State Model: Vermont

Health Care Reform In Vermont: A Work In Progress

by Howard M. Leichter

In the spring of 1992 a coalition of Vermont health care providers, business groups, and bipartisan political leaders joined forces to fashion the Vermont Health Care Act of 1992 (Act 160). Fully implemented, the law will assure all Vermonters access to a uniform package of health care services, control the costs of health care through a statewide global budget, reduce unfairness in health insurance through community rating, reform medical malpractice laws, and place health care under one state authority.

The Vermont experience challenges the conventional wisdom concerning coalition building in the process of health care reform. For example, Vermont physicians accepted greater state involvement in some areas, such as practice parameters and global budg eting, in exchange for the promise of reducing the burdens placed on them by lengthy and costly malpractice litigation, micromanagement by government agencies, and the blizzard of papenvork required by insurance companies and government.

In addition, many Vermont physicians, hospital administrators, business groups, and others see an essentially market-based system, with elements of managed care or managed competition, as far preferable to either the current system or a Canadian-style single-payer system. Fear of this more "radical" alternative can create the strangest, most reluctant of bedfellows.

Finally, postponing certain difficult choices may be the political price lawmakers have to pay to begin and sustain the reform process. In the case of Vermont, the state still must decide such fundamental issues as: What level of healthcare will each Vermonter receive? How will universal access be paid for? Should the state adopt a market-based multiple-payer system, a Canadian-style single-payer system, or something else? Postponing these decisions has given reform a chance to survive and flourish.

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Vermont Health Care Act

The Vermont Health Care Act of 1992 begins with the premise that all Vermonters should have "access to quality health services at costs which are affordable." To accomplish this, the state is attempting to improve the quality of health care, reduce costs and administrative fragmentation in the system, encourage local and regional participation in health policy decisions, and promote a more rational allocation of health care resources in the state. As stipulated in the law, this involves a process of incremental reform that began in 1992 and should culminate in 1994 with the implementation of universal access.

Beginning in 1992 the plan was to develop an insurance purchasing pool for employees of the state, the University of Vermont, Vermont State Colleges, municipalities and school districts, as well as some Medicaid recipients. (Others may join the pool later upon approval of the General Assembly after October 1993. As of May 1993 this provision had not yet been implemented, and state officials were of the opinion that the provision may need amending.) A second 1992 activity expanded the state's

"Dr. Dynasaur" program to cover low- and moderate-income children up to age eighteen and pregnant women who do not qualify for Medicaid. (Prior to reform the program covered children from birth to age six.) Under the new law, a family of four earning less than $30,150 a year is eligible for free medical care for their children. All copayments have been eliminated.

Also in 1992, the Vermont Health Care Authority (VHCA) was created, which has begun work on a comprehensive health care database covering expenditures, utilization, and services. Finally, the commissioner of banking, insurance, and securities in 1992 established a health insurance safety net for (1) individuals in the nongroup or small-group market who lose coverage because their insurer withdraws from the Vermont market or fails to register by 1 July 1993 as a nongroup carrier; and (2) individuals in the group market who lose their jobs and are not covered by another group plan.

Beginning in 1993, the state insurance commissioner, in consultation with the VHCA, developed mandatory uniform health insurance claims forms and standard procedures for processing claims to help reduce health care costs. Insurers have submitted cost management plans to the VHCA. The VHCA board adopted a Health Resource Management Plan that evaluates health resources in the state and sets goals and priorities for their distribution. In July 1993 the VHCA board will adopt a nonbinding health care expenditure target.

Community rating for nongroup insurance policies will go into effect in July 1993. This will affect about 35,000 Vermonters who purchase insurance policies on their own rather than through employers. Carriers are prohibited from using such risk classification criteria as age, gender, geographic setting, prior medical condition, and type of job. By November 1993 the VHCA board must submit detailed proposals to the General Assembly for two universal access plans: a single-payer system and a market-based, regulated multipayer system.

In 1994 the University of vermont Medical School will submit a proposal to the legislature and the VHCA to expand training ofprimary care physicians and to encourage rural practice. The General Assembly will meet in January 1994 and will consider the board's proposals. Lawmakers are not bound to adopt either or any plan.

