpelier, and Rep. Ancel of Calais as lead sponsors.

Other Representatives sponsoring are: Bohi of Hartford, Botzow of Pownal, Browning of Arlington, Cheney of Norwich, Clarkson of Woodstock, Donovan of Burlington, Emmons of Springfield, Fisher of Lincoln, Howard of Rutland City, Lorber of Burlington, Malcolm of Pawlet, Martin of Springfield, Miller of Shaftsbury, Mitchell of Barnard, Moran of Wardsboro, Nuovo of Middlebury, Pellett of Chester, Peltz of Woodbury, Sharpe of Bristol, South of St. Johnsbury, Stevens of Waterbury, Sweaney of Windsor, Till of Jericho, Webb of Shelburne, Weston of Burlington, Zenie of Colchester, and Zuckerman of Burlington [30 sponsors total].

OUTLINE OF THE BILL

This bill combines many separate ideas and approaches to health care reform. Among these are:

- a “public option” health care plan, “Green Mountain Care,” offering primary, preventive, chronic, acute, palliative, hospital, prescription, mental health, and dental care to all Vermont residents beginning no later than 10/1/11;
- rolling state health care programs (Catamount, VHAP, Dr. Dynasaur, VermontRX) into Green Mountain Care (while preserving to Medicaid recipients to those services Medicaid recipients receive now that go beyond this coverage);
- an “individual mandate” requiring all Vermont residents (subject to a religious exemption) to have a health care plan at least equivalent to Green Mountain Care, beginning 4/1/12;
- a penalty (“assessment”) imposed for failure to obtain coverage, equivalent to 50% of the highest premium under Green Mountain Care. This penalty becomes a tax deficiency, meaning the tax department can withhold a tax refund and take the individual to court to recover it;
- point of service presumptive eligibility for health care services, with a penalty imposed (also 50% of the premium) for anyone who obtains services 3 or more times without enrolling in Green Mountain Care;
- waivers of deductibles and co-pays for primary and preventive and for chronic care provided to individuals enrolled in a chronic care management program;
- evaluation of provider payment methodologies, and to the extent pay-for-service payments are used, payments at Medicare rates + 10%;
- payment for covered services to any willing provider acting within the scope of practice authorized by law;
- global budgeting for in-state hospitals and contracting with frequently-used out-of-state hospitals, with annual growth in hospital budgets limited to the existing budget plus 3% plus the consumer price index;
- other cost-containment strategies, such as an emphasis on primary, preventive and chronic care;

- a “preferred” drug list with exceptions for instances when the preferred drug is or is expected to be ineffective or harmful; and
- additional money for student loan forgiveness for providers.

Funding Mechanisms

Green Mountain care would be financed by means of a combination of:

- federal dollars paid for Medicare and state and federal dollars paid for Medicaid, if federal waivers are obtained;
- a 10% employer payroll tax (imposed on all employers with more than 4 employees);
- sliding-scale premiums (based on projected income), ranging from 1.5% to 10% of individual, two-person or family income, capped at the actual per-member cost of the plan for each individual covered (except for those at or below the federal poverty level);
- sliding-scale annual deductibles, ranging from \$0 to \$250 for an individual receiving health care services “in-network” to \$0 to \$1,000 for a family receiving health care services “out-of-network” (except for those at or below the federal poverty level);
- coinsurance of 20% (except for those at or below the federal poverty level);
- fixed co-payments of \$10 for an office visit, \$25 for emergency care and \$75 for non-emergency care received in a hospital emergency room;
- sales taxes on cigarettes, soft drinks and candy, and
- penalties for violation of the individual mandate.

Other Features

Prescription drug coverage would be provided with no deductible and with co-payments determined by a sliding scale based on income, ranging from \$1–10 for generic, \$2–30 for preferred drugs and \$3–50 for non-preferred drugs.

The annual cost sharing for individuals, two-person groups and families is capped at \$800, \$1,200 and \$1,600, respectively, for “in-network” care and \$1,500, \$2,250 and \$3,000 for “out-of-network” care.

Any individual could enroll in Green Mountain Health even if he or she is eligible for an employer sponsored health plan.

Pre-existing condition exclusions would be prohibited in individual and small group insurance policies.

Individual and small group policies would be required to have loss ratios (the amount to be spent on health care services) of no less than 90%.

A parent could keep children up to age 27 on the parent’s policy (Green Mountain Care and all private health insurance policies) as long as the child is unmarried, has no dependents and lives in Vermont.

The bill eliminates the Health Care Reform Commission and gives oversight of Green Mountain Care to the Health Access Oversight Committee.

HUMAN RIGHTS ANALYSIS

Universality

Green Mountain Care would be available to all Vermont residents not enrolled in Medicare, with enrollment available at the point of service. Depending on the definition of “resident”, this could meet the universality standard if all immigrants were included. But it does not provide for automatic enrollment or give people the right to health care. Green Mountain Care would provide coverage for primary care, preventive care, chronic care, acute episodic care, hospital services, palliative care (including hospice services), prescriptions, mental health, and basic dental care. But it is not clear that this coverage would guarantee access to care.

Equity

The premiums and the cost-sharing provisions (co-payments and deductibles) will create barriers to access for many. Though the coinsurance provision exempts individuals, two-person groups and families below the federal poverty level, the fee is not otherwise related to one's ability to pay. A system based on premiums and deductibles is inequitable, excluding those who cannot afford that level of premium payments and cost-sharing, as well as needlessly complex. H.510 also suffers from the same flaws as any individual mandate proposal: it fails to do anything to improve the efficiency of the system, and it fosters the false premise that insurance plans are the best way to finance healthcare.

Accountability

Unfortunately, the funding scheme for Green Mountain Care includes both some regressive taxation. Moreover, by maintaining as system that allows private health insurance and by treating this public system (Green Mountain Care) as a health insurance plan, complete with premiums, deductibles, co-payments and coinsurance, Green Mountain Care fails to embrace the principle that health care is a public good. We believe that the health care system should be financed [entirely] using broad-based taxes that are based on one's ability to pay. Whether or not one is “enrolled” in Green Mountain Care should not affect whether or not (or how much) one pays for it.

Transparency

To the extent the bill specifies covered services and funding mechanisms in the bill (including cost-sharing amounts), it is transparent. To the extent that services, funding mechanisms, sliding fee scales or other elements of the plan are determined by the executive branch, the amount of transparency remains to be seen.

Participation

The bill does not specify any means for public engagement or participation in setting the covered services. Slight public involvement is enabled in the hospital budgeting process and the rule-making to set cost-sharing amounts, but the bill does not require the government to take steps to engage the public. This bill does not satisfy the participation requirement.

COMPARISON TO H.100/S.88

This bill contains eligibility language that includes any person who can show Vermont residency and lists a number of ways of showing residency including by maintaining a principal home here, by having a

child enrolled in school, or obtaining a driver's license here. This bill is more explicit in defining residency than H.100, arguably would be just as inclusive as H.100.

The cost containment provisions are explicit and focus on primary/preventive care and include a disincentive for emergency care.

