

The Little State That Couldn't Could? The Politics of "Single-Payer" Health Coverage in Vermont

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Abstract In May 2011, a year after the passage of the Affordable Care Act (ACA), Vermont became the first state to lay the groundwork for a single-payer health care system, known as Green Mountain Care. What can other states learn from the Vermont experience? This article summarizes the findings from interviews with nearly 120 stakeholders as part of a study to inform the design of the health reform legislation. Comparing Vermont's failed effort to adopt single-payer legislation in 1994 to present efforts, we find that Vermont faced similar challenges but greater opportunities in 2010 that enabled reform. A closely contested gubernatorial election and a progressive social movement opened a window of opportunity to advance legislation to design three comprehensive health reform options for legislative consideration. With a unified Democratic government under the leadership of a single-payer proponent, a high-profile policy proposal, and relatively weak opposition, a framework for a single-payer system was adopted by the legislature—though with many details and political battles to be fought in the future. Other states looking to reform their health systems more comprehensively than national reform can learn from Vermont's design and political strategy.

Keywords single-payer, Vermont, health reform, universal health care, politics

Introduction

A "single-payer" system is one universal health coverage model that has consistently been politically "off the table" for discussion in federal health reform, but that has received attention in a number of US states and is widely supported among progressive advocates (Stone 2009). One of these states is Vermont, the second least-populous state in the nation and among those with the lowest rate of uninsured at 7 percent, about half the national

average (Hsiao 2011). Vermont began enacting legislation in the 1970s that increased coverage and put in place cost controls well beyond the level of other states (Davis 1999; Paul-Shaheen 1998). In 1994, in the wake of the defeat of President Bill Clinton's failed comprehensive health reform effort, Vermont made a bid to be the first state to adopt a universal health coverage system, including consideration of a single-payer option. However, this bid ultimately ended in defeat. In 2010 Vermont made a renewed effort on the heels of the Affordable Care Act (ACA), advancing legislation to design three comprehensive health reform options, including a single-payer option. The state adopted legislation that lays out an incremental plan aimed at achieving a single-payer health coverage system with the adoption of Act 48, Green Mountain Care, signed into law in May 2011 (Hsiao 2011; Hsiao et al. 2011).

This article explores the political factors that allowed Vermont to pass comprehensive health reform in the face of numerous hurdles, based on stakeholder interviews undertaken during the reform period.¹ First we discuss the history of state action on single-payer and other forms of comprehensive health coverage reform in Vermont and the differences between now and 1994, when Vermont made a first, failed bid to be the first state in the Union with a universal health coverage system. The article then chronicles the politics behind this most recent round of reform, beginning with legislation that called for the design of three health reform options

1. The analysis presented in this article summarizes our research on Vermont's "political landscape" for health reform as participant-observers during the time when three health reform options were being designed (July 2010–February 2011) and subsequent to Act 48's passage. We were part of the team commissioned to design a set of health reform options and were tasked with mapping the political landscape and examining different actors' policy positions to improve the political viability of the proposed reform options. The results of the stakeholder analysis have been discussed elsewhere (Blanchet and Fox 2012), though the politics that facilitated the passage of Green Mountain Care have not been analyzed. The political landscape analysis began with a historical investigation of Vermont's failed 1994 effort to advance comprehensive health reform, which included a literature review and interviews with over ten key informants who were participants in the 1994 health reform. Based on the literature review and interviews, we analyzed the political factors that contributed to the demise of the 1994 comprehensive reform effort and validated the emerging "lessons" with the same set of key informants. We then interviewed current health reform stakeholders (some of whom were engaged anew from 1994) and acted as participant-observers at a variety of health reform political events. In total, we conducted more than sixty interviews with over 120 stakeholders from Vermont's government, health providers, businesses, unions, and civil society organizations, described elsewhere (Blanchet and Fox 2012). The analysis here is based primarily on these interviews, historical literature review, and participant observation. As participant-observers, we must acknowledge the potential biases this position could introduce. For instance, as representatives of the technocratic wing of reform efforts, certain stakeholders might not wish to be candid with us about their true viewpoints and choose to keep certain goals or motivations hidden. Also, information that we might convey in talking with stakeholders about the direction that reform efforts might take could influence their own tactics. As a concrete example, a representative of the chiropractic association might try to gauge our willingness to include chiropractic services in the benefits package, which could influence his or her support for the reform effort.

(Act 128) adopted in May 2010 and continuing with the process of designing the three reform options between July 2010 and January 2011. Next, we discuss how different political factors interacted to contribute to the ultimate content of reform and the adoption of the final legislation (Act 48) in May 2011, including the factors that contributed to the final legislation being stripped of detail.

We conclude the article with a discussion of how Green Mountain Care (Act 48) is best understood. To some it is a decisive victory for single-payer. For others, the ultimate design, wording of the legislation, and incremental approach to implementation have left more questions than answers both about how to categorize the health system that will emerge from the legislation and whether its lofty goals will actually come to fruition. Finally, we discuss the implications of these findings for other states wishing to pursue more thoroughgoing health reform than the ACA. Although Vermont is in many ways exceptional, we believe that more universal lessons can be drawn from the process of reform in this tiny state.

To analyze the politics of reform as it was unfolding, we drew on several theoretical frameworks that have previously been employed in health reform studies. We applied different frameworks at different stages of the policy cycle to explain the unfolding politics, specifically the agenda setting, design, and adoption stages (Fox and Reich 2013). We applied John W. Kingdon's (2003) multiple stream framework to understand why health reform made it onto the legislative agenda in 1994 and again in 2010. During the design phase of the reform process from July 2010 to January 2011, we paid particular attention to the role of "policy entrepreneurs" and the perspectives of different interest groups and stakeholders that have been found to be significant during this period in influencing the reform proposals that are considered by the legislature (Fox and Reich 2013).² During the adoption phase when the legislature was considering the proposed bill

2. Oliver and Paul-Shaheen 1997 and Paul-Shaheen 1998 use the term *policy entrepreneur* quite broadly to encompass individuals in the public and private sectors, including governors and legislators, who take an active role in promoting a particular policy or problem, as well as private actors. Kingdon's (2003) definition is a bit narrower. He distinguishes between hidden participants, a community of specialists in a given field including bureaucrats, academics, and advocates, and visible participants, who include high-level political actors/advocates. He defines policy entrepreneurs within the realm of hidden participants as "advocates for proposals or for the prominence of an idea" (Kingdon 2003: 122). For the purpose of this article, and the sake of clarity, we distinguish among three types of influential actors in the reform process, according to the following labels: (1) *policy champions* include high-profile actors such as the governor and related "visible" participants in the reform process; (2) *policy entrepreneurs*—we reserve this term for hidden participants within the public realm, such as key legislators or bureaucrats; and (3) *policy technocrats* is used to refer to private actors, such as academics or policy experts who are not specifically elected or appointed to public office. However, we acknowledge that this categorization is imperfect, since, for instance, technocrats and entrepreneurs can also be quite visible participants.

from February to March 2011, we drew more heavily on theories that put different weight on the roles of interests, institutions, and ideas in influencing the decisions that legislators make and the strategies employed to secure passage (Hall 1997; Immergut 1990). At each phase we make comparisons with 1994 to draw inferences about why reform advanced in 2011 but was rejected in 1994.

The multiple streams framework suggests that a political window of opportunity emerges when three separate but parallel factors converge: an opening in the problem stream, whereby an issue comes to be seen as a public problem; a clear set of alternative policy solutions being actively promoted in policy networks in the policy stream; and an opening in the political stream occasioned by political transitions, such as elections. Once on the agenda, the design of policies often depends heavily on the ideas advanced by change teams of policy technocrats and entrepreneurs who fashion reforms behind the scenes (Waterbury 1992; Domínguez 1998). Finally, in discussing why health reforms pass legislative consideration or fail to pass, explanations tend to place a relative emphasis on one of three primary perspectives—interests, institutions, and ideas (Hall 1993). Interest-based arguments center on the powerful and exceptionally well-financed conglomeration of interest groups including medical societies, hospitals, insurance companies, business interests, and a variety of conservative forces that have historically aligned to quash reform efforts (Starr 1982; Marmor 1973). The institutional argument suggests that American political institutions, with many veto points and a fragmented power structure, are the most proximate reason that the United States has continually failed to adopt universal health coverage and tends to adopt incremental rather than big-bang reforms (Steinmo and Watts 1995; Immergut 1990). The ideas category is broader and encompasses the use of symbolic language and framing of issues, including the power of certain policy metaphors, as well as the influence of ideology (particularly in the form of state versus market policy approaches) (Wilsford 2010) and political culture, which draws on America's antistatist attitudes as an explanation for the failure of universal health coverage proposals to launch (Jacobs 1993).

