thread the political, administrative, financial, and legal needles necessary to pass a single-payer plan in the coming years.

B. *How State Single-Payer Plans Capture Employer Health Expenditures*

The billion-dollar question, both in terms of dollars at stake and legal hurdles from ERISA, is how the state single-payer plan addresses employer-sponsored health coverage.[50] In the U.S., forty-nine percent of the population is covered by employer-sponsored coverage, which amounts to twenty percent of our total national health care expenditures.[51] Once the single-payer system starts covering this population, it must capture the vast employer and employee expenditures that pay for such coverage.[52] State legislation faces a big obstacle in achieving this critical task: ERISA preempts state law that "relates to" employer-sponsored benefits, as detailed in Part II below. Additionally, the population covered by employer-sponsored health benefits tends to be healthier than those covered by public programs, which is critical to balancing the risk pool for the single-payer plan.[53] Of those with employer-based coverage, more than sixty percent are covered by self-funded plans (also called self-insured plans), where the employer pays for the health benefits with its own funds, retaining financial or insurance risk.[54] As discussed in Part

50 The other critical question is whether the federal Department of Health and Human Services (HHS) will grant states waivers to capture federal Medicaid (1115 waiver), Medicare (demonstration waivers), and ACA (1332 waiver) funds for the states' single-payer plans. These statutory waivers lie beyond the scope of this Article, but other scholars have provided analysis. *See, e.g.*, Wiley, *supra* note 8.

51 *Health Insurance Coverage*, *supra* note 9; CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2017 HIGHLIGHTS 2, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf [https://perma.cc/SX4S-6BQM] (last visited Nov. 20, 2019).

52 In addition to these direct expenditures, the federal government further subsidizes employer spending on health benefits by not taxing such expenditure as wages. *See generally Employee Benefits*, U.S. INTERNAL REVENUE SERVICE (Nov. 2, 2018), https://www.irs.gov/businesses/small-businesses-self-employed/employee-benefits [https://perma.cc/UC5E-BZJJ]. Although policy debates on the tax treatment of employee health benefits is beyond the scope of this Article, the larger point is that capturing what the system currently spends on employer health expenditures is critical for the financial viability of any single-payer plan.

53 Brief of Harvard Law School Center for Health Law & Policy Innovation, et al. as Amicus Curiae in Support of Petitioner at 19-20, Gobeille v. Liberty Mutual Ins. Co., 136 S. Ct. 936 (2016) (No. 14-181), 2015 WL 5261549, at *19-20; Victor R. Fuchs, *How to Make US Health Care More Equitable and Less Costly: Begin By Replacing Employment-Based Insurance*, 320 JAMA 2071, 2071 (2018).

54 GARY CLAXTON ET AL., HENRY J. KAISER FAM. FOUND., 2018 EMPLOYER HEALTH BENEFITS SURVEY 167 (2018), https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/167 [https://perma.cc/YN5Q-5KVJ]; *see also* CIGNA HEALTH & LIFE INS. CO., ADVANTAGES AND MYTHS OF SELF-FUNDING FOR EMPLOYERS WITH FEWER THAN 250 EMPLOYEES 2 (2014), http://www.cigna.com/assets/docs/business/small-employers/841956_b_self_funding_whitepaper_v8.pdf [https://perma.cc/YSW7-LNPJ] ("Traditional self-funding is defined as when an employer pays for their own medical claims directly, while a third-party administrator

II, ERISA's "deemer" clause has placed self-funded plans entirely beyond the reach of state regulation.[55]

To assess the distorting effect of ERISA preemption on states' health reform efforts, this project focuses on analyzing how states can capture employers' expenditures and transition the forty-nine percent of the population covered by employer-sponsored health plans into the state single-payer program.[56] We reviewed the sixty-six single-payer bills to identify their methods of capturing employer expenditures, as discussed below.[57] Eight of the sixty-six proposals purported to establish a single-payer program for the state, but did not contain an explicit mechanism to capture employer expenditures or move those with employer coverage into the single–payer program, for example by creating a state-based "Medicare-for-All" program, enrolling everyone in the state in an expanded version of Medicare.[58] Thus, we focused our analysis on the remaining fifty-eight state single-payer proposals for their methods of capturing employer expenditures and moving those covered by employee health plans into the single-payer program.