This bill defines a certain package of covered services, whereas H.100 leaves that process to be defined at a later date.

A sliding scale fee system for premiums is delineated in this bill, whereas determination of premium amounts and how they are assessed is not discussed in H.100.

This bill states that "income that is unlikely to continue" shall not be included in the income calculation for the "purposes of establishing a premium."

This bill contains specific language regarding how the Plan will be administered, including language regarding the issuance of forms, membership cards and the process for determining eligibility.

This bill specifies that payments to providers, outside the global budgeting process, will be paid at Medicare +10%.

The financing mechanism for this bill is stated in detail in contrast to H.100 which does not specify a financing mechanism.

This bill has explicit language regarding pharmacy best practices and preferred drug lists. This level of detail is missing from H.100 and allows the plan to move forward quickly and without further immediate newly-established-board work.

S.181

Sponsored by Sen. Bartlett of Lamoille (also know as the Leddy/Franco idea for global hospital budgeting)

OUTLINE

- Contains hospital costs through creation of an annual budget for each hospital, with annual increases limited to the consumer price index + 3%. Provision is made for hospital budgets to be adjusted upon a showing of need arising from unforeseen or exceptional circumstances.
- A single annual payment, consistent with this budget, would be made to each hospital for all inpatient services provided to Vermont residents covered by any insurer or public health benefit plan (but not ERISA/self-insured plans, and not Medicare).
- A separate fund for making these payments would be created and overseen by the treasurer. Payments into this fund would be from the global commitment funds (public benefit programs), insurance companies, and state and municipal funds.
- The annual hospital budget considers payment from other coverage and payers as well as the 'unified health care budget' (also known as the 'expenditure analysis') and the health resources allocation plan ("HRAP") completed by BISHCA, but does not require statewide hospital budgeting or planning beyond what is already being done under current law.
- Hospital submissions are required to be under oath and fines can be imposed for violations of the law. The state can bring a court case to enforce hospital compliance.

HUMAN RIGHTS ANALYSIS

Universality

The bill does not make clear whether or not people who are currently uninsured would be covered. Therefore it is not clear if it would accomplish universal coverage for hospital services. Even if hospital coverage is provided for all, the bill does not achieve universality because it does not cover those who need services other than inpatient hospital services.

Equity

The bill does not address or accomplish equity except to the extent that it attempts to achieve sustainability by limiting hospital cost increases. It does not make clear if health care would be provided to everyone.

Accountability

It is not clear if this bill establishes a right to inpatient services for every Vermonter. Nor does it establish mechanisms for ensuring that any individual receive any right or any service. In addition, it maintains the existing insurance system, and insurance companies are not accountable to the people. This bill does not satisfy the accountability standard.

Transparency

The bill sets the cost increase rate at the consumer price index plus 3 %. There is no indication how this was determined, or how Vermonters could be involved in determining this standard or any change in the standard.

Pursuant to this bill, BISHCA determines “. . . the types of inpatient hospital services provided to Vermont residents to be covered by the global hospital payment.” 9464(b). There is no more description of how this will be accomplished or how the information would be shared with Vermonters. The bill does not even specify that the list of services be determined by rule, and there is an argument that it need not be determined by rule or any other transparent government process. This bill does not ensure transparency.

Participation

This bill does not provided for citizen input and participation in decision making. The decision about how much hospital budget may increase each year is made in the bill, and subsequent decisions are entrusted to BISHCA, without specification for any particular process, rule making or otherwise, that would ensure public engagement.

COMPARISON TO H.100/S.88

Eligibility standards are are not addressed explicitly as they are in H.100.

This bill is designed to contain costs for hospitals by limiting annual growth to the CPI plus 3%. H.100 is not as specific in its cost containment provisions.

This bill seemingly would cover all hospital services. H.100 would leave the package of covered services to be decided at a later date, but is preferable in its intent to provide comprehensive services from the start.

This bill would maintain insurance companies and insurance premiums. H.100 does not require premium payments nor maintain insurance companies.

The funding sources for this bill are existing payments made by insurance companies, public benefit programs and other self-insured plans that can be state regulated (like the state employees plan). H.100 contemplates funding from broad-based and equitable taxes, whereas the funding in this bill is not based on ability to pay.

H.196/H.512

H.196: McFaun's 'global hospital budgeting' bill, as introduced in 2009. Rep. McFaun made some changes and additions and reintroduced the bill in 2010 as H.512. Analysis is done for both bills.

OUTLINE OF THE BILLS

These bills establish a hospital security plan to provide to all Vermonters coverage for any medically necessary treatment or procedure 'received in a hospital', including those necessary to mental health and services medically necessary to assist in activities of daily living. It is unclear if outpatient services are covered or if the bill is restricted to inpatient services. The hospital security plan would be implemented by H.196 no later than January 1, 2011. That date is changed to January 1, 2012 in H.512.

The bills create a new hospital security fund from which payments would be made to individual hospitals to cover services provided to Vermonters. The payments would be based on the global and individual hospital budgets. Provisions are made for payment to out of state hospitals and for collection of payment from out of state residents.

The bills control costs by establishing an annual, global (statewide) budget for hospital care costs and annual budgets for each hospital, with cost growth limited to the annual consumer price index plus 3 percent. No annual global budget is effective until approved by the legislature.

H.512 adds a provision enabling hospitals to raise funds through charitable contributions for any capital investment projects.

No funding mechanism is established in the bill. Rather, a committee would be created to make recommendations to the Health Care Reform Commission, which commission would then make its recommendations to the General Assembly. The deadlines in established for these recommendations in H.196 have passed. The deadlines in H.512 are for a report to the health care reform commission by November 2010 and to the general assembly by January 1, 2011. The committee includes members of the legislature and the executive branch, but no specified role or membership for consumers or other members of the public. H.512 adds to the committee membership the chairs of the house and senate money committees. Six hearings or public meetings are required.

The committee is required to consider the following as potential sources of funding: an income tax, a payroll tax, premiums or cost-sharing measures, a value-added tax, and an annual hospital care fee or other consumption tax. H.512 also requires the committee to consider a sales tax. The bill also requires the agency of human services to adopt a rule establishing "income-sensitized deductibles, co-payments, an annual hospital care fee, or other cost-sharing amounts . . ."2033(c). It is unclear if this rule-making provision applies regardless of the outcome of the recommendations and decisions on funding the plan.

Presumably, once the funding mechanism is chosen and the hospital security plan established, private insurance plans would be prohibited from continuing to collect premiums for hospital services. The bill does not state as much, however.

The state would be required to apply for federal waivers that would allow inclusion of Medicaid and Medicare recipients and funds. The deadlines established in H.196 for these recommendations have passed. H.512 sets the deadlines for these applications as September 1, 2010. The bill is written so as to enable the hospital security plan to work with or without the federal waivers.

Current law requires that, in the event that the Health Care Reform Commission determines that the private insurance model for Catamount Health is not cost-effective, an act that was to occur no later

than October 1, 2009 (I do not know if this happened), the agency of administration was to issue a request for proposals for administration of Catamount Health only, with the 'insurance' coverage to be provided by the state. These bills would require that hospital coverage for those Catamount Health enrollees would be through this hospital security fund and not through Catamount Health.