Though these theories have mainly been applied to explain health reform at a federal level, state health reform has largely been a microcosm of national health reform: while a number of states have pulled ahead of the national level in terms of coverage and cost controls (Paul-Shaheen 1998), no state has yet achieved what can rightfully be described as “universal coverage within a unified system” (Gray et al. 2010). Even the

designers of the Massachusetts health reform do not apply the label "universal" to the system because of the multiple loopholes that leave room for people to remain uncovered (McDonough et al. 2006). This situation is at least partly because, although granted some leeway, states face similar constraints as at the national level—mobilized interest groups, an ambivalent populace, and political institutions that are similarly fettered by checks and balances (Gray et al. 2010). In addition to these constraints, states face further federal limitations that they must operate under including federal funding of Medicare, obligations regarding Medicaid, and Employee Retirement Income Security Act (ERISA) requirements. These federal institutions constrain what is possible for states to achieve on their own without federal waivers. Through this analysis, we hope to advance understanding of state health reform efforts by separating the specific from the general to draw broader policy lessons while hewing closely to the particularities of events (Wilsford 2010; Tuohy 1999).

The case of Vermont illustrates that no one theory on its own is sufficient to explain the passage of a single-payer(ish) system. Rather, the interaction of different variables at critical points in the policy process increased the likelihood of reform. Nevertheless, at the end of the article we discuss the factors that had a particular impact in enabling passage of a single-payer bill and potential lessons that other states can draw from Vermont. Ultimately, we suggest that Vermont's liberal political culture on its own is not sufficient to explain the passage of Act 48 and that a series of other factors need to be in place to secure single-payer legislation even in equivalently liberal states.

As the article focuses on the politics of *single-payer*, some discussion is necessary regarding how we understand the term. Technically, single-payer plans can be defined as "those that rely on a limited number of revenue sources and systems in which financing is concentrated and private insurance for hospital and medical services is limited" (Glied 2009: 593). This term could encompass both a national health service model where the state is both the primary payer and the provider, as in the United Kingdom, and a national health insurance model where the state is the primary payer, but providers are not principally publicly employed, as in Canada (Hacker 2004). As we employ the term in its technical sense, we are referring to a national health insurance model financed primarily through taxes and whereby all payers are reimbursed from a single pool—sometimes also referred to as Canadian-style single-payer or "Medicare for all" by advocates, as we believe that those who most ardently promote

it commonly understand this term—such as Physicians for a National Health Program and policy actors in Vermont.³

However, from an analytic standpoint, we view *single-payer* more in its rhetorical sense, as “a term of surrender, a term of disguise and a term of strategy, an ideal type and an aspiration” (Stone 2009: 532). In its broadest sense, the single-payer health care model, as it has been heavily promoted by advocates, has come to signify more than its literal meaning to encompass “a metaphor for all the things we wish we had and don’t know how to get” (Stone 2009: 532). We employ the term *single-payer* because this system was the aspiration of some of the major architects of health reform in Vermont. Moreover, we also examine how and why the ultimate legislation falls short of this aspirational goal and aim to understand the strategic deployment of this term as the “paper tiger” of health reform as described by others (Paul-Shaheen 1998; Leichter 1993)—allowing the center of the debate to move farther left and thereby be tolerated by some moderates made uncomfortable by this term that remains universally scorned by the Right. The symbolic politics of single-payer and its framing effects are what we are most interested in elaborating and understanding, though we also devote attention in the conclusion to analyzing what the final legislation actually achieved and to what degree it conforms to a technical definition of single-payer.

Vermont Then and Now—a Failed Bid for Single-Payer in 1994

In 1994 Vermont came as close as any state to adopting comprehensive health reform legislation that would have created a unified single- or regulated multipayer health insurance system, riding the coattails of Clinton’s national reform efforts (Leichter 1994; Wright 1996, 2005; Davis 1999). Writing in *Health Affairs* that year, Howard M. Leichter (1994: 79) lamented that it had “seemed inconceivable that Vermont would not enact comprehensive health care reform.” Yet, by May 1994, Vermont’s promising reform plan had died, a victim not of any one silver bullet but of multiple setbacks.

A window of opportunity for comprehensive health reform had opened in 1991 when events in the politics and problem streams converged, enabling single-payer health reform to emerge as a potential policy solu-

3. See the Physicians for a National Health Program’s (n.d.) definition of *single-payer*.

tion in the policy stream. First, an opening in the politics stream occurred in August 1991 when Lieutenant Governor Howard Dean, a physician and up-and-coming Democratic political leader, inherited the governor seat after the untimely death of Republican governor Richard A. Snelling. As a physician-governor, Dean was seen as particularly credible to spearhead health reform. Furthermore, from a legislative standpoint, the time was ripe for comprehensive reform (Wright 2005). By 1992, for the first time since the Civil War, the Democrats had an overwhelming control of the House, though at the same time they narrowly lost control of the Senate (Graff 1999: 87).

An opening in the problem stream had occurred prior to Snelling's passing in 1991 when Snelling had established the Blue Ribbon Commission on Health Care to make recommendations regarding how to improve coverage and control costs in light of the failure of a bill that would have authorized the Hospital Data Council to set hospital budgets (Davis 1999; Oliver and Paul-Shaheen 1997). This failed legislation and heightened attention to health reform left an opening in the problem stream for the new Democratic governor to address. Following from the commission's recommendations, Dean submitted a bill that would establish a semi-independent health care authority whose role would be to research and make recommendations concerning different comprehensive health reform options; the bill was adopted in 1992 (Davis 1999). Soon after its adoption, Dean received national attention from newly elected President Clinton, who was himself embarking on federal health reform (Wright 2005; Paul-Shaheen 1998). The spotlight of national health reform also raised the salience of health reform at the state level (Gray et al. 2010). Thus, at the time, Dean was perceived as a proponent of comprehensive health reform, and the adoption of a bill to research and make recommendations concerning different comprehensive health reform options cemented an opening in the problem stream.

The emergence of the single-payer solution as one of the policy options in the policy stream stemmed from Vermont's long history of single-payer health care activism inside and outside the statehouse. With the strong presence of Physicians for a National Health Program, longtime single-payer proponent Representative (and now Senator) Bernie Sanders, and the Progressive Party, a successful third party with a single-payer platform as well as progressive-leaning Democrats in the House and Senate, the state has had a number of single-payer champions and policy entrepreneurs that periodically are able to bring the issue to the fore.

The major policy options that emerged in the policy stream to address “comprehensive” health reform were a regulated multipayer system, spearheaded by a moderate Republican senator, and a single-payer system, spearheaded by a left-leaning Democratic senator. The Vermont Health Care Authority (VHCA) was created from the 1992 bill and tasked with designing two universal access systems—one a single-payer system, the other a regulated multipayer system—which would form the basis for comprehensive reform deliberation in 1994 (Leichter 1994). The inclusion of the single-payer option was part of a deal that two progressive Democratic senators had struck with the House Speaker: they would not oppose the House bill when it got to the Senate if the Speaker would ensure that the VHCA would design a single-payer option in addition to a multipayer option. With Democratic control in the political arena, health reform having been clearly identified as a priority problem through the creation of a committee to study reform options, and two comprehensive reform options being advanced for consideration, including single-payer, a clear opening was created for universal health coverage to advance.

To prepare for the coming legislation, Speaker Ralph G. Wright established a joint House committee to consider the bill. Meanwhile, in the Senate, single-payer reform efforts were being spearheaded by two Democratic senators and were supported by powerful allies including the Vermont branch of the National Educational Association, Representative Sanders, and Physicians for a National Health Program, among others (Davis 1999). The VHCA had a short, eighteen-month window to develop its reform proposals in order to have health reform legislation considered in the second year of the biennium before the legislature faced elections, which could result in lost momentum (Davis 1999).

The VHCA met the deadline (Davis 1999); however, divisions in the policy stream ultimately led to the demise of the legislation and a failure of comprehensive health legislation to advance to a vote. A primary reason for the reform’s downfall in 1994 was the lack of political viability of the reform options proposed by the VHCA. The VHCA comprised three members representing different partisan interests and background—a moderate Republican state senator, a progressive welfare commissioner in the Agency of Human Services, and the dean of a business school, who brought the perspective of employers. However, in the end, both plans that emerged from the VHCA proved politically infeasible, as each was deemed too costly for the fiscally conservative governor (Leichter 1994). Rather than back either the single-payer or the multipayer plan, Dean proposed an alternative, more fiscally conservative bill (Leichter 1994), and the Speaker

of the House established a joint House committee to consider the bill (Davis 1999).

Without a single plan to rally behind, multiple different comprehensive reform plans emerged, with no stable majority behind one plan (Leichter 1994). Financing was a critical wedge issue, with single-payer "purists" backing more progressive forms of financing and more fiscally conservative moderates willing to entertain only more regressive forms of financing such as sales taxes. Physicians' early support waned as tort reform was dropped (Leichter 1994). In the final hour, the Speaker of the House substituted a radical bill that would cost more than \$750 million per year, financed primarily through payroll taxes, for what had been a very different approach proposed by the governor and the joint legislative committee (Wright 2005; Leichter 1994; Davis 1999). Ultimately, the final legislation was tabled in the finance committee, which was highly ideologically divided and could not find a compromise proposal.

