

Understanding Vermont's Health Policy Choices

*A collection of Ethan Allen Institute commentaries and reports
relevant to the legislative debate on health care policy in 2006.*

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An Ethan Allen Institute Report

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INTRODUCTION

This publication contains a selection of twelve Ethan Allen Institute publications relevant to the current debate over the future of health care policy. Eight selections (1-5, 7-9) originally appeared as commentaries in Vermont newspapers. Items 6, 11 and 12 appeared in the Ethan Allen Letter. Item 10 is the condensed final section of our report *Health Care in Vermont: A New Prescription*, released at our conference “Vermont Health Care in the 21st Century” in June 2004.

These publications clearly reflect a point of view. It is a point of view that favors a consumer-driven health care system, where empowered patients make informed choices about lifestyles, care and providers. It places a high value on personal responsibility and ownership, marketplace choices, limited government involvement, and concern for the tax burdens of Vermonters. It posits that lower income families continue to obtain government assistance.

This point of view is opposed to a government takeover of the health care, with its necessary allocation of funds and services, rationing, regulation, price controls, waiting lines, provider underpayment, obsolete technology, shabby facilities, all-powerful bureaucracies, and much higher taxes.

Having said that up front, even readers who have a different point of view will find this report to be well informed, well written, factually accurate, fairly argued, and independent of any economic or political interest. Other related topics addressed by Institute commentaries over the years include Medicaid, pharmaceutical pricing, the home health care monopoly, and medical malpractice liability reform. These may be found on the Institute’s web page, www.ethanallen.org.

– John McClaughry, President, Ethan Allen Institute

A Clear Choice for Health Care

Earlier this month one of Vermont's leading newspapers editorialized that "drift and confusion are words that could describe the present debate about health care issues in Vermont... Remedies are proposed from all sides, but they consist of stopgap measures designed to address a small part of the problem and usually for the short term."

Judging only from bills proposed in the legislature over the past two or three years, the editorial writer would have a case. There are, however, two clear, comprehensive, policy visions for health care reform competing for acceptance. Though the two are radically different in principle and in likely results, they do not evince "drift and confusion".

One vision is commonly called "single payer". It is based on the idealistic axiom that "health care is a right of all", although it is not so clear about just whence that right arises. That axiom translates in practice into a collectivist health care system where everybody (the government) controls or operates all health care providers, delivers to everybody as much non-elective care as the government believes each person needs, and sends the bill to everybody (the taxpayers).

The single payer plan controls health care costs by having bureaucrats allocate a politically determined amount of tax dollars to the various health care providers (doctors, dentists, hospitals, nursing homes etc.). As the Canadians have demonstrated, when the amounts allocated in the "global budget" are spent, doctors go on vacation and hospitals close wings until the next fiscal year brings new money.

Like any comprehensive system, single payer has its upside and its downside. The upside is that everybody can go to a clinic and get treated for free. The downside is that the patient may not get the treatment she really needs, she is likely to have to wait quite a while for even emergency care, more expensive and complex treatment is discouraged or pushed off, and she is given only the choice of what the budget and the bureaucrats offer, and that's it. And of course the single payer system has produced a financial crisis everywhere it has been tried (as in Canada, and increasingly in U.S. Medicare).

The other system, called "patient power", is almost diametrically opposite in principle. It is based on the individualistic idea that maintaining your wellness is your business, not everybody's business. No one has any right to demand that the government force his fellow citizens to pay taxes to cover his health care bills. On the other hand, everyone has a responsibility to learn what keeps them well and what will make them sick. If you want to do unhealthy things (smoke, booze, obesity, no exercise, drug abuse, etc.), the consequences are not everybody's problem. They are your problem.

The "patient power" policy includes spending more tax dollars (especially through schools) to educate people about wellness and the consequences of poor choices. It supports much better consumer information and informed choice through provider cost and quality reporting and Travelocity-style purchasing.

"Patient power" expects people to insure themselves against extraordinary health care costs. It prefers that people choose and own their own insurance policies that they can take with them from job to job and into retirement, instead of having to take what their employer chooses for them. It encourages both people and their employers to make tax-free contributions into family-owned Health Savings Accounts to pay for normal health care expenses. It favors allowing insurers to give healthy lifestyle premium discounts, like safe driver discounts in auto insurance. (Such discounts are currently illegal in Vermont).

There are of course many more items in the "patient power" agenda. Patient power advocates believe that health care providers will transform themselves dramatically to respond to a consumer choice environment. This is in fact going on at a remarkable pace all around the country, just as Health Savings Accounts are rapidly multiplying now that Congress has changed the tax law to make them attractive.

The one thing that single payer and patient power advocates can agree on is the present mixture of employer-based and government-funded health care is an expensive and illogical mess. We can do better.

The question is whether "better" means a completely government run, tax financed, third party system where bureaucrats and planners ration services, within government cost constraints; or whether "better" means a market-based, consumer oriented two-party system where consumers take responsibility for their lifestyle choices and own their own insurance and HSAs, with government subsidies to enable lower income citizens to afford decent coverage.

This is a very important policy choice. It will determine whether Vermont's health care will come to look like the single payer systems of Canada, Great Britain, or Russia; or the patient power systems of Switzerland, Singapore, and even, surprisingly, South Africa.

“Patient Power” vs. “Service Delivery”

Health care policy has emerged as the central political issue of 2004. Two radically different views of this issue are taking shape, associated with the respective political parties.

In his first year in office, Republican Gov. Jim Douglas has taken only two high profile steps in health policy. He petitioned the FDA to allow Vermont to import price controlled pharmaceuticals from Canada, and he had Vermont join Michigan in a drug buying pool. He also observed that Vermont needed competition among insurance providers, something that had been deliberately destroyed by the community rating legislation of 1991-92.

Sensing that Douglas might be vulnerable for not advancing a broader health care initiative, Democratic leaders in the legislature played their first card on December 30. At a news conference Sen. Peter Welch declared that “the real job killer in Vermont is a health care system with out of control costs and shrinking access, and the burden of paying for it increasingly being shifted to small business and individuals with ever higher co-pays and deductibles.” (He did not acknowledge that the higher co-pays were demanded by the most recent Democratic Governor, Howard Dean, after he saw the runaway spending projections for Medicaid.)

The Democratic program includes letting small businesses put their employees into state-run Medicaid, which would be cheaper for the businesses because the state seriously underpays the health care providers. They would expand the state-funded Dr. Dynasaur program from ages 0-18 to 0-25. The Democrats again endorsed the drug importation proposal. They have also denounced any weakening of community rating, the insurance regulation that requires young healthy families to pay the health insurance costs of their less healthy (but wealthier) parents and grandparents.