These bills also change the law governing the Health Care Reform Commission by giving voting rights on the commission to the two gubernatorial appointees to the commission.

H.512 adds sections not in H.196. The first requires all health insurance company (but not state benefit programs or the state employees' health plan) to report annually to BISHCA (executive branch) on the fees the insurer negotiates with any health care facility. The definition of health care facility includes hospitals, nursing homes, mental health agencies and centers, diagnostic imaging facilities, and psychiatric facilities, among other facilities. BISHCA is then required to post these negotiated rates annually, so that consumers can compare prices.

H.512 also adds a requirement that, effective July 1, 2010, all medical malpractice cases be submitted to arbitration.

H.512 also creates a loan repayment fund for hospitalists who live in Vermont, serve in a Vermont hospital, accept Medicare and state benefit program recipients as patients, and have outstanding student debt. A half million dollars is appropriated for this fund.

HUMAN RIGHTS ANALYSIS

Universality

Hospital services would be provided to all Vermont residents, which is defined to include those who show an intent to maintain a principal dwelling place in Vermont indefinitely and return to Vermont if temporarily absent. The bill does not make clear if Vermonters would be eligible at the point of service or if they would need to first show eligibility to an administrative agency. However, because the bill only covers services provided at hospitals, thus leaving out coverage for the vast majority of health services individuals use.

Equity

The funding mechanism is not established. It is possible that a regressive tax or fee could be used. The bill appears to anticipate cost-sharing or fee payment by individuals which would create barriers to access for some people. The bill does not address transportation costs, which can also create barriers to care. In addition, the bill only covers services provided at hospitals, thus leaving out coverage for the vast majority of health services individuals use. This bill does not satisfy the equity principle.

Accountability

Because the bill only takes the first step of covering hospital services, it does not satisfy the requirement that the government be accountable to the people to ensure that every individual receives the health care he or she needs. To the extent that it would eliminate insurance coverage for hospitals and make the government accountable to the people to provide hospital services, it takes a step toward satisfying the accountability principle.

Transparency

The bill sets the cost increase rate at the consumer price index plus 3%. There is no indication how this was determined, or how Vermonters could see how this standard or any change in the standard was

determined. The determination of what are covered hospital services is not made transparent. Rule-making procedures are required for the adoption of standards and procedures for determining payments to hospitals, for the creation of annual budgets, and for any cost-sharing measures.

Participation

The bill does not require that the public be engaged in participation in any part the hospital security plan.

COMPARISON TO H.100/S.88

Eligibility standards are essentially the same as in H.100.

This bill is designed to contain costs for hospitals by limiting annual growth to the CPI plus 3%. H.100 is not as specific in its cost containment provisions.

This bill would ensure all hospital provided medically necessary services. H.100 would leave the package of covered services to be decided at a later date, but is preferable in its intent to provide comprehensive services from the start.

Neither this bill nor H.100 require premium payments.

The funding sources for this bill are not yet determined, as is the case with H.100. However, H.100 contemplates funding from broad-based and equitable taxes, while the potential taxes or funding sources here (income tax, payroll tax, cigarette tax, sales tax & cost-sharing) have a strong potential to not be equitable.

Side-by-Side Vermont Legislation Human Rights Analysis

| | H.100/S.88 | H.491 | H. 510 | S.181 |
|--|------------|------------------|--------|------------------------|
| Does the system provide healthcare to all? | Yes | Yes | Yes | No |
| Does the system provide equal access to comprehensive healthcare services? | Yes | Yes | No | No |
| Does the system treat healthcare as a public good? | Yes | Yes | No | No |
| Does the system eliminate barriers to use of needed healthcare services? | Yes | Yes | No | No |
| Is the system financed equitably? | Yes | Yes ¹ | No | No |
| Do people pay for healthcare based on their ability to pay, without regard to unrelated factors such as age, health status, gender or employment status? | Yes | Yes | No | partially ³ |
| Does the system use money effectively and efficiently? | Yes | Yes ² | No | partially ³ |
| Does the system allocate resources equitably, according to health needs? | Yes | Yes | No | partially ³ |
| Does the system improve the quality of healthcare, by rewarding providers who utilize best practices and provide excellent outcomes? | Yes | Yes | Yes | partially ³ |
| Does the system enable meaningful community participation? | Yes | Yes | No | partially ³ |
| Is the system accountable to the people it serves? | Yes | Yes | No | partially ³ |

¹ Revenue sources to finance Ethan Allen Health include an income tax, progressive sliding-scale premiums, a business payroll tax or a combination of these sources.

² H.491 uses income-sensitive premiums instead of the (already income-sensitive) income tax, which we see as adding unnecessary administrative complexity.

³ S.181 applies only to hospitals. S.181 also includes private insurance, which makes it unlikely that the bill would result in a system that would satisfy human rights standard even if it were to apply beyond hospital care.

Comments on Proposed Federal Healthcare Reform Legislation

Summary

The current federal healthcare reform proposals, including House bill HR 3962, fail to meet human rights standards. Rather, they entrench the treatment of healthcare as a commodity by mandating that everyone purchase a private insurance product.

While HR 3962 contains some positive elements, such as expanding access for poor people through the public Medicaid program and regulating private insurance corporations to prevent the most egregious forms of discrimination, the overall reform approach is to lock people into a market mechanism that sells access to healthcare based on a person's ability to pay rather than their health needs.

The current approach fails to move us toward a healthcare system that is universal, equitable or accountable to the people that it serves, and the reform process itself has lacked transparency and participation.

It is hard to explain or justify this approach by any logic other than that of treating healthcare as a source of profit for the health insurance, pharmaceutical and other medical industries.

Introduction

We evaluate the ongoing federal healthcare "reform" proposals using the human rights principles of universality, equity, accountability, transparency and participation. These fundamental principles give rise to specific human rights standards for healthcare financing, which enable us to assess reform proposals through a set of key questions, outlined below.

Q & A

ARE THE BILLS DESIGNED TO PROTECT PEOPLE'S HEALTH AND GUARANTEE COMPREHENSIVE HEALTHCARE?

None of the current reform proposals entitle people to receive the healthcare they need. Instead, healthcare is treated as a commodity that people must buy from insurance companies, unless they are eligible for public programs.

The reform debate has not been about protecting and improving people's health but about the economic impact of health expenditures. A key concern of policymakers has been to protect the financial health of the private insurance, drug and hospital industries by avoiding a strong public plan, premium caps or price negotiations. Instead of eliminating market incentives and profit motives as factors that take precedence over people's health, the proposals solidify the role of private insurance as the principal funding mechanism for healthcare in the United States, by turning everyone into a mandated customer. In contrast, proposals such as single payer (Medicare for all), based on removing insurance middlemen in order to guarantee comprehensive care for all, were ruled out from the start of the debate.

