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How Vermont's single-payer health care dream fell apart

by Sarah Kliff on December 22, 2014

It was Friday, December 12, when Robin Lunge began worrying that Vermont's single-payer plan was doomed.

Lunge, Gov. Peter Shumlin's director of health reform, had spent weeks trying to make the math work for a public health insurance plan that would cover all Vermonters. Since Thanksgiving, she had been sending numbers off to M.I.T. economist Jonathan Gruber and Wakely Consulting, an actuarial firm.

The models Gruber was running were meant to project the cost of Vermont's plan under different scenarios. What if the health plan covered 80 percent of the typical Vermonter's health care costs? What about 94 percent? But as the numbers got more concrete — as they closed in on the plan the governor actually wanted — the financial foundation began to crack. Lunge knew by that Friday that the single-payer system Vermont wanted to build would require about $2.5 billion in additional revenue in its first year.

In Vermont, this is massive: the state only raises $2.7 billion in taxes a year for every program it funds. Early estimates said that Vermont's single-payer plan might need $1.6 billion in additional funds — a huge lift. But $2.5 billion was impossible.

"It was disappointing to me and my team that we weren't able to make the numbers work the way that we had hoped," Lunge said.

Lunge and her team worked through the weekend. Saturday and Sunday fell into a sort of rhythm: she would change their assumptions slightly and send the new figures off to Gruber. It took him about 24 hours to run the new figures in that model, which would produce projections for how much the single-payer system would cost.

"I kept running into them at the coffee shop," said Deb Richter, a long-time single-payer advocate in Montpelier. "They looked very tired. They were working their butts off."

Each new packet of Gruber data was essentially the same as the old Gruber data. It kept showing that a single-payer system would be more costly than initially expected. "It was really over the weekend that we started to realize this might be too big an obstacle to surmount," said Lunge.

After the non-stop weekend, Lunge met on Monday, December 15, with Governor Shumlin. He reviewed the weekend's work and delivered his final verdict: he would no longer pursue single-payer.

Shumlin's office kept the decision secret until a Wednesday press conference. The audience was shocked — many had turned up thinking that Shumlin would announce his plan to pay for universal coverage, not that he was calling the effort off.

"It was dramatic being in that room," Richter said. "You just saw reporters standing there with their mouths open."

Over the past three years, Vermont has come closer than any other state in building a publicly financed, universal health care system. I spent time in Vermont this spring talking to the key people trying to make single-payer a reality. I reached out to many of them again this week to understand how it fell apart — and what it means for the future of single-payer health care in America.

Vermont's case for single-payer health care can be summarized in one number: $82,975.

That's the amount a 2011 study in the journal *Health Affairs* found the average American doctor spends on dealing with insurance companies. Across the border in Ontario, doctors spend about a quarter of that amount — $22,205 per physician — interacting with the province's single-payer agency.

American doctors spend lots of money dealing with insurers because there are thousands of them, each negotiating their own rate with every hospital and doctor. An appendectomy, for example, can cost anywhere from $1,529 to $186,955, depending on how good of a deal an insurer can get from a hospital.

The average amount of money spent on health care per person has more than doubled since 1999 in Vermont, from $3,421 per person each year to $7,876 per person each year. The gap between the US's per-person spending and Vermont's per-person spending has decreased.

That doesn't happen in single-payer systems. When the government owns and operates one health insurance plan for all residents, it sets a single price for each medical procedure. Health providers can take it or leave it —and they typically take it.

Think of it as a bulk discount: when the government can promise to deliver loads of patients to a given hospital or doctor, they have leverage to insist on a lower price.

Administrative costs tend to be lower, too. Instead of dealing with dozens of insurers who set hundreds of prices, doctors only need to send bills to the federal government.

The administrative savings of a single-payer system do come at a price. Single payer requires the government to make difficult decisions about what benefits they will and won't cover — and often leave out pretty standard medical services, things like prescription drugs or dentist visits.

Single-payer systems can vary dramatically from country to country. "It's a label that gets applied as if you could put a bunch of countries under it, and they would all look similar," said Cathy Schoen, executive director of the Council of Economic Advisors at the Commonwealth Fund, a nonprofit that focuses on health policy research. "But there actually aren't very many health-care systems that look the same."

Some countries, like Canada, own the health insurance plan but contract with private hospitals and doctors. They pay claims in the same way American health insurers do. Others, like the United Kingdom, own the health-care providers themselves.

Countries make different decisions about which medical services they'll cover — and how much they'll ask citizens to chip in. New Zealand's and Norway's programs include co-payments for trips to the hospital; Italy's and Denmark's do not. Some plans include prescription drug coverage, while others stick residents with the tab.

Overall, single-payer systems tend to be especially good at two things: increasing health coverage rates and holding down health care prices. Getting people covered is, unsurprisingly,

a much easier task when the government is running a health insurance plan. When Taiwan implemented a single-payer system in 1995, the insured rate went from 53 percent to 96 percent in nine months.