In his January 20 budget message Gov. Douglas set out his counterproposals, devoting over half of that message to health care policy. After describing the fiscal black hole facing the Medicaid program – the program the Democrats are eager to expand – Douglas proposed state reinsurance of individual and small group portfolios, tax credits for small businesses that contribute to their employees’ Health Savings Accounts, increased Medicaid payments to providers, cheaper imported prescription drugs, and more money for community mental health.

But then Douglas broke out into new territory. He proposed to “empower the patient” by collecting and posting prices for treatments. He proposed to allow insurers to offer a “healthy choices discount”, so that those who avoid health-threatening behavior (tobacco, drugs, excessive alcohol consumption etc.) can benefit from lower insurance rates. This common sense idea is currently prohibited by the same community rating that Douglas’s opponents have nearly erected into a graven idol.

The two sets of proposals offer two diametrically opposed versions of health care policy. Douglas has adopted the “patient power” model. It’s based on consumers making informed choices in their own self interest among competing insurers and providers. Wise choices lead to better health and lower insurance costs. A key mechanism is the combination of a lower-cost, high deductible major medical policy and a tax-deductible Health Security Account. Lower income consumers are empowered by subsidies or tax credits to pay for adequate coverage, the key principle of the highly successful Swiss system.

The governor’s opponents favor the “service delivery” paradigm. Its key concept is “universal coverage” managed by a governmental authority through regulations, price controls, budget caps, reimbursements, and rationing, principally or entirely financed by taxation. In such a system, everyone has a right to as much health care as the government thinks they need, and the idea of empowered consumers is irrelevant. In this model, patients (not “consumers”) stand in line until their number is called, take what they are given, and do as they are told, at no direct cost to them, consistent with budget realities. These policies are exemplified in the taxpayer-financed Canadian and British systems.

The reason the “universal coverage” advocates are so opposed to repealing community rating is that it would bring back the competing health insurers who departed in 1994, and restore a marketplace for the benefit of empowered consumers. They also oppose Health Security Accounts that they claim, without evidence, would benefit “the healthy and wealthy”. If the ultimate goal is a single payer system, as theirs is, every incentive for people to act in their own interest is antisocial and thus a mortal threat.

As the political year progresses this debate will be waged in earnest. Vermonters will have to understand the implications of these diametrically opposed policies.

HSAs Promise New Era in Health Care Coverage

Tucked into the Medicare prescription drug “reform” bill signed into law last week is a section that will in time become extremely important to Vermonters and all Americans. That is the new section of the Internal Revenue Code authorizing Health Savings Accounts.

Many – perhaps most – working Vermonters are uninsured because their employer does not offer coverage, they earn too much to qualify for Medicaid, and they are hard pressed to pay soaring insurance premiums in what in Vermont has become a monopoly marketplace.

Since the early 1990s advocates have tried to persuade Congress to allow individuals and families to make tax-deductible contributions to Medical Savings Accounts, just like the familiar IRAs. The MSA account would be coupled to affordable high-deductible major medical coverage. The account would be used, by debit card, to purchase medical, dental, chiropractic, and eye care services, and prescription drugs, up to the insurance policy deductible. The funds in the MSA would remain available, earning interest, until used.

The MSA concept has the merit of putting individuals in charge of their own wellness. It emphasizes healthy lifestyles and preventive care to avoid large health expenses later. It promises to make patients more value-sensitive since it is they, not some distant third party, who pays the bills. People would own their own accounts, and could take them from job to job to retirement.

In 1996 Congress authorized a severely restricted – indeed, unworkable – MSA trial. The provision in the new Medicare bill – bitterly opposed by partisans of government run health care – finally does it right.

The 2003 bill authorizes both employers and individuals (employees and self employed) – to contribute to Health Security Accounts (HSAs), up to a total of \$2600 for an individual and \$5150 for a family. The account is coupled to a high deductible (and thus lower cost) health insurance plan offered by an employer or purchased in the market.

Nationally the health insurance industry is rapidly gearing up to launch HSA products in January. In Vermont, Business Resource Services of South Burlington will promote an HSA plan in partnership with Blue Cross/Blue Shield of Vermont.

Unfortunately, that’s about the only HSA choice that Vermonters are likely to find. The problem is that Vermont has little or no health insurance market for individual and small group coverage. That’s because the 1992 legislature mandated community rating as a way of bailing out then-failing Blue Cross/Blue Shield of Vermont.

Community rating requires insurers to charge all their customers the same premium for the same coverage, regardless of any factors – like especially age – that have a significant bearing on anticipated health care costs. With perfect logic, it also prohibits healthy lifestyle premium discounts. As intended, the community rating law drove out nearly all of the state’s active health insurers that once competed with Blue Cross.

Gov. Dean didn’t invent mandatory community rating, but he strongly supported it, and his insurance commissioner acted (probably extralegally) to make Vermont’s law the most absolute in the entire United States. There was a reason for this, beyond protecting Blue Cross. If a hundred thousand Vermont families owned their own health insurance policies and their own tax-free savings accounts, there would be little political support for the liberal dream of government-run single payer health care.

To give Vermonters a chance to ride what promises to be a national HSA flood tide, the legislature must act decisively to repeal the community rating law and reestablish a competitive health insurance market in Vermont. Just like the Vermont NEA teachers union fighting to preserve the public school education monopoly, Blue Cross/Blue Shield can be expected to oppose any backing off from the law that has given it a near-monopoly in the individual and small group health insurance market.

Once again, the legislature will face a choice: to protect a monopoly to benefit insiders, or to encourage market competition to benefit customers. The past thirty years has seen the steady dismantling of government-protected monopolies and cartels – airlines, trucking, telecommunications, delivery services, and currently elementary and secondary education. It’s high time for Vermont to give its citizens the opportunity to benefit from competition and choice in health insurance, along with millions of other Americans.

Empowering Patients for Wellness

Far removed from sweeping campaign proposals to force somebody else (often the taxpayers) to pay for the voters' health care expenses, the health industry is quietly doing something more important: working to improve outcomes and to bring down the cost of health care.

On September 28 [2004] MVP Health Plan, a Williston-based managed care organization, announced that it will now pay its participating primary care doctors extra for assuring that their chronically-ill patients meet high standards of care. Note: the reward is not for doctors "delivering" services. It's for doctors seeing that patients are informed and helped to manage their own care.