DO THE BILLS SECURE EQUAL ACCESS TO HIGH-QUALITY HEALTHCARE FOR ALL?

No.

Under HR 3962, each person — or family — would have to buy a plan from an insurance company, which would control their access to healthcare. Different insurance plans would cover some treatments but not others, would allow people to seek care from one doctor but not another or could even deny coverage for certain necessary care altogether.

In addition, different groups of people would get different coverage and therefore different access to care, depending on their ability to pay.

- Some women would not be able to obtain comprehensive reproductive health services.
- Lower- and middle-income people might be able to pay for just a bare-bones insurance plan, or they might have difficulties paying their co-payments and deductibles, or they might not be able to afford a plan at all — and instead would have to pay a tax penalty.
- Older people would have to pay twice as much under the House bill as younger people — and four times as much under the Senate bill.
- Immigrants — both “documented” and “undocumented” — would be excluded from public subsidies entirely.

In other words: people would not be able to receive healthcare according to their health needs. Instead, factors such as income or wealth, age, sex and immigration status would continue to determine access to care.

DO THE BILLS ASSUME RESPONSIBILITY FOR FINANCING HEALTHCARE PUBLICLY TO ENSURE EQUAL AND EASY ACCESS FOR ALL?

No. Healthcare continues to be treated primarily as a commodity sold by and for private interests, rather than a public good that belongs to all.

The exception is an expansion of the public Medicaid program to cover people with income under 150% of the federal poverty line, which is a positive measure included in the House bill.

It is also welcome that the bills would put a cap on some of the most drastic profiteering by the privatized Medicare Advantage plans by reimbursing them at the same level as other Medicare services.

But none of the proposals include a meaningful public insurance plan for everyone else. In the House bill, the so-called “public option” has been limited in such a way that the Congressional Budget Office (CBO) expects it to include only 6 million people (or less than 2% of the U.S. population). According to the CBO these are also likely to be people with greater health needs, which would lead to higher premium prices in the public plan compared to private plans. Consequently, the majority of the population would either be pushed into private coverage sold in a new marketplace, the so-called “Exchange,” or remain stuck with their employer’s plan, whether they like it or not.

DOES THE HOUSE BILL ELIMINATE FINANCIAL BARRIERS TO SEEING A DOCTOR, SUCH AS CO-PAYMENTS AND OTHER OUT-OF-POCKET COSTS?

No. Although HR 3962 ends cost-sharing for preventive care, all other doctor and hospital visits are subject to a deductible and co-pays, even for low-income people. These out-of-pocket expenses can be as high as \$5,000 a year. Beyond that amount, out-of-pocket expenses are capped (with lower caps for low-income people).

It has been shown that *any* payment at the point of service (i.e. seeing a doctor) deters people from utilizing needed care, which is why human rights standards call for the pre-payment of all costs — preferably through a system of broad-based, equitable taxation or sliding-scale social insurance contributions.

DOES THE HOUSE BILL PROPOSE AN EQUITABLE WAY OF FINANCING HEALTHCARE, SO THAT AFFORDABILITY IS NO LONGER AN ISSUE WHEN PEOPLE NEED CARE?

Equitable financing of healthcare would mean that people pay according to their means and corporations would contribute their share to the cost of the system as a whole. While the House bill mandates that all individuals buy health insurance, it requires only larger employers to contribute to this insurance. The Senate bill does not include an employer mandate. To enable individuals to comply with the mandate, the House bill expands the group of those who do not have to pay for their coverage (and are covered by Medicaid), and it subsidizes the insurance purchase of other lower income people on a sliding scale. The bill also outlaws gender rating, so that women no longer have to pay more than men (although women will now have to pay some additional costs to get comprehensive reproductive health services), and it prohibits rating based on health status or pre-existing conditions. But older people will still have to pay much more than younger people, with age assuming a proxy role for health status.

These new rules and subsidies fail to make healthcare more affordable for all. For example, those earning just under 400% of the federal poverty level (FPL) — an annual income of around \$44,000 — would pay \$5,300 a year in premiums and up to \$2,000 a year in cost-sharing for a “basic” plan, amounting to around 17% of their income. No support would be available to people earning more than that. For those at the bottom end of the income scale, earning just above 150% FPL, healthcare costs would be around 6-7% of a person's income — which is still higher than a general income tax increase proposed by single payer health insurance bills. Many immigrants would get no subsidies at all, and anyone unable to afford such an insurance plan would be subject to a penalty payment of 2.5% of their income. And even if subsidies were sufficient, and even if everyone who needed them were eligible, this money would only buy access to coverage, which is not the same as access to actual healthcare.

Moreover, access to coverage may likely become even less affordable as time progresses. Insurers have already threatened to increase premiums if Congress passes a version of the current bills — because they can. HR 3962 only seeks to review, not cap, premiums charged by insurers, so there is no control on prices and thus on the amount of matching subsidies needed. There is nothing in the current proposals to prevent insurers from increasing premiums at will, and taxpayer's subsidies would have to struggle to keep up with that, as growing costs in the “reformed” Massachusetts system demonstrate.

DO THE PROPOSALS USE RESOURCES COST-EFFECTIVELY AND SUSTAINABLY TO PROTECT THE HEALTH OF ALL?

No. The bills fail to enact health industry reform, with almost no changes to provider payments and no price controls on insurance and pharmaceutical companies. On the contrary, media and industry reports have predicted a substantial increase in revenues for both the insurance and drug industry, with insurers alone poised to receive around \$500 billion in subsidies along with many millions of new customers.

The lack of provider payment reform — with the exception of some pilot projects in Medicare — means that wasteful fee-for-service payments will continue, as agreed by the White House in its negotiations with hospital representatives.

In contrast, human rights principles require distributing funds according to health needs, not industry interests. Moreover, subsidizing the existing industry is not financially sustainable in the medium to long term, as experiments in a number of states — such as Massachusetts — have shown.

WOULD THE “REFORMED” HEALTHCARE SYSTEM BE ACCOUNTABLE TO THE PEOPLE?

No. The reform proposals treat people as consumers, not as citizens to whom the healthcare system has to be accountable.

Nor is sufficient attention paid to patients' rights, safety and participation. The House bill merely seeks to improve “consumer protections” through several regulatory requirements for insurance companies, including grievance and appeals mechanisms. But it does not address the market incentives that drive insurers to limit and deny care in order to generate revenue.

Moreover, through perpetuating a fragmented “system,” the functioning of this system is likely to become even more incomprehensible and opaque to ordinary people, rather than empowering them to exercise an oversight function.

By focusing on private insurance as the mechanism for financing healthcare, the current federal proposals fail to ensure that people can exercise control over the way healthcare is financed and delivered. There is no mechanism to assess whether the system is in compliance with human rights principles.

In contrast, public financing and administration of healthcare would utilize public agencies at local, state and federal levels that would be directly accountable to democratically-elected representatives and would enable people to take part in — and challenge — decisions that affect their healthcare services.

