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Single Payer Healthcare Systems

Vermont has had a long and complex history with attempts to change the healthcare system. For nearly a decade there have been different movements to adopt some form of universal healthcare for Vermont residents. Currently, Vermont has not made any large-scale changes to the healthcare system. There have been a variety of countries across the globe that have adopted forms of single payer or universal healthcare systems. These systems vary greatly from country to country, and it is important to understand the similarities and differences between these systems when looking at healthcare reform in Vermont. This report begins by looking at the history of the debate around healthcare reform in Vermont and the legislation brought forward at the time of these discussion. It then discusses the report created by a group of economists looking into the feasibility of universal healthcare in Vermont. The report also examines bills introduced by other states to adopt single payer healthcare systems as well as the systems adopted by other nations.

The 2018 Vermont Household Health Insurance Survey (VHHIS) found that of the 97% of Vermont residents who indicated they had a primary source of health insurance, 53% of these residents had private health insurance, while 19% had Medicare and 22% had Medicaid.¹ Approximately 19,800 Vermonters were uninsured according to the survey.² A “large proportion” of those who were uninsured but worked for an employer that offered health insurance indicated that “cost” was either “the only reason (51%)” or “one of the main reasons (22%)” that they do not have health insurance.³ A third of uninsured Vermonters also cited lacking or losing eligibility for a public health insurance plan as “one of the main reasons” that they did not have health insurance coverage.⁴ According to the survey, “over three-quarters of

¹ Vermont Department of Health, *Vermont Household Health Insurance Survey 2018 Report* (HealthVermont, 2018), 3, https://www.healthvermont.gov/sites/default/files/documents/pdf/VHHIS_Report_2018.pdf. Accessed April 29, 2021.

² Vermont Department of Health, *Vermont Household Health Insurance Survey*, 3.

³ Vermont Department of Health, *Vermont Household Health Insurance Survey*, 3.

⁴ Vermont Department of Health, *Vermont Household Health Insurance Survey*, 19.

the uninsured [were] very (51%) or somewhat (25%) interested in a state health insurance program.”⁵

Vermont Context

The Affordable Care Act

The Affordable Care Act (ACA) was enacted in March 2010 across the United States, including in Vermont. According to a report done by the National Conference of State Legislatures, the ACA “intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs.”⁶ Between 2013 and 2016 the number of uninsured individuals in Vermont decreased 48.9 percent, from forty-five thousand to twenty-three thousand, bringing the total proportion of uninsured individuals to 3.7 percent of the state’s population.⁷ This level is below the national rate of uninsured individuals, which was 8.6 percent in 2016.⁸ This decrease can be attributed to the ACA expansions in Medicaid eligibility and increased tax credits allowing individuals to purchase private insurance.⁹ Before the enactment of the ACA, the average monthly Medicaid enrollment in Vermont was 161,000, however in May 2017 that number had increased to 170,000 individuals.¹⁰

Act 128

In 2010, the Vermont Legislature passed Act 128, which outlined several principles for comprehensive health care reform. Governor James Douglas allowed the bill to become law without his signature. In the bill, legislators cited issues with the state’s current healthcare system, including that “the escalating costs of healthcare...are not sustainable” and that about seven percent of Vermonters did not have health insurance coverage.¹¹ The act stated that “[i]t is the policy of the state of Vermont to ensure universal access to and coverage for essential health services for all Vermonters.”¹² The state emphasized its commitment to slowing the growth of health care costs, and Act 128 established a commission on health care reform to “monitor health care reform initiatives and recommend to the general assembly actions

⁵ Vermont Department of Health, *Vermont Household Health Insurance Survey*, 3.

⁶ National Conference of State Legislatures, “The Affordable Care Act: A Brief Summary,” last modified March 2011, accessed May 5, 2021, <https://www.ncsl.org/portals/1/documents/health/HRACA.pdf>.

⁷ Ballotpedia, “Effect of the Affordable Care Act in Vermont,” accessed May 5, 2021, https://ballotpedia.org/Effect_of_the_Affordable_Care_Act_in_Vermont.

⁸ Ballotpedia, “Effect of the Affordable Care Act in Vermont.”

⁹ Ballotpedia, “Effect of the Affordable Care Act in Vermont.”

¹⁰ Ballotpedia, “Effect of the Affordable Care Act in Vermont.”

¹¹ Vermont General Assembly, *No. 128. An act relating to health care financing and universal access to health care in the state of Vermont*, VT Leg 269113.1 (2010), accessed April 20, 2021, <http://www.leg.state.vt.us/docs/2010/Acts/ACT128.pdf>.

