Vermont Legislative Research Service

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Single Payer Healthcare Systems

Vermont has had a long and complex history with attempts to change the healthcare system. For nearly a decade there have been different movements to adopt some form of universal healthcare for Vermont residents. Currently, Vermont has not made any large-scale changes to the healthcare system. There have been a variety of countries across the globe that have adopted forms of single payer or universal healthcare systems. These systems vary greatly from country to country, and it is important to understand the similarities and differences between these systems when looking at healthcare reform in Vermont. This report begins by looking at the history of the debate around healthcare reform in Vermont and the legislation brought forward at the time of these discussions. It then discusses the report created by a group of economists looking into the feasibility of universal healthcare in Vermont. The report also examines bills introduced by other states to adopt single payer healthcare systems as well as the systems adopted by other nations.

The 2018 Vermont Household Health Insurance Survey (VHHIS) found that of the 97% of Vermont residents who indicated they had a primary source of health insurance, 53% of these residents had private health insurance, while 19% had Medicare and 22% had Medicaid.

the uninsured [were] very (51%) or somewhat (25%) interested in a state health insurance program."[5]

Vermont Context

The Affordable Care Act

The Affordable Care Act (ACA) was enacted in March 2010 across the United States, including in Vermont. According to a report done by the National Conference of State Legislatures, the ACA "intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs."[6] Between 2013 and 2016 the number of uninsured individuals in Vermont decreased 48.9 percent, from forty-five thousand to twenty-three thousand, bringing the total proportion of uninsured individuals to 3.7 percent of the state's population.[7] This level is below the national rate of un

needed to attain health care reform."[13] The commission was to prepare a report on potential health care reform options, considering the financial, social, and administrative impacts of each option.

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pay copayments or deductibles.[36] The program would have been funded by tax increases that would have increased employer payroll taxes by 15 percent. The initiative received only 21 percent support from voters.[37] Since the 2016 vote the state has shifted their focus to reforming the existing program and a new healthcare bill is moving to a committee hearing.[38] The new bill would give private insurance companies until 2025 to make significant reductions in costs to patients, if this cannot be achieved a state insurance program would be created.[39] The plan is still in the early stages and the legislature is attempting negotiations with the hospital association.[40]

International Single Payer Healthcare Systems

Japan Healthcare System

Japan utilizes a statutory healthcare system (SHIS) which covers 98.3 percent of the population.[41] In addition to the SHIS there are some supplementary and complementary private insurance options. In 2015, total health expenditures were eleven percent of Japan's GDP, eighty-four percent of which was publicly financed mainly through the SHIS.[42]

The SHIS contains two types of mandatory insurance, employment-based plans which cover 59 percent of the population, an (,)5 5 98 (o)12 (nte)3 i4tm( )-10 (w)64 (a)4-0.u(o)2 (pu)10 (l)9opuaJ91j5

care, approved prescription drugs, home care services provided by mental institutions, hospice care, physical therapy, and most dental care.[48]

The SHIS has significant measures in place to keep out-of-pocket costs low for individuals. All enrollees have to pay thirty percent coinsurance for all health services along with small copayments for primary care and specialty visits, and preventative screenings.[49] There are also maximums for monthly out-of-pocket payments, determined by age and income. Subsidies are also available for low-income households for people with ongoing medical conditions, disabilities, and mental illnesses.[50] The SHIS has maximums on household health and long term care out-of-pocket determined by age and income, ranging from USD 3,4 to USD 21,200 per enrollee.[51]

Private insurance provides a supplementary role to that of public insurance, however more than seventy percent of the population has some form of secondary health insurance.[52] This is largely to serve as additional income in cases of sickness. Despite this, the number of supplementary privath473 (206c0 (e)13 ()2 (u)6 (ran)-4 (c)4 (e)-1 ( )10 4 (a)4 b5e)13 (0 4 (a)4)4 (e)hD

for care, prescription medication, and coinsurance for hospital stays.[67] There are exemptions from copayments in cases such as childbirth, specific catastrophic diseases and conditions, veterans and their families, low-income households, and children under three years of age.[68] However, even in cases where individuals are required to pay copayments, those who fail to pay are still guaranteed full access to healthcare.[69]

Conclusion

Due to rising healthcare costs, Vermont attempted to reform its healthcare system and transition towards a single