Resolution #1: **Resolution in support of a single-payer, national health program. Submitted to VMS Council by Jane Katz Field, M.D., September 16, 2020.**

Responses:

1. I am open to this as long as with current insurance, some offices can still maintain a private practice that takes no insurance
2. This comes across as a "kitchen sink" resolution. Many of the core criteria and principles may be better served as separate resolutions. While I support the focus of this resolution, it could benefit from some revising and separating out into categories (physician concerns, reimbursement strategies, hospital budgets, collective bargaining, etc).
3. The current hybrid system is inherently unfair. For many individuals who have access to HC now, our current system is unsustainable
4. Single payer in Vermont has led to decreased influence for physicians about important patient care issues and reimbursement. I am concerned that a national system will only accelerate this trend. Hospital administrations have too much power currently and this will only increase if we do not strongly promote and enforce the collective participation plan.
5. I strongly oppose this movement. A single payer system failed in Vermont, partly due to the immense cost of such a system. There is little hope that the nation can financially support this given the recent historic spending for COVID-related stimulus packages which has increased the national debt immensely, bringing some to question whether American debt will continue to be "attractive" for lenders. A national health program would ruin almost all private practices, forcing physicians to be employed by large hospital networks. It is foolish to think that administrative costs will be lower in this setting as private practices have markedly lower administrative costs compared to large, regional healthcare organizations. Furthermore, Medicare is responsible for creating some of the most asinine "hoops" for healthcare professionals to jump through (i.e. welcome to medicare physical, MIPS (which will add to administrative cost because physician groups will need to employ non-clinicians to manage these initiatives). Physician reimbursement under such a model will undoubtedly decline given the elimination of payer competition, yet I see no plan for addressing the cost of medical education (the existing shortage of physicians will acutely worsen if this is not addressed before a national plan is passed). Medicaid expansion at a state level since the ACA was passed has clearly demonstrated improved health outcomes and further expansion at a state level could be considered. Opening health insurance across state lines will particularly benefit states such as VT where the vast majority of insurance is provided by 2-3 insurers by introducing competition to drive down the cost of insurance. Mandating "emergency" or "catastrophic" coverage for all americans and allowing individuals to see the out of pocket cost of elective and outpatient healthcare will allow the market to functional naturally. This proposal also does not address what to do for those with HSAs. By moving to a single payer system, the assumption is that the private market has failed. A strong case can be made that the private market has failed in a large part due to the crippling of markets from governmental restrictions.
6. I agree with all of the principles elucidated but I think it is important to acknowledge that a single payor system, while it would accomplish them, is not necessarily the only way to do so.
7. I support this effort as I feel that overall it would likely improve care and (gradually) reduce overall cost of care delivery to the most people possible.
8. Consider adding neurology to the priority areas given the number of patients for whom neurologists assume chronic care (MS, Parkinsons, ALS, Muscular Dystrophy, etc).
9. I fully support this resolution
10. I think everyone in the US should be covered, no exceptions, no weaseling by insurance companies, no surprise nor arbitrary denials. I favor the first resolution.
11. No
12. OK with this

13. Oppose. Sadly, while there are many ideals in this proposal that I support, I see the resolution as unrealistic, setting unattainable goals in the current context.
14. Against. It is unrealistic at this time.
15. I am unequivocally in favor of this proposal as outlined
16. I support this
17. I would urge that we eliminate "h" and instead support a resolution that is more or less in line with the Democratic platform which is a "Medicare for all" option for anyone who wants it that does not eliminate private insurance.
18. Agree
19. Agree
20. I would add contraception to b)
21. I support it, but are we saying anything about what we will support as intermediate steps along the way? Such as standardization of forms and health plan offerings and benefits by private insurers? This too would generate savings along the way.
22. Disagree
23. looks good
24. agree
25. I am absolutely delighted and amazed by this. After all these years we're finally getting our act together.
26. YES, AGREE!!
27. I oppose socialism and socialized medicine. Why should productive, hard working, tax paying citizens who already have good health insurance be forced to accept government healthcare? We have Medicaid to insure the poor. We can subsidize private insurance plans for the working poor. Why the push to increase centralized government power? We fought the cold war to oppose communism and its cousin, socialism. There is no need to embrace socialized medicine.
28. I disagree with point C. There should be some type of nominal co-pay, this will limit abuse of a national health system
29. Agree
30. Support
31. I support a single payor system whereby the State collects the taxes and the re-imburses the insuror contracted with. That could be both a private insurer or the State, just as with traditional Medicare and Medicare Advantage. It it means sticking with the ACA for the time being, there needs to be a public option
32. c) affordability is relative.. and perhaps no cost sharing for primary care..but no cost sharing for anything, even with a sliding scale, is a big ask. f) what does "promotes global operating budgets for hospitals" mean? Hospitals that are low cost and value should be able to grow, and those that aren't should shrink. Are we wanting them to be regulated based on their global budgets? Does not work here in Vermont...misses the important issues of efficiency and value! and g) same thing.. we should not be getting into how hospitals are regulated or financed. We don;t know the right way to do that. It should not be the way it is in Vermont where Hospitals can spend on buildings when the health system can't afford it. h) private health insurance companies may often be able to function with less administrative burden and less cost, but Let's not get into whether there are private options... clinicians won;t sign on with them if they are administratively burdensome, and if the public system runs well.. many European countries have successfully created universal coverage, and allowed private options. There's no reason to make this a deal breaker
33. While I support much of this, I am more comfortable with next resolution.
34. fully agree and support
35. I support this resolution
36. nice idea
37. Agree
38. Completely agree