¹² Vermont General Assembly, *No. 128. An act relating to health care financing and universal access to health care in the state of Vermont*.

needed to attain health care reform.”¹³ The commission was to prepare a report on potential health care reform options, considering the financial, social, and administrative impacts of each option.

2011 Policy Report

As mandated by Act 128, a 2011 health policy report by health care consultants and economists Dr. William C. Hsiao, Steven Kappel, and Dr. Jonathan Gruber outlined three potential options for Vermont’s state healthcare system: a government-administered and publicly financed single-payer option, a “government-administered public option that would compete with private insurers,” and a “public-private single payer system.”¹⁴ Of these three options, Hsiao et al. determined that the public-private single payer system would be the most “viable and practical” plan for the state of Vermont.¹⁵ The proposed single-payer system would “cover every Vermonter with a standard benefit package.”¹⁶ Additional or multiple insurers would “only exist to offer supplementary benefits to wrap around the standard benefit package” and would thus be significantly reduced.¹⁷ Under this system, an independent board representing “all the major players” in Vermont’s healthcare system, such as employers, state officials, providers, and beneficiaries, would govern the single payer program.¹⁸ The single-payer system would thus not be entirely government-administered, which was expected to result in the greatest level of buy-in from citizens and other stakeholders. Additionally, this option was expected to provide the greatest cost savings of the three proposals outlined in the report.

The report outlined several benefits to instituting a single-payer healthcare system in Vermont. Hsiao et al argue that such a system be “better able to identify instances of fraud and abuse within the system, which could account for a significant level of health spending.”¹⁹ Additionally, Hsiao, Kappel, and Gruber claim that instituting a single-payer healthcare system in Vermont could reduce care costs by “8-12 percent in the first one to two years,” and could further reduce costs by “an additional 12-14 percent over time.”²⁰ Another potential benefit would be an increase in state population: a single-payer system would both create new jobs and

¹³ Vermont General Assembly, *No. 128. An act relating to health care financing and universal access to health care in the state of Vermont.*

¹⁴ William C. Hsiao, Steven Kappel, and Jonathan Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont* (2011), ix. Accessed April 20, 2021.

¹⁵ Hsiao, Kappel, and Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, ix.

¹⁶ Hsiao, Kappel, and Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, 34.

¹⁷ Hsiao, Kappel, and Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, 34.

¹⁸ Hsiao, Kappel, and Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, 127.

¹⁹ Hsiao, Kappel, and Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, xiii.

²⁰ Hsiao, Kappel, and Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, xix.

incentivize others to move to a place where they have access to healthcare coverage. However, the transition to a single-payer system would inevitably cause “certain private insurance functions...[to] become obsolete and leave the market in Vermont.”²¹

The researchers also recommended that Vermont transition towards a “capitation-based payment method”: a payment approach that provides “a fixed amount of money, usually on a monthly basis, for each individual for whom the provider assumes responsibility.”²² They recommend that these payment methods be managed by Accountable Care Organizations (ACOs), which are networks of providers that “[share] responsibility for managing the healthcare needs and costs of a defined population of patients.”²³ There is currently only one ACO in Vermont, OneCare. According to a 2021 press release from Vermont Attorney General TJ Donovan, OneCare is “charged with improving the health of Vermonters and lowering health care costs.”²⁴ In 2020, OneCare agreed to be “accountable for \$328 million in health care services” to Vermonters covered by Medicaid, and also agreed to “provide analytics and care coordination services.”²⁵ The organization has been accountable for over \$1 billion in “health care services provided to Vermonters through Medicaid” since 2017.²⁶

Act 48

Governor Peter Shumlin assumed office in 2011, committed to instituting a single-payer system in Vermont. Drawing from conclusions outlined in the Hsiao report, the Vermont legislature passed Act 48 in May 2011, which was signed into law by Governor Shumlin. The bill established the Green Mountain Care Board, which was tasked with transitioning the state away from a fee-for-service payment system. Additionally, the bill required that the Secretary of Administration outline a “detailed plan” for a single-payer healthcare system and established a Health Benefit Exchange to ensure that healthcare premiums would be “affordable for all Vermonters.”²⁷

The Green Mountain Care Board was intended to be fully functioning by 2017. However, by 2014, the Shumlin Administration found that the program would be costlier than originally expected, and its expenses could not be covered without a significant tax increase. Additionally,

²¹ Hsiao, Kappel, and Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, xix.

²² Hsiao, Kappel, and Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, 101.

²³ Hsiao, Kappel, and Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, 167.