If the legislature adopts a plan for universal access, then medical malpractice reform will begin. Reform will involve submitting malpractice claims to a three-member arbitration panel, whose purpose is to accelerate the processing of malpractice claims and thereby to reduce cost and anxiety for all parties involved. Arbitration decisions can be appealed to the Vermont Superior Court.

Finally, regardless of whether a universal access plan is adopted, the VHCA, after public hearings and negotiations with provider bargaining groups and insurers, will establish annual unified health care budgets, or global budgets, that set total spending levels for health care, functioning as the main vehicle for controlling health care costs in Vermont. At a minimum, spending caps will be applied to hospitals.

Vermont Health Care Authority. The administrative centerpiece of the law is the VHCA, which began its work in August 1992. The VHCA acts under the direction of a three-member administratively powerful board appointed by the governor and confirmed by the Senate. (The current board consists of a former state representative, a former state commissioner of social welfare, and a University of Vermont economics professor.) The board's responsibilities are far-reaching and include program design (typically requiring legislative approval), data collection, advisory work with other agencies involved in implementing reform, and working with existing public organizations to encourage local and regional health plans and primary health care systems and to negotiate with provider groups. The board represents one of the nation's most highly centralized and potentially powerful health care agencies.

The Road To Health Care Reform

By the time Vermonters embarked upon their ambitious reform in 1992, state law-

makers, health care providers, and other key players could draw upon over a decade of shared history with state involvement in health care regulation. The antecedents of the Vermont Health Care Act can be traced at least as far back as 1979, when the state enacted a certificate-of-need (CON) law, requiring hospitals and other health care institutions to apply to the Health Department for review and approval of new capital expenditures and the introduction of new health services. In 1987 this responsibility was moved to an independent, quasi-judicial CON board, and in 1990 the process was expanded to review some physicians' office services. It is indicative of the generally positive relationship that has existed between the state and health care providers that CON receives high praise in Vermont, unlike in other states.

This relationship was taken a step further in 1983 with the creation of a Hospital Data Council. The five-tnember council was responsible for conducting annual budget reviews of Vermont's eighteen nonprofit hospitals and for making cost control recommendations. In addition, it collected and analyzed financial and utilization data provided by the hospitals. Although a recent study found that "[t]he Council's [budget] recommendations can be, and often are, ignored," it has provided policymakers with a good database on the cost and use ofhospital care in the state.[1]

The state's first actual foray into dealing with its uninsured population came in 1987 with the creation of the Vermont Health Insurance Plan (VHIP) board, an administrative ancestor of the VHCA. The VHIP board was charged with studying ways to extend health coverage to the uninsured. The following year the board recommended a play-or-pay option for Vermont businesses and a state subsidy to finance a basic package of health services for the state's 32,000 uninsured people. However, neither the Vermont General Assembly nor Democratic Governor Madeline Kunin was willing to support a significant increase in state spending on health care at that time.

The 1988 legislature, however, did extend access to one portion of that uninsured population, namely, children up to age seven and pregnant women whose family incomes were above the Medicaid eligibility level but below 225 percent of poverty. This became the Prenatal and Children's Health Program (or Dr. Dynasaur), a highly successful and popular state effort.

In addition to this experiential base on which to build health reform, the legislature was receiving clear signals from several key organizations and individuals that it was time for major overhaul of the state's health care system. This included detailed reform proposals from the Vermont State Medical Society, the Vermont Hospital Association, the Vermont Employers Health Alliance, the Chamber of Commerce, and the Vermont Consumers Campaign for Health.[2] The most influential of these, however, was a report by the Vermont Blue-Ribbon Commission on Health (or the Gibb Commission), which had been appointed by then Republican Governor Richard Snelling in March 1991 "to explore and design a comprehensive group of proposals" that would, among other things, ensure "access to adequate health care for all Vermonters."[3] The report, submitted to the governor in December 1991, contained an ambitious list of recommendations, including guaranteeing all Vermonters access to "a common set of comprehensive health care benefits," reform of the state's medical malpractice laws, state encouragement of managed care and health promotion to help control health costs, and improvetnents in rural health care. The commission recommended the creation of a Vermont health care authority, with the responsibility to ensure universal access and contain health care costs.

However, the most important proximate precursor to Act 160, substantively and symbolically, was approval during the 1991 session of Act 52, which required insurance companies to use community rating and guaranteed acceptance in writing policies for the small-group health insurance market. The importance of this law, which had the support of the Republican governor and was written by a House committee with a Republican chairperson, cannot be overstated. Legislators realized that they could take on

one of the most powerful health-related lobbies-the insurance industry-and win. The effort was additionally important because it brought together some of the key players who would reassemble for the 1992 reform act.

