States as Policy Laboratories: The Politics of State-Based Single-Payer Proposals

Although the focus for most single-payer advocates is in Washington, DC, and on proposals for Medicare for all, there are also efforts in a handful of states to enact a state-based single-payer program. Moreover, the odds of legislative passage are better in a state like New York than at the federal level.

Even if enacted, however, state-based single-payer proposals face a distinct set of obstacles, including (1) the need to obtain federal permission (via waivers) to repurpose federal dollars, (2) the federal Employee Retirement Income and Security Act, and (3) the burden of state-only action in an interconnected 50-state economy.

The most likely result of the energized single-payer movement will be incremental public insurance expansions at the federal and state levels, including state programs to permit the uninsured to buy into the Medicaid program. Such an outcome is consistent with the most plausible path (incrementalism) to a US version of universal coverage. (*Am J Public Health*. 2019;109:1511–1514. doi:10.2105/AJPH.2019.305294)

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See also Donnelly et al., p. 1482.

Despite the gains generated by the Affordable Care Act (ACA), more than 30 million Americans remain uninsured, and millions more delay or defer needed medical care because of high deductibles and other out-of-pocket costs. This ongoing policy challenge prompts an increasing cadre of progressive Democrats to call for a comprehensive overhaul of the nation's health care system, dramatically reducing (or perhaps completely eliminating) the multipayer private insurance health insurance industry and replacing it with comprehensive publicly funded coverage for all, referred to generally as a "single-payer" insurance model.[1] Although the focus for most single-payer advocates is Washington, DC, where the rhetorical movement for Medicare for all animates the presidential campaigns of numerous Democratic candidates, there are also efforts in a handful of states to enact a state-based single-payer program that could become a model for federal policymakers.[2]

The political obstacles to the single-payer movement are obvious.[3] First, the interest group opposition is fierce, wealthy, and influential. Opponents include private insurers worried about being forced into bankruptcy, providers worried about lower reimbursement, employers worried about higher taxes and lost control over employee benefits, unions worried about losing dollars generated by their health benefit programs, and of course a variety of conservative and Republican advocacy groups. Interest group support for single payer is far weaker, more fragmented, and less wealthy.

Single-payer proposals also raise concerns about the appropriate role of government and the division of labor between the public and private sectors. These concerns are especially powerful here in the United States, where an antigovernment ethos resonates strongly with much of the population and where the view that government is less competent than the private sector is deeply engrained. This context makes any effort to dramatically raise taxes to fund a single-payer system even more difficult, even when economists point to administrative efficiencies, long-term system savings, and the elimination of insurance premiums.

The odds of overcoming these obstacles are better at the state level than in Washington, DC.

Although single-payer proposals at the national level have only recently received their first congressional committee hearing, there are several states in which single-payer proposals have received serious consideration. Vermont, for example, enacted legislation in 2011 that put them on the path to single payer (although that effort was eventually dropped in 2014). Colorado voters considered (but defeated) a single-payer referendum in 2016, as did voters in Oregon in 2002. More recently, the California state senate passed a single-payer bill in 2017 that garnered the support (at least during the campaign) of that state's newly elected governor, Gavin Newsom. And in New York, single-payer supporters saw a window of opportunity after the November 2018 election results in which the Democrats took control of the state senate, following several years in which a Republican senate had blocked an assembly passed single-payer bill.

There may indeed be a small window of opportunity for policymakers in a couple of states to enact legislation that would put their state on a path to a single-payer system—it is not likely, but it is possible. Even if enacted, however, state-based single-payer proposals face a distinct set of obstacles on the path to implementation. These barriers include (1) the need to obtain federal permission (via waivers) to repurpose the vast amounts of

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This article was accepted July 15, 2019.

doi: 10.2105/AJPH.2019.305294

federal dollars that now underpin the nation's health system; (2) the federal Employee Retirement Income and Security Act (ERISA), which significantly limits state jurisdiction over the employers' role in health insurance; and (3) the burden of state-only action in an interconnected 50-state economy.