²⁴ Vermont Attorney General, “Attorney General Donovan and State Auditor Hoffer Sue OneCare over Refusal to Release Records,” News release (February 3, 2021). Accessed 20 April 2021.

²⁵ Vermont Attorney General, “Attorney General Donovan and State Auditor Hoffer Sue OneCare over Refusal to Release Records.”

²⁶ Vermont Attorney General, “Attorney General Donovan and State Auditor Hoffer Sue OneCare over Refusal to Release Records.”

²⁷ Vermont General Assembly, *Brief Summary of Act 48: Vermont Health Reform Law of 2011* (2011), <https://hcr.vermont.gov/sites/hcr/files/pdfs/legislation/ACT-48-one-page.pdf>. Accessed April 27, 2021.

public support for single-payer healthcare in Vermont was low. A 2014 survey conducted by VTDigger and the Castleton Polling Institute revealed that only 40 percent of respondents supported “moving Vermont to a single-payer health care system,” while 39 percent of respondents opposed doing so.²⁸ In December 2014, Governor Shumlin announced that he would withdraw the single-payer healthcare proposal, citing economic concerns.²⁹

Single Payer Healthcare in Other States

Between 2010 and 2019 there have been 66 proposed bills for single payer healthcare models in 21 states.³⁰ Currently, Vermont is the only state that has passed a single payer healthcare bill, but no states have implemented any form of single-payer or universal healthcare.³¹ One of the major patterns that emerges in the states that have proposed single payer healthcare bills is that they have already expanded Medicaid under the ACA and have a relatively small population of uninsured resident's compared to other states in the US.³² One of the main barriers that has stopped any state from making real headway in implementing a single payer healthcare model is federal regulation around a state's capacity to regulate their healthcare laws. The major regulation that governs healthcare policy is the Employee Retirement Income Security Act (ERISA). ERISA was instituted in the 1970s by Congress to regulate pensions, but the impact has been much more far reaching and has made state reform to healthcare laws very challenging.³³ It is possible to get around ERISA, but in states such as Maryland, New York, and California, attempts to reform healthcare regulations have resulted in litigation over ERISA.³⁴

One state that made a major attempt at instituting a single payer healthcare system is Colorado. In 2016, a ballot initiative was put to voters on the creation of a program called ColoradoCare.³⁵ The program would have created an entirely new health insurance system that would have provided free health insurance to all Colorado residents without residents having to

²⁸ VTDigger, “VTDigger/Castleton Poll: 21 Percent Seem Confused by Term ‘Single Payer,’” VTDigger, published April 23, 2014, <https://vtdigger.org/2014/04/23/vtdiggercastleton-poll-21-percent-seem-confused-term-single-payer/>. Accessed April 28, 2021.

²⁹ Peter Hirschfield, “Shumlin: It’s ‘Not The Right Time’ For Single Payer”, Vermont Public Radio, published December 17, 2014, <https://www.vpr.org/post/shumlin-its-not-right-time-single-payer#stream/0>. Accessed April 28, 2021.

³⁰ Erin Fuse Brown, Elisabeth McCuskey, “Federalism, ERISA, and State Single-Payer Health Care,” *University of Pennsylvania Law Review*, 168, no. 389 (2019) 397, accessed May 10, 2021, <https://www.pennlawreview.com/wp-content/uploads/2020/04/168-U-Pa-L-Rev-389.pdf>.

³¹ Brown and McCuskey, “Federalism,” 398.

³² Brown and McCuskey, “Federalism,” 399.

³³ Brown and McCuskey, “Federalism,” 415.

³⁴ Brown and McCuskey, “Federalism,” 425.

³⁵ Dylan Matthews, “Single-payer health care failed miserably in Colorado last year. Here’s why,” Vox, published September 14, 2017, <https://www.vox.com/policy-and-politics/2017/9/14/16296132/colorado-single-payer-ballot-initiative-failure> Accessed May 10, 2021.

pay copayments or deductibles.³⁶ The program would have been funded by tax increases that would have increased employer payroll taxes by 15 percent. The initiative received only 21 percent support from voters.³⁷ Since the 2016 vote the state has shifted their focus to reforming the existing program and a new healthcare bill is moving to a committee hearing.³⁸ The new bill would give private insurance companies until 2025 to make significant reductions in costs to patients, if this cannot be achieved a state-run insurance program would be created.³⁹ The plan is still in the early stages and the legislature is attempting negotiations with the hospital association.⁴⁰