MVP's initiative, recently put in place at an MVP site in New York and by ConnectiCare and Blue Shield of California, marks a dramatic departure in medical practice. For hundreds of years physicians and hospitals have been paid for doing procedures. You break your arm, your doctor sets the bone and puts on a cast, and you (or your insurer) pay the itemized charges. Most doctors and hospitals are paid on the basis of medical skills required (rated on a relative value scale), equipment and consumables used (CAT scans, hip joints, injections), "hotel" care, and overhead costs.

But under traditional insurance plans, including Medicare, there's no provision for paying medical professionals for keeping patients healthy through regular examinations, counseling, and monitoring of patient performance. Like the economics of plumbing, conventional medical economics makes sense for fixing specific things that break, but it does not work very well if the goal is preserving wellness of a complex organism. That's a large part of the reason why chronically ill patients get the appropriate amount of care only about half the time, and why 40 percent of all medical expenditures are simply wasted (according to Paul Jarris MD, Vermont's Commissioner of Health.)

MVP's new initiative pays doctors for doing the cost-effective thing. It parallels Commissioner Jarris's Chronic Care Initiative, a pioneering effort to get diabetes patients to perform essential everyday maintenance.

Prof. James Fries MD of Stanford University is one of the nation's top health systems analysts. In testimony to Congress in July Dr. Fries argued, based on five detailed studies, that a health system that identifies risks in advance and intervenes prior to "medical events" (crises) would not only improve patient health outcomes, but would also yield a 4:1 return on investment.

Said Dr. Fries, "Investing about \$100 a year per person, less than 2 percent of the \$5500 paid out to the average beneficiary, should be expected to reduce Medicare claims by about \$400 per beneficiary per year, even in the first year." The intervention he's talking about is well organized but very low cost mail, telephone, and web communications with patients in their homes.

In the Netherlands, 700 home care patients now have a bedside webcam link to trained nurses. When the nurse sees a patient come onscreen, his or her medical records appear simultaneously on the nurse's computer screen.

A similar program in Florida called Lifemasters gives simple monitoring devices to congestive heart failure patients. They are connected from their homes via phone lines to medical office health monitors. Patients in that program averaged 38 fewer days a year in the hospital than comparable patients outside the program. Care South Carolina, a nonprofit with 21,000 mostly low income patients, has reduced Medicaid costs for diabetes hospitalizations by two thirds.

The Veterans Administration in Florida uses an electronic device called HealthBuddy that transmits daily information from patients' homes to the VA clinic. With a nurse giving real-time feedback to coach patients into compliance, the HealthBuddy program reduced VA hospital admissions by 63 percent and emergency room visits by 40 percent.

All of these examples exemplify a "patient power" model, based on "patients taking charge of their care and becoming active participants in it... [Patients] need information, including access to their own health records, and the tools to make better choices, manage their care more effectively, and communicate more efficiently with their health care providers." So wrote Sens. Hillary Clinton and Bill Frist MD in the New York Times in August.

MVP has set an important example. Its "patient power" approach promises more in both wellness and cost effectiveness than any of the proposals to put government in charge of the "delivery" of health services.

Single Payer Health Care: A Universal Disaster

“Universal” single-payer health care coverage, the longtime shining vision of liberals and progressives, is on the front burner in Montpelier. On April 21, 2005 the House passed H. 524. “Green Mountain Health”, by a vote of 86-58. The bill will create a publicly-financed, integrated, regional health care delivery system that is equitable, universal, well-coordinated, patient-centered, cohesive, unified, comprehensive, continuous, sufficient, fair, sustainable, and accountable.

That long parade of adjectives masks some really frightening concepts. Consider these features, translated from the bill’s fluffy language into plain English.

People covered: “All Vermont residents ... will be covered” by the new System. That means that if you are a resident of Vermont, this is the System for you. No options. No choices. Not for anyone. Why not? Because the Government said so.

What about the people who flock here to get Vermont taxpayers to finance treatment for their expensive diseases? Coverage must be “subject to reasonable residency requirements.” The single payer advocates are the same people who promote election-day voter registration, but now they ask us to believe that they will support a residency requirement for sick people migrating here to get Vermont’s taxpayers to pay for their care. Not believable.

Health Care Covered: “All essential health care services will be covered.” Who decides what is “essential”? Not you and your doctor. Translation: a “joint health reform committee” composed of 17 legislators (12 Democrats, 5 Republicans) will define “essential”, in light of “available funds”. When the government runs out of tax dollars, Grandma can wait until the next fiscal year when more funds become available.

Delivery of Care: By an “integrated, community-based system.” Translation: all providers of “essential” health care are locked into government-controlled regional “community health boards” where bureaucrats will tell doctors and hospitals what they can and cannot do.

Governance: the legislature will establish global budgets for health care, appropriate necessary funds, and establish state health care policy. The bill sets up a new Department to deal with planning, analysis, purchasing, and regulation, the “joint health reform committee” to define “essential” services, and a Regulatory Review Board to enforce the orders. This apparatus will supersede current health insurance regulation, since Vermonters will no longer have health insurance.

Make no mistake: Government will completely control this gigantic System with, presumably, typical Government efficiency and compassion. Not too reassuring.

Provider Reimbursement: How much will doctors and dentists get paid for their services? Their reimbursement will be “reasonable” and “sufficient”, as determined by the government. Translation: They’ll have to organize – perhaps even unionize – to fight for every nickel, against a state government that even now dramatically underpays them for serving its Medicaid caseload. On the other hand, the practitioners are not required to continue practicing in Vermont.

Financing: “Primarily from broad based taxes.” This doesn’t even require a translation. It means you will pay higher – much higher – payroll taxes and income taxes. The new taxes you pay may be offset by higher pay, made possible by your employer no longer paying health insurance premiums. Or maybe not. Probably not.

Cost Control: The bill requires the government to decide what services are “essential”, establish “cost containment targets”, and enforce them through “global budgets” for hospitals and caps on physician reimbursement rates. The advocates have made it clear that this combination of mechanisms will achieve “cost control”. The government controls the amount of money to be spent on health care. So Presto! Costs are contained!

Unlike the much-maligned Health Maintenance Organizations, the single payer System doesn’t set up criteria for denying care to individual patients. The Government, as in Canada, will set “global budget” limits, and leave the doctors and hospitals to do the dirty work of rationing resources to stay within those limits. If you liked HMOs, you’ll love this “integrated System.”