In addition to the lack of consensus over the various bills proposed, which was the most proximate cause of defeat, two circumstantial events sealed the defeat of comprehensive health reform in whatever form. First, the opaqueness of the issue impeded media coverage and led to the release of a misleading story concerning the tax increase that would come from the Speaker's health reform bill (Wright 2005; Davis 1999; Leichter 1994). Second, perhaps most unexpectedly, a grassroots opposition campaign spearheaded by the Vermont Grocers' Association emerged in response to the threat of an additional alcohol and tobacco tax to finance the reform (Leichter 1994; Wright 2005). Taken together, these two events weakened public support for reform and shook the resolve of vote-wary legislators. The defeat of the Clinton reform effort in the same year before deliberation over Vermont's comprehensive reform bill likely also weakened support for reform (Paul-Shaheen 1998).

We drew the following primary lessons from Vermont's failed reform attempt in 1994: First, supporters would need to rally behind a single, credible plan. The window of opportunity had closed because a single, credible plan was not in hand to advance to rapid legislative consideration. Second, the executive would need to be firmly behind the proposed plan, or there would need to be sufficient votes to override a veto. The opening in the political stream had proved illusory. Dean's fiscal conservatism made him wary of more radical comprehensive reform proposals even as he purported to be a proponent of comprehensive reform. Third, financing and tort reform would be key polarizing issues. Fourth, small businesses wield big power in a state where a majority of businesses have fewer than fifteen

employees. Fifth, although most of the ultimate comprehensive reform proposals considered were not single-payer, single-payer could serve as a symbolic threat, pulling health reform proposals to the left, and would need to be kept on the table to engage the support of the political Left. Whereas the radical nature of single-payer struck fear in the hearts of moderates and those on the right, there was also a strong constituency on the left that viewed anything but a full-fledged single-payer plan as “incremental” and concessionary.

Since 1994, Vermont has made other attempts at comprehensive reform, but another window of opportunity for single-payer has not presented itself. In 2005 the House passed a bill called Universal Access to Health Care in Vermont, but it was stripped down in the Senate and ultimately vetoed by Republican governor Jim Douglas. A number of other health reform bills have foundered in legislative committees. In 2006 the legislature passed and Douglas signed major health reform legislation known as Catamount Health, which widely expanded coverage in the state. A bipartisan effort, Catamount Health was viewed as both a success and a failure by many on the left, since it expanded affordable coverage, but it maintained the system of private insurance and did little to address rising costs. While it filled in some of the further coverage gaps, Catamount did not fundamentally restructure the financing or delivery of health care and has been criticized by business (for its cost inflation) and the Left (for subsidizing market mechanisms) alike.

The Politics of Agenda Setting, 2010: A Renewed Window of Opportunity for Single-Payer

The year 2010 marked a year of renewed hope for health reform advocates seeking universal coverage under a unified payment system. The factors that gave rise to reform efforts in 2010 greatly mirrored the same factors that had created a window of opportunity for reform in 1994. These included (1) political transitions opening space in the politics stream to consider more radical reforms; (2) momentum for health care reform in the problem stream from parallel developments at the national level and the emergence of a local health-reform social movement; and (3) single-payer entrepreneurs in the policy stream that had been waiting for another opportunity to advance comprehensive health reform legislation as well as a new set of proponents advancing single-payer as a policy solution. The convergence of these factors provided a window of opportunity for comprehensive health reform—and specifically single-payer—to again emerge

as a prominent issue on the legislative agenda, first as a bill to study different health reform options in the first year of the biennium and then as comprehensive reform legislation, much as in 1992–94.

Just as in 1992 with the untimely departure of Snelling the previous year, Douglas, a Republican, announced that he would not run again after serving three terms in office, increasing the likelihood of a Democratic victory in the coming 2010 governor's race, thereby creating an opening for comprehensive health reform in the politics stream. Douglas had been friendly to health reform, signing into law Catamount Health in 2006. However, proponents of comprehensive health reform knew that a Republican governor would veto any legislation that radically changed the financing and organization of health care in the state, as Douglas had previously done. Thus, in preparation for the upcoming contested governor's race, the Senate Health and Welfare Committee crafted a bill that called for consultants to develop two universal health coverage reform plans.

With Catamount Health having recently passed and the ACA hovering on the horizon, the time seemed unusual to make health reform a central legislative issue. However, outside the legislature, two factors contributed to raising the salience of the health reform issue in the problem stream. First, as the Vermont Senate Health and Welfare Committee was drafting its legislation to call for the development of a universal health care plan, at the national level the ACA had raised the saliency of health care reform as a political priority issue while leaving much to be desired for proponents of more thoroughgoing reform. Early on in the national health reform process, the most liberal health reform proposal—to have a public health insurance option that would compete with private plans—was dropped from among the design options being considered, further fueling the quest for more comprehensive reform options at a state level. To preserve the possibility for more comprehensive reform at a state level, Senator Sanders of Vermont, a longtime single-payer advocate, pressed to include an immediate waiver to states that could propose other ways to comprehensively cover the population; however, he ultimately lost this battle, with the waivers being pushed back to 2017. Similarly, an amendment put forth by Representative Dennis Kucinich (D-OH) would have allowed waivers to states that opted out of ERISA, the federal law that preempts state law that would regulate benefit plans offered by self-insured employers, which has often impeded comprehensive state health reform efforts, but it was also dropped. These defeats at the national level only added fodder to Vermont's state-led reforms, convinced that it could do better than federal reform. Previous studies have shown that the number of state-level health

policy proposals tends to rise with national attention to health reform (Gray et al. 2010).

At the same time, the costs of Catamount Health, which used public dollars to pay for private health plans, were skyrocketing and happening during a period of fiscal recession, allowing health reform to be framed in terms of the potential for cost savings. In addition, a social movement, the Healthcare Is a Human Right Campaign, spearheaded by a group called the Vermont Workers' Center, had been gathering steam, holding rallies across the state advocating for a single-payer, publicly financed health care system, drawing renewed attention to health coverage reform as a public problem. Raising the saliency of the movement, Sanders joined forces with the Healthcare Is a Human Right Campaign, touring the state to build support for comprehensive health reform. These factors drew attention to the health reform issue, enabling health reformers to paint health care as a continuing public problem.

Meanwhile, in the policy stream, the single-payer health care model had maintained a consistent presence as a policy solution advocated both inside and outside the legislature, with some of the same individuals from 1994 still active over a decade and a half later. Furthermore, the Healthcare Is a Human Right Campaign had adopted single-payer as its policy platform. The omnipresence of the Healthcare Is a Human Right Campaign at the statehouse and at every public meeting on health care reform served as a constant reminder to legislators of their unwavering position on single-payer health care and may have signaled to would-be Democratic nominees for governor that an organized, vocal group of advocates was looking for a nominee who could lead the single-payer charge.

Seizing on this open window, in May 2010, a mere two months after the passage of the ACA, the Vermont General Assembly passed Act 128. Act 128 committed the state to design a new health care model for Vermont, capped annual hospital budget growth, expanded the Blueprint for Health chronic disease management programs across the state, and required drug companies to report when they give out free samples. Most importantly, the act allocated \$300,000 to the Health Care Reform Commission to hire consultants to design three plans—a “pure” single-payer plan through a public or private single-payer, a multipayer system with a “public option,” and a third option that the consultant was given free rein to design. Each option needed to be designed with both a comprehensive and an essential benefits package and meet the principles and goals outlined in the legislation. The final report summarizing the three options would be presented to the General Assembly and the governor by February 2011.

Act 128 passed by votes of 91–42 in the House and 28–2 in the Senate, largely though not entirely reflecting the partisan divide in each chamber. As in 1994, the legislation was not a reform bill itself, but rather established goals and principles and called for the development of two proposals (one a single-payer plan and the other unspecified). The final version of the bill added the proposal for a public option (similar to the public option dropped from the ACA).⁴ In the end, a number of Republicans did vote in favor of Act 128 thanks to the addition of the public option as a plan to be researched alongside single-payer and the third option. Ironically, what was too liberal to pass muster at the national level was what brought bipartisan support in Vermont, primarily since the public option would preserve a role for the private health insurance market, with a public option competing alongside private plans. The addition of the third option would also prove politically and strategically important down the road, allowing the public option to be painted as the most conservative choice and a "pure" single-payer model as the most radical, providing space for a comprehensive middle-ground reform.

Three groups bid to perform the work commissioned by Act 128, including a team spearheaded by William C. Hsiao, a prominent health economist at Harvard well known for his work designing Taiwan's single-payer health system and health reforms the world over. Joining forces with Jonathan Gruber of the Massachusetts Institute of Technology, whose microsimulation models informed the design of both the Massachusetts reform and the ACA, and Steven Kappel, an independent health care consultant in Vermont, Hsiao proposed to create a plan that was the most "politically and practically viable" option for the state of Vermont (Hsiao, Kappel, and Gruber 2010: 2). In July 2010 the bipartisan Health Reform Commission unanimously voted to hire the Hsiao team as the consultants on the project. With this credible team of policy technocrats, the hope was that the proposals stemming from this work would be accepted as a template for a comprehensive health reform bill to be submitted to the legislature the following year, before the end of the biennium to avoid the multiple competing bills drafted in 1994. With the passage of Act 128, Vermont was on its way to designing a more politically viable comprehensive health reform.

