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Prologue: For several years the state of Vermont has been among those “states that could not wait” for the federal government to act on health care reform. Its unique political structure and relatively homogenous population have made it an ideal proving ground for various models of health system reform, including a single-payer system. In 1992 the Vermont legislature lay the groundwork for statewide health system reform by creating the Vermont Health Care Authority, a quasi-political, quasi-analytical body given responsibility to chart the course for the state’s health care reform effort. Another factor in Vermont’s favor is its physician-governor, Howard Dean, a Democrat who was reelected in November 1994. Dean has long championed health care reform on both ideological and practical grounds. Despite the positive outlook, however, Vermont’s 1994 General Assembly failed to reach agreement on health care reform. In this paper Howard Leichter examines the state’s political and economic landscape in the years following passage of Act 160, which among other things created the Vermont Health Care Authority. He traces the reasons why “the little state that could, could not” enact reform and, in rich detail, chronicles the demise of the shaky political coalitions and deals that had contributed to the state’s progress thus far. One of the most important lessons for the national reform effort, Leichter believes, is the state’s failure to convince skeptical interest groups and consumers that the government can ever reform the health care system. Leichter, a political scientist, is a professor at Linfield College in McMinnville, Oregon. He introduced Health Affairs readers to the 1992 Vermont reforms as well as reforms taking place in Minnesota (Health Affairs, Summer 1993) referring to Vermont’s health care system at that time as “a work in progress.”
Abstract: It seemed inconceivable that Vermont would not enact comprehensive health care reform in 1994. Two years earlier the Vermont legislature had created the Vermont Health Care Authority to prepare the groundwork for major reform. Yet the 1994 Vermont General Assembly could not reach agreement on legislation. What went wrong? Some on the political left and right say that the legislature stopped “bad” legislation. The Vermont story reveals the failure of reformers to convince interest groups and ordinary citizens about the capacity of government to reform the health system.

Many national media mavens and health policy cognoscenti deemed it “inconceivable that Vermont would pass no health system plan” in 1994.1 Vermonters shared and encouraged this view. In July 1993 the executive director of the state’s medical society told a gathering of state health policy experts that “if we can’t do this in Vermont, it can’t be done.”2 On the eve of the 1994 legislative session the speaker of the Vermont House of Representatives said, “This tiny and different state is on the brink of decision, and the rest of America waits our action with curiosity.”3

Vermont policymakers and -shapers could be forgiven their hubris and hyperbole; they were still on a political high from the much publicized, if overly romanticized, health care reform legislation (Act 160) they had forged in 1992. Among other things, the law promised Vermonters that the 1994 General Assembly would complete the journey that would end in guaranteed “access to quality health services at costs which are affordable.” Act 160 convinced state leaders that Vermont could become the first state to achieve universal access and cost containment. A visitor to the state in the early summer of 1993 found an air of confidence that reform, although neither easy nor inevitable, was likely in 1994. Fueling this optimism was the national attention Vermont had attracted, in part because of its high-profile physician-governor, Howard Dean.4 A “friend of Bill’s,” Dean was at the time vice-chair of the National Governors’ Association (he became its chair in July 1994), a de facto expert on health care reform, and a frequent commentator in the media and before congressional committees.

As the 1994 legislative session approached, local pundits declared that health care reform would be the defining political issue of the session, and the maker or breaker of political careers. Howard Dean, wrote one commentator, had “staked his political career” on health care reform, while an editorial proclaimed, “When history looks back on lawmakers’ work this winter, all it will remember is health care reform. . . . In 10 years, the 1994 Legislature will be considered either the group of Vermonters who sculpted a health care reform that covered everyone and reined in health costs, or the bunch of idiots who threw together a gumbo of regulation and bureaucracy that bankrupted the state.”5 The editorial writer apparently did not consider a third option: The 1994 legislature would be remembered as the group that killed, or at least postponed, health care reform.

It is tempting, in view of the high expectations and exposure attending
Vermont’s effort to reform its health care system, to ask, “What went wrong?” It is sobering when the answer comes back from some in the state, that “nothing went wrong.” In fact, in the minds of several legislators, on both the political left and right, the Vermont legislature accomplished something quite notable this session: It stopped “bad” legislation. This perspective provides insight into an important lesson from Vermont. The political center (that is, those willing to accept an incremental approach to reform) was neither well enough defined nor well enough organized to carry the burden of reform. The strength of the extremes, or the weakness of the center, in Vermont was nourished by increasing public uncertainty about, and ultimately hostility toward, revamping the state’s health care system. This in turn gave the left and the right a license not to legislate.

It is always a bit dicey to generalize from one state’s policy experience to that of others. This is especially perilous when the state is Vermont, inhabited by 560,000 mostly white, rural, and comparatively healthy people. Nevertheless, the Vermont story reveals and reflects many of the obstacles other states face in trying to refashion the nation’s health care system. One major impediment to comprehensive change was the increasing insecurity, felt by both lawmakers and the public, over the enormity of the task and the unpredictability of its outcome. Until Vermonters, and Americans, feel comfortable with the process of reform, and educated and confident about the content and potential consequences of change, a consensus will not emerge. The education process that has to precede reform may exceed the length of a state or congressional legislative session.

The way it was supposed to be. Act 160 seemed the ideal blueprint for successful reform. The law created the Vermont Health Care Authority (VHCA), one of the most highly centralized and potentially powerful state health reform agencies in the country, and authorized it to implement various reforms, including community rating of nongroup insurance, and effectively expand Medicaid access to more children from low-income families through the state’s Dr. Dynasaur program. In addition, the VHCA was to inventory the state’s health resources, develop a uniform benefit package and a global budget, and prepare two universal access plans—one a single-payer system, the other a regulated multipayer system.

By the time the Vermont General Assembly convened in January 1994, much of the work needed to reform the state’s health care system was to be completed, and the politicians could then make the necessary political choices. That was the vision, but it did not turn out to be the reality. By the time the legislature convened, the VHCA had become the subject of controversy that both adumbrated and contributed to the difficult legislative task ahead. A growing chorus of critics declared that the Health Care Authority was “a massive political failure.”
The Vermont Health Care Authority: A ‘Political Disaster’

The VHCA, which began operation in August 1992, can trace many of its problems back to Act 160 itself. Both critics and supporters acknowledge that the law bequeathed to the VHCA an overly ambiguous, ambitious, and politically perilous mandate. Part of the difficulty was that the agency had both regulatory (for example, certificate-of-need and hospital budget approval) and policy development responsibilities. Although not unprecedented, this duality of function created uncertainty about the VHCA’s role.

This ambiguity remained and became an institutional liability, particularly with regard to the authority’s role in proposing the two universal access plans. One of the agency’s most persistent critics, the head of the Vermont State Medical Society (VSMS), argues that the VHCA failed in its responsibility to build political consensus around the universal access plans.9 Others, including members of the governor’s staff, believe that Act 160 never gave the VHCA the responsibility of political or policy advocacy.10 Yet Paul Harrington, a VHCA board member and an architect of Act 160, admits that in hindsight the authority should have been given more of a political role in the sense of advocating a particular plan. According to Harrington, developing two separate plans without taking a position on either one was “unwise.” “To come forward with two plans,” he said, “without being able to say this one would make more sense for Vermonters than the other, really made our work more a theoretical exercise than a process that would assist the General Assembly.”11 Whether the authority’s mandate was ambiguous, faulty, or merely misinterpreted, the result was divergent and often irreconcilable expectations.