39. I agree.
40. I support the gust of the resolution. 1) I think no cost sharing is unrealistic 2) Eliminating private insurance will be a generational, gradual process 3) separating out "generalists" will likely heighten divisiveness, dualistic thinking, and decrease cohesion within medical professionals
41. Strongly in favor of universal access to health care
42. Agree
43. I do not support this.
44. Don't agree. We shouldn't cover everybody because they reside in the US. Private health insurers are running the medicare system now. I don't think we want government bureaucracy running it. We know they don't run the VA program well.
45. I agree
46. Agreed
47. Proposed modifications: To b) add to the examples of medically necessary services: “gender affirming medications and surgeries”; To d) insert after health care providers, “including independent clinicians,” ; In c) delete or modify “ban on investor-owned health care facilities” - Green Mountain Surgery Center is a lower cost site of care than UVMMC, for example;
48. I would support this, but congress will never pass anything like this in the current environment. I wonder if this is even this good in other countries that have a national health service. But, I agree in principle.
49. While I do support some form of single payer, the following concerns me re achievability: "Eliminates the role of private health insurance companies, thereby greatly reducing administrative costs and burdens on clinicians." Lobbying against such a provision would be prodigious & well funded, laudable tho the intention might be. Other countries with universal health care do accommodate supplementary private insurance, as with Medicare.
50. Agree
51. Great! Strongly support this.
52. Agree
53. It would be interesting to discuss these resolves, but as written, I would not be in favor.
54. Oppose
55. Yes
56. If we are all paid at Medicare rates, no one will be happy.
57. Disagree
58. I like the first resolve. I think the second resolve gets bogged down with 14 components. In "c", I would remove "a ban on investor-owned healthcare facilities since these can vary widely and not necessarily increase cost of care. I do not think "k" is clear to me. Why do healthcare and insurance workers need job retraining and job placement? Is this because the insurance companies will be eliminated and those employees will need jobs? For "n", I don't think that it is up to VMS to dictate that a publicly financed health care system should include a "modest new tax" on individuals
59. I support this resolution. I suggest a few changes for clarity: Line 87: “incentive” should be “incentivize”. Line 94: “family practice” should be “family medicine” Line 101: delete “providers” and substitute “physician and other medical practices, hospitals, and mental health facilities.” Also, a couple of comments on items under the second Resolved, for consideration : Paragraph c: There should be no cost sharing for primary care services. However, a co-pay for other specialist services might be considered, thus giving a financial incentive for patients to seek primary care first. Paragraph h: Private health insurance companies could continue, though on a greatly reduced scale, to cover services beyond the basic benefit package for individuals who choose to pay for this extra coverage. This would also be a resource for employers who may have union contracts to cover services beyond those in the national health program.
60. I am in full support of this resolution! Physicians as a group need to take a stand in favor of single payer, which is the only financing system that can control costs, provide universal coverage, decrease the

administrative burden on physicians and improve public health. COVID has exposed the need to separate health insurance from employment. The only change I would suggest is the 2nd sentence on principle (f), because paying physicians on quality and outcomes has actually increased administrative costs and added to the disparities in health care. We physicians have to say no to insurance companies calling the shots!

