Testimony for Mary Kate Mohlman, MS, PhD
Universal Primary Care Report
Senate Health and Welfare Committee
February 2, 2017

Chairwoman, members of the committee, thank you for inviting me to appear before you to discuss the 2016 report on establishing publicly-financed universal primary care.

As background, the Legislature passed Act 54 of 2015, which required the Agency of Administration to report on the cost of implementing universal primary care. Act 54 defined universal primary care as a publicly-financed program that would provide primary care services to all Vermonters, regardless of insurance coverage, ensuring that all Vermonters have access to primary care. To arrive at cost estimates, the report defined the services that would be covered, the providers that should be included, the administrative costs for implementation, and potential increases in provider reimbursement. Under a scenario that included cost-sharing, the state would need to finance between $121 million and $138 million to cover the cost of claims and administrative expenses. Additional revenue of $25 million to $124 million would be required to fund increases in provider reimbursement rate. Under a scenario without cost-sharing, those costs increase to between $187 million and $209 million for claims and administrative expenses, and an additional $27 million to $135 million for increasing provider reimbursement rate.

With that information, the Legislature in 2016 passed Act 172, which required the administration to report on:

1. Potential savings in universal health care programs that could be attributed to access to primary care;
2. Analysis of the primary care payment models created through the development of the all-payer model;
3. A potential implementation timeline for universal primary care.

The Administration review 49 articles on primary care initiatives, primarily in the United States. Of these, none focused specifically on cost savings attributable to universal access to primary care. However, many of the studies indicated that elements of primary care and prevention were associated with better outcomes and lower expenditures. Four of these studies found reduced expenditures associated with Vermont's Blueprint for Health. Other studies found positive associations between reduced costs and continuity of care, access to care, utilization of care, alternative payment models, and electronic health records.

Regarding task two, we are still in the development phase of the all-payer model. At this point, we would need more information on how the ACO all-payer system would affect patterns of care. The goal is that by incentivizing more primary and preventive care we will reduce expensive acute care and improve better management or prevention of costly chronic conditions. Because we do not yet know specifically how the all-payer model will affect patterns of care, we cannot estimate the implications this system model will have on the universal primary care model. One outcome could be the all-payer model

increases the use of primary care services, thereby increasing the cost estimates associated with universal primary care proposal.

Finally, the report also lays out a timeline for implementing universal primary care. These steps include further defining universal primary care to allow for more complete cost analyses and a financing plan; carrying out the cost analyses; passing legislation for a financing plan; and applying for federal waivers that would allow for the implementation of universal primary care.

Regarding the current Administration's position on this issue, the Scott Administration supports the goal to increase access to primary and preventive care; however, it has serious concerns about the cost of the proposed universal primary care and the burden it could put on taxpayers. These concerns are especially acute due to the uncertainty surrounding the future of the Affordable Care Act and the federal funds associated with that law and other health care programs.