Even if the framers of Act 160 did not intend to have the VHCA play a political role, the tasks assigned to it were quintessentially political. Thus, it became involved in such questions as: What constitutes a “health care provider” and, in particular, a “primary care physician?” What should be in a basic package of health care benefits? Should the Medicaid and Medicare populations be included in the reform? And, most importantly, should Vermont have a Canadian-style, single-payer health care system, a private insurance-based multipayer system, or something else? At stake was a redesign of the state’s health care system and redistribution of resources within that system. As a result, the VHCA became a lightning rod for all of the anxiety attending any such effort. Because the authority stood alone, legislators and the governor could watch from the sidelines, gauging public reaction to various proposals without taking any political blame.

Some of the organization’s problems were, however, of its own making. One such problem was the VHCA’s failure to assuage the fears of various stakeholders that they might not have “a place at the bargaining table.” For
example, various citizen advocacy groups complained that the panels established by the VHCA were dominated by business, insurance, and health provider interests to the virtual exclusion and detriment of “the public.” By one estimate, twenty-one of the 102 people serving on the five major advisory committees to the VHCA were “unaffiliated consumers or representatives from consumer groups,” a number critics felt was far too low.

Providers shared the view that they were being neglected by the VHCA. Thus, alternative health care practitioners— including chiropractors, naturopaths, acupuncturists, lactation consultants, and massage therapists, as well as nonphysician providers such as alcohol and substance abuse professionals and nursing home operators—complained that they and those who use their services were inadequately represented. More important to the fate of reform, however, was the sense of exclusion felt by traditional medical care providers. Both the VSMS and the Vermont Hospital Association (VHA) had been central players in the passage of Act 160, and both expected to occupy center stage once again. Yet by the fall of 1993 these two groups were off in the wings of reform.

The cause of the estrangement was both substantive and procedural. The hospital and medical associations shared common concerns on issues that have become part of the genetic code of health care reform: alleged government micromanagement of health care; rates and methods of provider reimbursement; and clinical freedom and patient choice. However, both organizations— but especially the medical society— were agitated as much over the process as over the substance of reform. The leadership of both organizations complained bitterly of being “kept at arm’s length” by the VHCA and not being given adequate time to respond to draft plans.

Of the two provider groups, the medical society was most alienated. Although the society took exception to some of the VHCA’s substantive proposals, relations truly deteriorated over the authority’s failure to grant formal bargaining status to the VSMS. Since the time of the debate over Act 160, the physician community has been obsessed with securing a place at the bargaining table. The medical society’s support for Act 160 was in no small part tied to a provision of the law that allowed the VHCA to create “health care provider bargaining groups” to negotiate two issues of vital concern to physicians: the health care budget and provider reimbursement.

The VSMS expected to be recognized as an official bargaining group once the VHCA adopted the necessary rules. By April 1993, eight months after the authority was formed, the administrative rules still had not been written, much to physicians’ dismay. The failure of the VHCA to fulfill its statutory, almost moral, responsibility to the provider community would haunt the reform process for the duration. According to the Senate minority leader, Mary Ann Carlson (D): “The one group you can’t alienate is the
provider group." Yet this is precisely what the VHCA board did. The VSMS saw its role considerably diminished, and its enthusiasm for reform commensurately dampened. It is possible, indeed probable, that the physician community’s support for reform would have become more tepid any way. There were simply too many unanswered questions. How, for example, were costs to be contained: capitation, fee schedules with utilization review, global budgets, insurance premium caps? The medical society’s feud with the VHCA hastened an unavoidable confrontation between the physician community and other public and private interests; it did not create it.

Although this alienation was an unforeseen blow to reform, the strained relationship between the VHCA and the single-payer lobby was more predictable—and only slightly less hobbling. Single-payer advocates had been largely reluctant supporters of Act 160. In fact, the most influential single-payer advocate in the legislature, Sen. Cheryl Rivers (D), voted against Act 160. To the extent that advocates held out hope for favorable action by the VHCA, it was because Act 160 required it to provide the legislature with both a regulated multipayer plan and a single-payer plan. Such hope was fairly short-lived. By summer 1993 single-payer advocates were accusing the VHCA of failing to develop a “true” single-payer model. In addition, at a meeting with the VHCA, U.S. Rep. Bernie Sanders (I), a staunch single-payer advocate, argued, “A true single-payer [system] has inherently in it some significant savings that we believe you may have not fully appreciated.” Leaders of the state’s Democratic Party shared his view.

Not to be slighted, the political right also weighed in on the issue of the VHCA’s unfaithfulness to Act 160. Republican leaders charged that “[t]he authority has substituted its own invention for the clearly stated legislative intent of the General Assembly.” Of particular concern here was the VHCA’s proposal to create purchasing alliances, which Republicans felt would lead to the elimination of private insurance companies.

Thus, the VHCA—the administrative core of Act 160 and the engine that would pull the state health care reform train—was under attack from forces on all points of the political compass. Instead of facilitating reform, the VHCA had become one of its obstacles. Some criticisms of the VHCA were the inevitable result of moving from such soft and fuzzy commitments as “universal access for all Vermonters” and cost containment to the hard realities concerning benefits, funding, consumer choice, and provider freedom. These issues would have been controversial regardless of how nimbly the VHCA had handled its legislative charge. But the three-member VHCA board proved unskilled at handling these politically volatile issues. The essence of the problem was a failure of communication, both among the members of the VHCA board and between the board and its various constituencies. Much of this problem can be traced back to the personal
skills of the three board members, none of whom had been at the top of the governor’s list for the appointments, and each of whom was repeatedly described as highly competent, decent, and hard-working but stiff and not particularly articulate. According to most accounts, board members, try as they might, never succeeded in communicating their message to the public and defusing potentially volatile conflicts with individual stakeholders. \(^{19}\)

To compound the problem, the board did not work well together. The main difficulty was between two of the three members, who, by virtue of differences in personal style and background (one, Paul Harrington, was a former state representative, the other, Veronica Celani, a former commissioner of social welfare), never developed an easy working relationship. The fact that Harrington was philosophically inclined to favor a regulated multipayer system and Celani a single-payer system added to the tension.

Left to referee the conflict was the VHCA’s chair, Richard Brandenburg, former dean of the University of Vermont business school. Brandenburg, who had no experience in government, politics, or health care, was described as “a fish out of water” who “was never really effective in public relations.” \(^{20}\) Dean had chosen Brandenburg in an attempt to bring the business community on board, something he was never able to accomplish.

The personality problems of the authority’s board were exacerbated by the informal decision to have the board operate with a “flat,” as opposed to a hierarchical, organizational structure. Despite Brandenburg’s titular leadership and the assignment of specific areas of responsibility to each board member, decisions tended to be made collaboratively. This style proved to be inefficient and sometimes impossible.