Accountability: The System must of course be accountable to the people. How? The Government will

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have total control over all health care providers. Since in the proposed government-run monopoly system all health care will be thoroughly politicized, no one should be surprised that politicians will make the key decisions. You get to vote for those politicians – Governor, Senator(s) and Representative(s). If your doctor and hospital tell you it will be a year-long wait for a hip replacement – sorry about the pain and suffering until then – your legislator is only a phone call away. Satisfied?

There are plenty of ways to achieve the real policy goal: helping Vermonters to enjoy improved health. The overall goal of the draft bill is quite different: it is to put Government in charge of an all-inclusive, taxpayer-financed, price-fixing, one-size-fits-all, bureaucrat-intensive monopoly health care System.

To the authors of the bill, that is a worthy, indeed the highest possible, goal. That is so even if in practice there turn out to be some annoying inconveniences, like rationing, waiting lines, maddening bureaucracies, demoralized doctors and nurses, shabby facilities, obsolete technology, declining quality of care, and of course much higher taxation.

Don't worry. Your Government can work those things out.

Ten Hard Questions about the “Green Mountain Health Plan”

1. Government run health care in Canada has led to long waiting lines, declining quality of care, maddening bureaucracies, shabby facilities, demoralized doctors and nurses, obsolete technology, province-mandated rationing, and ever-higher taxes. How will Vermont's government make an almost identical system – the proposed “Green Mountain Health Plan” – work here?

2. The proposed government-run health care system would require (in 2006) \$2 billion in new income and payroll taxes. What effect would \$2 billion in new income and payroll taxes have on our family budgets? On our businesses (even after subtracting their insurance premium costs)? On their ability to compete? On their capacity for job creation? On their willingness to stay in Vermont?

3. What happens when the state's “global budget” allocation runs out of tax dollars while people are still in need of “essential care?” Will they have to wait until the next fiscal year?

4. Under the present State-run Medicaid program doctors and hospitals are significantly underpaid. Under the proposed “global budgeting”, why won't doctors, dentists, hospitals, and nursing homes be even more underpaid whenever the government runs out of money? Why will doctors and dentists want to come to or continue to practice in Vermont?

5. If Dartmouth-Hitchcock, Albany Medical Center and other out of state hospitals decline to accept Vermont patients at the reimbursement rates that the State-run health care system offers them, where will those patients be forced to go?

6. Will Vermonters have to buy additional private insurance to cover care while traveling outside of the state? Or will the taxpayers be asked to pay the higher rates at the out-of-state hospitals?

7. With the government using its “global budget” to force medical providers to ration or delay care, will aggrieved patients have any right to sue the state government for damages? Will hospitals get to include damage judgments in their “global budget” appeals?

8. Will the government-run plan take away the very generous insurance coverage enjoyed by teachers, state and municipal employees, and other organized workers? Or will this plan create a two-tiered system, with the taxpayers financing both the gold-plated health care benefits for government workers, and a poorer system for themselves?

9. How will the “single payer” health system achieve its claimed efficiency benefits, when providers still have to bill Medicare, insurance carriers offering supplementary privately-paid coverage, the insurance plans of non-Vermonters, and perhaps private insurance for excluded teachers and municipal employees?

10. What will keep chronically sick people from flocking to Vermont to become “residents” to take advantage of “free” health care? What would an influx of such individuals do to the quality of care and waiting lines here in Vermont, and to the already high tax burden on Vermont taxpayers?

Understanding Health Care “Cost Control”

A central feature of health care “reform” proposals is “cost control”. That widely used term masks some real differences among reformers.

To those paying for health insurance – notably businesses – “cost control” means shrinking the business’s budget line item for health insurance. There are several ways to achieve this.

One way is to get out of the health insurance business and let employees deal with their own health care. This happens infrequently because key employees, including the officers and top managers making the budget decisions, would become very unhappy.

More commonly, companies switch to less expensive plans with less coverage, higher deductibles and higher co-payments. They may switch to a health care purchasing group that has more muscle to negotiate lower prices from medical providers.

To the advocates of single payer health care (“Green Mountain Health”), “cost control” has a quite different emphasis. It is on “control”. If the One Big System has complete control over doctors, dentists, hospitals, nursing homes, etc., the managers of the system can rationally allocate resources, deny expensive treatments, close down excess infrastructure, curb the use of expensive technology, and mandate use of generics instead of patent drugs.

Under Green Mountain Health and all other single payer schemes, “cost control” is achieved through the “global budget”. There is only so much money that the taxpayers can be made to put up to spend on everybody’s health care. Each fiscal year the single payer bureaucracy allocates that amount of money among all the approved providers. And Presto! Costs are controlled!

What this means, of course, is that the health care providers are given a budget number and told that that’s all they’re going to get. The government doesn’t actually ration treatments. By rationing the money, the government forces the providers to ration the treatments. That’s convenient for the government, because the aggrieved patient will blame the doctor or hospital for having to wait six months for an operation.

The hard fact that the advocates of government-controlled health systems would rather not deal with is that much of the high cost of health care is a result of government interventions.

Thanks to World War II wage and price controls, American health care evolved into a system dominated by third party payers. If your employer buys your health insurance, nobody pays taxes on it. If you buy it, you do so after you paid payroll taxes and income taxes.

Employees don’t own their insurance plan. Their employer does. When employees use insured health care, they’re spending somebody else’s money. Almost everyone will sooner or later make use of services that are “free” – services that they would never ask for if they had their own money in the game.

State and Federal underpayment for Medicare and Medicaid patients is a major cause of today’s high cost of private health insurance. The providers have no choice but to shift the costs to private patients.

In Vermont and a dozen other states, politicians decided that everyone must pay the same premium, regardless of medical risk. In no other kind of insurance is the premium divorced from risk. Under Vermont’s community rating mandate, young healthy families at the bottom of their career income ladders are taxed to pay the premiums of their grandparents, who have lots more income and assets but need more medical care.

State law also mandates that insurance must cover all sorts of benefits that the insureds may never want or need, such as pregnancy, drug and alcohol addiction, and often amorphous mental health benefits. And of course, you can’t (yet) go to another state to buy more economical insurance, because the government won’t let you.

This is only a modest sampler of foolish and costly government intervention that has driven up health care costs. There are powerful economic and political interests that do not want to see any of these government-mandated cost-inflating practices changed. They want no part of a consumer-driven marketplace, where well-informed people buy insurance to cover extraordinary health care costs, and have wide latitude to choose among competing providers.

That kind of market place is, however, growing steadily. The enactment by Congress of tax free Health Savings Accounts has been a major incentive. In other states with freer markets, all kinds of creative patient-centered health care plans are rapidly emerging.