Legislative Testimony (Blended Legislation Proposal), 29 January 2010

[presented to a Joint Hearing of the House Health and Senate Health & Welfare Committees]

INTRODUCTION

The following testimony proposes “blended” legislation, based on H.100/S.88, incorporating components of several of the half-dozen healthcare reform bills that have been introduced this biennium.

It begins by describing the Healthcare is a Human Right campaign of the Vermont Workers' Center and then introduces and attempts to explain the human rights principles that guide this campaign's analysis and evaluation of proposed legislation.

Vermonters overwhelmingly understand that healthcare is a human right, and we will not shy away from reminding you, in this testimony, of your moral obligation to the people of Vermont, who are asking you to enact the embodiment of this human right in law.

Though we are here to demand a system of healthcare that embodies that human right, our goal, in providing this testimony, is not to chastise you but to help you in crafting that system. To that end — in addition to providing a proposal in appropriate detail — we are prepared to answer your questions and address potential objections.

For example, some have argued that the current economic crisis precludes the possibility of a major overhaul of our healthcare system. We answer that, unless we fix our wasteful healthcare system, there can be no economic recovery.

Some are unwilling to consider raising taxes, which we dare to propose. We answer that spending a dollar on taxes to save a dollar and a quarter — or more — on insurance premiums, deductibles and copayments is a very good deal.

And some say that we must wait for the federal reform process to run its course. We note that our federal representatives do not agree. As we do, they believe that Vermont must lead the way in establishing healthcare as a human right.

About the Vermont Workers' Center and the Healthcare is a Human Right Campaign

The Vermont Workers' Center is a democratic, member-run organization committed to taking action on the full range of issues of concern to working people.

The Healthcare is a Human Right campaign is the Vermont Workers' Center's effort to change what is politically possible in healthcare reform. The campaign is a statewide, grassroots movement of Vermonters organized around the desire to have healthcare recognized (in law) as the human right that it is and embodied in a healthcare system that satisfies human-rights standards.

The Healthcare is a Human Right campaign began about two years ago, with a statewide survey of more than twelve hundred Vermonters. The results of this survey were released, on the sixtieth anniversary of the Universal Declaration of Human Rights, in our report, *Voices of the Vermont Healthcare Crisis*. This

report details some of the suffering of Vermonters who lack health insurance, who lack adequate health insurance or who are unable to use what health insurance they have, along with many other aspects of the current healthcare crisis in Vermont. These other aspects include crippling medical debt, homelessness, domestic violence and many other ways in which Vermonters currently suffer in this crisis.

The release of this first human rights report was followed by a series of public hearings around the state, in which Vermonters testified about their experiences under our current healthcare system. As Vermonters heard the stories of others and began to realize both that they were not alone in their own suffering and that their suffering was not their own fault, the Healthcare is a Human Right campaign began to grow. On May Day, last year, more than a thousand Vermonters gathered on the Statehouse lawn in the largest workday rally in recent memory, in support of healthcare as a human right.

Since then, the Healthcare is a Human Right campaign has continued to grow. While other non-profit organizations are struggling, laying off workers and closing, the Vermont Workers' Center has been hiring new staff to handle our growing statewide network of Vermonters committed to seeing legislative reform that recognizes healthcare as a human right.

For many years, the Vermont Workers' Center has worked with other organizations seeking to reform our healthcare system. We continue to work with many groups that share our vision, including Vermont Healthcare for All and the Vermont Citizens Campaign for Health. In addition to the many thousands of individuals that have joined our campaign, more than a hundred organizations and businesses have endorsed the Healthcare is a Human Right campaign and its principles. (A list is attached.)

The Healthcare is a Human Right Campaign has also been endorsed in editorials in the Pulitzer-Prize-winning *Rutland Herald* and *Barre-Montpelier Times Argus*.

In the past year, with regional organizing committees growing in every corner of the state, we have held local legislative forums, to speak with you, our elected representatives, about our principles and our goals. We are committed to working with you, to give you the political support that you need to overcome the obstacles preventing the kind of systemic reform that achieving healthcare as a human right requires.

Campaign Principles

The Healthcare is a Human Right campaign's support of any healthcare reform legislation depends on our assessment of whether the legislation satisfies human rights standards. It is as simple as that. We wish to see the human right to healthcare embodied in law.

In evaluating a specific bill, we apply the human-rights principles of *universality*, *equity*, *accountability*, *transparency* and *participation*.

Universality is the principle that human rights must be afforded to everyone, without exception. It is by virtue of being human, alone, that every person is entitled to human rights.

Equity is the principle that every person is entitled to the same ability to enjoy human rights. Healthcare resources and services must be distributed and accessed according to people's needs, not according to payment, privilege or any other factor. Disparities and discrimination in healthcare must be eliminated, as must any barriers resulting from policies or practices.

Accountability is the principle that mechanisms must exist to enable enforcement of human rights. It is not enough merely to recognize human rights. There must be means of holding the government accountable for failing to meet human rights standards.

Transparency is the principle that government must be open with regard to information and decision-making processes. People must be able to know how public institutions needed to protect human rights are managed and run.

Participation is the principle that government must engage people and support their participation in decisions about how their human rights are ensured.

In other words:

1. Every person is entitled to comprehensive, quality healthcare.
2. Systemic barriers must not prevent people from accessing necessary healthcare.
3. The cost of financing the healthcare system must be shared fairly.
4. The healthcare system must be transparent in design, efficient in operation and accountable to the people it serves.
5. As a human right, a healthcare system that satisfies these principles is the responsibility of government to ensure.

Another way to apply these principles is by means of a set of questions, such as these:

- *Does the system provide healthcare to all? Or are some groups of people excluded, as if they are not entitled to a human right?*
- *Does the system provide equal access to comprehensive healthcare services? Or does it separate people into different tiers of access or coverage, thus producing inequities, increasing administrative costs and weakening the system itself?*
- *Does the system treat healthcare as a public good? Or does the system treat healthcare as a source of profit for powerful vested interests?*
- *Does the system eliminate barriers to use of needed healthcare services? Or do “co-payments” and other out-of-pocket costs discourage people from accessing the care that they need?*
- *Is the system financed equitably? Or do people pay for healthcare based on conditions that are unrelated to their ability to pay, such as age, health status, gender or employment status?*
- *Does the system use money effectively and efficiently? Or do numerous “payers” with numerous administrative systems introduce unnecessary costs that add nothing to the quality of the healthcare provided?*
- *Does the system allocate resources equitably, according to health needs? Or are some communities better served than others?*
- *Does the system improve the quality of healthcare, by rewarding providers who utilize best practices and provide excellent outcomes? Or does the system simply pay providers for performing medical procedures?*
- *Does the system enable meaningful community participation? Or are decisions made far from the people affected by the decisions that are made?*

- *Is the system accountable to the people it serves? Or is it complex, mysterious and impervious to influence?*

Time Frame

While we recognize that the transition to a healthcare system embodying the human right to healthcare will require time for the establishment of its administrative structures and other transition processes, we believe that the bill enacted this year must contain all of the components of the system and a time frame that accomplishes an expeditious implementation. Unjustified delay is unacceptable in the face of Vermonters' suffering unnecessary hardship, preventable illness and death. Though a direct transition to a public, single-payer healthcare system might seem daunting, the economic and humanitarian benefits of this change can only be enjoyed completely once the transition is complete.