The VHCA’s efforts, then, were undermined both by faulty enabling legislation and by internal organizational problems. Neither problem was a particularly well kept secret in Montpelier, yet Governor Dean, to whom the VHCA board reportedly regularly, chose not to intervene. He thereby missed an opportunity not only to help manage the dysfunctional relationships within the authority, but also to use his considerable communication skills to build public support for reform. As a consequence, when policymakers geared up for the 1994 legislative session, they inherited a legacy of suspicion and disarray. The VHCA never created a process with which health policy constituencies could feel comfortable, and this made reaching consensus on the content of reform all the more difficult.

### The Politicians Take The Reins

A headline in The Burlington Free Press, 24 July 1993, announced that “Dean Takes Reins on Vt. Health Care.” The governor, the story explained, had decided to develop his own health care plan—months before
the VHCA was even scheduled to make public a draft of its universal access plans. Up to this point, Dean and his staff were ambivalent about the role they should play in the VHCA’s work. As the authority’s problems accumulated, however, and with time growing short to develop his own plan and to build political support for it, the governor decided to offer his particular vision of reform. By way of justification for seemingly undercutting the authority’s work, the governor’s deputy chief of staff explained that the VHCA effort was “a somewhat theoretical exercise based on what the law says,” while the governor’s job was “to connect reform to reality.”

Part of the reality facing the governor was that if Vermont was to have health care reform, policymakers would have to reassemble the now crumbling coalition that had come together over Act 160. In addition, the governor felt that the VHCA might not be sufficiently mindful of the state’s fragile economic situation and might propose taxes that he would not support or a too generous benefit package that the state’s economy could not sustain. It appeared to most observers that the governor was distancing himself from his own agency’s work.

In the months leading up to the start of the 1994 legislative session, then, health care reform in Vermont traveled on two separate tracks. The VHCA continued with the process dictated by Act 160 by holding public hearings, including an interactive television broadcast on Vermont public television, to collect public comment prior to submitting its final report to the legislature in November. Although some came to these meetings to praise the authority’s work, most were critical.

The VHCA also contracted with the Vermont Ethics Network (VEN), a nonprofit educational group, to conduct “Neighbor-To-Neighbor” meetings to educate the public about health care reform and to encourage their involvement. VEN held nearly one hundred such meetings, attracting about 1,800 people who expressed their views on such issues as eligibility, access, quality, and affordability. These meetings did not (nor were they intended to) develop popular support behind any particular vision or model of reform, a task left to policymakers and stakeholders.

Meanwhile, the governor, his staff, and key legislators had begun meeting during the summer to prepare for the legislative session. The pace of this preliminary activity picked up dramatically in October, when the speaker of the House of Representatives, Ralph Wright (D), announced that he was creating a special health care reform committee to draft legislation. The purpose of the committee was to expedite House consideration by avoiding four of the six standing committees that had jurisdiction over health care reform legislation. It would also give the speaker greater control over the process and its outcome. Wright chose Rep. Sean Campbell (D), the House majority leader and a close political ally, to chair the committee. Mindful of
the need for Republican votes to gain passage in the House, Wright asked
the Republican minority leader and three other (moderate) Republicans to
serve on the eleven-member committee. The only litmus test for committee
membership was a commitment to support universal access.

In late November Governor Dean, in an extraordinary gesture, appeared
before the special committee to outline his own vision, which was based on
certain principles. The final legislation should provide universal access,
contain costs, not endanger the fiscal or economic viability of the state, and
not disrupt Vermont’s health care system. \(^{24}\) Within these broad parameters,
Dean would be flexible—critics would later charge, too flexible. However,
on one point he was completely unyielding: The governor would never
accept an increase in the state’s income tax to fund health care. Dean was
convinced that Vermont’s high income tax was already a drag on the state’s
economy and its capacity to attract new businesses. This position put the
governor at odds with single-payer advocates, and liberals in general, who
favored progressive funding for health care reform.

The governor called for a regulated, multipayer system with an employer
mandate in which employers and employees would each pay 50 percent of
the premiums. Many in his own party criticized the fifty-fifty split, which
they feared would encourage employers, most of whom now paid 75 to 80
percent of their employees’ premiums, to drop back to 50 percent. In
addition, Dean proposed subsidies for small businesses and low-income
persons, as well as expansion of Medicaid to help cover the unemployed.
This latter provision was opposed by the VSMS, whose members dislike
Medicaid because of its underreimbursement. The plan would cost $30–$38
million and be funded through “splinter taxes” (on gasoline, tobacco, and
alcohol). Employers would be encouraged to join a state insurance buying
program that would emphasize managed care and, it was hoped, help lower
costs. Finally, the state’s health system would operate under a global budget.

The governor’s plan reflected a confluence of political calculation and
personal commitment. Dean recognized that passing health care reform
would require support of the business community and the slim (16-14)
Republican Senate majority. In addition, Dean’s insistence on reform that
would be fiscally and economically responsible represented a continuation
of the pro-economic growth, balanced budget position he had embraced
since becoming governor in 1991, when he inherited a budget deficit from
his Republican predecessor. The governor emphasized the relationship
between health care reform and economic development in his presentation
to the special committee. Republicans and business leaders reacted posi-
tively to the governor’s outline. John Carroll, the Republican majority
leader, declared the governor’s plan “a good start,” and said: “All of this
causes me to feel that the governor has made a good faith effort to address
at least some of the concerns that we expressed.”

While Dean’s plan seemed to satisfy the political right, at least for the moment, it did nothing to assuage the concerns of the state’s strong single-payer lobby. In December Representative Sanders, the state’s only U.S. House member, issued a report on the cost of a single-payer system that grew out of the Task Force on Single-Payer Health Care, which he had created. The task force concluded that it would cost Vermonters $562 million to fund a single-payer system, “$284 million less than the $846 million Vermonters will spend in insurance premiums and out-of-pocket payments in 1994 for the same benefits if there is not reform” and $427 million less than the VHCA’s proposed multipayer plan. Dean, himself a single-payer advocate earlier in his political career, denounced the task force’s findings as misleading and irresponsible.

The prospects of Vermont’s going to a single-payer health care system in 1994 were remote: Republicans, who controlled the Senate, and Governor Dean (“I would never do a Canadian-style single payer”) both opposed the model. Nevertheless, single-payer advocates were a force that could not be ignored; they were the best organized and most dedicated (nearly the only) health reform lobby in the legislature and in the state.

While single-payer advocates were proposing a major overhaul of the state’s health care system, the state’s Republican leaders were promoting something more modest. Republicans’ wish to proceed cautiously entailed as little structural change in the current system as possible: It would cover only the uninsured population, not involve employer mandates or global budgets, and be funded by splinter taxes or perhaps a provider tax.