However, the critical question for the prospects of a single-payer or a single-payer-like model was who would become governor. Of the five major Democratic hopefuls, three had long-standing legislative experience

4. For more on the public option that was dropped from the ACA, see Brasfield 2011.

in health care reform. Doug Racine was chair of the Senate Health and Welfare Committee and had introduced a bill calling for the design of three health reform options; Susan Bartlett, chair of the Senate Appropriations Committee, had proposed a bill in 2008 and again in 2010 to budget hospital costs through global budget spending caps; and Peter Shumlin, Senate president pro tempore, had made single-payer health care an explicit platform of his campaign (though he had little previous health experience). Racine's and Bartlett's positions on health reform were more circumspect than Shumlin's. Although Racine had been the brainchild behind the bill to study different health reform options and was widely viewed as a single-payer supporter, Shumlin strategically developed a strong single-payer platform to secure a wider Democratic base in the primary.

Shumlin won the Democratic nomination by a narrow margin against Racine in August 2010. This win put Shumlin up against incumbent Republican lieutenant governor Brian Dubie. Although Dubie never commented publicly on his views on single-payer, the widely perceived view was that he would veto any single-payer legislation that came across his desk. While Vermont has been a predominately Democratic state in national elections since the 1960s, the governorship has consistently rotated between Democratic and Republican incumbents and had been controlled by Douglas since 2003, following Dean's Democratic tenure beginning in 1991. One factor that boded well for Shumlin was that the Progressive Party, a party that supports single-payer and often serves as a spoiler for Democrats in close elections, strategically decided not to run a candidate for governor as a result of Shumlin's open support for single-payer. Nevertheless, it proved to be a close race, and the fate of single-payer largely depended on the election's outcome. Shumlin defeated Dubie by a narrow margin in November 2010, securing the open policy window and building momentum for comprehensive reform in the second year of the biennium. With the unfinished business of health reform viewed as a salient public problem, single-payer being bandied as a potential solution, and a political opening occasioned by the succession of a pro-single-payer Democrat to the governorship, an open policy window was secured to advance comprehensive health reform legislation.

The year 2010 had much in common with 1994, but with three primary differences. First, the elected governor had won specifically on a single-payer platform, clearly committing himself to this policy option and to comprehensive reform. Second, health reform at the national level had not ended in defeat as it had under Clinton, but still left enough room for improvement that comprehensive state-level reform was deemed

necessary and justifiable. Third, the health reform design team enjoyed higher legitimacy and fanfare than the previous VHCA, which Dean had minimized.

The Politics of Designing Single-Payer Health Coverage, 2010–2011: Balancing Competing Interests

Designing the most "politically and practically viable single-payer system for Vermont" (Hsiao, Kappel, and Gruber 2010: 2), as the Hsiao plan had proposed to do, required a delicate balancing act of different interests. Reform skeptics and outright opponents such as segments of the business, insurance, and health care industries as well as groups on the political right such as the Ethan Allen Institute would oppose comprehensive health reform no matter what its contents. However, among supporters of reform, a balance was required between remaining marginally acceptable to single-payer purists who wanted radical change and other proponents of reform that were willing to accept a more gradualist, heterodox approach. Single-payer purists were in favor of immediate reform, with progressive tax financing, automatic eligibility by residence, and a rich benefits package, with little to no cost sharing.

Perhaps the largest group, however, was moderate single-payer skeptics that wanted some reform but nothing as radical as single-payer. They included certain legislators, members of the health field, midsize businesses, and bureaucrats. One of the biggest political hurdles to overcome with this group was a sentiment among many political moderates that a single-payer health reform model in a lone state is simply not viable, for a variety of practical reasons. These included the usual trumps such as the unprecedented waivers from ERISA and Medicare that would be required: To achieve a single-payer system with one state health insurance plan would require Medicare, a federal program, to be integrated with the state plan. Single-payer without Medicare, even as a parallel single-payer system, was simply not single-payer to purists. Although Vermont already had obtained a Medicaid waiver, assumptions about the series of waivers that could be obtained were just that—assumptions.

The tacit understanding from Act 128 was that a middle-ground proposal should fall somewhere in between a full-fledged Canadian-style single-payer model and the more moderate alternative of a public insurance option to compete with private insurance on the new health care exchanges that would come into place in 2014. Of course, the possibility of stalemate and

no reform was omnipresent. Although the inclusion of the public option was an afterthought, its addition proved quite consequential in strategically positioning the consultant's most "politically and practically viable option for the State of Vermont," as the more moderate option between pure single-payer and the public option.

Meanwhile, large employers that self-insure posed a particular problem because their existing plans are protected under ERISA. For a single-payer model financed through payroll taxes to be viable, self-insured employers would be required to double pay for insurance—through the payroll tax and through their self-insured plans—since they cannot be required to participate. To design a single-payer system around ERISA (without the assumption of receiving a waiver) would rest on businesses voluntarily giving up their self-insured plans in order to avoid double paying for health care. Whether this indirect double-payment mechanism would itself be considered a violation of ERISA is unclear, since no such court precedent exists (Hsiao et al. 2011). For businesses that currently offered insurance, many did see a benefit to replacing employer-sponsored health plans with a payroll tax, with the caveat that the payroll tax would have to be less than what they were currently paying for health insurance and with some credible commitment on the part of the government that the payroll taxes would not substantially fluctuate. Previous studies have noted large employers' ambiguous and somewhat puzzling position on health reform (Smyrl 2014). Given the rising cost of health insurance and its impact on corporate bottom lines, large businesses' silence on the issue of health reform, except to eschew employer mandates, has been puzzling, particularly since business would likely benefit from a decoupling of insurance from employment. This ambiguous attitude was reflected in the position of medium to large businesses in Vermont and seemed to reflect, as Marc E. Smyrl (2014) has suggested, an ideological contradiction. On the one hand, the idea of being freed from the cost of employer-sponsored insurance was viewed in a positive light; on the other hand, it was accompanied by a highly skeptical position on whether the government would be able, on its own, to restrain an unfettered urge to continually hike taxes in ways that might be damaging to business. In that sense, it was businesses' ideological skepticism toward government that seemed to drive their opposition to single-payer more so than a rational calculation of cost and benefits.

Hospitals and providers expressed a similar sentiment—the need for stability and the ability to project their budgets. In general, the experience of having been underpaid in reimbursements from government-run

programs had soured many businesses, hospitals, and providers against the idea of a purely government-run health plan. As in 1994, the Vermont Medical Society, now headed by Paul Harrington, the former Republican member of the VHCA in 1994, was mostly amenable to reform, seeing less administrative burden as a potential benefit of reform, but with tort reform being among the important policy issues that would gain the organization's support. Uncertainty and fear of the unknown were the overarching concerns of physicians, but they also were quite unhappy with the current system and supportive of reform.

New constraints imposed by the ACA made health care bureaucrats particularly uneasy and skeptical of comprehensive reform. These new constraints included the fact that states were required to implement the exchanges (or the federal government would implement them for the state) and could not get a waiver out of the exchanges until 2017. Running a health care exchange with a single health plan would inherently contradict the idea of the exchange, and having two parallel systems was not economically sustainable (Hsiao et al. 2011). Furthermore, the state stood to lose a great deal of federal revenues from subsidies it would receive if it implemented the ACA. Thus to implement single-payer before 2017 would have required seeking a series of highly uncertain and improbable waivers.

Other general concerns included the fact that Vermont is not an island (Blanchet and Fox 2012: 82)—a possible reference to Hsiao's contribution to designing Taiwan's single-payer health care system—and its implications for the potential flight of business and providers and concern about an influx of the sick and uninsurable. On the left, single-payer purists worried about losing momentum by waiting until 2017 to seek a waiver out of the ACA and urged designers not to recommend waiting for 2017 and to assume that Medicare and ERISA waivers were obtainable. Thus, for those in the political center, these practical constraints posed serious political obstacles, and moderate legislators had to be convinced that what they were voting for was possible before expending precious political capital, whereas single-payer purists were skeptical of any reform that did not immediately lead to one state-run payer.

Thus, to be reasonably acceptable to opponents and skeptics while maintaining the support of comprehensive health reform advocates, a reform design would have to (1) adhere to the ACA timeline to maximize federal funds and minimize uncertainty about federal waivers; (2) lead to a net economic benefit to a majority of employers; (3) be governed by a public-private entity (not exclusively government run); (4) provide mechanisms

for tort reform and incentives for primary care for providers; (5) provide a benefits package at least equal to the benefits currently enjoyed by state employees; and (6) transition to residency-based rather than employment-based health coverage to prevent a 1994-style loss of support on the left.