But in Vermont, the majority of the legislature is ardently committed to creating Green Mountain Health, a government-shackled high-tax single payer system that will make past government interventions appear almost reasonable by comparison. Fortunately Gov. Douglas temporarily forestalled that with his veto, but the battle next year will be titanic.

Project Access: Covering the Uninsured

In the South in the 19th century, “buncombe” (later “bunkum”) came to mean an unbelievable tall tale that originated in the remote backwoods of western North Carolina, in Buncombe County. Today the word has earned new respect, thanks to the leadership of the Buncombe County Medical Society.

In 1995 that professional organization decided to see what it could do to cope with the problem of the uninsured. Marshaling the resources of state and local government, foundations, pharmacists, hospitals, nurses, dentists, educators, community clinics, churches, and social service workers, the Buncombe County doctors created Project Access.

When Project Access began there were about 15,000 uninsured low and moderate income people in the county of 190,000. After six years of operation, 17,000 out of 19,000 eligible people had joined the program. Each of them signed personal responsibility agreements for keeping appointments, taking medications as prescribed, and complying with treatment plans. In return they were given an access card for use with the providers.

Participating physicians agree to see 10 patients a year for primary care (20 per year for specialist care), or to volunteer eight sessions at a neighborhood free clinic. Eighty-five percent of the county’s MDs are committed to the program. Hospitals donate inpatient and outpatient services and lab tests. Pharmacists provide prescription drugs at cost; the patient pays a \$4 co-pay, and local government funds subsidize the difference.

The medical society recruits doctors, keeps the database, handles funds, and reminds patients of appointments (the no-show rate is under five percent). Local state government offices verify eligibility, as in Medicaid. The state medical board created a special license for retired and VA doctors who volunteer for the program. North Carolina’s “Good Samaritan” law protects volunteer providers from most malpractice liability.

Since 1996 the providers have given \$30 million in documented care. Because of the ready access, eligible people are showing up earlier for preventive care. Emergency room visits by the lower income population are less than one third that of similar populations in similar cities. Reduction in avoidable repeat visits has allowed the clinics to increase by 50 percent the number of primary care patients they see.

Businesses report that absenteeism is down and productivity is up among low-wage workers. Interestingly, more than half of the participants become insured after six months, suggesting that their better health and attitudes make them more likely to find and keep jobs with employers that offer insurance benefits.

The Buncombe County initiative has received dozens of awards, and the American Project Access Network (www.apanonline.org) has been created with foundation funds to package Project Access for export. There are now 27 similar projects in operation or in planning stages. They range in size from Dallas, TX to Spruce Pine, NC. Only one is in New England (CarePartners of Portland, ME).

There are several important lessons from a decade of Project Access. One is that astonishing things can be achieved when community leaders determine to get everyone working together to solve problems. Another is the crucial importance of physicians in offering that community leadership.

But perhaps the most rewarding lesson is this: the lower income people who benefit from Project Access understand that fellow members of their community are helping them at little or no cost because they care about them and their community. As a result, most of the recipients respond by taking better control of their lifestyles and health. They show up on time, follow treatment plans, and stay out of the emergency room unless there is a genuine emergency. They come to view themselves as members of a community, and they try, as best they can in often straitened circumstances, to do their part.

Why not make Vermont a statewide Project Access model? That’s an excellent idea. The trouble is that the most ardent advocates for health care “reform” here are committed to installing a taxpayer-financed single-payer system, where the government will have total control over everything. Helping people to become healthier is not their primary objective. Their primary objective is to give the government the power to make rules, give orders, impose penalties, control rationing, fix wages and prices, control providers, and demand that taxpayers foot the bill.

And if they should gain that power, all the good things that were made to happen in Buncombe County will never come to pass here. Instead of community cooperation, Vermont will become a battlefield of competing political interests, scrambling for power, status, paychecks and privileges. Amid the wreckage left behind by that struggle will be the responsive high-quality community-oriented health care system that most Vermonters want, and could have.

The Douglas Health Care Initiative

On December 22 Gov. Jim Douglas put down his marker for health care reform in the 2006 legislative session. Unlike last year's proposal, which rested on an unpopular tax on the premiums of the insured to subsidize the uninsured, the 2006 Douglas plan requires no new taxes. That's a big plus.

Another big plus is that it does not attempt to impose a mandate on businesses or individuals. Yet a third plus is that it does not "set the stage" for rapid movement toward the government-controlled taxpayer-financed universal health system that so inspires the Democrats in the legislature.

The core of the Douglas plan is a "premium assistance program" for uninsured people with incomes between 150 and 300 percent of the federal poverty levels. The premiums will pay for a "basic insurance policy" featuring major medical coverage with a high deductible (\$2500 for individuals, \$5000 for families). The policy would however have a "preventive care carve out", where the insurance pays for preventive care without regard to the deductible. The policy could be combined with a tax-free Health Savings Account to pay for expenses below the deductible, and also many other medical expenses not covered by insurance (cosmetic surgery, non-prescription medications, optometry, hearing aids).

Such an individual policy, the governor says, could be purchased for \$2100 a year. The individual in this income range would pay \$1100 and the state would pay \$1000. By making the policy affordable, he reasons, many more people would be able to obtain private coverage. As they do so, hospitals and doctors will experience less uncompensated care, and will thus be able to moderate their charges for everyone.

So how can one find a policy that costs \$2100 a year, less than half the price of a comparable Blue Cross policy (if there was one)? The governor's staff says that it has actuarial data to support the estimate. The main reason for the relatively low cost, they say, is the high deductible that most people will not likely reach in a given year.

People in the new program will also be rated based on the claims experience only of their group. Since the people in the new program will be typically younger and healthier than the average Blue Cross customer, their claims experience will not reflect the higher costs of the older and sicker patients in the insurer's existing pool. Hence the considerably lower premium.

The governor also reiterated his support of the Chronic Care Initiative, electronic patient records systems and improved consumer information. He called again for premium discounts for people who practice healthy lifestyles, and for rather modest medical malpractice reforms. He also endorsed legislation in Congress that would allow Vermonters to buy health insurance coverage across state lines, an idea that Vermont based carriers like MVP and Blue Cross will certainly strongly oppose.

There are some weaknesses in the package. Its success depends on persuading the 30,000+ Vermonters eligible for Medicaid but not enrolled in it to come into the program, already heading for a major financial crash in 2007. It requires that working people now on expanded Medicaid (VHAP) to go back to employer coverage where it is available. It does not appear to do anything to create a competitive health insurance market in a state where Blue Cross, MVP and their affiliates now provide over 95 percent of all individual and small group coverage.