Perhaps ironically, the most likely result of an energized single-payer movement is a series of incremental public insurance expansions at both the federal and state levels. Instead of Medicare for all, Congress may enact Medicare for more. Instead of the New York Health Act, New York may permit the uninsured to buy into the state's Medicaid program. Such an outcome would be consistent with the most plausible path to an American version of universal coverage, one that emerges step by step through incremental expansions that build on the current system, as opposed to proposals to fundamentally change the way the system works. More on this later. First, however, I review the limits on state efforts to enact their own version of a single-payer program.

THE NEED FOR FEDERAL WAIVERS

The federal government is the largest single funder of health care services, and state-based single-payer proposals seek to use federal dollars as a core fiscal component of the new state program. To do so, however, requires federal permission to redirect funds from Medicare, Medicaid, the ACA, the Federal Employees Health Benefit Program, the Veteran's Health Administration, and perhaps other federal programs as well. Federal officials in the Trump administration have already made clear that they will oppose any such waiver requests.[4] Even assuming an eventual friendly Democratic administration, the details of such waiver requests would be complicated and controversial.

For more than 50 years, for example, Medicare has served as a single national program, with federal rules governing eligibility, benefits, and provider reimbursement. There are, of course, some exceptions to the uniformity requirements, including the all-payer hospital reimbursement program, which allows Maryland (and previously a few other states) to set the allowable hospital charges for all payers, including Medicare. Similarly, Medicare Advantage plans have some flexibility to add benefits and set reimbursement rates. These exceptions pale, however, in comparison with a proposal that the program (and all its dollars) be turned over to state officials, an idea that will raise concerns not only among federal policymakers but among politically influential Medicare beneficiaries and advocates on their behalf as well. (The effort to redirect Veteran's Health Administration funds to a state will likely also generate fierce resistance from an even more potent political group, the nation's military veterans!)

State officials have a somewhat easier path to redirecting Medicaid and ACA funds. Medicaid, for example, already delegates broad authority to determine eligibility, benefits, and reimbursement rates to the states, and there is a long history of granting waivers from the federal rules designed to limit such state discretion. Moreover, conservatives have long proposed that federal officials give states a fixed amount of federal Medicaid funding, and the block grant concept is very close to what state-based single-payer advocates seek. The ACA also contains explicit authority (in section 1332 of the law) for state-based experimentation along the lines proposed by single-payer advocates. Here again, however, despite its rhetorical support for state experimentation, the Trump administration is unlikely to be receptive to comprehensive Medicaid or ACA waivers designed to create a path to a single-payer system. Nor would the waiver process be simple and straightforward even in a Democratic administration.

The single-payer proposal now under consideration in New York (the New York Health Act) contains a backup plan in case the state is unable to obtain the desired federal waivers, under which the state would provide supplemental wraparound coverage for Medicaid and Medicare beneficiaries. In other words, those programs would continue as is, but the state would ensure that those beneficiaries also receive the additional benefits covered by the new single-payer program. Such a system would be quite administratively complex, undermining one of the guiding principles of the reform. At the same time, the cost of such supplemental coverage would be significant, thereby making it even more difficult to generate political support for the initiative.

EMPLOYEE RETIREMENT INCOME AND SECURITY ACT

ERISA, enacted by Congress in 1974, is concerned primarily with employer pension programs (requiring that such programs be adequately capitalized, avoid inequitable vesting requirements, and provide clear disclosure about terms and conditions). But ERISA also has two provisions likely to generate court challenges to state-based single-payer programs. First, the law prohibits states from regulating, taxing or otherwise interfering with companies that have self-insured health plans in which the firm itself holds the financial risk of employee medical costs.[5] More than 60% of the 173 million Americans with group coverage receive coverage through one of these self-insured ERISA plans. State legislation that imposed a significant payroll tax to fund a single-payer plan would almost certainly be challenged in court as unlawful under ERISA. Second, ERISA also prevents states from enacting a so-called employer mandate, or a requirement that firms provide health coverage (or pay for such coverage) for their employees. Here again, any state legislation that imposed a significant payroll tax to fund a single-payer plan would likely be challenged as an unlawful employer mandate, a claim that could have special resonance with small businesses that currently are exempt from the federal employer mandate contained in the ACA.