One player who would be missing from that assemblage was Governor Snelling, who died unexpectedly in August 1991. He was succeeded in office by the Democratic lieutenant governor, Howard Dean, an internist who continued to practice medicine until he became governor. It is important to underscore the impact Howard Dean's becoming governor had on the reform effort. When Governor Dean speaks, the views of Dr. Dean are never entirely obscured. Dean, for example, shares the distaste of his colleagues for federal micromanagement of medical practices, especially through the much-hated Medicare program. "My biggest fear has been . . . that the federal government would impose Medicare for everybody, and that would be national health care," Dean said. "And, in that case I think you would see the end of decent health care in this country. I didn't want to see that in Vermont."[4] Dean brought a unique level of knowledge and a physician's perspective to the reform process. He also brought something else to the battle for reform: an ability to assuage the concerns of the provider community. He was similar in this regard to Oregon's John Kitzhaher.

The gospel of the single-payer plan. If the emergence of Howard Dean as governor was comforting to the medical community, the appearance of another political actor proved much less so. In 1991 state Senator Cheryl Rivers, a progressive (left-leaning) Democrat, introduced a bill (S. 127) that would establish universal access to a comprehensive package of health care benefits administered through a single-payer insurance system. Rivers allied herself with a like-minded Senate colleague, Democrat Sally Conrad, who was chair of the Senate Health and Welfare Committee. The two legislators held hearings around the state in the summer of 1991, soliciting opinions, gaining much press coverage, and promoting the cause of a single-payer system.

In this effort, Rivers and Conrad were joined by two Vermont political heavyweights. The first was the state branch of the National Educational Association (NEA). Vermont-NEA, with nearly 8,000 members, is one of the most effective lobbying organizations in the state, and it aggressively supported Rivers's bill. The second was Vermont's maverick, and politically astute, U.S. Rep. Bernie Sanders. Sanders, the former Socialist mayor of Burlington, has close ties to both Rivers and Vermont-NEA and used his considerable political organization and skills on behalf of the single-payer idea, appearing with Rivers at meetings and rallies in support of S. 127.

The Vermont Health Care Act: The Legislative Process

Coalition building. Two things were clear on the eve of the 1992 Vermont legislative session: There was broad and deep support for health care reform, and the option with the most visibility, although not necessarily political support, was S. 127. A single-payer system was unacceptable to many in government and to key portions of the business and provider communities. During the spring and summer of 1991 the single-payer advocates had done an extraordinary job stimulating and cultivating popular support for their plan-and raising the anxiety of several key players in the game, including the Vermont State Medical Society, the Vermont Hospital Association, the Vermont Employers Health Alliance, local members of the Health Insurance Association of America, and key state political leaders from both parties. Some who opposed S. 127 did so on ideological grounds; mainly, it involved too much government intervention. Others, like Howard Dean and Jeanne Keller, president of the Vermont Employers Health Alliance, felt that the bill was a fiscal and policy leap in the dark.

The Vermont State Medical Society, while sharing these concerns, had another concern that was in some respects more important than any particular facet of the single-payer plan. In both its original (1991)

and revised (January 1992) form, S. 127 specifically excluded health care providers from participation in the proposed health care authority. The medical society and its member physicians found this to be both troubling and offensive. They wanted to be at the negotiating table, actively influencing the process on such issues as a proposed global health care budget, practice parameters, malpractice reform, and simplification of insurance claims. As one official of the society explained it, the deliberate and pointed exclusion of providers under S. 127 was interpreted as a message to physicians that "[y]ou will not participate in this. You are the bad guys. You are the ones to be regulated. We will set your reimbursement, and if you don't like it, that's just too bad."[5]

For a variety of reasons, then, S. 127 became the magnet that attracted a coalition that, according to Governor Dean, was "different from any other state's coalition."[6] As one player explained to me, "It was fairly easy in some ways for us to build the necessary coalition if we could find something to bind it together. There needed to be a common goal, and the common goal really was [defeat of] S. 127."[7]

In December 1991 the Democratic House Speaker, Ralph Wright, announced that he would introduce health care reform in the upcoming session. A month earlier, Wright and Dean had agreed to join forces in this effort. Since the state had a $57.2 million deficit, both the speaker and the governor agreed that such reform would have to be gradual and not require a significant investment of new money. The Republican leadership found enough common ground between the proposals in the Blue-Ribbon Commission report-which had been created by a Republican governor and chaired by a former Republican state senator-to support Wright's bill, H. 733.