Hsiao, basing his findings on both the political analysis and the micro- and macrosimulation models, released his final report to the Health Reform Commission in February 2011. The report called for a plan to incrementally implement 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 reasonably rich benefit plan with an actuarial value of 87 percent to all Vermonters. The 14.2 percent payroll tax was estimated to be \$1,429 less per employee than the amount currently paid by the median business in Vermont, and the benefits plan was estimated to be equivalent to existing public-sector union benefit plans in the state. With a 3.6 percent contribution to the payroll tax, the average household would pay \$370 less than its current premiums, though wealthier households (with incomes above 400 percent of the federal poverty level) would pay more. Self-insured employers would still be required to pay the payroll tax in the hopes that they would encourage their employees to join the single-payer system, a design that steered clear of ERISA constraints. In response to widespread concerns about the unfettered role of a strictly government-run payer, the system would be governed by a public-private board comprising government and industry to oversee the system, and a third party (possibly including a current health insurer in the state) would administer the program. The plan further called to move toward a “no-fault” medical liability system to save additional costs (Hsiao et al. 2011). Finally, the plan was to be implemented incrementally in line with national health reform rather than take on the national government in court battles to try to gain immediate federal waivers. Importantly, because technically Medicare would not be integrated with the single-state plan (since payment comes from the federal government), and health insurance plans from outside the state would still need to be processed, Hsiao et al. (2011: 1239) used the metaphor of a “single-pipe,” where all payment and revenue sources are streamlined, rather than *single-payer* to describe the plan.

In contrast to 1994, moving into the biennium, a clear set of policy options had been presented to the legislature, with the third option framed as the moderate choice between pure single-payer and an option closer to the status quo. Moreover, this policy option was one that the governor had a stake in

supporting given his single-payer platform. With these options, comprehensive health reform was poised to advance to legislative consideration.

The Politics of Adopting the Single-Payer Option, 2011: What Went Right?

Armed with the Hsiao report, in January 2011, on being sworn in as governor, Shumlin placed single-payer health reform at the center of his executive agenda and assembled a team of skilled health reform technocrats to assist in his efforts. He appointed former governor candidates with health care experience to top posts in his administration: Bartlett was appointed as special assistant on his transition team, and Racine was appointed as secretary of human services. Some former health reform players from 1994 were also brought back. Anya Rader Wallack, a former Dean aide who oversaw the health reform efforts in 1994 and was now a seasoned health policy expert trained at Brandeis, was hired as special assistant to the governor for health care to spearhead Shumlin's health reform efforts.

Shumlin's administration worked closely with his advisory team to develop a proposal to submit to the legislature for consideration. The plan maintained some of the central features of the reform recommendations from the Hsiao-Gruber report but was stripped of much of its detail. Most prominently, based on lessons from the past, Shumlin's team deemed financing to be too contentious, and it was therefore left to subsequent legislative sessions to hash out. Tort reform was similarly not decided on, though funds were set aside to study alternative methods of reform. The legislation maintained a role for a public-private intermediary, the Green Mountain Care Board, to which it gave the responsibility of deciding on final benefits packages. Finally, in keeping with the recommendations, the single-payer plan would be implemented incrementally in tandem with national reform, which did not allow for states to seek a waiver from implementing the exchanges until 2017. Thus, as the bill originally came to the House (H. 202), it had already been denuded of much of the more contentious design decisions.

The decision to reserve certain design issues for future consideration including financing, and tort reform was therefore primarily an elite-driven political calculus that was reinforced by the implementation's delay until after 2017. Shumlin's administration and change team made a determination, given delayed implementation, to leave certain battles to be fought later. Conservatives in the legislature were in fact some of the biggest advocates to include a financing plan so it could be attacked. Furthermore,

the uncertainty of the ACA's future provided justification for delayed implementation. With the future of Supreme Court challenges to the ACA and the outcome of the 2012 presidential elections uncertain, the ACA faced the possibility of being modified or repealed, which would potentially allow for a speedier implementation of Green Mountain Care. Thus equally important to what was enacted was what was left out of the legislation.

In spite of the details being left to future legislative sessions, the passage of the bill was by no means inevitable. While Democrats enjoyed the majority in both the House and the Senate, votes in the General Assembly on controversial legislation usually split in thirds, with the moderate middle needing to be courted to ensure passage. The 2010–11 session was made up of ninety-four Democrats, five Progressives, and three independents who tend to vote with the Democrats in the House, controlling 68 percent of the vote share compared with forty-eight Republicans controlling 32 percent of the vote share. The thirty-member Senate comprised twenty Democrats, one Progressive, and seven Republicans.

The term *single-payer* did in fact become a sticking point for both moderate and left-leaning Democrats during legislative consideration. One controversial change that occurred in the House was that the term *single-payer* was stripped from the bill's title, replacing "An Act Relating to a Single-Payer and Unified Health System" with "An Act Relating to a Universal and Unified Health System." This symbolic change was made by the House sponsor of the bill because of contention over the title given that Medicare would likely be a parallel "single payer" in the system (absent an unprecedented federal waiver to integrate it), thus making the title with *single-payer* misleading to single-payer purists while posing an obstacle to others turned off by the hyperbole of the term. Apart from this change, the bill emerged mainly intact.

Although the Democrats had a wide enough margin to pass the bill without Republican support and to block Republican amendments, moderate Democrats still needed to be convinced to vote in favor of a bill that would lay the groundwork for a system that in national politics has been referred to as "socialized medicine." Among those Democrats most skeptical of reform, the major sticking point was the level of uncertainty they were willing to tolerate. For some, the bill provided clear end points—steps and milestones to achieve a single-payer system. For others, the road map was not clear enough. Building support among Democrats required the active cajoling of Democratic votes and was not a simple mathematical given, but rather necessitated would-be supporters to take a leap of faith

that the single-payer system that would emerge from the legislation would be feasible even without all of the details spelled out. Thus the successful adoption of Green Mountain Care was not a foregone conclusion.

Act 48 (Green Mountain Care) cleared both the House and the Senate in the 2011 legislative session and was signed into law by the governor in May of that year. The bill passed by a wide margin—ninety-two votes (far more than the seventy-two needed) in the House and twenty-one votes in the Senate out of thirty, largely reflecting partisan divisions. In addition to creating Green Mountain Care, Act 48 also created the Vermont Benefit Exchange in preparation for the ACA implementation, a fully state-run exchange that is the only marketplace for nongroup and small group insurance, which has been described as a "ramp" to a single-payer system. The exchange that was adopted limits the purchase of private insurance to the plans available through the state-run exchange, with the goal of phasing out private insurance by 2017, when Green Mountain Care can take effect. Whereas in most states the ACA requires the continued availability of private insurance outside the exchange, Vermont is the only state where the purchase of insurance within the exchange will be mandatory, with two or three carriers (currently Blue Cross Blue Shield [BCBS] and MVP Health Care) expected to offer four comparable plan levels. Current state Medicaid plans and related programs such as the Vermont Health Access Plan (VHAP) and Catamount Health were wrapped into Green Mountain Care in 2014. In this respect, the ACA implementation has provided additional opportunities for the state to ease its residents into a gradual narrowing of insurance plan offerings to reduce the shock of a single plan being offered in 2017.

Act 48 also created the Green Mountain Care Board, a five-person board that was originally headed by Rader Wallack, Shumlin's special assistant on health reform, and granted unprecedented responsibility for addressing all the major factors influencing the cost of health care assigned by the legislature. The board's primary role is to oversee the design of Green Mountain Care. As implementation of the ACA continues, the board will determine benefits, coverage, deductibles, co-payments, premiums, technology, and provider payments, among other decisions—responsibilities that are typically spread across different agencies, limiting coordination. For instance, among other powers, the board reviews and approves recommendations for new insurance rates, hospital budgets, and major capital expenditures by health care providers, as well as approving benefit plans for Vermont's health care exchange, responsibilities formerly held by the Vermont Department of Banking, Insurance, Securities and Health Care

Administration (BISHCA). The Green Mountain Care Board in construction is somewhat different from how this public-private intermediary was envisaged in the Hsiao report. The board is functioning mainly as a regulatory, public service board that oversees reform rather than acting explicitly as a public-private partnership. It has a quasi-judicial policy-making role and has been pursuing federal opportunities on payment reform. The board interfaces with the private sector and health care providers, but board members make the ultimate decisions. To critics, the board is viewed as a set of unaccountable, unelected bureaucrats, but the board is also viewed as taking a more rational approach to decision making. Current board members include a mix of individuals with public- and private-sector backgrounds as well as some longtime reform stalwarts, such as Cornelius Hogan. The board members are nominated by a broad-based committee and appointed by Shumlin. As explained by one stakeholder involved in the reform, while the Hsiao report recommended more of an independent regulatory body, the governor and his advisers early on determined that they would need to play a more centralized role in overseeing reform, especially with implementation occurring incrementally and much of the details of Green Mountain Care left to be hammered out at a later date.

The decision to save more contentious issues to a later date was an effective strategy to pass reform, but it has also meant that certain myths about Green Mountain Care have been perpetuated. For instance, self-insured businesses continue to view the financing mechanisms that may come into effect in 2017 as double payment. As in the 1994 debate, because of the opaqueness of the issue, the idea that Green Mountain Care would replace current health insurance has been lost, a notion that has been fueled by Republican Party leadership. Similar confusion over financing in 1994 led to an inaccurate news story concerning reform financing and contributed to the downfall of that effort. To date, the Shumlin administration has not released a specific financing plan, largely to deter attacks from reform opponents, though the governor has intimated that the plan will likely rely on payroll tax financing. Thus what has emerged from the legislation adopted in May 2011 is a plan to gradually phase out private health insurance and incentivize self-insured employers to drop coverage through the levy of a payroll tax. Since Medicare may continue to exist in parallel with the state health plan, a single-pipe rather than a single-payer system may be a more appropriate metaphor to describe Green Mountain Care.