Due to ERISA preemption, discussed in Part II, states cannot simply mandate that employers adopt the single-payer plan as their employee health plan. However, states must capture employers' expenditures and shift those covered by employer-based health plans into the single-payer system, or else its single-payer plan is not truly a single-payer plan, and the economics will not work.

Unable to mandate that self-funded employers drop their benefit plans and participate in the single-payer plan under ERISA, state single-payer proposals mix and match the following tools to capture employer expenditures: (A) imposing a payroll tax on employers, an income tax on individuals, or both to fund the single-payer plan; (B) requiring or creating incentives for all provider payments to be made through the single payer entity at single-payer rates; and (C) subrogation, assignment, or secondary-payer provisions allowing the single-payer entity to pay for services and seek reimbursement from employer plans or other collateral sources.

In addition, most proposals contain nonduplication provisions prohibiting insurers from offering health benefits that duplicate those covered by the

administers the health plan by processing the claims, issuing ID cards, handling customer questions and performing other tasks.").

55 *See infra* Section II.A.

56 *Health Insurance Coverage*, *supra* note 9.

57 *See infra* Section I.B.

58 *See, e.g.*, S. 2598, 218th Leg., Reg. Sess. (N.J. 2018) (purporting to provide all New Jersey residents with federal Medicare coverage).

single-payer plan.[59] The idea behind nonduplication is that if insurers cannot sell plans that cover any of the services or benefits covered by the single-payer plan, then there are no competing private plans to choose from. Insurers may only sell so-called wraparound services that supplement the single-payer coverage. On its face, a nonduplication provision appears to do much of the work of shifting those with employer-based coverage to the single-payer plan, because employers would not have any health plan options to offer their employees in the single-payer state. However, as discussed in Part II, ERISA preemption likely would make the nonduplication provisions unenforceable against self-funded employer-based health plans.[60] Thus, state single-payer proposals must use other provisions to draw the self-funded employers' expenditures and their enrollees into the single-payer plan.

Appendix A contains a list of the single-payer bills proposed between 2010 and 2019 and their mechanisms to capture employer-sponsored health spending. Appendix B details our methodology for collecting and analyzing these state single-payer bills.

1. Type A—Funding Plan

The Type A—Funding Plan model captures employer expenditures and participation through a payroll tax, an individual income tax, or both. Payroll taxes are levied on employers and are calculated as a percentage of the wages that an employer pays its employees.[61] The fact that the payroll tax is based on wages and not the employer's spending on employee health benefits is significant for the ERISA preemption analysis below.[62] As tallied in Table 2, forty-five bills across sixteen states contain a Type-A funding plan.[63] State proposals may impose a flat[64] or graduated payroll tax rate,[65] which also may

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59 *See, e.g.*, H. 2352, 87th Gen. Assemb., Reg. Sess. § 7(3) (Iowa 2017) ("An insurer, carrier, or health maintenance organization that is issued a certificate of authority by the commissioner of insurance may offer only the following: . . . Benefits that do not duplicate the health care services covered by the healthy Iowa program.").

60 *See infra* subsection II.B.4.

61 *Cf.* John A. Brittain, *The Incidence of Social Security Payroll Taxes*, 61 AM. ECON. REV. 110, 110 (1971) (noting that while payroll taxes may be imposed on the employer, some economists believe that they are typically paid by the employee in the form of reduced wages).

62 *See infra* subsection II.B.1.

63 *See infra* Table 2.

64 *See, e.g.*, S. 1014, 2017–2018 Gen. Assemb., Reg. Sess. § 904(a) (Pa. 2018) ("[A] tax of 10% is imposed on payroll amounts generated as a result of an employer conducting business activity within this Commonwealth."). Vermont's plan would have imposed a flat 11.5% payroll tax as well as a graduated income tax. *See* STATE OF VERMONT, GREEN MOUNTAIN CARE: A COMPREHENSIVE MODEL FOR BUILDING VERMONT'S UNIVERSAL HEALTH CARE SYSTEM 5 (2014), http://hcr.vermont.gov/sites/hcr/files/pdfs/GMC%20FINAL%20REPORT%20123014.pdf [https://perma.cc/4QTX-AR2C].