Douglas's vision emphasizes personal responsibility, encourages wellness, coping efficiently with chronic illnesses, getting everyone insured, and improving informed consumer choice. Perhaps above all, it resists any temptation to compromise with leftist legislators intent on forcing all Vermonters into a one size fits all, taxpayer-financed Canadian-style health care system.

But even if he is successful in getting most of the uninsured into private coverage, the Governor and legislature still have a way to go. Health insurance in Vermont will remain costly, compared to many other states. Small businesses faced with high premium bills are likely to get little relief. Medical providers will need to embark on major changes, technological, organizational, and cultural. And, of course, Medicaid, whose expenditures will increase under the Governor's proposal, remains the 800 pound gorilla in the state budget.

To solve the larger problems, Gov. Douglas will need to go further down the road toward a safe, innovative and efficient wellness system, where empowered consumers make informed choices about their lifestyles, their financial risk, and the treatments necessary to extend their active lives.

Fundamental Health Care Reform: Seventeen Steps

Two of the key features of true health care reform are equalizing the tax treatment of medical expenses and minimizing third-party payment for insurance claims. Both of these needed reforms, however, will require national action. There are nonetheless a number of steps that can be taken by the Vermont legislature to effect a market-based health care system.

A sound reform of health care in Vermont, including a badly needed revival of a competitive health insurance market, should be based on these principles and policies.

1. The primary responsibility for maintaining wellness and paying for health care rests with the informed individual and family, not with the government. Over a lifetime – and especially up to Medicare eligibility age – individual choices are directly related to the great majority of health problems. The opinions of some doctors and program managers notwithstanding, patients are not mere passive receptacles for the delivery of health care. They are conscious human beings whose understanding, involvement and cooperation are essential to maintaining or restoring wellness. People who regularly make important decisions about family, career, and investments must be considered competent to recognize the essentials of healthy lifestyle choices and effective self-treatment for non-acute conditions.

2. Wellness can be significantly increased and demand for expensive health care can be significantly reduced if individuals are educated as to the personal health consequences of their choices, especially those relating to smoking, drinking, drug use, exercise, nutrition, and sexual activity. The explosion of health care information through periodicals and internet sources has led to a corresponding increase in patient awareness of health care considerations, self-medication, and lifestyle modification. Every public and private program, including especially high schools, should offer a strong health consumer education component, and reward individuals and families who make healthy choices.

3. Health insurance exists to protect individuals from unexpected occurrences. It was never intended to pay for expected and predictable wear and tear. First dollar or low deductible coverage leads directly to costly overutilization of health resources; the patient believes he or she is getting “free” care and thus consumes more of it, even though it yields little or no improvement of health outcomes.

4. Individuals and families should be encouraged to create tax-favored Health Savings Accounts (HSAs). HSAs are coupled with a relatively inexpensive high deductible major medical insurance policy. Employer and employee funds deposited in an HSA can be used to pay for such routine expenses as physical examinations, immunizations, vision care, prescription drugs, over the counter remedies, and all covered medical costs until the annual deductible is reached.

HSAs give families a financial incentive to use preventive care to maintain wellness. As balances in their HSAs increase, they can switch to higher deductible coverage and pay lower premiums without giving up major medical protection. In addition, many doctors will give up to a 25 percent discount for patients who pay for treatment at the time of service, a practice that an HSA makes easy. The federal deduction from income for HSA contributions carries through to state tax law, that uses the federal definition of adjusted gross income.

5. The legislature should repeal community rating. Insurance carriers ought to be allowed to distribute the cost of insurance fairly at least among recognized actuarial categories such as age, gender, geography, and occupations. This traditional method of pricing coverage justly assigns costs in proportion to expenses incurred. Community rating has the regrettable effect of overcharging younger, healthier, but poorer families in order to subsidize older, sicker but wealthier (and thus more politically influential) families. Government mandates which have the effect of making the poor subsidize the rich are inherently unacceptable. Such mandates should be doubly unacceptable when their hidden purpose is to create a virtual monopoly for one struggling but politically influential health insurance company.

6. Insurance carriers should also be allowed to offer healthy lifestyle discounts. Auto insurance carriers offer discounts for the absence of accidents and traffic violations. Property insurers offer discounts for fire protection. Most commercial health insurers offer discounts or “preferred” policies for non-smokers, etc. but such discounts are currently illegal in Vermont. The discounts should be made available to insureds on the basis of their lifestyle choices, and not limited to insureds who are struggling to overcome unhealthy choices as part of a government-qualified program.

7. Government mandates that force insurance customers to buy coverage they do not want and will never use should be rolled back. These include pregnancy benefits, excessive drug and alcohol abuse coverage, and mental health parity. Lower income families ought to be able to buy a minimum-benefit policy that does not require them to subsidize the health care costs of others who choose to practice unhealthy lifestyles, or pay the costs of normal pregnancy and childbirth. By thus reducing the cost of basic coverage, thousands of Vermonters who have been incorporated into Medicaid will once again be able to pay their own way.

8. The state should resolve to pay the true cost of services provided to Medicaid patients by hospitals, nursing homes, and medical professionals. There is always much room for debate over what such “true cost” is, but the present practice of often paying less than half of the going rate for Medicaid patients requires other patients to absorb a hidden tax on their own premiums to make up for what the government declined to tax openly.

9. Medicaid for acute care patients (other than the elderly or institutionalized) ought to be converted into an HSA-style program, with the state providing sliding scale subsidies for Personal Health Accounts. PHAs will offer real incentives for involving customers in maintaining their own wellness, because they will not only live healthier lives but will benefit financially. It would almost certainly be less expensive for the state to fund PHAs and buy corresponding catastrophic coverage for such Medicaid-eligible Vermonters, rather than continually expand managed care or first dollar fee for service coverage. Since the taxpayers would fund these PHAs, there would presumably have to be some limitations on the use of the account balances. Allowed uses might include the purchase of long term care insurance, continuing education and job training, or other investments in family earning power, wellness, and independence.

10. The legislature ought to repeal the CON process, as many other states have done. The Federal government in 1974 pushed the government-issued “certificate of need” idea on the states in what proved to be a futile effort to curb health care cost increases and duplication of services. By 1986 the Federal government had given up on the idea and repealed the mandate. Since then 20 states have repealed CONs, and 12 never instituted one.