In contrast to the 1994 legislative deliberations, in 2011 support was built early on around a single proposal. Strategically, based on experience

from 1994, health reform entrepreneurs and the governor chose to strip out the most potentially contentious pieces of the legislation (e.g., financing) and focus on passing a framework that could build toward a single-payer system while maximizing federal subsidies. Support from the governor and little overt opposition to still ill-specified reforms allowed reform to pass with sufficient votes.

Discussion: How Can the Experience of Vermont Inform Theory on Health Politics and Future State Efforts to Adopt Comprehensive Health Reform?

Below we discuss the lessons that can be drawn from the comparison of the 1994 and 2011 episodes of comprehensive reform in Vermont and consider the implication of these findings for theories of health reform and the future prospects of Green Mountain Care. The landscape in 2011 shared many characteristics with that in 1994, yet a pseudo-single-payer system survived legislative deliberation and was signed by the governor, whereas in 1994 the longest-running Speaker of the House was forced to resign in defeat over the comprehensive health reform legislation that went nowhere. In assessing "what went right," the following interrelated explanations are what emerge most strongly from discussions with those involved in the reforms and from analysis of past efforts compared with present efforts.

1. *Executive leadership and strategy.* Previous research has observed that Democratic control of the governorship increases the likelihood of comprehensive reform plans being considered (Oliver and Paul-Shaheen 1997). Indeed, the election of a Republican to the governorship would have certainly spelled defeat for any single-payer plan, which would inevitably have been vetoed. However, the experience from two episodes of comprehensive health reform in Vermont suggests that not all Democrats are created equal. Even though Dean has traditionally been considered to be among the more liberal Democrats nationally, his commitment to comprehensive health reform was weaker than progressive health reformers in the state had hoped or believed. By contrast, Shumlin was elected explicitly on a single-payer platform and made single-payer a top priority once in office, bringing in support from a talented health reform entourage. Given Shumlin's business background, he was also able to effectively frame the issue in terms of the potential cost savings both to businesses, by decoupling insurance from employment and thereby

creating job growth, and to the state, by reducing waste and inefficiency. The explicit support of a governor for single-payer legislation lent credence to the bill and rallied the Democratic base in the legislature. Shumlin's health reform team also made strategic decisions that increased the likelihood of legislation passing, such as pushing off consideration of the more controversial aspects of the legislation including financing and tort reform to a later date. However, because some controversial pieces were left unresolved, the fate of the reform largely hangs in the balance.

2. *Support in legislature built behind one plan designed by high-profile technocrats and supported by entrepreneurs.* As Thomas Oliver and Pamela Paul-Shaheen (1997) have observed, the one common factor among states that have taken the lead in advancing policy innovations that move toward universal health coverage is the presence of "policy entrepreneurs" who formulated the plans for system reform in addition to prominent "investors" who were in a position to contribute substantial political capital to the development of these reforms. Shumlin and his health reform entourage and Hsiao and Gruber arguably fit this mold. In contrast to 1994, when the final report of the VHCA was ignored and multiple different health reform plans were proposed, in 2010 forward-thinking policy entrepreneurs in the legislature deliberately commissioned high-profile policy technocrats with experience designing and modeling health reform to create a credible plan to be introduced to the legislature. Given that much of the content from the report was ultimately ignored, the impact that engaging these technocrats had in the passage of the legislation is unclear, but their involvement spurred a good deal of media attention and may have increased single-payer purists' willingness to accept certain design compromises. However, what is more certain is that the forward-thinking strategies of various policy entrepreneurs in passing legislation for the design of health reform strategies, even while not knowing in advance the outcome of the gubernatorial election, enabled them to seize the open policy window in the biennium once a Democrat was elected.
3. *Less overt opposition.* With only three insurance companies in the state and the specific financing plan left off the table, business or other would-be opponents expressed little vocal opposition to the legislation. Vermont's highly regulated health care environment had driven out a number of insurance companies since 1994, and the ones that remained did not explicitly say that they opposed the reform but

rather tried to inform their subscribers about the potential consequences on coverage, perhaps hoping to stir up concern among their customers.⁵ No equivalent grassroots movement from the grocers' association emerged to oppose single-payer in 2011, partly because the association increasingly represented larger grocers and chains, which had more in common with larger businesses. Also, unlike in 1994 when latent threats were made about IBM divesting from the state, in 2010 businesses tacitly agreed that the way care was being delivered was not working, though they did not necessarily agree that single-payer was the correct solution. While IBM never actively used the word *oppose*, it did spearhead a campaign to gather business interests to protect self-insured plans. It raised questions and clear concerns about what the change would mean. Among unions, a great deal of confusion remained about what a single-payer system would mean, and the message that insurance would no longer be linked to employment seemed to be lost to some. The benefits package, which was delegated to the Green Mountain Care Board to define, left a number of open questions that could serve as lightning rods for labor in future discussions. Tort reform was given a sufficient nod to keep physicians at bay.

4. *Supportive social movement.* Previous research has found "consumer advocates" to be important, though not necessarily decisive, actors in comprehensive reform efforts (Oliver and Paul-Shaheen 1997). Some reports have pointed to the role of advocates, specifically the Healthcare Is a Human Right movement spearheaded by the Vermont Workers' Center, as a decisive factor in getting single-payer legislation adopted (Rudiger 2011). The efforts of the center did function to lower resistance and enhance support for Green Mountain Care. As one legislator explained: "If instead of having a mass of supporters, you had had a mass of opponents showing up at every meeting, the outcome could have been very different. So they were impactful." These advocates may have also been instrumental in strengthening then gubernatorial candidate Shumlin's explicit single-payer platform. Although in 1994 a set of advocates were

5. In 1991 the Vermont legislature passed Act 52, mandating guaranteed issue and community rating of insurance policies offered in the small group market and, in 1992, adopted Act 160, extending the guaranteed issue and community rating mandates to insurers offering policies in the individual market. Companies such as Aetna, Fortis, Golden Rule Insurance, Nationwide, Trustmark, and Mutual of Omaha left the market. Kaiser Permanente pulled out of the Northeast entirely. The two major health insurance companies still operating in the small group market were BCBS and MVP.

very vocal, and many remained so in 2010, none quite rose to the level of a social movement as the Vermont Workers' Center. Single-payer has also enjoyed support in recent Vermont polls at around 50 percent (see more below), but whether mass popular support has increased is difficult to say without comparable polls from 1994.

5. *National attention to health reform and passage of the ACA.* As with past reforms, the fact that health reform was being discussed and enacted at a national level increased attention to state reform (Leichter 1992; Gray et al. 2010). As one legislator explained, the sense was that since reform was occurring anyway, the question was more over controlling the direction that reform would take rather than whether reform was needed *per se*. This crescendo was heightened by rising health care costs and the feeling, even among more conservative members of the legislature, that something needed to change. Health care was the biggest public expenditure, a theme the governor frequently repeated, and was growing at a rate well above the national average. This factor on its own cannot be decisive, since in 1994 health care costs were rising rapidly and a similar sense of urgency was felt, but it was an important development in the problem stream that constructed health care as a state priority worthy of attention. However, in contrast to 1994 when the Clinton reform plan had ended in defeat, the fact that the ACA passed meant that change was on the horizon anyway, which may have served to soften up the policy space.
6. *Federalism as a double-edged sword shaping reform.*⁶ On the one hand, Vermont's journey toward single-payer demonstrates the state's desperate desire to shape its own unique agenda and represents the best of the power of states as "laboratories of democracy." On the other hand, Vermont was constrained in its design choices in that it was neither willing nor able to enact a reform that would come at the expense of federal financing. With Sanders having failed to secure an immediate waiver out of the ACA, taking a chance with waivers in 2017 was the state's best option. This approach created a slightly different dynamic from 1994, when the reform would have gone into effect immediately and may have provided an important "escape hatch" that enabled legislators to take the necessary "leap of faith" to adopt single-payer legislation, knowing that time would remain to work out the exact details.

6. We thank the editor for this observation.

7. *Single-payer as the "paper tiger" of comprehensive health reform.*

The inclusion of three options (as opposed to two in 1994) gave the appearance of choice and also was used as a paper tiger, with the third option able to be viewed as the moderate choice between pure single-payer (the far left choice) and the public option (the more conservative choice in this instance). This dynamic has been observed in other states that have undergone comprehensive health reform (Paul-Shaheen 1998). Each of these options was far to the left of national politics. Whether Green Mountain Care can rightfully be described as single-payer from a technical standpoint remains an open question, as we discuss below. Regardless, pushing off some of the critical questions about financing and waivers proved to be a critical compromise both for single-payer advocates and for opponents, forestalling criticism for a later date.

Apart from these more general lessons, below we analyze how the case of Vermont helps us to understand different theories about the politics of reform—specifically, whether it can help us resolve the perennial debate over the primacy of ideas, institutions, or interests in health reform struggles.