As originally introduced, H. 733 provided for the establishment of a three-member health care authority that would, among other things: (1) design a health care database; (2) adopt annual health care expenditure targets; (3) establish a statewide health care resource management plan; (4) conduct hospital budget reviews; (5) administer the certificate-of-need program; (6) design a comtnon benefits program that would constitute a minimum standard for health insurance plans offered in Vermont and "serve as the administrator and single negotiator with hospitals and providers for common benefits provided through the plan;" and (7) design and implement a unified system of purchasing medical supplies and equipment.

H. 733 contained two other significant proposals. The first built upon the insurance reform of the previous legislature and proposed expanding community rating to the nongroup insurance market. To some, including the governor, this provision would offer the most important immediate benefit of the act; it would also prove to be one of the most contentious issues. Nongroup community rating would make affordable health insurance more accessible to some Vermonters (such as older people and those with preexisting medical conditions) but more costly to many others (younger, healthier people).

A second issue that would prove difficult was malpractice reform, which was a matter of considerable importance to two powerful lobbies–physicians and attorneys. The legislative finding introducing the tort reform section reflected the main concerns of both physicians and plaintiffs; the system is slow, costly, inaccessible to many, and seemingly unconnected to quality assurance in medical practice.

Finally, the bill addressed the extreme adtninistrativc fragmentation of the state's current health care system by bringing various existing state agencies under the jurisdiction of the new health authority.

Legislative politics. The legislative odyssey of H. 733 took over three months (January through April 1992) and involved an unusually high level of personal effort by the governor and his staff, as well as the legislative leadership. Despite this support, the bill's voyage through the legislature was anything but smooth.

Problems began in the House of Representatives, where H. 733 was initially assigned to the Health and Welfare Committee. A jurisdictional and personal problem emerged between the Health and Welfare

and Commerce Committees. The Commerce Committee chair was Republican Paul Harrington, a highly regarded legislator with considerable experience in insurance reform (his committee had crafted Act 52 the previous year). Harrington believed that H. 733 was poorly drafted and wanted his committee to have a more active role in revising the bill than would be the case if Health and Welfare retained dominant jurisdiction. An agreement was worked out whereby the Health and Welfare Committee would release the bill to Commerce, where it would receive full scrutiny. The bill was redrafted with the approval of the key legislative leaders and the governor.

With a redraft in its possession and greater autonomy over the bill's content, the Cotnmerce Committee-much to the annoyance of its colleagues on Health and Welfare-proceeded to address all aspects of the bill. The result was several weeks of sometimes strained exchanges between the two committees (actually, three additional committees–Judiciary, Appropriations, and Government Operations–looked at the bill as well), as each held public hearings and brought different perspectives to the task.

The strain between the two committees was in part about protecting legislative turf and in part about substantive disagreements. The policy differences ranged from the trivial, such as the salaries and length of terms of the health authority members, to the more consequential. For example, the Health and Welfare Committee favored limiting participation in the insurance purchasing pool to health benefit plans funded in whole or in part by state funds, while Commerce proposed beginning the pool with public employees but eventually extending it to private individuals and groups. Furthermore, Commerce wanted to require community rating in the pool, while Health and Welfare did not.[8]

Meanwhile, lurking in the shadows was the single-payer lobby. Fortunately, a solution to what might well have been an ugly battle between the two forces presented itself just five weeks into the legislative session. At Harrington's suggestion, Speaker Wright offered Senators Conrad and Rivers a deal: Abandon S. 127, allow H. 733 through Senate Health and Welfare, and do not insist upon specifying a funding mechanism for any reform bill (Rivers's bill proposed a payroll tax). In return, Wright would offer certain concessions, including (1) a requirement in the law that the health care authority report back to the legislature with two universal health plans-a single-payer plan and a regulated multipayer plan-and accelerate this report from 1995, as proposed by the governor, to 1994; and (2) postponement of medical malpractice reform until universal access to health care was achieved. Single-payer advocates believed that the proper emphasis of reform was consumers, not physicians; hence, providers should receive no benefits from reform before consumers did. Rivers and Conrad agreed to the terms of the compromise.