61. Compelling and comprehensive! I have no changes to suggest.
62. YES!! I fully support this resolution and believe the medical society's support is critical. The economics of our current insurance system contributes to and reinforces the inequities in health care that we as physicians have a duty to address in our advocacy role. I believe a single payer system in which everyone is in the same system assures equity and quality care accross the board and is the only way to achieve cost savings. The majority of Americans support a single payer system and the current pandemic with massive unemployment underscores the problem with our current employer sponsored health insurance model in which costs are spiraling out of control and patients and providers struggle to get and provide the care needed. It is time for the VMS to take a leadership role and advocate for the system that will lead to better health outcomes and a sustainable system over the long run. Our professional ethics and responsibility requires this and our patients lives depend on it.
63. While I favor a single payer plan this resolution would cover every conceivable type of health care with essentially no regard for how it would be paid for. Therefore I would vote against it.
64. STATEMENT IN SUPPORT OF VMS RESOLUTION #1 IN SUPPORT OF A SINGLE PAYER, NATIONAL HEALTH PROGRAM I'm writing to express my strong support for the Resolution that proposes a single-payer, national health program. In the US, we've fumbled along from Health Systems Agencies, to HMOs, to managed care, to disease management, to consumer driven health plans, and most rently accountable care organizations. Each of these was touted as a solution to the multiple dysfunctions in the US health care system. But despite them—and in many cases because of them, the US system offers its citizens tremendous limits on access to care, embarrassingly poor public health outcomes compared to every other wealthy across the globe, and despite these, by far the highest per capita cost in the world. One would think that with such poor health outcomes and access that our spending would be lower, but in fact per capita health care spending is double the average of the other two dozen developed nations, each of which provides coverage to their entire populations with minimal patient copayments. The model of competing insurance companies is a dismal failure, and basic microeconomics explain its failure at cost control: Each insurer inflicts its own unique set of steps for pre-approval of tests and treatments physicians have ordered, or subcontracts out the prior approval activity, creating another profitable niche in the medical marketplace. While the activities of these companies provide handsome dividends to their stockholder, this micromanagement leads to unending annoyance to doctors and the administrative staffs in physician offices. This gratuitous industry sector is unknown in the other developed countries. Each insurer has a different formulary which they don't disclose to physicians. This often forces physicians into a time-consuming guessing game to identify the "right" medication, i.e, the one that insurer will pay for. The hundreds of insurers have no bargaining power vis-à-vis vendors of medical equipment and supplies.. And no other nation has any need for pharmacy benefit managers, which siphon off yet more money out of the pockets of Americans for providing a disservice: We end up paying far more than any other nation for drugs, whether measured per pill, per prescription, or per capita. The single strategy used by private insurance companies that is effective in controlling their cost is the most harmful: the practice of selective marketing to the healthiest potential customers and, conversely, avoiding those who are sicker and more likely to generate high cost in the subsequent year. This insurer practice leads to untold tragedy: Especially poor coverage for rehab care, cancer medications, and durable medical equipment has the tacit goal of discouraging the sicker customers from re-enrolling in the subsequent year. The many nations with single payer systems deploy cost control strategies—exactly as outlined in Resolution #1—that meet 3 criteria: Don't impose financial barriers to care on patients; don't create a hassle to physicians and other providers, and improve the public health. Among the many dysfunctional developments in the US health care system over the last 20 years is

the degradation of primary care. As a primary care provider, I live every one of the administrative hassles I referred to above, and is leading to my decision to retire within the next year—sooner than I would otherwise have done. A nurse practitioner in my practice in Ludlow, VT who recently completed her training just cut her hours from full time to 50% FTE due to primary care burnout, and will work in urgent care during the other 0.5FTE. Our disorganized health system doesn't lift a finger to either improve primary care compensation or relieve the administrative burden because it can't: It's baked into the system. Each insurer is just doing what they can to reduce costs—not total system cost—just their own cost. It's unsurprising to read in the February 4, 2020 issue of the Annals of Internal Medicine that one of the largest national insurers—covering approximately 10 million Americans-- reported a 24.2% reduction in the number of primary care visits per capita between 2008 and 2016 (Ann Intern Med. 2020;172:240-247). The authors attribute this primarily to the increase in deductibles and copayments through the period. There is a near universal consensus among experts in health policy that a healthy, vigorous primary care sector is essential to both cost control and public health. So the degradation of primary care among insured Americans is unwelcome. And it is not occurring in the other developed nations. I also strongly support the twelfth core principle in Resolution #1 (labeled "l") that supports the development of software within the public sector which would then be given free of charge to every provider of care in the US. Not only will this eliminate annual licensing fees the hundreds of EMR software vendors charge, but also will resolve the Babel-like information silos in which medical practitioners work. So often, we wait around hoping that a fax will arrive from Florida providing at least a little useful information when the snowbirds return from Florida each spring. But it's not merely the snowbirds—I rely on faxes to get records from UVM, and even from the 3 closest hospitals to the one I work at. This leads to both sub-optimal care, and needless cost due to duplicative testing, and failure to fully understand the patient's medical circumstances. The American experience of the last 70 years provides more than enough reason to support major change in the US health care system. But lest anyone had failed to recognize that need, the COVID pandemic has laid bare the degree of dysfunction in our health care system: Exactly when we need every American to have access to the care they need, millions of additional Americans lost their health coverage, ,adding on to the 30 million Americans who were already uninsured, and the 50 million underinsured Americans. It wreaked havoc on hospital budgets, esp in rural areas. None of these adverse effects occurred in any country with a single payer system: Hospital budgets were not imperiled, not one citizen lost their health coverage. From a political standpoint, incremental reform is far easier than the major system change Resolution #1 envisions. But Americans have been waiting 70 years for even a single incremental system reform to simultaneously expand coverage and control cost. This includes Obamacare, which has not prevented ongoing medical inflation despite imposing high deductibles and copays on Americans who use the health care exchanges it created. It's long overdue for Americans to take on this difficult struggle, but based on the enormous successes experienced across the globe among the developed nations which have single payer systems, we have every reason to expect similar, tremendous benefit to our population, and to the budgets of state, local, and federal government, businesses, and most importantly---families' budgets. And in so doing, physicians can return to providing care rather than endlessly clicking and wasting time with prior approval phone calls. It is high time to see our profession finally take on a leadership role in the struggle for a humane, affordable health care system. The Vermont Medical Society can demonstrate this leadership by adopting