Ideas. One might aver that Vermont's progressive political culture predisposed single-payer to success in a highly receptive state, and one would be largely correct. Indeed, research on state politics has found that state policy choices are generally reflective of the politics of citizens of that state, and health care policies are no exception (Erickson, Wright, and McIver 1993). In other words, liberal populaces beget liberal policies. Vermont is among the most liberal states in the country by certain metrics, with over 70 percent of the vote share going to President Barack Obama in 2012. However, previous research on policy congruence and responsiveness in Vermont has revealed an interesting paradox (Lax and Phillips 2012). On the one hand, majorities of Vermonters hold liberal policy attitudes, including on health care. But, surprisingly, Vermont adopts more liberal policies than are warranted from opinion alone, yielding among the lowest congruence of states between opinion and policy. This finding suggests that Vermont policy makers are more liberal than the public at large (Lax and Phillips 2012). Indeed, the limited polling data on single-payer from Vermont supports the liberal bias of state policy making in Vermont. Although polls show a plurality of support for single-payer, the margins are quite small and not terribly different from national estimates. A recent poll found 48 percent favoring a single-payer health care system without

specific reference to Green Mountain Care and 36 percent opposing (Costa 2012). Another poll conducted just before the 2012 elections showed that 53 percent of Vermonters “approve of Vermont going forward with Green Mountain Care, a single-payer health care system that will guarantee coverage for everyone in the state,” with 38 percent disapproving (quoted in Hirschfeld 2012). These findings are not widely different from national polls, which have at various times found a majority of the population favoring a national health care system (Blendon and Benson 2001). With the state political culture described by one stakeholder as “socialist-libertarian,” some aspects of the proposed health reform may be at odds with Vermont’s political culture—such as rationalizing the hospital system in ways that might limit free choice or undermine local hospitals—though these elements were not a major focus of the legislation.

Furthermore, without regular opinion polls being conducted on the topic and filtering back to decision makers, seeing how polls would influence decision making is hard. R. Douglas Arnold (1990) suggests that even without polls directly informing candidates’ positions, politicians prospectively judge what they think will resonate with their constituents and support policies accordingly. Other accounts of political responsiveness suggest that politicians do not “pander” to the public; rather, they use information on public opinion to shape messaging on issues to bring the public around to their own position (Jacobs and Shapiro 2000). Thus, in Vermont, political leaders’ perceptions of policy liberalism among their constituents may be what drives policy to be more liberal than actual attitudes would dictate.

In addition, research suggests that the concept of political culture constitutes more than the mere composite of the ideological leanings of its residents. Political culture is rather conceptualized as widespread attitudes that shape how public institutions actually operate and as a common belief in what is the proper purpose for government (Fitzpatrick and Hero 1988). Studies of state political culture have classified Vermont as a “moralistic” state, in which political positions are typically justified by appeals to the “public interest,” rather than narrower interests, and public administration is strong (Elazar 1984). In moralistic political cultures, political representatives might be more inclined to act according to their own convictions on behalf of the public interest rather than according to the policy preferences of the public or special interests and therefore more willing to undertake controversial policy decisions. However, previous studies have found that moralistic political culture is insufficient on its own to explain why certain states have taken the lead on health reform, since certain key

states that have taken a lead in health reform, like Massachusetts, are not classified as moralistic (Oliver and Paul-Shaheen 1997). At minimum, the fact that Vermont's left-leaning political culture has translated into firm Democratic and Progressive control in the legislature influenced the range of options that were placed on the initial agenda for serious consideration, putting single-payer front and center and pulling the agenda to the left; in a more conservative political context, single-payer might be off the table.

The idea of single-payer itself, or the presence of a pure single-payer "demon lurking in the closet" (Paul-Shaheen 1998: 351), may have also assisted in enabling a comprehensive reform to pass that is far farther left of center than might have otherwise been possible, even if some would dispute whether what has been adopted can rightfully be called single-payer. Regardless of whether Green Mountain Care can rightfully be called a single-payer system by some technical definition, an important question that emerges from this analysis is whether the single-payer mantle is in fact its own worst enemy. Single-payer has become the symbolic gold standard of progressive health reform advocates. Certain single-payer supporters were so wedded to this model that they insisted the term *single-payer* be dropped from the final bill, not because of pressure on the right, but rather because the reform did not technically achieve a literal interpretation of a system with only one payer. This pursuit of "ideological purity" among single-payer advocates led one stakeholder to describe single-payer as similar to "abracadabra": "Nobody knows exactly what it is, but it has magical properties." Although the term *single-payer* was dropped from the final legislation, the governor and nightly talk shows continue to describe the system that emerged from the legislation as single-payer, presumably to be able to claim a political victory for Vermont as the first state to adopt this universal health coverage model.

Institutions. Regardless of Vermont's political culture, any reform proposal would still have to make its way through the institutional meat grinder and would face opposition from a host of interests. As at the national level, in Vermont, health reform legislation must make it out of committee, pass the House and the Senate, and survive a gubernatorial veto. Vermont's liberal political culture only began being translated into its representative structures since redistricting in the 1960s, which allowed liberal emigrants to the state from large urban centers to have greater representation, pushing out much of the leadership from rural Vermont (Davis 1999). With the House, the Senate, and health committees now firmly in Democratic hands, the largest hurdle in Vermont has been the

governorship. Once elected, incumbent governors tend to stay in office—Vermonters have not turned out an incumbent governor since 1962. After Dean, Douglas controlled the governorship until he stepped down, creating a political opening for a Democratic candidate to fill the office. Vermont has one of the most successful third parties in the country, the Progressive Party, which has helped, along with progressive Democratic representatives, to pull legislation to the left. In addition, by adopting early cost-containment “institutions” developed in response to the initial distribution of different types of hospitals and insurance markets, Vermont’s past reforms conditioned current reforms. This initial starting point set Vermont on a path that enabled it to pursue more solidaristic financing mechanisms (Chen and Weir 2009). Thus Vermont’s political institutions were already well primed to tackle single-payer legislation, especially with the addition of a Democratic governor, though importantly this same constellation was not enough to pass a single-payer bill in 1994.

Whereas Vermont’s past and present political institutions enabled the passage of single-payer legislation, the biggest constraint Vermont faced to more comprehensive reform was not something the state had control over: federal institutions and programs—that is, ERISA, Medicare, Medicaid, and the ACA—posed the largest hurdle to designing and adopting a universal health coverage system. Implementing an immediate pure single-payer system would have required getting unprecedented waivers out of ERISA, Medicare, and the ACA. Only far-left-leaning single-payer supporters advocated for this big-bang approach. Moreover, forgoing implementation of the ACA would have meant losing substantial federal funds, which were deemed essential for the viability of any health reform option. Sanders had made repeated attempts during ACA deliberations to allow for immediate waivers out of the exchanges for states that were experimenting with more thoroughgoing reform, but he was unsuccessful.

Interests. While health reform was still facing opposition from the insurance and business sectors most prominently, the intensity of opposition from business had waned somewhat, and few insurance companies operated in the state. Although large businesses still wished to hold on to employer-sponsored plans and believed that they were managing the increasing costs of coverage through wellness programs and increasing employee contributions, businesses were not opposed to reforms that would bring down the cost of care or alleviate some of their burden. This position mirrors the general softening of interests to health reform at the national level (Brown 2011; Hacker 2011). Yet, whereas the national health reform stands to benefit insurance companies through the individual

mandate, a single-payer system extends no such benefit to insurance companies. However, because many of the details of reform were left unspecified, and with the possibility of BCBS or another insurer having a role to play in administering state health insurance, opposition from insurance companies was not forthcoming. With financing and other basic issues yet to be worked out, the role of interests in deciding the fate of reform was left unresolved in the legislation.

Interests can also cut both ways. Advocacy groups like Physicians for a National Health Program also try to sway the political process through their own tactics. The presence of a social movement spearheaded by the Vermont Workers' Center—the Healthcare Is a Human Right movement—likely played a role in the success of legislation, but gauging the contribution of this movement to the ultimate legislative outcome is difficult to assess. Research suggests that social movements succeed when “political opportunity structures”—exogenous factors that limit or empower collective actors—present an opening to advance a movement’s cause (Tarrow 1998). The possibility of having a Democratic, single-payer-supporting governor created such an opening for the single-payer movement, but single-payer was being discussed in Vermont well before the workers’ center began its campaign. Its primary contribution seems to be a lowered potential for resistance among moderate (on-the-fence) legislators because of the movement’s omnipresence at public meetings and its unwavering support for single-payer.

Beyond these more structural factors, the role of agency and political entrepreneurship must be given its proper dues. As David Wilsford (2010: 666) reminds us, “A critical point to emerge from an examination of the interaction effects between structure and agency is that choice exists within the boundaries of structure.” The Senate Health and Welfare Committee, knowing that a political opening would be created with Douglas stepping down, proactively commissioned a study that could be the basis of legislation under a Democratic governor. Shumlin, recognizing a political opportunity to differentiate himself from his Democratic competitors, chose to make single-payer a focus of his campaign and his executive agenda. Including three design options enabled the Hsiao-Gruber report to position the third option, the single-pipe option, as the moderate choice between pure single-payer and a public option that would preserve a significant role for the market. Leaving out key components of the reform allowed it to pass through round one. Support among Democrats in the legislature was not guaranteed but rather needed to be built.