‘Health Plan Du Jour’: The House Does Reform

When the Vermont General Assembly convened 2 January 1994, despite a general mood of support for health reform, none of the plans that had been publicly discussed had the support of more than one out of five members. In fact, in the next five months Vermont legislators would consider, only to abandon, every major option available: a single-payer system, the governor’s proposal for an employer mandate, and the moderate Republican plan. These options ranged in cost from around $35 million to $750 million—the latter figure was $90 million more than the entire state budget. It seemed that although almost everyone acknowledged that Vermont’s health care system needed changing, there was no majority agreement on such questions as how much change, at what cost, and, most intractably, how it should be financed.

The divisions, and evolving anxiety, among Vermont legislators mirrored those of the general population and interest groups. The business
community, whose support Dean deemed vital to passage of reform, was all over the map on the issue. The 1,500-member state Chamber of Commerce opposed both employer mandates and a single-payer system; the Vermont Employers Health Alliance, representing more than 100 large and small businesses in the state, favored employer mandates but opposed single payer; and the Vermont Retail Association favored a single-payer system.

First out of the gate was the governor’s bill, which was formally sponsored by Speaker Wright. The Democratic leadership of Vermont would not speak with one voice this year on health care reform. In October Wright, a liberal Democrat, announced that he personally favored a single-payer system. Thus, although he formally sponsored House bill 645, “An Act Relating to Universal Access to Health Care,” it was with little enthusiasm. In fact, members of the governor’s staff fretted over how reliable the speaker might be in moving the governor’s bill through the House.

H. 645 was assigned to the special committee; by the time the committee received the bill, it had heard nearly three months of testimony from every conceivable interest group in the state. With H. 645 as its starting point, the committee proceeded to wrestle with each issue of reform ad seriatim: universal access, health alliances, global budgets, benefits, and funding. In late January the committee agreed in principle on a comprehensive benefit package similar to that proposed by the VHCA. In addition to a standard package of in- and outpatient care, the committee gave preliminary approval to including mental health care, alcohol/substance abuse treatment, prescription drugs, vision care, routine dental care for children, and emergency care for adults. No formal vote was taken on the package, and critical questions such as whether providers would be reimbursed on a fee-for-service or capitated basis, and whether or not Vermonters would receive benefits in a managed care or traditional “open” system, were left undecided.

This first tentative step toward reform was followed by a much bolder one. The conventional wisdom in Vermont (and in the nation) was that a single-payer system, for all of its putative virtues, is politically unfeasible. Although the single-payer lobby has consistently been the only group in the state with organization and a coherent message, most policymakers and the media had written off the vision as too radical. It came, then, as more than a small surprise when the chair of the special House committee, Sean Campbell, announced to his colleagues that he had figured out, in the middle of the night in a Boston hotel room, how Vermont could do a payroll and income tax-financed system in which one state health alliance would purchase insurance for all Vermonters.

Campbell’s “bombshell,” as it was called, caused quite a stir in the Statehouse: Senate Republican leaders warned Governor Dean that if he did not “straighten out” Campbell and Wright (who Republicans suspected...
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was the real cause of the mischief, a charge Campbell denies), health care reform would be dead for this session. For his part, Dean tried to downplay the significance of the proposal, which was, in fact, nothing more than an outline on a blackboard in the committee room. The governor first indicated that he had no intention of intervening in the committee’s work, but several days later he spoke out against the Campbell proposal.

Events now began to move quickly and somewhat chaotically. The prospect of a single-payer system again became a catalyst for a search for a less “radical” plan. One week after Campbell’s bombshell, two moderate Republicans on the special committee, Rep. Richard Westman, the House minority leader, and Rep. Thomas Little, submitted such a plan. Incredibly enough, even for moderate Republicans, the proposal called for an employer mandate, with a seventy-thirty employer/employee split; state subsidies for low-income and unemployed persons, as well as certain small businesses; and a prescription drug benefit for Medicare recipients. The plan would be funded by beer, tobacco, and gasoline taxes and by a 5 percent provider tax. The total cost of the plan, around $75 million, was more than twice that of Dean’s proposal but considerably less than the estimated $610 million for Campbell’s scheme. Governor Dean reacted favorably, and Lieutenant Governor Barbara Snelling (R), while cool to the idea of an employer mandate, saw the alternative as something “we can work with.” The Little-Westman proposal supplanted Campbell’s tax-based idea as the focus of the committee’s work—at least for the moment.

Support for this “moderate” plan did not foreclose consideration of other options. At about the time the Little-Westman proposal was the “plan du jour,” the special committee heard testimony from officials of the VHCA and a supporter of Representative Sanders about the savings that could be realized by adopting a single-payer system. As noted earlier, single-payer advocates accused the VHCA of failing to calculate the savings that such a system would generate. In December the Sanders task force issued a report that calculated that the state could save an additional $131 million over the plan offered by Governor Dean if it adopted a single-payer system. The figure was accepted by Veronica Celani, a member of the VHCA’s board. Thus, for the first time the authority and the single-payer lobby agreed on the magnitude of savings that a single-payer system would provide the state. Or so it seemed. The following day Paul Harrington announced to the press that he did not accept the judgment of his colleague about the savings and argued that more work needed to be done before any valid conclusions could be drawn. The episode only served to further confuse the public and tarnish the image of the authority.

About two weeks before they were scheduled to vote on a reform bill, the eighty-eight Democrats from the 150-member Vermont House caucused to
hear a report on the special committee’s progress. As of mid-February this is where the committee stood: It started with the Dean fifty-fifty employer mandate and its $35 million price tag; it had flirted with Campbell’s $610 million tax-based system; and it was now back to a premium-based, seventy-thirty employer mandate plan. Meanwhile, the single-payer lobby lurked in the shadows. Although no formal vote was taken, the caucus appeared evenly divided between supporters of a single-payer, tax-based system and a system based on employer mandates and multiple insurance carriers. House Republicans, on the other hand, could agree on only what they did not want: a single-payer system.

In this atmosphere of political uncertainty, the special committee gave preliminary approval to the Little-Westman proposal 22 February. The committee planned to work out the specific details during the following week and then send the bill on to the Ways and Means and Appropriations Committees for action. The critical problem now was whether enough single-payer Democrats and anti-employer mandate Republicans were willing to hold their noses and vote for a premium-based system. Signals coming from the Democratic left (that is, the single-payer caucus) were not encouraging. Rep. Ann Siebert (D), sponsor of the single-payer bill in the House, said, in reference to the emerging special committee bill, “I think it’s far less than anything we could support,” while Senator Rivers characterized the “Dean-Westman-Little” plan as “a disaster for the citizenry and the economy of Vermont.”

Despite this opposition, the committee gave final approval 4 March to a modified version of the Little-Westman proposal-the vote was ten to one, with a single-payer advocate dissenting-and sent it on to the Ways and Means and Appropriations Committees. The bill called for raising just over $90 million from beer, tobacco, and gasoline taxes; a payroll tax of up to 1 percent on employers whose health insurance costs were less than 7 percent of payroll; and a 0.7 percent income tax to pay for nursing home and home-based care. In addition, Vermont employers would pay 70 percent of workers’ insurance premiums. In return, all Vermonters would be guaranteed comprehensive health care benefits starting 1 January 1996. The bill also set a cap on insurance premiums and created a Vermont Health Alliance to collect premiums and negotiate with insurance companies. Insurers then would organize provider networks, emphasizing managed care. Smaller private alliances would be allowed to operate as well.