The compromise was the source of endless speculation and comment. The two most frequently asked questions were, Why did Rivers and Conrad abandon their plan so quickly, and why did Speaker Wright make concessions to the two senators? In answer to the first question, all of the players, including Senators Conrad and Rivers and Speaker Wright, agreed that S. 127 did not have enough votes to get out of the Senate Health and Welfare Committee, much less through the General Assembly. Although there may have been strong popular support for a single-payer system, there was relatively little legislative enthusiasm for it. What support there was-and a January 1992 survey by the Burlington Free Press found that only about one-third of the leg islators favored a single-payer system–eroded in January with the release of a study by the legislative joint fiscal office showing that Rivers's financing plan would fall far short of the revenue needed to pay for her program.9 The credibility of the Rivers plan, at least among her colleagues, was severely damaged.

What, then, was Wright's motivation? If single payer could not pass, why bother making concessions? There are a number of possible explanations, all of which relate to the dynamics of coalition building and mainte-

nance. First, although there was little support for S. 127 inside the statehouse, there was considerable support "in the streets," and some legislators were being asked, "How come you're not supporting single payer!""

A second explanation lies in Speaker Wright's politics. A political pragmatist, he knew in general what he wanted in health care reform: universal access, a comprehensive benefit package, and a plan that was fiscally realistic. Beyond that, he was neither committed nor opposed to any particular vision of health reform, although he believed that a multipayer system is politically more practical.

A third explanation for Wright's intervention is that he was helping a governor of his own party. The dance of legislation that was taking place involved a number of partners. Governor Dean and his staff were working closely with the legislature to build a consensus around H. 733. From their perspective, Rivers and Conrad continued to pose a threat to the reform, since they showed no signs of abandoning their single-payer crusade. The compromise would allow the reform to go forward, while postponing the larger battle over the actual financing system.

With the deal, a major impediment to passage of H. 733 was removed-or so it seemed. Although the single-payer plan was dead, at least for this session, Conrad and Rivers were still very much alive. Their main concession was to concede the political battlefield to H. 733; they did not abandon their right to try to change that bill once it got to the Senate.

On 21 February 1992, about six weeks after H. 733 was first introduced in committee, the House Health and Welfare Committee unanimously voted to recommend the bill to the full House. The major provisions of the committee bill, which for the most part were adopted by the full House, included creation of a health care authority; development of two plans for universal access to health care; mechanisms for cost control, including hospital budget reviews, a health care management plan, global budgeting, utilization review procedures, and uniform health insurance forms and claims procedures; a health insurance purchasing pool; community rating of the nongroup market; and medical malpractice reform. The House approved the measure a week later by a vote of 119-17.

H. 733 now entered the much less friendly arena of the Vermont Senate, where the progressives enjoyed greater strength and where the bill would be taken up by Conrad's Health and Welfare Committee. Depending on whom you listen to, the five-member committee either "eviscerated" the bill or "improved" it." The critical moment in the process came when the Senate Health and Welfare Committee voted (3-2) to strip H. 733 of the insurance purchasing pool, community rating, and medical malpractice reform. The result was explosive. As Rivers described it, "Once we took those sections out of the bill, all hell broke loose."[12] Jeanne Keller, president of the Vermont Employers Health Alliance, said of Conrad and Rivers, "It seems that if they can't get universal access right now and under their terms, they'll kill any effort to improve the lot of Vermonters, even temporarily."[13]

Conrad and Rivers had several objections to H. 733. First, it did not immediately address the needs of the state's 60,000 or so uninsured persons. Second, they were concerned that community rating would drive insurers from the state, leaving thousands of Vermonters without coverage or alternative carriers. This concern was a bit more than theoretical, since insurance companies were threatening precisely that. Third, insurers warned that many Vermonters faced "rate shock" when community rating went into effect. This would happen to younger and healthier Vermonters who would subsidize the decreased premiums that older, sicker folks would be paying under community rating and guaranteed acceptance. Fourth, Conrad and Rivers argued that the insurance pool, while negotiating favorable rates for its members (such as state employees), would cause rate increases for nonpool subscribers as insurance companies made up for lost revenues from the pool. The result, they argued, would be that some would be forced to drop their policies and join the ranks of the uninsured.