65 *See* A. 4738-A, 2017 Leg., Reg. Sess. § 4(2)(a) (N.Y. 2018); LIU ET AL., *supra* note 49, at 2.

apply to self-employed income.[66] Some states divide the payroll tax among employers and employees, with the employer paying a larger proportion of the tax, similar to the current division of premiums for employer-based coverage.[67] Other states would impose an income tax on employees to capture the employee share of spending on health coverage.[68] Income taxes may apply to unearned income to capture non-wage earnings, such as interest, capital gains, or dividends,[69] and can be progressively scaled to income levels. Sales and excise taxes are possible, but potentially more regressive than taxes scaled to individual income.

A payroll tax would lead many employers to drop their own coverage if they must pay the tax regardless of whether they offer their own employer-based plan.[70] The individual share of a payroll tax or an income tax is a way to replicate the employee's contribution to health care premiums and capture unearned income and income of state residents who are employed by out-of-state employers. If employees are required to pay a tax to fund the state single-payer program, many will elect to drop their employer-based plans so as to avoid double-paying for redundant coverage.[71]

The simplest form of Type A plan would rely solely on a payroll tax and/or income tax to capture employer expenditures and move enrollees to drop their employer coverage. These "Funding Only" proposals capture employers' health care expenditures directly via a payroll tax and assume that few employers would continue to offer their own coverage for employees subject

66 *See* S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018).

67 *See id.*; LIU ET AL., *supra* note 49, at 14. The New York Health Act (NYHA) would divide the payroll tax, such that employers pay 80 percent, and employees pays 20 percent.

68 *See* STATE OF VERMONT, *supra* note 64, at 5 ("[T]he highest-income Vermonters would pay 9.5 percent of income through a public premium, up to a maximum of $27,500, while lower-income Vermonters would pay based on a sliding scale tied to a lower percentage of income ranging from 0 up to 9.5 percent.").

69 *See* S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§ 23-95-12(j)) ("There shall be a progressive contribution based on unearned income, i.e., capital gains, dividends, interest, profits, and rents. Initially, the unearned income RICHIP contributions shall be equal to ten percent (10%) of such unearned income."); *see also* LIU ET AL., *supra* note 49, at 2 ("Individuals would not pay premiums for [the New York Health program, or] NYH. Instead, the program would be financed by new graduated state taxes on payroll and nonpayroll income (such as interest, dividends, and capital gains) and redirected federal funding through waivers and state funding for current health care programs.").

70 *See* LIU ET AL., *supra* note 49, at 2, 50 (explaining that "[w]hile the NYHA does not prohibit employers from offering health insurance, it does include a mandatory employer payroll tax contribution to help fund NYH," and noting the assumption that the payroll tax will replace employer spending on employer-sponsored insurance, with overall employer spending on health care unchanged).

71 As discussed in Part II, a funding plan based on a payroll tax should avoid preemption by ERISA, but it is far from certain whether courts will agree. Income taxes generally would not implicate ERISA. *See infra* subsection II.A.2.

to the payroll tax assessment, and even if they do, few employees will continue to take up employer coverage once they are covered by the state single-payer plan. An example of a Funding Only model is Washington's 2017 single-payer bill, which would fund its single-payer plan using a payroll tax for employers, with no exceptions.[72] Most of the state single-payer bills that contain a funding plan combine the financing mechanism with other tools, discussed below, to entice individuals into the single-payer plan and capture employer health expenditures.

The Type A—Funding Plan can be analogized to public school financing. All households must pay property taxes to fund public schools that all children are eligible to attend.[73] If certain households wish to pay for private school, they are free to do so, but it does not excuse them from their property tax. The public school analogy also reveals a nuance of the Funding Plan approach: unless the quality or choice of providers is the same or superior in the single-payer plan, there may be employers and employees who continue to maintain their employer-based plans, even when subject to the taxes to fund the single-payer plan.