Worries about rationing made "single-payer" a polarizing term — even in deep-blue Vermont

Single-payer countries are often associated with longer wait times, a perception that stems from Canada's system. One recent Commonwealth Fund survey found 36 percent of Canadians say they wait six days or more to see a doctor when they're sick, compared to 23 percent of Americans. Long wait times don't appear to be systemic to single-payer systems, though. Australia and the United Kingdom, for example, have shorter wait times than the United States

Worries about rationing and wait times made single payer a polarizing term, even in deep-blue Vermont. It's often used in attacks on government-financed health care, conjuring up images of long wait times and rationed care. Supporters of single-payer didn't like to use it, instead preferring to discuss universal coverage or publicly financed health care. Shumlin was among the rare few who will use the term liberally, mostly out of convenience. He hadn't found a better term to describe what he wanted to bring to Vermont: a system where a single entity (the state) pays for everyone's health care. And he didn't care to spend much time thinking up a better description.

"I don't care what you call it," Shumlin told me in March, during a lengthy interview in his office. "I care that we get it right."

Vermont wasn't satisfied with the health reform law that Congress passed in 2010, the Affordable Care Act. That law expands health coverage by growing the existing health-care system. Americans who already had health insurance have seen barely any change. Uninsured people have gotten covered through two existing programs: the individual insurance market (where millions of Americans now receive subsidies to help buy coverage) and Medicaid, a public program for low-income people.

Shumlin had a different idea. He didn't want to build on what existed. He wanted to blow up what exists and replace it with one state-owned and operated plan that would cover all of Vermont's residents — an example he hopes other states could follow.

Vermont has long prided itself on leading the nation. It was the first state to abolish slavery in 1777 and, in more recent history, pioneered same-sex civil unions with a 2000 law. Shumlin thought it could be the first state to move to single-payer health care, too.

Shumlin surprised local activists by running for governor in 2010 on a single-payer platform. While most Democrats across the country shied away from health care in that election, reassuring angry constituents that they didn't support a government takeover of health insurance, Shumlin was on TV expressly endorsing that idea.

"It was the first person I ever heard in politics who was a serious candidate, said the words 'single payer,' and weren't using them in an attack ad," says Richter, who is the president of Vermont for Single Payer. "It was amazing."

Shumlin wanted to move quickly. He worked with Harvard health economist William Hsiao, who has helped many other countries launch single-payer plans. He wrote an outline for Vermont on what their plan could look like (the document is ubiquitous in the statehouse,

known simply as the Hsiao report). On May 26, 2011, Vermont passed Act 48, the first law in the nation that provides health coverage to all residents of a state.

Act 48 outlined a set of benefits — namely, that all Vermonters would gain access to a public health plan. The law, however, didn't outline how the state would pay for those benefits. Some now reflect back on that as an ominous sign for what would happen next.

"I was skeptical when the original bill passed," Peter Galbraith, a Vermont state senator, said. "When you pass a benefit and don't say how you're going to pay for it, it raises the obvious question of, 'How are you going to pay for it?'"

Putting a price tag on Vermont's single-payer plan was a maddening task for health economists after Act 48 passed. In just the past two years, different economic modeling firms have priced the project anywhere from $1.6 billion to $2.5 billion during its first year.

"There are so many different factors and you could end up with a gazillion options. When you make choices on some of these things, they all have repercussions in terms of cost," Katharine London, a health economist at the University of Massachusetts, told me in March (she declined an interview Wednesday).

The Shumlin administration contracted with London and a team of economists at her university last year to estimate the cost of Vermont's plan. Their report estimated that Vermont will need to raise an additional $1.6 billion in tax revenue in 2017 to pay for a single-payer system. (Lunge says, due to some different assumptions, this report and the new one estimating a $2.5 billion price tag are not completely "apples to apples" comparisons).

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As the 2017 launch date for single-payer grew closer, the Shumlin administration began to dive into the details of how, exactly, it would work — and began to falter.

Shumlin had planned to increase Medicaid spending by 3 percent each year from 2012 to 2017. This money was especially important because, for every dollar that Vermont puts towards its Medicaid system, it gets a match of $1.17 from the federal government.

But the Vermont economy wasn't growing as quickly as expected — and that meant the state couldn't afford those 3 percent pay bumps. And that, in turn, meant they didn't get the federal funds, either. "We couldn't provide the investment in Medicaid that we had initially thought we'd depend on," Lunge said.

Specific policy decisions started to make the program more expensive, too. Shumlin decided recently, after getting input from the business community, that Vermont's program should cover out-of-state commuters who work in the state. It would be too complex, business owners advised, to have to offer something separate to employees who came in from New Hampshire or Massachusetts each day.

Covering more people meant spending more money. "This is a challenge we face as a state setting up a system, rather than an entire country," said Lunge. "We have borders, and people come in across those borders every day."