Simply put, the CON process does little or nothing to restrain costs because politically powerful applicants eventually get what they want from the process (Fletcher Allen’s \$326 million “Renaissance Project” comes to mind.) CONs’ principal effect has been to protect monopolies against competition (and lower prices for consumers), even for home health care providers where capital investment is negligible. If a CON process is continued, it should be limited to very large capital projects and purchases of very expensive equipment that could lead to inefficient utilization.

11. The state should explore a program for the recapture of unpaid medical bills of persons who choose to spend their resources on things other than adequate health insurance. Two options are expedited legal recovery and using the income tax system to collect unpaid obligations over a period of years. Such programs could not realistically be expected to recover a large fraction of unpaid bills, but they would forcefully emphasize the individual’s responsibility for paying for care received. In so doing a recovery program would have a positive influence on patient behavior.

12. The legislature should create a high-risk pool to cover the health care costs of the medically uninsurable – persons with known, costly health care problems who have been denied coverage by an insurer. Over 100,000 people in 28 states now participate in such pools, commonly called Health Insurance Plans (HIPs), which date back to 1978. A typical HIP requires insureds to pay 150 percent of the average premium for a comparable coverage, with premium subsidies available for lower-income insureds. It offers them a choice of competing insurance plans, including HSA plans and HMOs. Its costs are usually funded by assessing the premium receipts of all health insurers, or by general revenues, or both.

Typically the fraction of the population covered by a HIP is around one percent. An added advantage of the HIP pool is that it makes it unnecessary to mandate guaranteed issue on insurers. However, the HIP must be viewed explicitly as a means of covering only the medically uninsurable, not as a vehicle for expansion of government-financed health care.

13. The legislature should examine and tighten tort liability standards governing medical malpractice to reduce the exposure of health professionals, hospitals, nursing homes, and HMOs to predatory tort suits. Provisions for arbitration of malpractice claims were included in Act 160 (1992) but were never put into practice because the universal access plan contemplated by that act was never adopted. The growing en-

thusiasm among trial lawyers for suing HMOs – and through them, the employer contracting with the HMO – makes this step one of high urgency.

Vermont has not yet suffered the fate of states like Pennsylvania, West Virginia and Illinois, where skyrocketing malpractice insurance premiums have caused a serious curtailment of access to providers. But the existence of an aggressive plaintiff's bar, coupled with the proliferation of high-dollar judgments in other states, suggests that the problem will grow here to similar magnitude.

14. The state should actively promote the purchase of long term care insurance. Act 160 of 1996 requires the state to “propose and implement methods that permit strategies to provide alternative financing of long term care services by shifting the balance of the financial responsibility for payment for long term care services from public to private sources by promoting public-private partnerships and personal responsibility for long term care.”

Gov. Douglas proposed in 2004 that seniors with adequate long-term care insurance should face less stringent asset spend-down requirements for access to Medicaid in their final years. The legislature declined to act on the proposal.

15. The state needs to move quickly to support the development of health care information and management technology. It is vital to start the process for integrating patient care, managing claims and billing, updating medical best practices for clinicians and specialists, and bringing user friendly health care information to consumers.

16. Vermont's ten independent community-based free clinics merit continued state support. These clinics offer primary and preventive health care, wellness counseling, pharmaceutical assistance, and referrals to free or discounted specialist services for needy, uninsured Vermonters. They make use of the volunteer services of health care professionals, including complementary treatment practitioners, students and community residents. Patients pay “what you can, when you can”.

Since 1999 the nine free clinics and the Burlington Health Center have received appropriations support, plus grants from foundations, federal programs, and community contributions. The grassroots free clinics serve a population that is often transient, between jobs, or otherwise hard to enroll in Medicaid, and do it as a genuine community service. A portion of the tobacco settlement fund should be set aside every year to assist the free clinics and encourage new clinics to organize in underserved parts of the state. AHS should refrain, however, from incorporating the free clinics into a bureaucratic system.

17. The legislature should, as essential housekeeping, revisit Act 160 of 1992 and systematically repeal all the provisions that failed, were ignored or abandoned, produced grievous consequences, or appear to commit the state to moving toward a government-controlled health care monopoly. Typical of the provisions meriting repeal is the statement of policy: “Comprehensive health planning through the application of a statewide health resource management plan linked to a unified health care budget for Vermont is essential.”

The only alternative to a market-based “patient power” system proposed in this report is a totally government controlled “service delivery” system. Such a system, whether enacted in small stages or in one great convulsion, is the logical outcome of today's health care policy.

Under such a system government becomes the single payer for all non-elective health services; private health insurance is illegal; patients receive only such care as the government agrees to pay for; hospitals and nursing homes operate on mandatory government-fixed budgets; all health care investments are strictly government-controlled; medical professionals, in effect if not in fact, work for the government; doctors, dentists, nurses, and technicians are unionized to protect their interests against a monopoly employer; and the bill for all covered health expenses is sent directly to the taxpayer. Why any reasonable person would favor such a system, variations in which are currently collapsing in Great Britain and Canada, is hard to imagine.

Ten Tools for Achieving Consumer Driven Health Care

American health care is moving rapidly toward consumer driven models built upon consumer-friendly information, choice, and two party relationships, backed by insurance coverage to protect against large and unpredictable medical events.

Every family has long used this consumer-driven model to select food, clothing, housing, cars, and vacations. It seeks to minimize third-party intervention, where an insurer, employer, provider, or the government decides what is medically necessary and what it will pay for. Its goal is to insofar as possible give patients control over information and resources, so they can ration their own purchases in light of their own values and priorities. Here are 10 tools currently developing to bring consumer-driven health care into being.

1. Health Savings Accounts. Authorized for 2004, HSAs are individually owned (and thus portable) accounts funded with tax-deductible contributions from the individual, the employer, or both. The HSA is coupled with a high-deductible major medical insurance plan. The account owner uses the HSA to pay for health care expenses up to the deductible amount, where the insurance takes over. Unused funds stay in the accounts and build interest over time. (HSAs replace the MSAs authorized as a demonstration program in 1996).

2. Flexible Spending Accounts. FSA “cafeteria plans” can be established only by employers. Employees may assign part of their salaries into an account to pay for health care expenses. The accounts have a use-it-or-lose-it provision that requires unspent funds to be forfeited to the employer at the end of the year.

3. Health Reimbursement Arrangements (HRAs). First authorized in 2002, HRAs allow employers to fund employer-owned accounts from which employees can reimburse themselves for a wide range of health care expenses. HRAs may be used with any kind of insurance plan, and may be for any amount of money. Unlike FSAs, they may rollover and build-up over time.