Richard Gottfried, the legislative sponsor of the single-payer proposal in New York, dismisses the ERISA challenge as unlikely to succeed, noting that (1) the state has clear authority to impose payroll taxes; (2) the proposed law does not require any firm to provide coverage but, in fact, does just the opposite, relieving firms of any such obligation; and (3) firms could still maintain their employer-based coverage, although it would be irrational for them to do so because they also would be contributing to the cost of the single-payer program.[6] There is no clear precedent

suggesting how the courts would rule in the inevitable ERISA challenge to a state-based single-payer initiative. It is quite likely, however, that the litigation would drag on for years, complicating at a minimum any effort to implement such a program.

AN INTERCONNECTED 50-STATE ECONOMY

The implementation of a state-based single-payer program is complicated by the nation's interconnected 50-state economy. States need to decide, for example, whether the new program will cover nonresidents (and, if not, how businesses can provide coverage to that population). Former Vermont governor Peter Shumlin, the guiding force behind that state's single-payer proposal, decided to include the out-of-state commuters, but that decision both raised the overall cost and added to the potential implementation challenge.[7] There also are a host of potential unintended consequences that are hard to predict or plan for. Will businesses and high-income individuals exit the state to avoid paying the new taxes needed to finance the system? Will physicians and other health care providers exit the state to maintain income generated from commercial insurers? Will severely ill individuals move to the state to receive comprehensive coverage, and, if so, what would be the fiscal result of such a "health care magnet" effect? What will be the impact on large companies that operate in multiple states?

It is plausible that these concerns are overstated. For example, despite the longstanding differences in state-based health and welfare programs, there is little evidence of a significant health care magnet effect. Nor is there evidence of a major exodus of high-income individuals following the imposition of new state income taxes or of a large-scale physician exit because of cuts in reimbursement. This is especially true in New York City and other destinations of choice among the nation's most wealthy individuals. Nevertheless, in its analysis of the proposed New York Health Act, the RAND Corporation projected that if roughly 50 000 high-income taxpayers changed their domicile, the state would lose more than $30 billion in revenue, or more than 20% of the estimated $139 billion needed to fund the first year of the new single-payer program.[8]

The fiscal (and political) capacity of a single state to generate sufficient tax revenue to finance a single-payer system is also questionable. For example, when Vermont's Governor Shumlin pulled the plug on that state's single-payer initiative, he cited the "economic shock" of having to impose dramatic tax increases (11.5% on employers and 9.5% on individuals) that would increase the state's budget by almost 50%.[7] New York assemblyman Richard Gottfried argues that the progressive tax scheme contained in the New York Health Act enables the state to more easily withstand the economic shock of the massive tax, but the potential exit of at least some of the state's wealthiest citizens would undermine that assumption.

Finally, single-payer advocates can also face unexpected resistance from presumed political allies based on the idiosyncratic provisions in state constitutions. For example, both Planned Parenthood and NARAL Pro-Choice America opposed the 2016 single-payer referendum in Colorado because the state's constitution banned public funding for abortions, and reproductive rights advocates feared the initiative would eliminate access to abortions for women now covered by private health plans. The referendum's supporters challenged that assumption, arguing that the new law would lead to the repeal of the constitutional ban. But the uncertainty about this issue undoubtedly contributed to the overwhelming rejection of the proposal.[9]

ADVANTAGES OF INCREMENTALISM

Those who propose Medicare for all and who tout the economic and moral virtues of a single payer argue persuasively that such an approach would dramatically reduce the inequities and disparities deeply rooted in the nation's complicated, fragmented, and decentralized system. Medicare is a national program with uniform rules; it is viewed by most Americans as an "earned right," and although it now has a relatively limited benefit package, Senator Bernie Sanders and other advocates promise vastly expanded coverage. But the notion that the United States (or any of its political subdivisions) is going to replace (nearly overnight) the longstanding system of employer-sponsored coverage runs contrary to both US history and US politics. The interest group opposition is too strong, the cultural concerns about government are too deep, and the opportunities for opponents to stymie the policy process are too plentiful. Moreover, state officials who hope to create the policy laboratory that enacts and implements a single-payer program must overcome additional obstacles, including ERISA, the need for federal waivers, and the complications generated by an interconnected 50-state economy.