A compromise ultimately was worked out by the governor's staff. It included the following: (1) An insurance "safety net" was created to protect individuals whose insurance companies left the Vermont market. This service would be provided by a nonprofit hospital and medical service corporation. (2) To avoid "rate shock," the commissioner of banking, insurance, and securities would set maximum annual premium percentage rate increases. Under no circumstances could the commissioner approve a rate increase greater than 20 percent in any year. In addition, the insurance commissioner was granted the authority to deny a rate increase for any nongroup insurance policy in which the insurer paid out less than 70 percent of the premiums in claims in the previous year.[14] (3) The Vermont Health Care Purchasing Pool Trust Fund was established under the secretary of administration. The secretary was authorized to withdraw funds from the pool to subsidize the purchase of health care services for uninsured Vermonters on an income-based, sliding fee scale. (4) Health care benefits under the Dr. Dynasaur program for non-Medicaid-eligible children and pregnant women would be extended to age eighteen from the current limit of age six. In addition, current copayments in the program would be eliminated. (5) The state would allocate $350,000 to the University of Vermont College of Medicine to fund six additional family practice residency positions. (6) Malpractice reform remained unresolved. Each side agreed to take its case to the full Senate.

Despite the agreement, the bill was by no means home free; it still had to be considered by both the Senate Finance and Judiciary Committees. A slightly modified version of the bill narrowly passed the Finance Committee-with committee members expressing concerns about the safety net and the seemingly hostile nature of the bill to commercial insurers-and was sent back to the Health and Welfare Committee.

The next apparent catastrophe in the saga of H. 733 occurred in the Senate Judiciary Committee, where the state's Bar and Trial Lawyers Associations successfully lobbied to prohibit admission of the malpractice arbitration board's findings in a jury trial. The lawyers argued that jurors should not be exposed to any nonjudicial decisions that might influence their judgment. At this point the Vermont State Medical Society threatened to withdraw its support if the committee's decision was not reversed. Nevertheless, the Judiciary Committee approved the change and sent it on to the full Senate. The Dean administration and Speaker Wright were clearly troubled by this turn of events and by the possible defection of the medical society.

The bill's next test came in the full Senate. Insurance companies, which had unsuccessfully fought to remove the community rating provision, marshaled their forces for one last assault. The insurance industry, however, had few friends in the Senate, and that body easily defeated an effort to remove community rating. Next, the senators overrode their Judiciary Committee colleagues and voted to admit an arbitration panel's decision as evidence in a jury trial. On 13 April 1992 the Senate passed H. 733 by a vote of 23-4.

It remained now for House and Senate conferees to iron out the nearly thirty (mostly minor) differences between the two versions of the bill. Of these, only a few were significant. The first dealt with the insurance purchasing pool. The House version prohibited private employee groups or individuals from joining the pool; the Senate favored opening the pool. The real issue here, explained by the state's banking and insurance commissioner, Jeffrey Johnson, was fear that the pool would become "the Trojan horse of health care reform. And, frankly, that's not a completely wrong thought. The pool, if it's big enough, can ultimately become a very large player in deciding how health care is administered in the State of Vermont; particularly in a state of 500,000 people if it ends up with 100,000 risks."[15] The Senate conferees prevailed in the end, although the legislature must approve the admission of private groups or individuals to the pool. (As of this writing, the status of the purchasing pool is still very much undecided.)

A second issue involved the definition of

single- and multipayer systems. The House wanted to leave the definitions open, allowing the health care authority maximum flexibility. The Senate, on the other hand, wanted detailed definitions to prevent any bias the authority might have toward a particular plan. In the Senate version, which was ultimately adopted, the single-payer system was modeled after the Canadian system and the multipayer plan after the German program.

Finally, the two houses differed over two provisions that would address specific health delivery problems. The first was expansion of the Dr. Dynasaur program. The House conferees were concerned about the financial effect of expanding the program (at a cost of $750,000) when the state was running a huge deficit, although they ultimately accepted the expansion. Second, the House opposed the Senate-inspired provision requiring the University of Vermont Medical School to add six family practice residencies. The House conferees argued that this interfered with the professional judgment of the institution; their view prevailed. The conference report went back to each house, where it was approved overwhelmingly.

