

## Introduction

As of June 2017, Vermont's attempt to establish a single-payer healthcare system in the state remains the most comprehensive attempt to achieve universal single-payer healthcare in the history of the United States. Unfortunately, it failed. Spearheaded by Vermont Governor Peter Shumlin and passed on May 26, 2011, the plan would have established a government-financed system, called Green Mountain Care, to provide universal coverage. However, by the end of 2014, [the governor had reversed his position](#). Citing a combination of lower-than-expected state revenues and the taxes that would need to be paid to implement Green Mountain Care, Shumlin declared that the initiative had become [too costly](#) to properly implement and called it off. While Shumlin and other stakeholders in the reform effort knew that the ambitious plan would cost the state a significant amount of money, the 11.5 percent payroll tax on businesses and the implementation of a new income tax of up to 9.5 percent was simply considered unfeasible to get the support necessary to pass it.

While one may take the governor's statement to mean that Green Mountain Care failed simply because it was fiscally unfeasible, closer analysis paints a more complex picture. While the question of how to pay for Green Mountain Care played a major role in its failed implementation, no one study provides evidence suggesting that the plan failed purely due to its fiscal infeasibility. Rather, a careful study of the timeline of events suggests that Green Mountain Care failed in large part due to public and political mismanagement. According to this reading, the true barriers to a universal, single-payer healthcare system in Vermont were political and institutional rather than purely economic.

## The Passage of Green Mountain Care

Green Mountain Care began its life as a reaction by healthcare activists in Vermont to the passage of the Affordable Care Act (ACA) in 2010. While many of the policymakers and stakeholders who would go on to help pass Green Mountain Care supported the ACA, these people were nonetheless disappointed by the law's compromises with the nation's private insurance industry. To these activists, establishing a universal, single-payer healthcare system that covered the entire population was the end goal of healthcare reform, a goal that made the ACA seem at best a placeholder until bolder reforms could be undertaken. [While the construction of such a system has been attempted at the federal level since the presidency of Harry Truman](#), only slow, incremental progress towards the goal has been made in the decades since.

However, a series of factors came together to give activists in Vermont an opportunity to push for radically comprehensive reform. Firstly, the state's Republican Governor, Jim Douglas, chose not to run again in the 2010 gubernatorial election, and he was ultimately succeeded by progressive Democrat Peter Shumlin. [Shumlin had surprised local activists and media by running for governor on a single-payer platform](#), and his winning the governorship meant that, for the first time, single-payer advocates had a firm ally in the governor's office. Additionally, the very public conflicts surrounding the creation and passage of the Affordable Care Act (colloquially known as Obamacare) at the national level and the prior passage of a statewide reform known as Catamount Health had brought made healthcare one of the key issues dominating state politics. While supportive of reforms like the Affordable Care Act, proponents of single-payer were disappointed by its' accommodation of the private insurance system and energized by the idea that they might still have an opportunity to prove that their more comprehensive ideas for reform were viable in the United States. Further, the costs of the aforementioned Catamount Health program, which used public dollars to pay for private health plans, were skyrocketing during an economic recession, allowing single-payer advocates to frame their reforms as a potential cost-saver for the state.

Long-time advocates for single-payer within the state did not waste time, beginning to prime the state for a major healthcare bill well before Shumlin took office. For example, the "Healthcare Is a Human Right" Campaign, spearheaded by a grassroots advocacy group known as the Vermont Workers' Center, began to actively campaign for single-payer healthcare at the state level, allying with longtime single-payer advocate Senator Bernie Sanders to hold rallies around the state and lobbying days at the statehouse. In May 2010, just two months after the passage of the Affordable Care Act, the Vermont state legislature passed Act 128, which compelled the state government to design a new healthcare model for Vermont and allocated \$300,000 to the Health Care Reform Commission to hire consultants to design three plans for achieving universal coverage. The legislature ultimately chose to hire a team of consultants led by Harvard health economist William Hsiao, a well-known expert on health system reform who had advised the nation of Taiwan during its transition to a single-payer system. Also on the team were Jonathan Gruber, a Massachusetts Institute of Technology economist well known for his work on both Massachusetts' healthcare reform and the Affordable Care Act, and Steven Kappel, an independent healthcare consultant from Vermont. Overall, the team brought an enviable level of policy expertise on the issue of healthcare that the legislature hoped would lend a level of technocratic legitimacy to their reform efforts.