4. Indemnity Coverage. Indemnity insurance, long common in property insurance, is a “two-party” contract in which an “insured” pays a premium for protection against future medical costs. The insured pays the health care provider, and is reimbursed by the insurer.

5. Defined Contribution. “Defined contribution” means that the employer provides a fixed payment dedicated to employee health insurance benefits. Employees use that contribution to select from a variety of benefit plans, often supplemented with their own funds.

6. Opt-Out Provisions. These provisions in health care plans allow workers to use their employer’s defined contribution to supplement a spouse’s coverage, or for both earners to pool their funds to purchase coverage for the whole family.

7. Direct Pay: A growing number of physicians, either independently or as part of networks, are offering offer their care for cash (credit card) payment, at substantial discounts made possible by their dramatically reduced costs of dealing with third party payors (especially Medicare and Medicaid).

8. Independent Medical Centers. Some health care providers- often offshore – are starting to offer fixed prices for defined services. This is especially suitable for “focused factories”, facilities that specialize in one or a few treatments or procedures such as cosmetic surgery, heart bypass surgery, and hernia repair, achieving high volume, high quality and high efficiency.

9. Expanding Insurance Markets. Insurance markets have traditionally been rigidly separated by regulatory jurisdictions. By requiring expensive mandates (community rating, guaranteed issue, mental health parity, pregnancy coverage, etc.), state regulatory regimes deny consumers the opportunity to find the kind of insurance coverage that best meets their needs and resources. National “association plans” (not yet authorized by Congress) will allow association members to buy appropriate coverage not available in their own state.

10. Information Technology. Few of these changes could happen without the remarkable power of the CD and the Internet, which now allow consumers to identify their resources and match them up with preferred coverage or services.

“Health care is about people. The best way for people to express their needs, values and desires is through a market-based system that gives them the power to spend resources in keeping with those values.”
– Greg Scandlen, Director of the Center for Consumer Directed Health Care at the Galen Institute in Alexandria, VA. This brief is based on a paper of the same title published by Greg Scandlen in 2003.

Ten Things to Do to Make Vermont America's Health Leader

JOHN McCLAUGHRy, PRESIDENT, ETHAN ALLEN INSTITUTE

Governor's Health Care Summit, Killington, October 17, 2005

1. Adopt the broad goal of maximizing the conditions for Vermonters to achieve and maintain good health. This is not the same as finding other parties (business, taxpayers, etc.) to pay everyone's health care bills.
2. Recognize and affirm that personal responsibility lies at the core of any health promotion and health improvement strategy. "Health and wellness" cannot be injected into passive vessels by experts. The "vessel" has to play an active role.
3. Begin a strong effort to bring Vermont's health information technology into the 21st Century. The FY 2006 budget bill made a good beginning by mandating a state Health Information Technology Plan (sec. 277 of Act 71).
4. Begin a strong effort to make Vermont's hospitals, clinics and nursing homes America's safest.
5. Continue support for the Chronic Care Initiative, emphasizing continuous monitored patient self-care and new self-care technology.
6. Replicate the successful community-based physician- and pharmacist-led Project Access model from Asheville NC, to draw the uninsured into preventive and acute care services.
7. Make Vermont a provider-friendly state by changing the medical liability process: create a patient negligence formulary, eliminate joint and several liability, establish a pre-trial medical review board or Health Court, authorize court appointed expert review, and exclude provider wrongdoing from damages.
8. Plan to make Vermont a "wellness destination", where patients and families can come for diagnosis, excellent treatment, and recreational opportunities.
9. Adopt and promote an advanced Consumer Driven Health Care model: "The new consumer driven health insurance system will enable consumers to choose from a large array of differentiated health insurance options with the support of employers or other groups who will help to provide the pre-tax money to buy them. New intermediaries will supply enrollees with information and assistance so they can select intelligently among these options. Consumer-driven innovators will create newly productive high quality health care services and technology that respond to consumers' needs. And a newly consumer driven government will oversee the suppliers and protect the consumers." [2004: Herzlinger, R., *Consumer Driven Health Care*, (Jossey-Bass)]
10. Abandon the notion of a single payer system. It will inevitably produce an all-inclusive taxpayer-financed, bureaucrat-intensive, price-fixing, monopoly health care system, characterized by maddening unresponsiveness, long waiting lines, demoralized doctors and nurses, shabby facilities, obsolete technology, declining quality of care, and higher taxes.

Useful References for the Health Care Policy Debate

Ethan Allen Institute Reports (available at www.ethanallen.org)

Reviving Health Insurance in Vermont (2000).

Vermont's Health Care Policy (2002)

A Health Care Agenda for Vermont (2003)

Health Care in Vermont: A New Prescription (2004)

The first of these reports is particularly useful in tracing the development of Vermont health care policy since 1980. The fourth one brings health care developments up to date through the 2004 legislative session. The recommendations section of this fourth report is reproduced on pages 11-13 of this booklet.

Many other Vermont reports and links, representing a wide variety of viewpoints, are available at www.ethanallen.org, in the new Health Care section.

Other Useful Published References

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Ethan Allen Institute

The Ethan Allen Institute, founded in 1993, is Vermont's independent, nonpartisan, free-market public policy research and education organization – a “think tank” for issues facing Vermonters.

The Mission of the Institute is to influence public policy in Vermont by helping its people to better understand and put into practice the fundamentals of a free society: individual liberty, private property, competitive free enterprise, limited and frugal government, strong local communities, personal responsibility, and expanded opportunity for human endeavor.

The Institute's areas of interest include –

- Vermont's economic future, particularly the vitality and diversity of its competitive free enterprise sector.
- The fiscal practices and condition of state government – taxation, spending, and borrowing.
- State and local regulatory practices, and their effect on the economy and the rights of the people.
- Better education for all Vermont children, and an efficient, accessible health care system, each based on the principles of personal responsibility, competition, and empowered consumer choice.
- The preservation of free, accountable, democratic government, where public decisions are made at the level as close as possible to the people themselves.
- Adherence to Vermont's basic charter of government, the Constitution.
- The strengthening of Vermont community and family life, and the protection of local government from burdensome and costly mandates.

The Institute advances these ideas through print and radio commentaries, publications, newsletters, conferences, debates, and public dinners and meetings.

The Institute is supported by the annual contributions of over 600 Vermonters. It is governed by an 11-member Board of Directors and has a 17 member Advisory Council. The Institute is a 501(c)(3) educational organization, contributions to which are tax deductible for individuals and corporations. The basic annual membership is \$30.

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