International Single Payer Healthcare Systems

Japan Healthcare System

Japan utilizes a statutory healthcare system (SHIS) which covers 98.3 percent of the population.⁴¹ In addition to the SHIS there are some supplementary and complementary private insurance options. In 2015, total health expenditures were eleven percent of Japan's GDP, eighty-four percent of which was publicly financed mainly through the SHIS.⁴²

The SHIS contains two types of mandatory insurance, employment-based plans which cover 59 percent of the population, and residence-based plans which cover 39.7 percent of the population.⁴³ Employment-based plans are affiliated with an individual's place of work, resulting in there being more than fourteen hundred such plans.⁴⁴ Residence-based insurance plans are run by Japan's regional governments, resulting in only forty-seven such plans throughout the country.⁴⁵ Within residence-based plans, there are Citizen Health Insurance plans for unemployed individuals 74 years old and younger, accounting for the insurance of twenty-seven percent of the population.⁴⁶ There are also Health Insurance for the Elderly plans which cover all adults age 75 and older, accounting for the insurance of 12.7 percent of the population.⁴⁷ All SHIS plans provide the same benefits which are determined by the national government. These services include hospital visits, primary and specialty care, mental health

³⁶ Matthews, "Single-Payer Healthcare."

³⁷ Matthews, "Single-Payer Healthcare."

³⁸ Andrew Kenney, "Colorado's Public Health Care Option Moves Ahead After Hospital Negotiations Break Down," Chicago Public Radio, published April 8, 2021, <https://www.cpr.org/2021/04/08/colorados-public-health-care-option-moves-ahead-after-hospital-negotiations-break-down/> Accessed May 20, 2021.

³⁹ Kenney, "Colorado's Public Healthcare Option."

⁴⁰ Kenney, "Colorado's Public Healthcare Option."

⁴¹ Roosa Tikkanen, Robin Osborn, Elias Mossialos, Ana Djordjevik, and George A. Wharton, "International Health Care System Profiles: Japan," *The Commonwealth Fund*, June 5, 2020, <https://www.commonwealthfund.org/international-health-policy-center/countries/japan>.

⁴² Tikkanen et al., "Japan."

⁴³ Tikkanen et al., "Japan."

⁴⁴ Tikkanen et al., "Japan."

⁴⁵ Tikkanen et al., "Japan."

⁴⁶ Tikkanen et al., "Japan."

⁴⁷ Tikkanen et al., "Japan."

care, approved prescription drugs, home care services provided by mental institutions, hospice care, physical therapy, and most dental care.⁴⁸

The SHIS has significant measures in place to keep out-of-pocket costs low for individuals. All enrollees have to pay thirty percent coinsurance for all health services along with small copayments for primary care and specialty visits, and preventative screenings.⁴⁹ There are also maximums for monthly out-of-pocket payments, determined by age and income. Subsidies are also available for low-income households for people with ongoing medical conditions, disabilities, and mental illnesses.⁵⁰ The SHIS has maximums on household health and long-term care out-of-pocket determined by age and income, ranging from USD 3,400 to USD 21,200 per enrollee.⁵¹

Private insurance provides a supplementary role to that of public insurance, however more than seventy percent of the population has some form of secondary health insurance.⁵² This is largely to serve as additional income in cases of sickness. Despite this, the number of supplementary private insurance policies held nationally has increased from 23.8 million in 2010 to 36.8 million in 2017.⁵³

German Health Care System

Germany requires all citizens to have health insurance. Germany had the first social health care system starting in 1883. The current German healthcare system combines state and federal government as well as private companies.⁵⁴ The federal government is responsible for regulating the health care system but is not directly involved in providing care.⁵⁵ Citizens have the choice between the publicly funded health insurance and private health insurance that is heavily regulated by the state. Most Germans get healthcare through the government and the money is paid out through the sickness fund which is funded through taxes and wage contributions from employees and employers.⁵⁶

In Germany, more than 10 percent of the GDP is spent on healthcare (250 billion euros). Germany requires citizens with an income under a certain level to get public health insurance

⁴⁸ Tikkanen et al., "Japan."

⁴⁹ Tikkanen et al., "Japan."

⁵⁰ Tikkanen et al., "Japan."

⁵¹ Tikkanen et al., "Japan."

⁵² Tikkanen et al., "Japan."

⁵³ Tikkanen et al., "Japan."

⁵⁴ Mirian Blumel, Reinhard Busse, "International Healthcare System Profiles, Germany" *The Commonwealth Fund*, June 5, 2020, accessed May 3, 2021, <https://www.commonwealthfund.org/international-health-policy-center/countries/germany>.

⁵⁵ Blumel and Busse, "International Healthcare System Profiles."