Normally, a bill with ten-to-one bipartisan committee endorsement should have relatively easy sailing. However, from the moment it left the special committee, this was not the case. The great divide in the House, and among the public, was over financing. The political left favored progressive (that is, income and/or payroll) taxes; the political right, to the extent that
it supported reform at all, would accept only splinter taxes; and the political center, which dominated the special committee, preferred primarily premiums, with additional revenue from splinter taxes. For the House Democratic leadership, the immediate question was which option could attract the seventy-six votes needed to pass a bill.

Following a weekend of telephone calls to House members by Ralph Wright, Sean Campbell, and Howard Dean, the speaker concluded that the premium-based, employer-mandate system endorsed by the special committee was not that option. On 15 March, Wright, after conferring with other House Democrats, dropped the second “bombshell” of the session: He and the Democratic leadership were switching their support to a tax-based system. The plan, which was hastily put together, called for an 8.8 percent payroll tax and a 3.2 percent income tax, which would raise just over $750 million. Although strictly speaking not a single-payer system, since it allowed nonprofit insurance companies such as Blue Cross and Blue Shield and the Community Health Plan (the second-largest insurer in the state) to participate, the plan was close enough with its progressive funding to gain single-payer support. The special committee now voted eight to three, with three of the four Republican members opposed, for the tax-based plan that maintained most of the provisions of the original bill.

The shift to tax-based funding was an act of political desperation. Although Speaker Wright counted eighty-one votes for the tax-based system, five more than were needed for passage, everyone understood that there was no way that either Howard Dean or Senate Republicans would ever accept it. House approval of a tax-based system recommended itself for one reason: It would keep reform alive by moving the bill on to the Senate. In one of the more curious moments in an already bizarre session, Dean urged House Democrats to vote for the bill he would veto if it ever reached his desk, simply to get it out of the House.

What occurred next was one of the pivotal moments in the Vermont health care debate; one key legislator called it the “moment health care reform crashed and burned in the House.” Thursday, 17 March, The Burlington Free Press ran a table on its front page showing how much the taxes of various sample families and individuals would increase under the most recent Democratic plan. It showed, for example, that a middle-class family of four with an adjusted gross income of $60,000 would see its Vermont income tax go from $1,909 to $3,714 per year, a 95 percent increase, while an individual with an annual income of $30,000 would see a 101 percent rise, from $898 to $1,801. The impact of the story was dramatic: Legislators heard from angry constituents that if this was the cost of health care reform they wanted no part of it. Meanwhile, the governor reiterated his position that “we’re not going to raise the income tax to pay
for health care,” a position endorsed by key business groups as well as Republican legislators. But most ominously for the leadership, many of the eighty-one Democrats who had told the speaker that they would support a tax-based bill were getting skittish about signing on to a $750 million tax increase that would hit the middle class particularly hard, even though the new taxes would replace, and in many instances be cheaper than, household health insurance premiums.

Legislative leaders now scrambled to find an alternative to both the tax-based system—which the governor, most Republicans, and now the public rejected—and a premium-based system, which did not have seventy-six votes in the House. The day the Free Press article appeared, the speaker’s office was a hub of activity as key legislators met behind closed doors trying to find a way to keep health care reform alive in 1994. What began to emerge was a plan that would keep most of the structure of the latest version of H. 645 and commit the state to providing universal access and cost control in 1996. However, it would postpone until 1995 decisions on the benefit package (and hence the cost) and, most notably, financing.

In the interim the VHCA would prepare a “Goldilocks plan”- high, medium, and low benefit packages and funding for each. Although the bill retained structural features of its predecessor, it was a mere shell of a program. The governor once again urged Democrats to vote for the “plan du jour” merely to get it out of the House. In the end that is precisely what the legislators did. On a vote of ninety-nine to thirty-nine, the House approved H. 645 (in principle), which promised to provide all Vermonters access to health care beginning 1 January 1996, and to control health care costs through global budgeting and caps on insurance premiums. The 1995 General Assembly was left the task of resolving what the 1994 legislature could not: Who was going to pay for universal access? How much would it cost? And what benefits would Vermonters get for their money?

Before taking a final vote on the bill, however, the leadership allowed a vote on a single-payer amendment to H. 645. For the first time state legislators would have an opportunity to vote on a Canadian-style single-payer system. The result was a resounding defeat: 112-29. The numbers, however, are misleading. With the pressure off from the Democratic leadership, those who would have voted for a single-payer system out of loyalty to the speaker no longer saw the need to do so. In addition, even some committed single-payer advocates did not support the bill because it had been sponsored by the House’s two Progressive members, neither of whom had endeared themselves to many Democrats. Most informed estimates of single-payer strength in the House put the number of solid supporters at about thirty-five to forty House members, with an additional twenty-five to thirty who would support the option as a favor to the speaker. The amend-
ment was defeated, and the House postponed yet again the difficult decisions on health care reform. If Vermont was going to enact meaningful reform in 1994, it would be up to the Republican-controlled Senate.

The Senate Will Fix It

At various times while H. 645 was in the House of Representatives, the speaker and the governor looked to the Senate to “make things right.” At one point, Ralph Wright announced that his plan was to push a bill as far to the left as possible so that the Republican-controlled Senate would move it to the center and make it enactable. In the waning days of the House debate, when it looked as if that chamber might pass a tax-based bill, Dean announced at a press conference, “There’s practically nothing that’s unacceptable coming out of the House because it’s going to go to the Senate and be reworked.” In fact, Senate Republicans took to wearing buttons that read: “Vermont Senate: Fix Its R Us.”

Initially, it seemed that the governor would get his wish. Senate Majority Leader John Carroll asked the Senate president pro tempore to convene a special bipartisan group to identify areas of agreement on reform and to prepare legislation. The message seemed to be that the Senate Republican leadership wanted some kind of health care reform. Although this group met only three or four times before the process reverted to the normal committee system—reasons that were unclear even to the participants—Carroll’s overture and his decision to work with the Democratic chair of the Senate Health and Welfare Committee, Jan Backus, seemed to bode well for a bipartisan effort.

Carroll and Backus began by identifying points of agreement between them. Given the spectacle of the House debacle and the lateness of the session, both had independently concluded that only modest or incremental reform was possible at this point. The two agreed on a four-page outline of principles, including: (1) Uninsured Vermonters would have to purchase health insurance by 1 July 1995 (an individual mandate); (2) persons who could not afford to do so would receive an income-based sliding-scale subsidy from the state; (3) all employers now providing health insurance would have to continue to do so; (4) state subsidies would be gradually replaced, over a two- or three-year period, by mandatory employer/employee contributions; and (5) the program would be funded by a 5 percent tax on all health goods and services.

Led by Senator Backus, the Health and Welfare Committee began to flesh out the bill. Unlike the House committee, which spent nearly five months and held more than sixty committee meetings, taking testimony from hundreds of interested parties, the Senate committee would have
about six weeks to do its work. Senator Backus decided to narrow the focus of her committee meetings and to limit the range of people from whom the committee would take testimony. In addition, she scheduled two public hearings outside of Montpelier to gauge public opinion and enlist public support.