Resolution #2: **Reaffirming VMS principles of health reform & statement of need for universal coverage Submitted to VMS Council by S. Glen Neale, M.D., September 16, 2020.**

Responses:

1. I oppose resolution #2, a wish list offering no viable strategy to achieve any of its stated goals. It would be embarrassing for VMS to adopt, giving VMS the appearance of being feckless, avoiding the difficult issues.

2. I support this resolution and agree with the stated principles. There is too much emphasis on the ACP in the various “whereas” paragraphs. The ACP deserves credit for advancing the cause but other organizations have offered similar ideas. The resolution does and should clearly state that a single payer plan could accomplish the goals of these principles.
3. I do not support this resolution (2 submitted by Glenn Neale) as the strategies suggested (ie continued support of the current pluralistic system, employer based insurance coverage and state reform efforts embodied in the All Payer model) cannot achieve the goals outlined including equitable and universal access that adequately address social determinants of health and that prioritizes primary care and provides essential care for low income patients. The ACA should not be rolled back and it's protections are valuable but it has not worked to make care equitable and available to all. I have patients who are forced to drop insurance because the premium is too expensive and they fall short of state assistance but still must choose between multiple family needs and health insurance. Further I have working patients who cannot afford the prohibitive co pays and deductibles that are a component of our current insurance system. The strategy to achieve the goals outlined in this resolution cannot be achieved through the current state based reform efforts, the so called All Payer Model established through One Care. This model in it's current form increases complexity, burdens independent primary care providers with costly documentation of quality that is tied to their reimbursement but is not necessarily a true measure of quality. One Care, our Vermont All Payor Reform effort creates a system of competing risk bearing entities which leads to cherry picking and lemon dropping whereby sick people are pushed out. When you contract with a 3rd party like One Care, there will inevitably be excess administrative costs and no savings. PCP's who operate according to a fee for service model are not the cost drivers nor are they providing excessive care. One Care's rationale to shift risk to doctors is thus ineffective and worse.. it will put independent physicians out of business. The current risk adjustment formula is not accurate and, in a capitation system where risk is shifted to the doctor, the doctor must make a huge investment in IT and younger doctors starting out without a stable middle class and healthy population will be unable to compete and survive. This is hardly consistent with the principle of expanded and effective primary care in Vermont. Instead the way to achieve the principles outlined in the beginning of this resolution would be to support a single payer sytem whereby the system is simplified and where savings can be achieved through the elimination of the many unnecessary administrative costs associated with our pluralistic system including billing departments, scribes, coders etc. A national single payer system is the way to achieve these goals and I urge the VMS to reject this resolution and to support the single payer resolution (#1 submitted by Dr Jane Katz Field) that speaks to this.
4. I personally believe the theoretical benefit of cost savings from eliminating bureaucratic hurdles in a single payer system will be lost in a government-sponsored public option system as the insurance infrastructure will persist. This weakens the argument that introduction of universal healthcare will lead to cost savings and I fear would lead to inequitable care between the 2 systems. However, I understand the move to a single payer system is quite drastic and unimaginable for some folk and I appreciate the language in this resolution that reaffirms the components of universal coverage.
5. I am not in support of this resolution. Some of the reforms mentioned-- public option, the All-Payer model (represented by OneCareVT), and an improved ACA--do not meet the criteria stated in the 1st "resolved," the way single payer would. Multipayer systems incorporating for-profit insurers have not gleaned large administrative savings, which is needed to cut healthcare spending. Including support for those reforms adds to the confusion around healthcare reform. To get the maximum percentage of health care dollars into direct care, a principle in the VMS 2003 statement, we need single payer. It would be a big change, but a needed change. And through collective bargaining, physicians could ensure a just reimbursement, especially for primary care. Only a single payer reform could resolve coverage and affordability problems, preserve the choices patients value (choice of doctor and hospital, not insurance co) and allow us physicians to focus on what matters most: caring for our patients.