Proposal

We recognize that Vermont has done much, over many years, to make healthcare more universal, more affordable and of higher quality than in many other states in this country. But the rest of this country sets a very low standard, compared to the rest of the developed world, in healthcare outcomes and in cost-effectiveness. The situation demands more fundamental change, if our healthcare system is to satisfy human rights standards.

At the beginning of the 2009-2010 Vermont legislative biennium, the bill that came closest to satisfying human-rights standards was H.100/S.88. Accordingly, the Healthcare Is a Human Right campaign focused on attaining passage of this bill.

In the course of the past several months, several new bills have been drafted and introduced, including:

- Senator Bartlett's hospital global-budgeting bill, S.181
- Representative Davis' "single payer" bill, H.491
- Representative Poirier's "public option" bill, H.510
- Representative Maier's bill, H.627

Each of these recent bills contains one or more features that improve upon H.100/S.88, by means of greater specificity of detail or by improved compliance with human rights standards. In addition, a number of other related bills, including Rep. Fisher's bill (H.372) and Rep. McFaun's hospital bills, H.196 and H.512, offer useful ideas. In the interest of achieving legislation that satisfies human rights standards most fully, we are proposing to incorporate some of these features into a "blended" bill, based on H.100/S.88, with the following components.

I. **UNIVERSAL & UNIFIED**

The most obvious goal of healthcare reform is achieving universality. To that end, we strongly support the requirement in H.100/S.88 that VermontCare provide for automatic enrollment at the point of service of any Vermont resident who seeks services covered by VermontCare.

We also strongly support any efforts to unify our healthcare system, particularly in reducing the extent to which individuals are separated into different "pools" and in reducing the number of administrative systems involved in healthcare finance. The former strengthens the system itself. The latter allows for greatly reduced administrative overhead and offers opportunities for more effective cost containment.

II. FOCUSED ON HEALTH

H.100/S.88 calls upon the newly created Vermont health care board to develop a “package” of essential health services to be covered by VermontCare. Some of the considerations mandated, such as comparison with available health insurance plans and anticipated revenues, are at odds with human rights principles. Moreover, we believe that there is no reason not to enumerate the initial healthcare services to be provided by VermontCare in the bill, as is done (for example) in H.491. H.491, however, fails to include family-planning [reproductive] services, which must be added to the list of covered health services enumerated, if the bill is to satisfy human-rights standards.

We wish to emphasize a few of the covered health services enumerated in H.491, which are necessary but often omitted from health insurance plans. These are dental care, vision care and transportation.

III. PUBLIC

We believe that, as a public good, our healthcare system must be both financed and administered publicly. Therefore we would require the department of health care administration to administer the system rather than allowing the department to contract with a private third-party administrator.

IV. FREE AT THE POINT OF ACCESS

We strongly support the requirement in H.100/S.88 that no payment be required for healthcare services received. Even small copayments and coinsurance deter some individuals from seeking necessary health care. Obviously such a barrier tends to worsen health outcomes. It also tends to increase rather than reduce the ultimate cost of care, by delaying that care.

V. EQUITABLE

We support the goal, in H.100/S.88, of financing our healthcare system by means of broad-based taxes and an employer tax. The progressive income tax is the most equitable revenue source currently available to us, and the historic role of employers in providing health insurance as a benefit of employment necessitates an employer contribution during the transition away from this historic period.

(The availability of an exemption from provisions of the ERISA would allow for a “fairer” employer tax, but the absence of such an exemption should not constitute an obstacle.)

H.510 proposes to supplement the system’s revenue with “sin” taxes. Though we accept the historical role of tax policy as a way of influencing individual behavior, we are uncomfortable with the regressive nature of the proposed sales taxes.

We strongly support the “just-transition” language of H.491, which calls on the board to work with the department of labor to create a program to provide support and retraining for workers dislocated by the healthcare system transition. We see this as a minimum effort in addressing our responsibility to those affected by public policy decisions that, in improving the common good, make the job of a few obsolete.

VI. CENTERED ON CARE

We specifically reject the “individual mandate” and “public option” of H.510 for several reasons.

- First, we believe that “insurance” is not an appropriate mechanism for administering healthcare financing, and our healthcare reform effort should not continue to foster this misconception by treating a public good as a “benefit.” Instead, we are seeking *social insurance*.

- Second, we believe that the free market is not an appropriate domain for attempting to ensure a public good. Adding another “option” — public or otherwise — to compete with existing private insurance plans does nothing to ensure that healthcare will become universal, affordable or of high quality.
- Third, many of the most important cost containment mechanisms that are available to us depend on reducing — not increasing — the number of “payers” and administrative systems. Adding another insurance plan would add another risk pool, another payer and another administrative system. (We recognize that H.510 would attempt to merge several public programs, but so would H.100/S.88, and the latter would also eliminate the unnecessary private insurance plans.)

VII. RESPONSIVE TO NEEDS

We believe that regional healthcare planning is vitally important to the system for several reasons, including optimization of resource allocation and, particularly, local participation of the people affected by the system. H.100/S.88 proposes a three-member board and envisions community health boards in at least three regions, with the details to be left to a future general assembly. We see no reason to delay this planning stage and would offer as an alternative the more detailed proposal in H.491, allowing the commissioner (or health care board) to propose the specific regions and provide for election of representatives to those boards.

H.491 is also helpful in offering specific considerations to be used in establishing the regions of the regional boards.

VIII. REWARDING QUALITY

We strongly support the continuation of the work that has been done in Vermont to begin compensating healthcare providers based on the quality of care rather than the number of procedures performed. Much work has been done to begin to align provider compensation with improved health outcomes, and we expect that the results of the ongoing pilot projects and studies will deepen our understanding of how to optimize care.

In addition to rewarding providers for the best healthcare outcomes and utilization of best practices, it is important that the healthcare system offer incentives for providers to deliver primary care and to practice in underserved communities.

IX. COST-EFFECTIVE

Several of the bills introduced this biennium address global budgeting, as it is a relatively straightforward way of avoiding wasteful or uncontrolled spending. We believe that the basic components of S. 181 could and should be incorporated into H.100/S.88, to provide the detail in this area that H.100/S.88 lacks.

Both H.491 and H.510 include specific language that could be incorporated into H.100/S.88's general efforts at improving the system's ability to manage healthcare provision efficiently. Though we are wary of incentives to recipients of healthcare, there is undoubtedly a great deal of efficiency to be gained by making coordinated care a given in our healthcare system and by providing other cost-containment incentives to providers, especially in the area of chronic care, as we have already begun to do and as H. 627 would accelerate.

We also support the general concept of a pharmaceutical formulary, as a mechanism for encouraging healthcare best practices.