In this context, the most likely reform scenarios are incremental rather than comprehensive. One idea generating significant momentum is to expand Medicare enrollment (either by lowering the eligibility age or by permitting additional populations to buy into the program). But Medicare for more is politically plausible only if the Democrats control both the White House and Congress, a scenario that cannot happen before 2021. States, however, can act more quickly, aiding their remaining uninsured (and underinsured) and providing a model for national reform (much as the 2006 coverage expansions in Massachusetts provided a model for the ACA). Washington state, for example, recently passed the nation's first so-called public option, Cascade Care, under which buyers on the state's insurance exchange will soon be able to purchase a lower-cost plan in which premiums (and deductibles) are kept low because of state-mandated caps on provider reimbursement. The private carrier that operates this plan will need to meet a host of additional requirements not imposed on the other plans in the insurance market.[10]

Similarly, several states are currently considering different versions of a Medicaid buy-in, which could lead to a policy menu for future reformers. Such buy-in programs could differ on

1. whether to offer the buy-in product on or off the ACA insurance exchange,
2. the benefit package,

3. out-of-pocket costs,
4. provider reimbursement, and
5. how to finance the initiative.[11]

Under the proposal now under consideration in New Mexico, for example, the state would establish a buy-in plan available to all those not otherwise eligible for public or private coverage, with out-of-pocket costs based on household income and benefits delivered by plans currently operating in the state's Medicaid managed care market.[12]

The argument for relying on Medicaid as a path to universal coverage is strengthened as well by the program's 30-year history of incremental expansion, under both Democratic and Republican administrations. Medicaid now has more than 70 million enrollees, its cost is shared by the federal government and the states, and its political resilience was an important factor in the failure of the Republicans to repeal and replace the ACA. The program has surprisingly strong interest group support, it is administered by the states (thus shielding it from claims that it is a big government monolith), and it provides an insurance safety net for public health crises (from AIDS to the Flint, MI, water crisis). Finally, Medicaid buy-in strategies are not precluded by ERISA, can proceed without federal waivers (although such waivers could help), and can proceed without raising concerns about nonresidents or neighboring states.

At the same time, Medicaid politics also shows the potential risk of relying on states to provide a path to universal coverage. After all, there are still more than a dozen "red" states that have not adopted the ACA Medicaid expansion. There is increased pressure in many red states to expand coverage, as illustrated by the recent voter referendums in Idaho, Nebraska, and Utah requiring state officials to expand Medicaid.[13] But the political pressure in these states to expand coverage competes with equally strong (if not stronger) pressure to cut back, suggesting that universal coverage in the United States will not happen without federal legislation. The question, however, is whether the best path to universal coverage is through a single-payer path or through incremental expansions of current programs.

There is no doubt that many progressive Democrats will continue to advocate the more ambitious single-payer approach, and in some states there clearly are going to be windows of opportunity for legislative success. But single payer even in the most liberal of states is still a political long shot. In New York, for example, Richard Gottfried and his colleagues could not round up the votes to pass the New York Health Act in the most recent legislative session, even with the current Democratic control of both the state legislative and executive branches. And legislative enactment even if achieved would lead to further battles over waivers, ERISA, and nonresidents.

The argument here is that the single-payer debate at both the national and state levels will ultimately generate consensus on a more incremental proposal, one that looks much more like a Medicare or Medicaid expansion or buy-in. Such an outcome would be consistent with long-standing trends in US health policy. It also would be a welcome step on the path toward a US version of affordable universal coverage. AJPH

CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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