But time was not the only enemy of reform in the Senate. First, it was not merely a question of the amount of time remaining in the session, but the timing of the Senate’s deliberations. Health care reform now was competing for the time, attention, and political energy of senators who faced a second major piece of controversial legislation: property tax reform. In addition, with the debacle of the House efforts fresh in their minds, most Vermonters were at best skeptical of the legislature’s capacity to accomplish reform. Second, although the political dynamics of the thirty-member Senate are different than those of the 150-member House, the political divide over health reform was just as wide. If anything, the relative size of the bloc of legislators who were willing to do nothing was greater in the Senate than in the House. Some in this group favored waiting to see the fate of the federal reform effort, some preferred waiting until their (single-payer) day would come, and some believed that nothing should be done.

For his part, Governor Dean continued to hope that the Senate would produce legislation that would at least address the problem of the uninsured, thereby keeping health care reform alive until the larger questions could be resolved at either the federal or state level. As support for even modest reform flagged, Dean threatened to withhold his support for property tax reform if the Senate took no action on health care.

The bill that took shape in the Senate Health and Welfare Committee followed the broad outlines agreed to by Carroll and Backus. It proposed to extend health insurance benefits to the uninsured by requiring that they purchase insurance from new insurance purchasing cooperatives that would offer both a health maintenance organization (HMO)–style managed care option and a standard open plan. The proposal called for a relatively modest benefit package, to keep the cost down. Low-income persons would receive a sliding-scale subsidy. Funding for the subsidies would come from an increase in the cigarette tax of ten cents a pack, and a 5 percent tax on health insurance premiums for individuals and businesses. Most importantly, the bill included a play-or-pay option: Employers that were not providing health insurance to their employees had to either do so or pay tax-deductible fees, not to exceed 6 percent of their payroll, to help pay the costs of the uninsured. The plan proposed to contain costs by setting nonbinding budget targets and by making the managed care option as attractive as possible. The total annual cost of the plan, by 1996, was $53 million. The committee also proposed replacing the VHCA with a new
Department of Health Security.

Despite the relatively modest nature of the proposal—in essence it left the health care system alone for all but the approximately 56,000 uninsured Vermonters—it attracted criticism from all political directions. The Vermont Grocers’ Association, which had opposed employer mandates, payroll taxes, and cigarette and beer taxes when the bill was in the House, came out in opposition to the Senate bill, as did the influential state Chamber of Commerce. The Vermont Consumers’ Campaign for Health, a single-payer advocacy group, renewed its call for a single-payer system, while Senator Rivers declared the Senate Health and Welfare plan “an unaffordable disaster for working Vermonters.”

Nevertheless, on 3 May, the Senate Health and Welfare Committee approved the bill three to two and forwarded it to the Finance Committee. The close committee vote, with two of the three Republicans voting against the bill, did not bode well for bipartisan support in the Senate. And the next bit of news did not improve its prospects. The day after the committee vote, IBM, the state’s largest private employer, announced that the tax on health insurance premiums was unacceptable. In a thinly veiled threat, a company spokesman noted that IBM has a significant investment in Vermont, “[b]ut if that kind of tax change were to take effect we would certainly have to look long and hard before making additional investments” in the Vermont facility. Other business interests and groups also weighed in against the employer mandate. The position of the business community was reflected in the Republican caucus, in which nine of the sixteen Republican senators indicated that they would support the bill only if the employer mandate were eliminated, and another five said that they favored allowing the bill to die in the Finance Committee.

This latter option had haunted reformers from the very beginning of the legislative session. The seven-member Finance Committee consisted of three Democrats, including Cheryl Rivers, who were strongly identified as single-payer advocates, and four Republicans, two of whom were among the most conservative members of the party and unalterably opposed to mandates. In fact, the committee chairman, Stephen Webster (R), had indicated publicly for some time that he thought that the health care crisis was the result of foolish federal laws and should be dealt with by the federal government. (Webster was also reported to have told a lobbyist that “Act 160 would lead Vermont to socialized medicine.”) The political “center” of the committee, then, consisted of three Republicans, only one of whom appeared willing to entertain the idea of an employer mandate.

The Senate Finance Committee held two days of perfunctory hearings, during which one of the oddest marriages of political convenience in recent Vermont legislative history occurred. Cheryl Rivers worked with the con-
servative Stephen Webster, with whom she normally has nothing in common politically, to highlight problems with the bill. Witnesses who spoke in support of the bill complained of being given little opportunity to make an adequate case, and one lobbyist reported that the committee “was incredibly hostile.” 39 The problem for the bill’s supporters was that the left was as critical of its content as the right was. Rivers opposed the bill for three main reasons—aside from the fact that it was not a single-payer plan. First, the individual mandate imposed an undue hardship on working-class Vermonters. Second, the 5 percent health premium tax would increase health insurance rates for all Vermonters, without any offsetting cost containment. Finally, the bill provided that employers providing health insurance could not drop their coverage and that their contribution could not fall below 50 percent of premiums. This meant, Rivers charged, that some companies could drop their contribution from, say, 75 percent to 50 percent. In the end she concluded, “Many of us that were concerned about the problem [of health care] felt that the uninsured Vermonters would be better off with the status quo.” 40

With no center to sustain it, either on the committee or in the full Senate, this latest version of H. 645 died 11 May when the Senate Finance Committee voted unanimously to table the bill. Although the committee was criticized by the governor and the Republican majority leader for not allowing the full Senate a chance to vote on the bill, there was general agreement that it would have made little difference—the votes were not there. Nor did it appear that most Vermonters wanted any further action in 1994. The day after the Finance Committee vote, an editorial appeal by The Burlington Free Press to the “people of Vermont” to “get on the phone to Montpelier, to remind senators why reform matters” resulted in a deafening silence. Stephen Webster reported receiving one telephone call following the editorial—on bovine growth hormones.

H. 645 was formally laid to rest 14 May when Governor Dean conceded defeat at a press conference. The eulogy occurred almost two years after the passage of Act 160, with its promise of universal access and cost containment by July 1994. Health care reform in Vermont would have to wait until either the federal government or a new state legislature could find the way and the will to do what the 1994 legislature could not.

What Went Wrong: Lessons From Vermont

If you ask Vermonters why health care reform failed in 1994, you will get one or more of the following answers: (1) There was a lack of leadership from the governor, both before and during the legislative session. (2) The 1994 legislative session witnessed an unprecedented level of lobbying,
especially from groups opposed to health care reform. (3) Unlike in 1992, when both branches of government were controlled by the Democrats, the partisan split in the General Assembly produced an unusual degree of conflict in 1994. (4) Between the political left (who wanted an as yet unenactable single-payer system) and the political right (who wanted little if anything), there was not enough of a center to pass a bill. (5) The VHCA poisoned the well of reform by its failure to develop a process that allowed the key players to be accomplices to reform. (6) The legislature simply tried to do too much at once. (7) The contemporaneous national debate over health care reform undermined some of the urgency for a state solution.