2. Type B—Provider Restriction

A second variation, the Type B—Provider Restriction model, uses a form of provider regulation to draw individuals away from employer-based plans into the single-payer plan. Thirty-four of the single-payer bills across fourteen states contain a Type-B provider restriction.[74] Because provider regulation tends to fall beyond the reach of ERISA preemption,[75] state single-payer proposals use provider regulation to move individuals to drop their employer coverage. These provisions restrict participating providers from billing anyone other than the single-payer plan, whether the patient or any third-party payer, for services rendered to a patient with single-payer coverage. In addition, the provisions limit providers' payment rates to the single-payer rates. For example, California's S. 562 says that participating providers may not "charge any rate in excess of the payment established under this title for any health care service provided to a member under the program and *shall not solicit or accept payment from any member or third party for any health care service*, except as provided under a federal program."[76] The proposals may

72 S. 5747, 65th Leg., Reg. Sess. §§ 16-17 (Wash. 2017).

73 *See* STATE OF VERMONT, *supra* note 64, at 11 (explaining the analogous relationship between public school financing and the Vermont single-payer plan, Green Mountain Care).

74 *See infra* Table 2.

75 *See infra* Section II.A.

76 S. 562, 2017–2018 Leg., Reg. Sess. § 2 (Cal. 2017) (§ 100639(e)(2)) (emphasis added). The proposed statute further states that "[t]his section does not preclude the program from acting as a

automatically enroll all residents in the state single-payer plan, or they may deem all residents presumptively eligible, but require an affirmative step to enroll.[77] Under either model, most plans assume all residents would be covered by the single-payer plan.

The Provider Restriction model creates incentives for patients to drop their employer-based coverage because if providers want to participate in the single-payer plan, they are barred from billing employer-based plans and would thus cease participating in those plans. If providers are unable to be paid from any other source, they will no longer see patients who have other coverage. The limitation on providers' charges to the single-payer rate also reduces incentives to continue to participate in other plan networks, such as employer-based plans, because they will not be able to earn more from those payers than from the single payer. Thus, the provider networks for the employer plans would shrink considerably, perhaps to the point where employer-based coverage is all but worthless to employees. Employees will drop employer coverage if it lacks a functioning provider network.

In some instances, we characterized single-payer proposals as Type B models even when they lacked an explicit limit on providers' ability to be paid from non-single payer sources. For example, a plan could be characterized as containing a Provider Restriction where it contained strong incentives for providers to participate exclusively in the program short of a mandate to do so, such as requirements that providers participate on an all-or-nothing basis[78] or onerous notification requirements.[79] Another example is South Carolina's bill, which would allow providers to be reimbursed at a higher rate if they participate in the single-payer plan's network than if they do not.[80]

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primary or secondary payer in conjunction with another third-party payer when permitted by a federal program." *Id.* In other words, for programs like TRICARE and the federal employee health benefits programs, which do not provide waivers, presumably the provider would be permitted to bill these federal programs directly, and the state single payer could be the secondary payer.

77 *Compare* S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§ 23-95-5(a)(1)) (requiring the plan director to "identify [and] automatically enroll . . . qualified Rhode Island residents"), *and* H.R. 74, 147th Gen. Assemb., Reg. Sess. § 1611 (Del. 2013) (declaring "[a]ll Delaware citizens" entitled to benefits but establishing no enrollment procedure), *with* H.R. 1793, 165th Gen. Ct., 2d Sess. § 2 (N.H. 2018) (§ 404-J:4) (extending presumptive eligibility to "[a]ll individuals legally residing in New Hampshire" but requiring completion of an application for payment of benefits).

78 *See, e.g.*, H. 2436, 100th Leg., Reg. Sess. § 40(g) (Ill. 2017) ("Providers who accept payment from the Program for services rendered may not bill any patient for covered services. Providers may elect either to participate fully, or not at all, in the Program."); *see also* S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§§ 23-95-7(a)(2), 23-95-9(d)) (using nearly identical language).

79 *See, e.g.*, S. 1014, 2017–2018 Gen. Assemb., Reg. Sess. § 507(b) (Pa. 2018) (requiring a nonparticipating provider to notify patients of the provider's nonparticipation and to have the patient sign a form acknowledging he or she is solely responsible for amounts charged in excess of the approved single-payer rates, and imposing penalties of up to 200% of the amount billed to a patient for a provider's noncompliance).