X. ACCOUNTABLE

The healthcare horror stories that we hear — both from providers and from patients — revolve around access to care. We are just beginning to understand and implement ways of avoiding medical error, and we will continue to do so. But what our system fails to do is prevent denial of care. To do so, we need a publicly-administered system, one that is accountable to the people. We believe that our proposal is the legislation that will put us on track toward establishing this system.

Conclusion

Here in Vermont our neighbors and loved ones continue to die — and our families continue to suffer — needlessly, because we have not yet realized the universal right to healthcare. The Vermont Workers' Center believes — and we have demonstrated — that the desire to see the human right to healthcare embraced in public policy and embodied in law is a desire that engages the enduring shared values of Vermonters. Thus, it becomes a moral obligation upon you, our elected representatives.

There are real obstacles to fundamental systemic reform of healthcare. But Vermonters are no longer willing to accept obstacles as excuses for inadequate and insufficient change. Vermonters expect their elected representatives to work to overcome obstacles. We are here to help you.

Vermont has a long history of leading our nation in the establishment of human rights. It is with great excitement that we offer our assistance in establishing the human right to healthcare.

Organization/Business Endorsers of the Healthcare is a Human Right Campaign (partial list)

American Federation of State County and Municipal Employees (AFSCME) Local 1343
 AFSCME Local 1369
 AFSCME Local 1674
 American Friends
 Andy's Power and Lights, Williston
 Artist Loft, Brattleboro
 Aspergillus Association of America
 Barre Education Association
 Beth Jacob Synagogue, Montpelier
 Black Sheep Books, Montpelier
 Bob's Camera, Barre
 The Bobbin Sew Bar & Craft Lounge, Burlington
 Boisvert's Shoe Repair, Barre
 Brattleboro Bicycle Shop
 Brattleboro Books
 Brattleboro Drop-In Center
 Burlington Teachers Association
 Cafe Bueno, Barre
 Center for Media & Democracy - CCTV, Burlington
 Central Vermont League of Women Voters
 Central Vermont Peace and Justice Center
 Central Vermont Women's International League for Peace and Freedom (WILPF)
 Chris Gray Memorial Fund
 Communication Workers of America (CWA)
 Congregation Beth Jacob, Montpelier
 Cover to Cover Book Store
 Delibac Construction Company LLC, Williston

Democracy for Vermont
Diggers Mirth Farm, Burlington
Dogstar Healing Arts
Exile on Main Street, Music, Barre
First Step Print Shop, Underhill
First Unitarian Universalist Society of Burlington, Social Justice Committee
Fletcher Allen Nurses Union, Federation of Nurses & Health Professionals, UPV/AFT Local 5221
Free Vermont Radio
Global Justice Ecology Project
Green Mountain Book and Prints
Green Up SMC
Healthcare-NOW!, National
Hedding United Methodist Church, Barre
High Road VT, Middlesex
Hunger Mountain Coop UE Local 255, Montpelier
IAM Local 1829
IWW, Vermont Chapter
In the Moment~Music and Gifts, Brattleboro
Independent Tax Service Inc., Burlington
International Brotherhood of Electrical Workers Local 300
Iron Workers District Council of New England
Iron Workers Local 7
Kayak For Jack, Waterford, VT
Kingdom Recovery Center, St. Johnsbury
L.A.C.E.- Farm Market and Cafe, Barre
Langdon St. Cafe, Montpelier
Li Pon Artifacts, Brattleboro
Local Motion, Burlington
Marty's Auto, Milton
Middlebury Global Health Action Network
Moonshadows~Gifts Shop, St. Albans
National Association of Letter Carriers (NALC) 521
National Economic and Social Rights Initiative
New Leaf CSA, Brattleboro
North Country Coalition of Peace and Justice
Northeast Kingdom Healthcare for All
Old Barn Vermont, LLC, East Montpelier
Old Spokes Home, Burlington
Older Women's League
Peace & Justice Center - Vermont Livable Wage Campaign
People's Health and Wellness Clinic, Barre
Pie-in-the-Sky Farm B&B, Marshfield
Plainfield Coop
Qi River Acupuncture
Queen City Soil and Stone
Red Hen Bakery, Middlesex
Rosebud Florist, Randolph
Safeline Inc.
Small Dog Electronics, Inc.
Somali Bantu Community Association of Vermont Inc
SonMar Business Services, Colchester
St. Andrew's Episcopal Church, St. Johnsbury
St. Luke's Episcopal Church, Alburgh
Student Global Aids Campaign
Student Labor Action Movement (St. Mikes College)

Student Trade Justice Campaign (UVM)
Students For Peace and Global Justice
Umbrella, Inc., St. Johnsbury
Unitarian Universalist Church of Rutland
United Academics
United Electrical, Radio & Machine Workers of America (UE), Northeast Region
Universalist Society of W. Burke
UVM Service & Maintenance Workers Union, UE Local 267
UVM United Staff
Vermont AFL-CIO
Vermont Businesses for Social Responsibility
Vermont Cares
Vermont Center for Independent Living
Vermont Health Care For All
Vermont Iraq Veterans Against The War (IVAW)
Vermont League of Women's Voters
Vermont National Education Association (NEA)
Vermont Office of Health Care Ombudsman
Vermont Partnership/ALANA Community Org., Brattleboro
Vermont People with AIDS Coalition
Vermont Progressive Party
Vermont Public Interest Research Group (VPIRG)
Vermont Refugee Assistance
Vermont School of Herbal Studies
Vermont State Employees' Association (VSEA)
Vermont Trans Action
Vermont Workers' Center - Jobs With Justice
Washington/Orange Co. Central Labor Council AFL-CIO
Women and Children First, Barre
Zumba Burlington

[The following were accidentally omitted from the listing.]

Copley Hospital United Nurses & Allied Professionals, 5109
United Nurses and Allied Professionals

The Cost of Healthcare

“A single payer plan could extend coverage to all non-Medicare eligible residents of the state, and reduce overall state healthcare spending by approximately \$51 million”¹.

How much does health care cost in Vermont?

- Projections show that health care spending in Vermont will total \$4.9 billion in 2008 and will rise 6.2% to \$5.9 billion by 2012.
- In 2008, if health care costs were averaged for each Vermonter, each of us would have paid \$7,414. This amount is projected to be \$9,463 in 2012 ².
- From 1992 to 2009, the amount Vermonters spent on health care shot up from about 10% of the state's economy to over 17%³.
- In Vermont in 2004, health care spending was 16.2% of Gross State Product (GSP)⁴.
- From 2004 to 2008, Vermont healthcare spending grew at an average rate of 8% compared to 5% nationally⁵.

National Health Care Costs

- In 2007, U.S. health care spending was about \$7,421 per resident⁶.
- Health care spending surpassed \$2.2 trillion in 2007⁷.
- In the past decade, health care spending per person has increased 40%.
- Nationally, between 1980 and 2007, the share of gross domestic product (GDP) devoted to health care almost doubled⁸.
- In 2009, health care expenditures are expected to be approximately 18% of GDP⁹.

