Yellow highlighted is from Act 48
Red is from S. 120

Good morning! Thank you so much for inviting the League of Women Voters of Vermont, and the Vermont Physicians For A National Health Program, to give you testimony regarding the healthcare bills S 120 and S 132.

I am Betty Keller from St. Johnsbury, president of the Vermont Chapter of Physicians for a National Health Program, but I believe what you would like to hear from Physicians for a National Health Program today is the perspective of an actively practicing physician. Since I left practice quite a few years ago, I have asked Dr. Marvin Malek, our past president until last May, to speak on our behalf.

Today I am speaking on behalf of the League of Women Voters of Vermont, for whom I serve on the health care committee. The LWV of Vermont has strongly advocated for Vermont to pursue a universal, publicly funded health care system for a long time, and recently has been active in raising concerns about the lack of accountability in our accountable care organization. We are also concerned about the failure of the Green Mountain Care Board to perform the work for which it was created.

I absolutely recognize that good people can have different opinions about how to achieve a shared mission. My good colleague Dr. Malek does not share all my opinions about S 120, but right now I am representing the League of Women Voters. And some of you here have worked very hard for a very long time to try reduce health care costs for Vermonters, and very much want to be actively working on something to make things better. Thank you for your passion.

I would like to share with you a few of the sections of Act 48 that are particularly relevant as we look at S 120 and S 132.

From Act 48:

> (3) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves.

My comment:
Our current health care system is not in any way transparent or efficient, and it has become less transparent, less efficient and less accountable since OneCare has been inserted into our health care system as an additional, totally unnecessary, layer of administration.

I am not entirely convinced that this study committee is necessarily a good use of taxpayer money. We seem to have these cycles of doing a study, deciding what would be the best thing to do, deciding that is too hard, doing something else that is

unproven, not getting the result we want, and going back to another study. **However, if you are going to do another study, by all means, here is the most important sentence in S 120, which must be retained:**
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Section 2, c, The committee shall consider the following: (2) the efficacy of Vermont's All-Payer Accountable Care Organization Model and the changes to the Model that would be necessary to make health care more affordable for Vermonters or whether an alternative model may be more effective;

It would be more efficient to cancel the ACO project, or, at a minimum, to not renew it. You don't need a study to review these simple facts:

- ACOs are based on the erroneous premise that people overuse their health care, so you need to make people be more accountable in the care that they seek or the care that they give. People in the United States actually go to the doctor LESS and spend LESS time in the hospital than in developed countries with universal health care - they can't afford to go, because of deductibles and co-pays - but we still spend a lot more on health care than those countries.
- Integration of care and coordination of care are a couple of phrases that are used to speak of purported benefits of an ACO. But you don't need an ACO to Ito do those things in a rural area, with only one hospital and not that many practitioners. Maybe you need to improve the training of your health care workers, or change the culture in the workplace. A uniform electronic medical record would help. Having more money to pay for allied health professionals would help. But mostly you need to allow time in their schedules to talk to each other. That doesn't require an ACO, and an ACO may actually make it harder.
- What we want right now is affordability and access. This ACO has nothing to do with improving access. And there is no way they can improve affordability. It isn't their fault - ACO's can't improve affordability without reducing either access or quality. When any money is saved, it gets split between the clinicians and the administration - it doesn't reduce costs for the patients or for taxpayers. The way to improve affordability is to reduce administrative costs, and an ACO is ADDED administrative costs.
- OneCare is a monopoly.
  1) A single private ACO as a monopoly is dangerous: we need a single risk pool, but it must be transparent and accountable, which OneCare is proving it is not and it will fight.
  2) Several private ACO's, with defined geographic borders and a monopoly within the borders of each, carries the same risk.
  3) Multiple risk-bearing entities competing on the same turf cannot save costs because they will be spending money trying to compete. They will be lemon-dropping and cherry-picking if at all possible; they will be gaming the system for billing; they will be increasing administrative costs and reducing quality of care, because of the nature of the beast. And in a rural area, this competition would only fracture care instead of coordinating it.

From Act 48:

> (4) Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities… and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.

When you talk about "payment reform" and "value-based payments," the payment reform that is really proven - used in multiple countries that spend far less on health care - is global hospital budgets. Global budgets can also be used for other entities, like clinics and long-term care facilities. What the Green Mountain Care Board calls "Global Budgets" are actually impostors. I urge you to get a 5 or 10 minute lesson on what they really are, and teach it to every rural hospital administrator and CFO in the state, and you will see a huge difference in the attitude of rural hospital administrators toward a system that actually used them. That could be a good use of time while this Study Committee is speaking with stakeholders.

From Act 48 again:

> (10) Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth.

The mechanism to remove the most obvious unnecessary expenditure and source of excess cost growth would be to eliminate OneCare. I am particularly alarmed at having heard that we won't be able to "test the model" because expenditures related to the pandemic will throw the data off not just for 2020 but for 2021 and 2022. The justification given for renewal despite poor showings, is that we need to give it more time, but here we aren't even going to use this time to evaluate it. I am flabbergasted that this state of fiscally responsible citizens would commit to this project under these circumstances. That we would sacrifice needed health services like addiction services, so that rural hospitals can pay their fee to the ACO, is astounding to me.

> (11) The financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably.

There will be disruptions someday when we transition to a national health program. I was disappointed that on a federal level so little was done to deal with the health care crisis while we already were moving money around to help companies, families, states and communities weather the economic impact of the pandemic. That would have been the perfect time to take up the federal Medicare for All bill. But here we are. In

Vermont we are looking at how to use some of the money to help people pay for their health insurance.
In S 120, Section 2,
(c) Powers and duties. The Committee shall explore opportunities to make health care more affordable for Vermont residents and employers, including identifying potential opportunities to leverage federal flexibility and financing and to expand existing public health care programs. The Committee shall consider the following: …

(5) opportunities made available by the Biden Administration to expand access to affordable health care through existing public health care programs or through the creation of new or expanded public option programs, including the potential for expanding Medicare to cover individuals between 50 and 64 years of age and for expanding Vermont's Dr. Dynasaur program to cover individuals up to 26 years of age to align with the young adult coverage under the Affordable Care Act.

I urge you to add: or through pursuing other programs with a State Innovation Waiver through Section 1332 in the ACA.

So here is where the public hearings come in. As long as you are traveling around the state, what are the most productive ways to use those hearings?
1) Teach what ACO's are, what their maximum potential is, what they can't possibly do, how much they cost, and where the money goes. Then ask for their input, and make their thoughts loudly and clearly known to the Agency of Human Services, the Governor, and the GMCB.
2) Before you go, decide what innovation waivers you want to pursue, and be ready to gather the needed input for your application.

There is a strong urge to DO SOMETHING! And there is this feeling that you have to pursue the ACO because you don't have anything else to try.
First Do No Harm. Sometimes the patient will get better from a useless intervention due to the placebo effect, because you were nurturing them. But bloodletting, for instance, was doing harm.
ACOs are not a harmless intervention. Even if you don't have a "Plan B," it is better to abandon this Plan A.