The role of interest groups. To supporters of a single-payer system, such as Vermont-NEA, the critical juncture in this saga was the Wright-Rivers-Conrad summit in February. From that point on, although they continued to monitor the process, their efforts were not nearly as enthusiastic as they were before. For example, no one from Vermont-NEA, which had invested heavily in S. 127, formally testified before any legislative committee on H. 733, although the organization enthusiastically endorsed some of its provisions (for example, expansion of the Dr. Dynasaur program).

By way of contrast, the Vermont State Medical Society left no doubt where it stood on the two measures: "We have major concerns with S. 127, whereas our concerns and questions regarding H. 733 may be resolvable."[16] The society's lobbyists appeared at least once and often several times before each legislative committee. As noted earlier, Vermont physicians were, in the first instance, concerned that they not be cast as the heavies and excluded from the process of reform-precisely the role they felt was allocated to them under S. 127. The society wanted physician participation in the various councils, panels, and boards envisioned in H. 733. In this way they could help to influence rules governing practice parameters, compensation rates and contracts, the health care budget, and a benefit package. In the end, despite considerable anxiety and uncertainty about what the future might hold, the society declared itself "very happy with the final bill."[17]

The Vermont Hospital Association, too, supported the general direction of H. 733 but had specific objections to the bill as it underwent its various transformations in committee. Much like their colleagues in the medical society, the hospital association was particularly concerned that cost containment not occur largely on their shoulders in the form of unreasonable hospital budget caps.

Yet another group that declared itself "extremely pleased with the shape of the final bill" was the Vermont Employers Health Alliance.[18] Throughout the process the alliance had insisted that for reform to work it had to involve an integrated delivery and financing system, one that would help rein in health care costs. The business community supported adoption of a unified health care budget, global budgeting, a health resource management plan, and a database to help guide the authority in a rational allocation of capital and human resources and the development of common insurance claims forms and procedures-all potentially cost-saving features.

With few exceptions (notably, Blue Cross/Blue Shield), health insurance companies saw the legislation, but especially the nongroup community rating provision, as yet another assault on their profitability and autonomy. No group played a more visible role and garnered more enmity than the insurers. The industry strategy was to emphasize the harm that community rating would cause many, especially younger, Vermonters, by dramatically increasing their premiums. By one estimate, persons ages twenty-four to twenty-five could expect to

see their quarterly premiums increase 233 percent, from $102.77 to $414.10, forcing thousands of Vermonters into the ranks of the uninsured.[19] It would also, they believed, force many insurers out of Vermont.[20]

The law addressed many of the constituent and legislative concerns over community rating and guaranteed acceptance. Not only did it provide a safety net in the event that some insurers left Vermont, but it also limited annual premium rate increases to no more than 20 percent. Furthermore, to qualify for a rate increase, insurers had to have loss ratios of at least 70 percent.

Where Vermont Is Now

Where, then, does Vermont stand in its pursuit of health care reform? With the exception of the formation of an insurance purchasing pool, the VHCA is on schedule for accomplishing all of the tasks outlined above. Two critical chores currently occupy the authority: preparing the two financing models and defining a basic benefit package.

In April 1993 the authority issued a "Working Document" that reflected current thinking on these all-important issues. According to the VHCA, the goals of the reform process are to improve access to care, quality of care, and the health status of Vermonters, while assuring provider choice and containing costs.[21] The authority believes that these goals can best be achieved through "integrated systems of care" (ISC), which it defines as "a network of providers, facilities, and administrators which has been established under a single management structure for the explicit purpose of providing a range of health care services for Vermonters." Each health care provider would join such an ISC, and each Vermonter would receive health care services from an ISC of his or her choice. Although the draft document does not address the issue, presumably this system could be established within the context of either a single- or a multiple-payer framework.

The other critical task of the authority is to propose to the legislature a "Vermont Uniform Benefit Plan" that would constitute the guaranteed package of health services for all Vermonters. This task promises to be challenging for two reasons. First, as Oregonians can attest, defining a basic benefit package is a political minefield. Second, the richness of that package will define the state's cost and test the resolve and resources of state officials. Clearly, a poor package would undermine the fundamental goals of the law, while a rich package might bankrupt the state.

Whatever the fate of these two issues, state officials are convinced that their reform is already or soon will be a significant accomplishment. The state will have expanded state-funded health care to include all poor and moderate-income children from birth through age seventeen and will have developed a global health care budget and a health resources management plan, uniform health insurance claims forms, community rating throughout its insurance market, and a rationalized public health bureaucracy.