⁵⁶ Blumel and Busse, "International Healthcare System Profiles."

but those with higher salaries have the option to opt into a private health care plan.⁵⁷ Within the public healthcare system there are a variety of separate funds that serve specific populations. Currently, there are more than 170 of these funds that focus on the needs of groups such as the elderly or those with chronic illness.⁵⁸

The German health care system is overseen by the Federal Ministry of Health.⁵⁹ They are responsible for creating laws around healthcare and insurance. They also oversee smaller government institutions that deal with more specific sectors of the healthcare system.⁶⁰ There is also a Federal Joint Committee that is made up of a variety of medical professionals, insurance companies, hospital administrators, and citizens. This group is responsible for deciding the coverage offered to citizens through the statutory insurance, which is the insurance provided to all citizens.⁶¹ This group makes decisions regarding specific services offered and allows for citizens to appeal decision made on healthcare coverage.⁶²

Taiwan Health Care System

In 1995 Taiwan implemented a single-payer national health insurance (NHI) program that provides universal coverage to all citizens and legal residents.⁶³ The program is overseen by the National Health Insurance Administration with most services being administered by private providers. In 2017 national health expenditures were 6.4 percent of Taiwan's GDP, with NHI expenditures making up 3.4 percent of their GDP.⁶⁴ Services covered by the NHI include inpatient and outpatient care, prescription medication, dental care, traditional medicine, maternity care, child delivery, home care, chronic mental health care, preventative care, and renal dialysis.⁶⁵

Taiwan's NHI is funded largely by payroll-based premiums, with some exceptions of government subsidies for low-income households, civil servants, and others. The amount of an individual's payroll-based premium is based on their Population Category, which is determined by their job and socioeconomic status.⁶⁶ Out-of-pocket costs for individuals include copayments

⁵⁷ Josef Dullings, "Overview of the German Healthcare System," *ICU Management and Practice*, 12, no. 1, (2010), accessed May 10, 2021, <https://healthmanagement.org/c/icu/issuearticle/overview-of-the-german-healthcare-system>.

⁵⁸ Dullings, "Overview of the German Healthcare System."

⁵⁹ Andrea Doring and Friedmann Paul, "The German Healthcare System," *European Association for Predictive, Preventative, and Personalized Medicine Journal*, 1, no. 4 (December 18, 2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405354/>.

⁶⁰ Doring and Paul, "The German Healthcare System."

⁶¹ Doring and Paul, "The German Healthcare System."

⁶² Doring and Paul, "The German Healthcare System."

⁶³ Roosa Tikkanen, Robin Osborn, Elias Mossialos, Ana Djordjevik, and George A. Wharton, "International Health Care System Profiles: Taiwan," *The Commonwealth Fund*, June 5, 2020, <https://www.commonwealthfund.org/international-health-policy-center/countries/taiwan>.

⁶⁴ Tikkanen et al., "Taiwan."

⁶⁵ Tikkanen et al., "Taiwan."

⁶⁶ Tikkanen et al., "Taiwan."

for care, prescription medication, and coinsurance for hospital stays.⁶⁷ There are exemptions from copayments in cases such as childbirth, specific catastrophic diseases and conditions, veterans and their families, low-income households, and children under three years of age.⁶⁸ However, even in cases where individuals are required to pay copayments, those who fail to pay are still guaranteed full access to healthcare.⁶⁹

Conclusion

Due to rising healthcare costs, Vermont attempted to reform its healthcare system and transition towards a single-payer system over the past decade. However, the plan outlined by the Legislature's Act 128 in 2010 and Act 48 in 2011 ultimately failed, due to unexpected financial costs of the specified single payer system. After the single payer system was abandoned by Governor Peter Shumlin in 2014, a 2018 survey revealed that nearly 20,000 Vermonters remained uninsured, mainly due to unaffordable private health insurance premiums. While the single-payer effort has lost traction within the State of Vermont, one other state, Colorado, attempted to institute a single-payer system that was ultimately rejected by the voters on the ballot. Currently no state has a single-payer healthcare system in place. Single-payer systems, however, have been formed in Japan, Germany, and Taiwan. These nations each have their own unique financing plans for such a system, but they provide examples that Vermont's state legislature could look to if interest in the state's single-payer healthcare system is renewed.

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Contact: Professor Anthony "Jack" Gierzynski, 534 Old Mill, The University of Vermont, Burlington, VT 05405, phone 802-656-7973, email agierzyn@uvm.edu.

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⁶⁷ Tikkanen et al., "Taiwan."

⁶⁸ Tikkanen et al., "Taiwan."

⁶⁹ Tikkanen et al., "Taiwan."