Following a series of preliminary studies, Hsiao released his final report to the Health

Reform Commission in February 2011. The reform called for a plan to incrementally move the state to a public-private system, financed through a 14.2 percent payroll tax (with employers paying 10.6 percent and employees the remaining 3.6 percent) that would provide a benefit plan with an actuarial value of 87 percent to all Vermonters. The 14.2 percent payroll tax was estimated to cost \$1,429 per person per year, and the 3.6 percent contribution to the payroll tax was estimated to cost an average household \$370 less than current premiums (though wealthier households with incomes above 400 percent of the federal poverty level were projected to pay more). To assuage fears of a wholly government-run program, the system would be governed by a public-private partnership, and a third party would administer the program. If adopted, the plan would have been implemented incrementally alongside the rollout of the Affordable Care Act to avoid legal battles with the federal government. Due to the federally-funded Medicare not being integrated with the plan—and the fact that health insurance plans from outside the state would still need to be processed—the authors used the metaphor of a “single-pipe,” where all payment and revenue sources are streamlined, to describe the plan instead of the term single-payer.

Armed with this report, Shumlin moved quickly to develop a proposal to submit to the legislature. While the plan he and his advisors developed maintained some features of the reform recommendations from the Hsiao report, including the creation of a public-private intermediary (the Green Mountain Care Board) to design a benefits package and incremental implementation in tandem with national reforms, it was ultimately much vaguer on specific details. Critically, the proposal contained no details on financing Vermont's new healthcare system, with that vital aspect of the program being left to future legislative sessions to hash out. This decision was based on Shumlin and his staff concluding that including a financing plan in the initial bill would leave it open to attacks from opponents and thus potentially fatally wound it in the legislature. With delayed implementation incorporated into the bill, the team reasoned that they could leave details such as financing until later after the initial bill had been passed. The final version of the bill, known as Act 48, was submitted to Governor Shumlin and signed into law on May 26, 2011.

### **Stalled Implementation**

As previously noted, a key part of Act 48 was the creation of the Green Mountain Care Board, a five-person board to oversee the design of Green Mountain Care. This board was granted unprecedented levels of responsibility for addressing all the major factors, influencing the cost of health care, including benefits, coverage, and premiums. Administration of these factors was normally spread across different agencies, and this centralization began to limit overall coordination in the state government on the reform effort. The board's construction was also different from the public-private partnership that

Hsiao's team envisioned, with the board instead functioning as a regulatory public service board with a quasi-judicial policy-making role. While the board did interact with stakeholders in the healthcare sector and the private sector more broadly, board members made the ultimate decisions concerning health policy matters such as hospital budgets and insurance rates. The decision to have the Green Mountain Care Board more centralized under the control of the governor was also a deliberate move by Shumlin's team, as they believed that centralization was necessary to direct the reform in a timely manner.

Behind the scenes work continued on Green Mountain Care for several years after 2011, but as the 2017 launch date drew closer, more problems began to reveal themselves. The biggest issue was the unresolved matter of paying for the reform, which turned out to be a far more complex issue than anyone in Shumlin's administration had realized when they put off designing a financing plan back in 2011. Initially, the governor had planned to gradually increase Medicaid spending by three percent from 2012 to 2017, and use that money to help set up the infrastructure for the program. As the state received \$1.17 in matching funds from the federal government for every \$1.00 it put into the Medicaid system, it was thought that they could use these incremental increases to fund Green Mountain Care without having to raise taxes too much. However, the Vermont economy was not growing as quickly as analysts thought it would, [meaning the state could no longer afford](#) the three percent increases or the match funds that would come alongside those increases.

Further complicating the cost issue were the changes Shumlin had made to the law after its passage. For example, in the years since Act 48's passage, Shumlin and the state legislature had responded to lobbying by business interests and adjusted the law to allow nonresidents working in Vermont to join Green Mountain Care. They also implemented changes that raised the actuarial value of coverage — the expected portion of medical costs covered by a plan rather than by out-of-pocket spending — from 87% to 94% and eliminated the state's taxes on medical providers. While not necessarily bad policies on their own, they had the cumulative effect of increasing the cost of the program while decreasing the revenue necessary to pay for it. A 2014 analysis conducted by the Shumlin administration estimated that to raise the necessary amount needed to pay for the program, [it would need to increase payroll taxes by 11.5 percent](#) and the state income tax by 9 percent and would only save 1.6 percent in costs, much higher numbers and lower savings than many had expected.