Lessons From Vermont

There is a temptation to suggest that Vermont is unique-a point Vermonters make repeatedly-so that few other states can replicate the successful coalition building there. The state is indeed small (560,000 people), and the "friends and neighbors" approach evident throughout the reform debate would have been impossible in many larger states. Add to this the fact that the state has a completely nonprofit hospital system, a physician governor, and a medical community that has long been supportive of state intervention in health care, and the case for uniqueness appears strong.

Nevertheless, some lessons here transcend this special case. First, the author's experiences in Oregon and Minnesota confirm the effectiveness of the "It Could Be a Lot Worse" strategy of coalition building. Fear of a Canadian-style single-payer system can bring even the most reluctant player to the table. In fact, "the Canadian system" has replaced "socialized medicine" as the great attention-getting device in the health reform debate.

Second, Vermont physicians have something important to say to their colleagues in other parts of the country: More government involvement in the health care system may mean less involvement in their practices, or at least a less onerous involvement. The litany of complaints by Vermont physicians will be familiar to any physician in this country: They are being driven to distraction by federal micromanagement of their practices; the burden of paperwork from insurance companies, government, and private billings is intolerable; and they are haunted by the specter of malpractice litigation. Any state-sponsored reform that promises relief from these burdens may well be embraced with enthusiasm by the provider community, especially if providers are allowed to be active participants in both the formulation and implementation of policy.

Physicians, hospitals, insurance companies, and political leaders of both parties no longer question the need for or likelihood of reforming the nation's health system. The discussion now focuses on how to achieve reform in such a way that will maximize its prospects for success. About this, Vermont has a good deal to say to the nation.

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NOTES

1. "Health Care Planning and Regulation in Vermont" (Report by the Legislative Council and Joint Fiscal Office, January 1992), 19.
2. Among the various formal statements on the subject were the Vermont State Medical Society's *A Call for Health Care Reform; the Vermont Hospital* Association's *A Yardstick to Measure Health Care Reform;* and the Vermont Employers Health Alliance's Elements of *Health System Reform: An Employer Perspective.* Each of these documents included an endorsement of universal access to health care.
3. *Final Report of The Vermont Blue-Ribbon Commission on Health* (January 1992), 2.
4. Author's interview with Governor Howard Dean, 21 July 1992.
5. Author's interview with Nancy Eldridgc, director of governmental relations, Vctmont State Medical Society, 23 July 1992.
6. Author's interview with Governor Dean.
7. Author's interview with Norman Wright, director, Vermont Hospital Association, 21 July 1992.
8. For a provision-by-provision comparison of the committee drafts, see "Memorandum from Herbert W. Olson, Legislative Counsel, to Members of the House Commerce Commiccee" (25 February 1992).
9. *Burlington Free Press,* 5 January 1992, 1.
10. Author's interview with Rep. Hamilton Davis, 24 July 1992.
11. B. Pfeiffer. "House-Senate Split on Health Care Widens," *Rutland Herald* 23 March 1992, 5.
12. Author's interview with Sen. Cheryl Rivers, 22 July 1992.
13. Pfciffer, "House-Senate Split on Health Care Widens."
14. A major source of antagonism toward insurance companies in Vermont was thar on average the ten largest insurance companies doing business there were spending only fifty-two cents on medical claims for every dollar they collected; one company paid only thirty-six cents per dollar. By way of contrast, Blue Cross and Blue Shield paid between eighty-five and ninety cents for every dollar collected. See *Burlington Free Press,* 6 April 1992, 1.
15. Author's interview with Jeffrey Johnson, Vermont Banking and Insurance Commissioner, 24 July 1992.
16. Vermont State Medical Society, *Legislative Bulletin* 1 (24 January 1992).
17. Author's interview with Eldridge.
18. Vermont Employers Health Alliance, "Health System Reform" (29 April 1992), 1.
19. Testimony of Suzanne Katt, Golden Rule Insurance Company, before the House Commerce Committee, 24 January 1992.
20. Testimony of Mark Litow, actuary, Milliman and Robertson, before the House Commerce Committee, 24 January 1992.
21. Vermont Health Care Authority, "Introduction to Integrated Systems of Care," Working Document Draft 2 (16 April 1993).