The increased costs and decreased revenue started to add up. The Shumlin administration estimated it would need to increase payroll taxes by 11.5 percent and income tax by 9 percent.

"There had been whispers that maybe [the payroll tax increase] would get as high as 8 percent," said Al Gobeille, chair of the Green Mountain Care Board, the independent agency overseeing the implementation of universal coverage.

When the governor mentioned the 11.5 percent figure at his Wednesday press conference, Gobeille said it was a shock to the business owners in the room. "They didn't know the tax would be so high," he said. "But then they were relieved, because he said he wouldn't do it."

About half of countries who attempt to build single-payer systems fail. That's Harvard health economist William Hsiao's estimate after working with about 10 governments in the past two decades. Whether he is in Taiwan, Cyprus, or Vermont, the process is roughly the same: meet with legislators, draw up a plan, write legislation. Only half of those bills actually become law. The part where it collapses is, inevitably, when the country has to pay for it.

In the United States, the failure rate is even higher. The California legislature has twice passed single-payer legislation, only to have the bills vetoed by Gov. Arnold Schwarzenegger. There was also a single-payer ballot measure in California in 1994, but the insurance industry pushed back aggressively against it. And those are relative success stories: activists in Colorado failed to get enough signatures for a single-payer ballot measure this past November. Rep. John Conyers (D-Mich.) has introduced and re-introduced a bill to bring a public plan to the entire country since 2009. It has languished through three consecutive sessions of Congress.

In a way, the fact that America hasn't taken serious steps to control health spending makes it particularly hard for the country to move to a single-payer system in the future. Our health-care system costs $2.8 trillion annually, about 17.7 percent of the entire economy. This is way more than any single-payer system anywhere in the world costs. Take Canada, where 11.2 percent of all spending goes towards medical care.

That's the irony of America's health-care system: its incredible failure to control costs makes change that much harder, because so many powerful players profit so handsomely from the status quo, and because rearranging the financing creates so many losers.

"If Vermont was spending 10 percent of its economy on health care, this would be hugely cheaper," Schoen at the Commonwealth Fund said. "But that's not the health care system they're raising funds for."

Another strike against single-payer systems, compared to other American health-care arrangements: they're financed in an unusually transparent way. And arranging that financing, from scratch, often proves impossible.

Right now, most Americans get their health insurance through an employer. That employer, unbeknownst to us, typically puts thousands of dollars into our policy alongside the money we kick in. According to the Kaiser Family Foundation, employers, on average, pay more than 80 percent of an individual worker's premiums. But Americans usually don't notice their employer subsidy for health insurance; it doesn't show up on their paycheck anywhere.

Or take Obamacare, which is funded partially by taxes on the rich, partially by fees on various players in the medical industry, and partially through cuts to Medicare. The cost is spread across many groups, and many government functions.

But by moving all the financing to the government, a single-payer health plan like the one Vermont considered would lay naked the incredible costs of our health care system.

Vermonters would certainly notice the 9 percent income tax hike and 11.5 percent payroll tax that the Shumlin administration concluded would be necessary to raise enough funds.

What's more, single-payer would not have just changed how Vermont pays for health care — it would have changed who pays, shifting more of the burden onto large companies.

Right now, the way workers pay for health insurance is regressive: a private insurance company sets a price for their policy, and a worker who earns $30,000 has to put a bigger share of her paycheck towards buying it than someone who earns $100,000.

Single-payer systems often rely on taxes, rather than set premium contributions. And that links the price of health insurance to how much someone earns. The proposed 9 percent income tax, for example, would be far more expensive for that $100,000 worker than the $30,000 earner.

That new taxes are unpopular, even in Vermont, is not a surprise. But if Shumlin could have told Vermont businesses, "You'll pay slightly less than you used to for health care — it'll just be a tax rather than a premium," his plan may have just barely squeaked by.

But he couldn't: the proposed taxes would ask higher earners to spend more on health care than they do now — in some cases, far more.

"An 11.5 percent tax would look great if I'm a low-wage employer," said Schoen. "But I'm a high-wage employer, 11.5 percent is going to be way higher than what I used to pay to buy insurance."

"You'd think that, if there was any state where this could fly politically, it should have been Vermont," said Matthew Dickinson, a political science professor at Middlebury College. "But in this case, the price was so big that even a state as solidly blue as Vermont wasn't able to swallow it."

When I interviewed Shumlin in March, he said that whether or not Vermont succeeded at its single-payer push would have huge national ramifications. Back then, his state had the potential to serve as a model. It could be what Romneycare was in Massachusetts: a template for national reform. But if single-payer couldn't succeed in deep-blue Vermont, Shumlin and others mused, how could it possibly move forward anywhere else?

"If Vermont gets single-payer health care right, which I believe we will, other states will follow," he predicted. "If we screw it up, it will set back this effort for a long time."

I asked Shumlin's office for an interview Wednesday to discuss what the plan's failure meant. Through a spokesperson, that request was declined.