Newsletter for Aug 22, 2026 : Healthcare #3

Battenkill Valley Health Center Receives Awards

BVHC is a community health center in Arlington that serves Bennington County and adjoining areas of New York and Massachusetts, providing primary care, dental care and behavioral health services. Nationally, community health centers, funded in part by the United States Department of Health and Human Services Health Resources and Services Administration (HRSA), served more than 32.7 million patients in 2025. More than 1200 health centers have been recognized for providing outstanding clinical quality through HRSA's Community Health Quality Recognition (CHQR) program. BVHC is one of those recognized.

On August 3, as part of National Health Center Week, BVHC was one of only two health centers in Vermont to be further recognized as a National Quality Leader in Cancer Screening, recognizing their commitment to improving cancer screening rates and helping patients receive preventive care that can save lives.

BVHC also received the Advancing Health Information Technology badge for their commitment to using technology to improve patient care through telehealth services, secure electronic information exchange, patient engagement tools, and the collection of data that helps address patients' health related social needs.

Please join me in congratulating CEO Kayla Davis and her team at BVHC!

More About Community Health Centers

Regardless of who pays for it – private insurance, Medicare, Medicaid, or even out of pocket – healthcare only works if there is a provider available to see patients. I view community health centers like BVHC as a critical link in the healthcare chain. They are funded in part by the Federal Government and also, as non-profits, by donations, along with payments they receive for services. Patients are charged according to their ability to pay, and no one is refused treatment. Because they also provide dental and behavioral health services, they are able to provide a "whole person" approach to healthcare. And because many

patients have additional challenges in their lives besides health issues, BVHC maintains contacts for, relationships with, and does referrals to, other services available in the community. That includes addressing food insecurity, reproductive services, transportation challenges, and many others.

I think that one goal Vermont needs as a state is to ensure that every community has a community health center available nearby, and that everyone who needs healthcare or other health and wellbeing related services has access (and transportation) to those services. We know that, over time, preventive care, along with additional support when needed, results in better overall health outcomes and reduces healthcare costs.

But This is Only One Piece of a Larger Issue

It's no secret that the United States has the most expensive healthcare system in the world. Vermont's healthcare costs are directly tied to the existing system: employer provided health insurance, health insurance provided by private for-profit insurance companies and, increasingly, for-profit hospitals and private medical practices. The collective lobbying that keeps this system in place has successfully blocked any serious reform. As a result, healthcare costs continue to rise faster than the rate of inflation. It does not have to be that way.

A pre-print study by Yale University's School of Public Health released on July 24 found that under our current system of private health care insurance Americans spend approximately $5.2 trillion dollars per year on health care. They compared that cost to a "Medicare for All" system which they estimated would cost around $4.2 trillion. That's $1.04 *trillion* dollars *less* per year for a system that would provide universal coverage – every person in the country insured – than we pay no for our current system under which millions are uninsured. In addition, the researchers estimated that a universal, single-payer healthcare system would save an additional 114,000 lives each year.

It must be noted that this study is not yet peer reviewed – which is the "gold standard" for research publications. In this study, "Medicare for All" means extending the current Medicare system, which provides health insurance to Americans aged 65 and older, to all Americans. The researchers attribute most of the savings to reduced drug costs and the elimination of fraudulent billing from

insurance companies. Additional savings would come from avoiding unnecessary emergency and inpatient care. A similar study in 2020 estimated the savings at $450 billion per year, and the lives saved at 68,000 per year. The difference largely stems from increases in overall medical care costs in the preceding 5 years.

So Where Do the Savings Really Come From?

First, they estimate $377.5 billion in lower pharmaceutical costs. Second, applying Medicare provider compensation to all services would save $295.6 Billion. Third, lower administrative overhead would save $286.3 billion. Fourth, reduced fraudulent billing would save $285.7 billion. Fifth, avoiding unnecessary emergency and inpatient care would save $100 billion.

Add those numbers up and it's well over than the $1.04 trillion in savings cited. The difference is that you are adding millions of currently uninsured people. The cost of caring for the currently uninsured, plus additional dental care and other services not currently covered adds up to $304 billion. So with Medicare for All, we are covering everyone, with broader coverage than we now have, and still *saving over one trillion dollars* in the process.

Are These Numbers Real?

The answer is "yes and no". The first probably is. Drug prices in the US are currently higher than elsewhere in the world. The second may be valid, but a bit less so. Insurance payments to providers, even when indexed to Medicare, are often higher than what Medicare would pay. They are often some multiple of the Medicare rate, and some providers already see them as inadequate. The fourth, fraudulent billing exists, but is probably harder to quantify than the study suggests. The fifth, reduced use of emergency and inpatient services, assumes that if everyone has affordable health care available they would, as a result, be healthier and need fewer emergency services (due to receiving regular care now avoided because of the cost) and patients spending fewer days in inpatient care (for similar reasons). You can argue about the exact amount, but the savings would probably be real and similar in scope.

The “real deal” number here is savings in administrative costs. A large US medical center may have hundreds of staff dedicated to billing services: billing insurance companies for services they provide, and billing patients for whatever the insurer doesn’t cover. A similar medical center in Canada, which does have a single-payer system, may have a dozen or two. To be competitive, and to make a profit, insurance companies may have dozens of policy types, with an array of different coverage levels available. Doctors, hospitals, and patients need to know which procedures are covered for each patient with their particular policy, with their particular insurance company. That turns out not to be a trivial exercise, and it costs doctors, hospitals (and often patients as well) a lot of time and money to navigate the process.

I mentioned “profit” there, too. Guess who pays for the profits the insurance companies make: you do. You pay either in increased insurance premiums or in increased copayments and/or deductibles. Because the insurance companies want to maximize profits, they’ll often argue over whether every item on the bill is covered, and at what level. All of that back and forth costs money and time, often involving the doctor and the patient as well as the hospital. Oh, and if you are treated at a for-profit hospital you pay for their profit, too, one way or another.

All of this is real money, so a change would result in a real savings.

What if the Numbers Aren’t What the Study Says?

Let’s assume for a minute that Medicare for All doesn’t save any money at all. We end up paying exactly what we pay now, somewhere around $5 trillion a year. How bad would that be? Well, for starters, everyone would have medical insurance, even the millions now uninsured. As a result of that, everyone should be a bit healthier, and some people would be a lot healthier. Somewhere around 100,000 people who would have died because they did not have access to health care would still be alive.

Is that an outcome you could live with?