Taken together, these explanations provide the necessary but not sufficient cause for the failure of reform in Vermont. To this equation one must add the factor that connects these discrete explanations: namely, the failure on the part of the governor, the legislators, and nongovernmental advocates of reform to convince Vermonters of the need for comprehensive change and of the capacity of government to accomplish this change. This, I suggest, is the major lesson from Vermont.

The difficulties facing state and federal lawmakers in this regard are indeed formidable. One must remember three critical existential realities: (1) The vast majority (85 to 90 percent) of Vermonters, and Americans in general, have health insurance; (2) 80 percent of Vermonters (and a comparable percentage of Americans) indicate that they are satisfied with the health care they receive; and (3) dissatisfaction with government is at an all-time high: About 80 percent of Vermonters believe that the 1994 General Assembly did a “fair” to “poor” job, a figure comparable to that of citizens’ evaluation of U.S. senators and representatives.41

No one in the state made a credible case, especially to middle-class Vermonters, about why they should abandon what they had for something they knew nothing about and that in the end seemed to benefit only the uninsured. Looking at the national scene, David Rothman sees failure to “co-opt the middle-class” as the underlying explanation for the failure to pass national health care reform. He argues that this point underscores “a demonstration of a level of indifference to the well-being of others that stands as an indictment of the intrinsic character of American society.”42 This is a view shared by Howard Dean: “The biggest factor [explaining the defeat of reform] was a climate of fear among the public that reform was going to cost a lot of money. I don’t think, when it came to the bottom line, many people care about the uninsured.”43

The task of educating Vermonters about the need for reform was indeed a daunting one. To begin, in both micro- and macroeconomic terms, there was no longer the sense of urgency that seemed to have fueled public demand and support in previous years. In 1992, when Act 160 was passed,
George Bush was president, health costs were soaring, and the number of Vermonters without health insurance had doubled in just three years. Bill Clinton’s election, to some, recast the issue from one that had to be solved at the state level to one that the federal government would or should take care of—a rather quaint notion, given the unfolding events in Washington.

In addition, and ironically, health care reform in Vermont in 1994 was partly a victim of its own earlier successes. In 1989 the state had mandated guaranteed acceptance and community rating for small-group health insurance, and Act 160 extended this to the individual insurance market. These reforms, along with an improving (albeit very slowly) Vermont economy, resulted in a leveling off of the rapid growth (from 30,000 to 60,000 people) in the state’s uninsured population between 1989 and 1991. The number of uninsured persons held steady in 1992 and 1993 and appeared to be declining, slightly, in 1994. Part of the reason for this was the increase in the number of children from low-income families who were receiving health care under the state’s Dr. Dynasaur program as a result of Act 160.

Finally, the sense of urgency to reform the health care system that gripped Vermonters, and the rest of the nation, in 1992 moderated in part because health care costs had moderated in the state. Much of this moderation was prophylactic in anticipation of mandatory hospital budget caps. Whatever the reason, in fiscal year 1993 Vermont’s fifteen nonprofit hospitals increased their budgets by an average of 7.7 percent, the lowest increase in five years. In 1994 the overall increase was held to 5.1 percent. Vermont hospitals were lauded for cutting bureaucracy, improving efficiencies, and freezing patient costs.

However, the cooling of the public’s ardor for health care reform was both cause and consequence of the events that unfolded in 1994. Popular disenchantment was not exclusively the consequence of the changing personal economic calculus of individual Vermonters and was by no means inevitable at the start of the legislative session. Vermonters were soured on reform in no small part because they had lost faith in the capacity of government to get it right. As described above, the seeds of this disillusionment were sown by the VHCA, which, despite mandated efforts to engage the public, was never able “to get people fired UP.”

Reform’s rocky start need not have proved fatal to the enterprise. In the final analysis, it was always up to the state political leadership to build a legislative and interest-group coalition around reform and then sell it to Vermonters, especially the middle class. This was never done successfully, and many in Vermont find fault with Governor Dean. Health care reform needed a leader, someone who could help to mold public opinion and rally public support during an often acrimonious legislative session, Howard Dean-physician, national celebrity, and perhaps the most popular gover-
nor in America—was particularly well positioned to play this role. Yet there is a widespread perception that the governor never fully exploited his advantage with the public, the coalition, or the legislature.

In terms of rallying legislators, the message one hears over and over again is that the governor was “detached,” or “disengaged” during the legislative session. To a certain extent, this was, according to the governor himself, a deliberate strategy. “Last year, when I was swinging with both arms, everybody was mad at me. This year I’m trying to be more laid back and let the staff do the work while I meet with people in private,” he said. Although this approach may now be viewed as merely a tactical error, many believe that the problem is more basic. One senator spoke for many other legislators on this issue: Howard Dean “has a very difficult time developing any kind of rapport with lawmakers on an individual level.” Either way, the bitterly divided legislature did not get the leadership that would help it attract and sustain public confidence in reform.

A number of legislators, of both parties and in both chambers, believe that the governor also failed to provide popular leadership. Sean Campbell argues that only the governor could have gone around the state to rally public opinion behind health care reform, but he does not “recall seeing or hearing about the governor out stomping the state for health care.” The need for the governor to “stomp the state” and prowl the Statehouse corridors was particularly acute on this issue because of the unprecedented lobbying that took place. Between 1 July 1993 and 30 June 1994, $3.4 million was spent on lobbying in Vermont—an unheard-of sum of money in the state. Not all of this, of course, was used to influence the health care debate, but the four largest spenders were Philip Morris (which lobbied against attempts to raise cigarette taxes), Community Health Plan, Blue Cross and Blue Shield, and the VSMS. It is particularly important to note that no group or organization conducted a public education campaign urging support for H. 645, in any of its incarnations. The only group that has maintained any statewide visibility and organization is the single-payer force, but even they were oddly “detached” during the legislative session. Unlike in 1992, when Vermont-NEA (National Education Association) conducted a massive campaign in favor of a single-payer system, no such activity was evident in this session.

Certainly there were groups (most notably the Vermont Employers Health Alliance, which supported an employer mandate) that presented a consistent message throughout the debate. But neither this message nor any other was aimed at enlisting the support of the general public on behalf of a particular reform option. Hence, the playing field was left largely to the opposition. And no organization proved more adept at playing the field than the Vermont Grocers’ Association. At critical junctures in the debate
the association, representing most of the “mom-and-pop” grocery stores in the state, ran dramatic (and critics argued misleading) newspaper advertisements, complete with legislators’ home telephone numbers, urging the public to “Save your job, save your business, save your tax dollars!” “Call Your Senators Today or at Home This Weekend,” and tell them to vote “NO” on H. 645. Most legislators agree that the campaigns were enormously successful in influencing public opinion against H. 645.

In this instance, as in others, the important point is that there was no one—not the governor, not legislative leaders, not any organized interest group—to counter negative arguments and rally the public behind H. 645. Reformers were never as clear, coherent, confident, and steadfast about what they stood for as opponents were about what they were against. Without public support behind it, no vision of health care reform could withstand the onslaught of opposition from the scores of groups with largely limited, parochial interests to protect. This is especially a problem in a state such as Vermont with its citizen legislature, where a lobbyist can stand in the well of the House of Representatives and speak on a cellular telephone to a client flying over Colorado, but state legislators have no personal offices, no personal telephones, and no personal staff.