6. I would support this with some changes. Some of the premises upon which the “Resolves” are based are questionable; most are fine. I suggest the following changes: Line 74: after “essential care”, delete the rest of the sentence and substitute “for everyone.” Line 88: delete “continues to” and substitute “will” Line 90: delete: “including participation in the All-Payer Model” Line 93: delete “even as” and substitute “if”
7. I can support this resolution
8. Agree
9. Yes
10. Agreed
11. I support these resolves.
12. Agree
13. Agree
14. I fully support a commitment to Universal Coverage & feel it might be more efficacious than support of Single Payer, although I personally would prefer the latter.
15. Agree
16. Agreed
17. I agree
18. I support this
19. Agree with this
20. very important in all resolutions to state that telemedicine should be reimburse with equitable dollars to in person. It has to be the same. Patient are going to demand it after this COVID period. We can't go back to the torture on billing and compliance of the past. trust in physicians needs to be restored. many people are quitting medicine over this type of torture.
21. Agree
22. continued efforts to study and evaluate the All-Payer experiment also needs to be embedded in the resolution. the hoped for outcomes are laudable, but not yet fully supported by the current state of evidence
23. I agree.
24. Agree
25. Seems different from the other one, pusillanimous.
26. I support this resolution
27. agree and fully support
28. I find this more in keeping with my current thoughts, with more flexibility as we try to reach consensus. I may adjust my thinking as I go forward, but this is more in keeping with my current thinking on this subject.
29. the third resolved is problematic. The State medical society needs to take a critical assessment of the All Payer Model before supporting it again. There is not enough evidence that it is based on sound principles of reducing cost, or focus on primary care, and it is extremely costly, with no sign of reducing costs for the average Vermonter, especially the commercial insurance market.
30. Support
31. Support
32. Agree
33. AGREE
34. Ditto
35. Would change that VMS recognizes the APM as a stepping stone to more equitable progressive health care such as single payer. Perpetuating APM means playing in the sandbox with private insurance companies.
36. Agree

37. Agree, but I take issue with "predictable" charges; too vague to be meaningful, and need for care often not "predictable"
38. Looks good, these resolutions.
39. Agree
40. Agree
41. Without spending tons of time, unclear why 1 and 2 are not combined
42. Support universal coverage but again not supportive of eliminating private insurance for those who want it
43. I support this
44. I am unequivocally supportive of this resolution as proposed
45. For.
46. Support.
47. OK with this too, as long as nothing in it interferes with overriding goal of resolution #1.
48. No
49. I fully support this resolution
50. Defining high value care for all patients will be a challenge. Metrics to measure this are robust for inpatients (e.g. MI, CHF, stroke, sepsis, etc.) and much less robust for outpatient conditions. For example, there are no quality metrics by which to evaluate care for a patient with peripheral neuropathy that could be measured for such a purpose.
51. I support this effort
52. Agree
53. Instead of using "social determinants of health" to push forward universal insurance, VMS should focus efforts on stimulating research to answer questions about what interventions effectively improve "social determinants of health" since these undoubtedly result in detrimental chronic disease. While much research has been done to identify a variety of social determinants as problematic, I have seen very little research showing interventions which have changed outcomes (in fact many interventions have been shown to be ineffective in producing lasting effects when the intervention is withdrawn). VMS should focus on generating interventions that have been shown to be effective for the long term via research. Many public organizations and governmental agencies are citing social determinants of health as reasons to spend money on a variety of programs in which the evidence is simply not there to support their efficacy. Tax payer money should be spent on programs that have not been shown to provide a lasting benefit when the interventions are withdrawn.
54. I belive that health care reform must separate patient care principles from reimbursement concerns. Otherwise, it's just a variation of past and current sysytems. Which mostly focusses on "who is paying for health care" rather than caring for each person. When we conjoin these issues we confuse everyone who may want to improve the delivery of health care to our citizens.
55. Yes