Thus a clear victory for any one explanation does not emerge from the case of Vermont; instead, a series of situational factors combined with

institutional factors to generate a window of opportunity that allowed comprehensive reform legislation to be adopted.

Conclusions: How Are We to Understand Green Mountain Care and Prospects for Other States?

This discussion raises the question of how Green Mountain Care is best understood—as an incremental reform or as a reform that has fundamentally shifted the health care landscape in Vermont. Incremental change is usually conceived of as change on the margin—a Band-Aid slapped on a bigger problem. Big-bang policy change occurs when a radical departure from the status quo fundamentally reorganizes existing institutions (Baumgartner and Jones 1993). Green Mountain Care seems to be somewhere in between. In its current form it remains a shell, a framework of how to proceed but devoid of substance. Yet it lays the groundwork for a major discontinuous shift from the status quo, not only extending coverage to every state resident, but also fundamentally reorganizing the health system, something never before achieved in any other state.

Thus, in spite of the alignment of these different stars—unified political institutions, a liberal political culture, lower than usual opposition (coupled with higher than usual support), and a plan designed by a team of highly respected policy technocrats—Vermont's single-payer legislation can at best be characterized as a step in the direction of a unified payment system and universal coverage. Many battles remain to be fought before a single-payer system can come to fruition. Future legislation will determine the financing and organizational structure, whether it includes a no-fault tort reform system, and the generosity of the final benefits package, among other details. The plan cannot be fully implemented until after 2017. Yet, while other states are fighting with the federal government over the constitutionality of the ACA and refusing to implement exchanges, Vermont has been fighting over how quickly it can do more to go beyond national reform.

The passage of single-payer legislation in Vermont can provide lessons for other states. A number of states have advanced single-payer legislation in the past with varying degrees of success. California has tried several times, most recently in 2009 when a bill, which passed the legislature, but ultimately did not advance. Hawaii similarly passed a bill through the legislature that was vetoed by its Republican governor. Massachusetts eschewed single-payer legislation early on because it was not likely to succeed in favor of increasing coverage through mandates on employers and later individuals (McDonough et al. 2006).

As the case of Vermont demonstrates, to design and adopt a single-payer reform that can withstand the legislative process is possible, though not without certain casualties to substance. However, given Vermont's relatively unique political culture and its existing history with health reform, the odds of succeeding at adopting single-payer reform in other states are low. Passing even skeletal reform required a coalitional alignment that occurs extremely rarely—at minimum, a governor willing to champion (or at least not veto) single-payer, a firmly Democratic (left-leaning) legislature, a team of star technocrats devoting time and resources on a shoestring budget to develop a credible reform plan, and the ability to work around federal institutions. The odds of successfully implementing may be even lower.

Nevertheless, states have served as laboratories for experimentation with different health reform models that sometimes filter up to the national level or diffuse across state lines (Leichter 1992). As Carolyn Hughes Tuohy (1999) notes, this tension between the idiosyncrasies of reform designed for a specific context and the eternal search for external models generates vibrant health reform models. If Vermont succeeds in its experiment, other states may be able to gain more political traction for single-payer if they have a credible model to draw on. Indeed, the Canadian single-payer system started in a single province before ultimately being adopted nationally.

Many will ask whether Vermont is simply a liberal anomaly. Is there potential at a state level for reforms that have seemed unreachable in the US context?⁷ We suggest yes and no. First, as we previously discussed, the Vermont public is apparently not as liberal as its legislators. In this sense, the difference between states may be less a function of public sentiment than the willingness of political leaders to go out on a limb to advance legislation that is in the public interest. However, even though Shumlin was careful to cast his rhetoric on single-payer in terms of its benefits for the economy, conservative states would be unlikely to succeed at advancing a single-payer platform even with this market spin given that the primary goal of single-payer is to eliminate the insurance market. Appealing to market principles seems to be the main way that conservatives have been able to frame recent health reform proposals. For instance, Arkansas and several other states are pursuing the so-called private option in lieu of the Medicaid expansion in spite of the fact that this approach is likely to be much more costly to the state. Without appeals to competition, conservative states would be unlikely to succeed in advancing a

7. We thank the editor for posing these questions and assisting us in reflecting on them.

single-payer option, even if the cost controls are as impressive as advocates claim they are. Yet liberal states where insurance markets are also weak may be able to have some success with a single-payer platform. In general, smaller, less densely populated states have fewer insurers (Underwood 2009). In Hawaii, one insurer covers 78 percent of the population, and in New England states, one insurer (generally BCBS or WellPoint) covers at least half the population (Underwood 2009). In these states, moving to a single-payer system, particularly where a role is guaranteed for the largest insurer to be the administrator of the system, may not be entirely far-fetched.

By contrast, in states with highly competitive insurance markets, comprehensive regulated multipayer reforms may be a more realistic goal to pursue, potentially even in conservative states. Evidence from comparative health systems suggests that single-payer systems, to the extent these can be identified, are not substantially superior in terms of cost savings or equity to other universal health coverage models, such as regulated multipayer models (Glied 2009). Although single-payer is an ideal type pursued by left-leaning advocates, other ways of organizing universal health coverage systems may be more viable for politically conservative states.

In addition to these structural factors, such as the number of insurers, one strategic question for states like California and Hawaii is why continue to put forward single-payer bills when the political climate is not right—that is, when a Republican governor is in power or if both chambers are not solidly in Democratic hands? Although it is not certain that Democrats will support single-payer, it is more likely. Vermont adopted a number of health reforms under Republican governors, including the adoption of Catamount Health, a public-private health insurance plan, under Douglas. However, the two major recent attempts at single-payer have largely been spearheaded when the potential for a Democratic governor was high.

In sum, we find that Vermont faced a number of constraints and opportunities that contributed to the ultimate design and adoption of the final legislation. A political opening in the governorship, a progressive social movement and national health reform raising the saliency of the problem, and a single-payer plan devised by high-profile policy technocrats combined to open a window of opportunity for single-payer to make its way onto the legislative agenda. Once on the agenda, a unified Democratic government under the leadership of a single-payer proponent and lower than expected opposition from traditional opponents enabled Vermont to consider legislation far to the left of the rest of the country. Federal constraints on state-led reform (e.g., Medicare, ERISA, and changes under

national health reform) posed the greatest challenge to designing a single-payer system. Further political challenges will undoubtedly arise as the details of the legislation are hashed out and as implementation begins (if it begins), but we hope that other states can draw relevant lessons from the Vermont experience.

Epilogue

On December 14, 2014, nearly four years after the passage of Green Mountain Care, and as this article made its way to print, Governor Shumlin announced that his administration would not proceed with the rollout of a single-payer health care plan. Financing proved to be the death knell of reform. Shumlin explained his reasoning in detail on his state website—public financing for the health care plan would have required an 11.5 percent payroll tax on all Vermont businesses (large and small) and a public premium assessment of up to 9.5 percent of individual Vermonters' income. This was an amount the governor could not "responsibly support or urge the Legislature to pass" (Shumlin 2014). An 11.5 percent payroll tax was less than the 14.2 percent payroll tax recommended in the Hsiao et al. report, which was projected to be less than what the median business currently pays in health care premiums.

Shumlin framed his decision as at least partly driven by economic factors beyond the state's control. First, the Centers for Medicare and Medicaid Services (CMS) provided \$150 million less than anticipated to make the transition. Second, the state's inability to meet Medicaid provider-payment increases required under the ACA added an additional deficit of \$150 million that would need to be raised through public financing.

However, the decision likely also reflects Shumlin's fiscal conservatism, including a reluctance to raise taxes proportionally more on large businesses and corporations. The financing mechanisms considered by Shumlin's administration included only a flat payroll tax with and without a phase-in for small businesses and additional out-of-pocket payments for individuals but excluded more progressive financing mechanisms advocated by the Vermont Workers Center, including "taxes on earned and unearned income, a wealth tax, and a progressive payroll tax for employers only, with exemptions for the smallest businesses" (Early 2014). Shumlin has consistently tried to sell single-payer as a boon for business and the economy rather than appealing to public financing on equity grounds. Yet for many employers and employees the proposed new taxes would reflect less than they currently pay in premiums for health care. This failure to adequately

convey the fact that new taxes would replace current premium expenditures also contributed to the previous demise of single-payer in the state. Ultimately, the decision that an 11.5 percent payroll tax and 9.5 percent public premium was a price too high to pay was a political calculation.

Shumlin's decision came in the wake of a closely contested race in which he almost lost reelection to a relatively unknown Republican contender. In fact, Shumlin will not be officially reelected until the Vermont legislature meets on January 8, 2015, to pick the next governor, because no candidate won more than 50 percent of the popular vote. This near defeat does not necessarily reflect declining popular support for single-payer in the state, as the pro-single-payer Progressive Party had a relatively strong showing in the same election, increasing their number of seats in the state House of Representatives from five to seven members and maintaining three seats in the thirty-member Vermont Senate.

Overall, the failure of single-payer to advance can largely be attributed to the long implementation timeline opening opportunities for backpedaling, as well as the passage of only a skeleton framework without key financing details.

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