Overhead & Administrative Costs in the United States

- In the government- administered portion of the U.S. healthcare system, administrative costs account for about 5 % of spending¹⁰.
- In the private (insurance company) portion of the U.S. healthcare system, administrative costs can consume more than 30 % of every healthcare dollar¹¹.

Who Pays?

- Over the past nine years, premiums for employer-sponsored health insurance have more than doubled, a rate equal to four times our cumulative wage increases¹².

- According to the Kaiser Family Foundation, the average cost nationally of an employer-based family insurance policy premium in 2008 was \$12,680 – nearly the annual earnings of a full-time minimum wage job¹³.
- In 2006 the average employer- based family premium in Vermont was \$11,631, compared to a national average cost in 2006 of \$11,381¹⁴. In 1999 this coverage cost Vermonters \$6,358¹⁵.
- In Vermont, family insurance purchased through an employer will cost \$24,747 in 2016, an increase of 113 % above 2006 premium costs¹⁶.
- Projections show that by 2016 Vermonters will be spending 42.8% of their income on health insurance alone¹⁷.
- **Cost shift:** Vermont families pay an additional \$500 in premium costs due to the cost shift, and individual insurance premiums in Vermont are \$170 higher¹⁸.
- **Lost Productivity:** A recent study shows that the Vermont economy loses between \$190 million and \$380 million due to uninsured Americans who live shorter lives and have poorer health¹⁹.
- **Small Business:** Nationally, small businesses usually pay premiums that are 18 % greater than larger companies. Administrative costs account for up to 25 % of the cost of premiums for some small business health plans, compared to 10 % for large firms²⁰.
- **Schools, Local & State Government:** Our property taxes support health insurance for our municipal and school employees. If we had a system that was funded equitably and functionally run, we could save a big chunk of money on our property tax bills.

Footnotes

¹ Costs and Implications of a Single Payer Healthcare Model for the State of Vermont; Thorpe, 06

² BISHCA January 2010 Report http://www.bishca.state.vt.us/HcaDiv/Data_Reports/expenditure_analysis/healthcare_expenditure_analysis_index.htm)

³ Health care is the budget-buster— not education; 1/18/10, <http://publicassets.org/blog/health-care-is-the-budget-buster%E2%80%94not-education/>

⁴ Centers for Medicare and Medicaid Services (CMS), 9/2007, CMS 2/2007

⁵ BISHCA January 2010 Report http://www.bishca.state.vt.us/HcaDiv/Data_Reports/expenditure_analysis/healthcare_expenditure_analysis_index.htm

⁶ http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358

⁷ http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358

⁸ Health Care Reform: The Cost of Doing Nothing in Vermont, 6/19/09; dpc.senate.gov/docs/states-fs-111-1-87/vt.pdf

⁹ CEA, 6/2/2009] Health Care Reform: The Cost of Doing Nothing in Vermont, 6/19/09; dpc.senate.gov/docs/states-fs-111-1-87/vt.pdf

¹⁰ CMS

¹¹ Costs of Health Care Administration in the United States and Canada Steffie Woolhandler, M.D., M.P.H., Terry Campbell, M.H.A., and David U. Himmelstein, M.D. in the New England Journal of Medicine

¹² Kaiser Family Foundation, 9/24/2008; HealthReform.gov, 3/2009; can be found at dpc.senate.gov/docs/states-fs-111-1-87/vt.pdf

¹³ Kaiser Family Foundation, 9/24/2008; HealthReform.gov, 3/2009; can be found at dpc.senate.gov/docs/states-fs-111-1-87/vt.pdf

¹⁴ Medical Expenditure Panel Survey, accessed 6/15/2009

¹⁵ Medical Expenditure Panel Survey, accessed 6/15/2009; can be found at dpc.senate.gov/docs/states-fs-111-1-87/vt.pdf

¹⁶ [New America Foundation, accessed 6/15/2009; can be found at dpc.senate.gov/docs/states-fs-111-1-87/vt.pdf

¹⁷ v

¹⁸ Health Care Reform: The Cost of Doing Nothing in Vermont, 6/19/09; dpc.senate.gov/docs/states-fs-111-1-87/vt.pdf

¹⁹ Center for American Progress, 5/29/2009; can be found at dpc.senate.gov/docs/states-fs-111-1-87/vt.pdf

²⁰ National Center for Policy Analysis, 2/11/2009; can be found at dpc.senate.gov/docs/states-fs-111-1-87/vt.pdf

Talking Points for Conversations with Legislators

Questions

- *Will you support a bill that ensures health care as a human right consistent with these principles?*
- *Will you be a champion for the Health Care is a Human Right campaign and do anything you can to get a bill consistent with these principles passed this year?*
- *What reservations do you have? What information do you need?*
- *What can we, The Peoples' Team, do to help you get a bill consistent with these principles passed?*

Issues

THERE IS A HEALTH CARE CRISIS IN OUR COMMUNITIES

Despite the fact that we are spending twice as much on health care than all the other nations with universal care, thousands of Vermonters lack of access to quality health care. People are dying and suffering from illness because of current barriers to care. Many Vermonters now live in fear of what will happen if they get sick, and health care is now the leading cause of bankruptcy and homelessness.

ON PASSING A BILL THIS YEAR DURING A STATE BUDGET CRISIS

Vermonters can't afford the broken health care system any longer. The exploding costs of health care are bankrupting our state, and leading to a loss of much needed public services. An organized health care system that eliminated waste, inefficiency and profit and had global budgeting of hospitals would be able to provide high quality comprehensive care for every resident while savings Vermonters tens of millions of dollars.

ON COST

All the money that's needed is being paid by Vermonters now, spent through state health care benefit programs, private and employer insurance payments, and out of pocket payments. If we take out the profit and excessive administrative costs and use an organized system to control costs we can provide comprehensive care for all Vermonters.

ON FEDERAL WAIVERS

Just other programs like when we started VHAP and Dr. Dynasaur, we do not have to wait to receive the waivers before moving forward with creating a new program. Sen. Bernie Sanders has already begun been pushing the waivers we need. We need to move forward now.

We need our Vermont legislators to find ways to resolve these problems; we won't accept excuses any longer.

Guide to Vermont Representatives and Senators

[This section is currently located on the web at http://workerscenter.org/peoples_directory.]

Committee Hearing Logging Form

Healthcare Human Rights Principles: Universality, Equity, Accountability, Transparency, Participation

Date: _____ Committee: _____

Hearing Subject: _____

Person Completing this Form: _____

Who testified? Whom/what did the witness(es) represent? *(You may want to use abbreviations or a numbering system to identify who said what in the next section.)*

Summary of Witness(es)' Testimony:

Questions, Comments & Reactions of Legislators *(name legislator)*:

Follow-Up/To-Dos *(hand-outs to get, things to inform legislators of, etc.)*:

Summary and/or Important Information to Get Out to Everyone:

Revision History

- 2010-02-09 added committee hearing logging form
added FAQ: "Wouldn't a government-financed healthcare system result in rationing?"
added "Healthcare is a Human Right Campaign" to the document page header
changed page numbering to begin after the table of contents
corrected several misspellings
- 2010-02-08 initial version