The politics of health care reform in Vermont and in the nation will remain the politics of the center for the foreseeable future. The political left and right can only prevent or delay reform; they cannot pass something on their own. In the case of Vermont—and I suspect the nation as well—it will take a coalition of the left (who after all wants something, as opposed to those on the extreme right who want either nothing or something so minor as to be inconsequential) and the center to enact reform. This means that single-payer advocates will have to reconcile themselves to the fact that they may not get all they want immediately. Many in Vermont believe, as I do, that the state, and perhaps the nation, will ultimately end up with something looking very much like what the single-payer lobby prefers.

Even if such a center-left coalition emerges in Vermont, and it is by no means certain that it can, the governor and the legislative leadership still must present a focused, consistent message to the public, one that explains why reform is in the interest of all Vermonters, not just the uninsured. A majority of Vermonters still believe that health care reform is necessary. It is now up to the state’s political leadership to assuage the public’s anxiety about government’s capacity to enact reform in a way that will not endanger what Vermonters, and Americans, like about the health care system.

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NOTES


2. Author’s interview with Karen Meyer, executive director, Vermont State Medical Society, 3 August 1993.


4. The state’s national visibility was further heightened when Governor Dean’s deputy chief of staff, Anya Rader, was appointed to the Clinton Task Force on National Health Care Reform.


10. Author’s interview with Anya Rader, deputy chief of staff to Governor Howard Dean, 1 June 1994.

11. Author’s interview with Paul Harrington, VHCA board member, 6 June 1994.


13. Pfeiffer, “Health Care Reform Hard to Do.”

14. Author’s interview with Norman Wright, president, Vermont Hospital Association, 26 July 1993.


16. Author’s interview with Sen. Mary Ann Carlson (D), 7 June 1994.


19. The board implicitly acknowledged these criticisms when, about ten months after it began work and just five months before it submitted its universal access plans to the legislature, it created a Public Education Task Force. However, the board was never really able to engage the public effectively. In January 1993 the outgoing communications director of the VHCA urged the board to “prepare itself for plenty of ‘butt time’—hours spent sitting and listening to people” (Memorandum from John Dillon to the VHCA board and staff, 15 January 1993). Yet six months later the editor of a state health care newsletter complained at a public hearing on the universal access plans that “it took an hour and fifteen minutes [into the public hearing] to get to the first substantial question from the audience” (Memorandum from Steve Larose, editor of HealthBeat, to Paul Risley, communications director, VHCA, 29 July 1993).


22. In another measure that would further distance the governor from the VHCA and indicate that the locus of the center of health care reform had shifted, Dean announced in October that the authority’s highly respected executive director, Rachel Block, was moving over to the governor’s office. Block, a self-described “health policy wonk,” brought knowledge about the content of health care but also, by virtue of her four years’ experience as executive director of the majority leader’s office in the New York State Assembly, a good deal of political savvy. With Block, two of the seven members of the governor’s staff would concentrate on health policy.

23. In its final report on universal access, issued 1 November 1993, the authority proposed guaranteeing a package of health care benefits for all Vermonters that included inpatient and outpatient care, mental health and substance abuse services, various forms of therapy, prescription drugs, and an emphasis on preventive care. Vermonters could receive these services either in an “integrated” (that is, managed) system of care or in an “open” system in which consumers would have greater choice but pay more out-of-pocket expenses. In the single-payer model, businesses would pay between 7.7 percent and 8.4 percent of their gross payroll, and households would pay between 3 percent and 3.5 percent of gross income. Under the multipayer model, insurance would be funded primarily through premiums, with the employer picking up 80 percent of the cost of full-time employees and 50 percent for their dependents. Finally, in the single-payer system, a “single state-run Health Care Purchasing Trust would be established to determine eligibility and enrollment, coordinate benefits, [and] pay providers.” In the multipayer system, Vermonters could purchase a health plan through either the state-run trust or a private purchasing alliance. See Vermont Health Care Authority, “Universal Access Plans,” 1 November 1993.


30. At the time the Vermont House of Representatives included eighty-eight Democrats, fifty-seven Republicans, three Independents, and two Progressives.


34. In the Vermont General Assembly, members of the minority party can chair legislative committees. In this case Jan Backus, who had experience on the Senate Health and Welfare Committee during enactment of Act 160, was appointed chair by the Senate Republicans despite her somewhat liberal inclinations.

35. As it turned out, instead of adjourning in early to mid-May, as it had done in most years in the past decade, the 1994 legislature would not adjourn until 12 June, the latest date...
since 1965, when the General Assembly did reapportionment.


38. Author’s interview with Jeanne Keller, president, Vermont Employers Health Alliance, 3 June 1994.

39. Ibid.

40. Author’s interview with Sen. Cheryl Rivers (D), 1 June 1994.

41. A recent Vermont poll found that 80.2 percent of Vermonter were happy with the quality of health care they received, although the source of dissatisfaction most frequently cited (by 46.2 percent) was the cost of care. See M. Lewis, “Cost Worries Vermonters,” *The Burlington Free Press*, 23 July 1994, 1B. Regarding dissatisfaction with government, see J. Hoffman, “Lawmakers Fate Poorly in Poll of Voters,” *Rutland Herald*, 28 June 1994, 1. The disapproval rating for members of Congress in June 1992 was 77 percent. See “Organization of the Congress: Final Report” (Washington: U.S. government Printing Office, 1993), 185.


44. Although Vermont’s 1993 economic growth rate was a paltry 0.5 percent, this was a significant improvement over the 3.4 percent declines in 1990 and 1991.

45. Pfeiffer interview.

46. Howard Dean has remained a remarkably popular governor throughout his tenure. In December 1993, on the eve of the legislative session, 63 percent of Vermonters thought he was doing a good to excellent job, whereas in June 1994, after the demise of health care reform, 67 percent approved of his performance.


49. Campbell interview. Aides to the governor find this assertion preposterous. They argue, perhaps with some overstatement, that “the governor hasn’t given a speech for a year where he has not talked about health care, and at times it’s seemed like he was the only guy in the state who was talking about health care reform and everybody else was finding one reason or another why we didn’t need to do anything and he wouldn’t give up.” Rader interview, 1994.

50. One of the untold stories of 1994 was the relative quiescence of the 11,000-member Vermont-NEA. In 1992 Vermont-NEA was a major supporter of the Sanders-Rivers single-payer movement. The organization provided the field troops and the communications network to bring the word of single payer into every Vermont town. Recently, however, Vermont-NEA reached an agreement with the state, after years of effort, to join a state health insurance purchasing alliance. Local teachers’ organizations now bargain with each school board to choose one of five plans offered through the trust. Vermont-NEA thus shifted its focus from systemic health care change to protecting its own health insurance program. As a result, single payer lost a major organizational and tactical ally.


52. This example was provided to me by Rep. Ann Siebert (D).