Importantly, while Shumlin's projections were lower than then Hsiao's projections for the original version of the plan, they were in line with a study by the University of Massachusetts Medical School and Wakely Consulting, which projected savings of 1.5% over 3 years. [It was also still true](#) that even this more expensive version of the bill would lower costs for the 90% of Vermont families with household incomes under \$150,000.

Fundamentally, the initiative remained economically viable, although the projected savings were much less than what was initially promised by the state.

The issues Shumlin and his team had with the numbers had much less to do with the economic aspects of the policy than their political implications. Between 2011 and 2014, Shumlin's team had worked hard to develop the policy of Green Mountain Care, but had neglected to launch a serious and sustained effort to educate the public about what the act did and how it impacted people's lives, allowing confusion to fester in the vacuum. A survey conducted in April 2014 showcased this, [with 40 percent in favor of Green Mountain Care, 39 percent against it, and 21 percent unsure](#). Further, trust in the state's capacity to assume management of Vermont's healthcare system had become much more strained after the disastrous launch of Vermont Health Connect, the state's ACA health insurance exchange website. Launching on October 1st, 2013, the website had been [plagued with issues](#), which the Shumlin administration had very publicly tried and failed to fix for almost a year before finally having it shut down indefinitely for repairs in September 2014.

By the end of 2014, Shumlin's confidence in the reform effort had completely collapsed. Although, [as John McDonough points out](#), the reform-related taxes would have replaced private insurance premiums that employers and individuals currently pay, and although the Internal Revenue Service had agreed that the taxes would be federally deductible, the taxes would nonetheless be a mammoth increase that would have been obvious to every Vermonter's tax bill. Shumlin believed the political furor that would have erupted upon making the plan public would subsequently have made it toxic to the legislature. Even before the 2014 gubernatorial election, where he won the popular vote by a single-percentage-point margin against an opponent who actively campaigned against single-payer, Shumlin felt that the battle was lost, and on December 17th, 2014, [he would publicly withdraw the plan](#).

## Conclusions

Taken together, this information paints a more complex picture of Green Mountain Care's administrative failure rather than purely its economic inviability. Three studies on Green Mountain Care's potential impact were undertaken during its drafting, passage, and implementation: the 2011 Harvard study, the 2013 University of Massachusetts study, and the 2014 State of Vermont study. All three studies found that the state would save money by implementing the program, with the savings put forward in the [2011 Harvard study](#) were much rosier than the two studies undertaken later on in the implementation process. Further, while the studies all differed in their projections for the amount of revenue the state would receive from the federal government, the amount it would need to tax, and

overall cost, they all concluded the proposal would be economically feasible should the state choose to commit the needed resources.

Based on the preceding series of events, it is better to view the plan as a sound idea scuttled by political barriers and poor management of the reform effort. As James McDonough has argued in his article on the failure of Green Mountain Care, while these taxes would have replaced the private insurance premiums that employers and individuals currently pay, [the sheer size of this increase](#) would have been a political nonstarter without a sustained effort to educate the public. While the Shumlin administration was heavily invested in trying to make the policy side of the reform effort work, it ignored or put off an equally vital component of implementing such a large and complex public policy initiative: ensuring that the public was educated on what the reform did and what its costs would be, as well as making the case that the end result would be worth the cost of those costs. By putting off how the program would be financed until later, the Vermont State Government missed a vital opportunity to build a constituency and stakeholder network to argue that the benefits of Green Mountain Care outweighed the costs. This, combined with the mission-creep of the Green Mountain Care Board and the collapse in state credibility following the failure of Vermont Health Connect, fostered an atmosphere of uncertainty and distrust in the state government, turning a politically steep climb into a politically insurmountable one.

The rise and fall of Green Mountain Care in the state of Vermont serves as a microcosm for the difficulties that plague advocates for comprehensive healthcare reform at both the state and federal level and provides several important lessons for reformers tackling the issue now and into the future. Firstly, reformers must constantly be engaged in not just developing good policies but also ensuring that those policies develop constituencies aware of their benefits and costs. In the case of universalist programs such as Green Mountain Care and other single-payer health care initiatives, this is doubly important, as such programs require broad public support to sustain themselves in the long term. Further, such programs require flexible and adaptable public management strategies that take into account the often-unpredictable nature of long-term reform efforts. The Vermont State Government had no real answer for issues such as the higher-than-expected payroll tax or the issues with Vermont Health Connect, making the government appear to political observers to be floundering when it came to the issue of healthcare. More than simply economics, it was this breakdown of trust between the state government and the people, and the fear of subsequent political reprisal, that ultimately doomed Green Mountain Care.

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