80 S. 786, 121st Gen. Assemb., 1st Reg. Sess. § 2 (S.C. 2015) (§§ 44-18-920, 44-18-940).

Standing alone, the Provider Restriction model may move individuals into the single-payer plan and out of employer-based plans, but it does not capture employers' expenditures on health coverage. Thus, a provider restriction would almost certainly need to be paired with a payroll tax or other funding mechanism to capture employers' financial contributions. In effect, the provider restrictions in this model are designed to simulate the effects of a nonduplication provision through provider regulation: they limit the market for employer-based coverage by shrinking the provider networks for that coverage, but without triggering ERISA preemption.

3. Type C—Assignment, Subrogation, Secondary-Payer

A third variation, the Type C model, includes an explicit subrogation, assignment, or secondary-payer provision to facilitate the single-payer plan's ability to recover paid claims from collateral sources of coverage, including employer-based plans.[81] Twenty-five bills across nine states employ a Type-C subrogation, assignment or secondary-payer provision.[82]

Subrogation is the action, typically by an insurance carrier, to assert the rights of the insured to reimbursement or payment against a third party.[83] In the single-payer context, the single-payer plan could pay for the health care services of a member, and then assert a subrogation claim to recover those costs against a third party that is responsible for paying for the member's care, including collateral sources of health coverage. Oregon's most recent single-payer bill provides an example of a subrogation provision:

> (2) The Oregon Health Authority is subrogated to the rights of any participant that has a claim against an insurer, tortfeasor, *employer, third party administrator,* pension manager, public or private corporation, government entity or any other person that may be liable for the cost of health services provided to the participant and paid for by the Health Care for All Oregon Plan.
>
> (3) The authority may enter into an agreement with any person for the prepayment of claims anticipated to arise under subsection (2) of this section during a biennium. At the end of each biennium, the authority shall

81 Other collateral sources may include out-of-state coverage, government payers where a waiver is not secured, TRICARE, federal employee health benefit plans, tortfeasors, workers compensation plans, accident or auto insurance policies, or other plans that are not included in the single-payer plan.

82 *See infra* Table 2.

83 *Subrogation*, BLACK'S LAW DICTIONARY (10th ed. 2014) ("The principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.").

> appropriately charge or refund to the payer the difference between the amount prepaid and the amount due.[84]

An assignment of benefits is a legal agreement where the individual agrees to transfer the right to reimbursement for his or her health care services to another party, typically to a provider.[85] In the single-payer context, an assignment provision would transfer to the single-payer plan the individual's right to reimbursement from another third-party payer, such as a health plan.[86]

Similarly, secondary-payer provisions make the single-payer plan the secondary payer to any other coverage the patient may have, including employer-based coverage.[87] This means that the collateral source of coverage has the first obligation to pay for the patient's services, and the single-payer plan will only pay for services not otherwise covered by the primary payer. The secondary-payer provision may be paired with a subrogation provision that authorizes the state single-payer plan to recover amounts that it paid that were the responsibility of the primary payer.[88]

To illustrate the mechanics of these provisions, assume an employee gets an MRI and a bill for $800 for the service. Her employer's plan agrees to pay up to $1,000 for an MRI. Under a subrogation provision, the state single-payer plan would pay the provider's bill of $800, then charge the employer $800.[89] Under an assignment provision, similarly, the state single-payer plan

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84 S. 631, 78th Leg., Reg. Sess. § 15(2), (3) (Or. 2015) (emphasis added).

85 *See* 46A C.J.S. *Insurance* § 2001 (Dec. 2019 update) ("A form authorizing a [health care provider] to receive payment of a patient's insurance benefits is sufficient to effect an assignment of the patient's claim against the insurance company to the [health care provider].")

86 See, for example, the single-payer bill introduced in Rhode Island in 2018, which provides:

> Receipt of health care services under the plan shall be deemed an assignment by the [Rhode Island single payer plan] participant of any right to payment for services from a policy of insurance, a health benefit plan or other source. The other source of health care benefits shall pay to the fund all amounts it is obligated to pay to, or on behalf of, the [Rhode Island single payer plan] participant for covered health care services. The director may commence any action necessary to recover the amounts due.

S. 2237, 2018 Leg., Reg. Sess. § 3 (R.I. 2018) (§ 23-95-12(g)).

87 *See, e.g.*, H.R. 887, 128th Leg., 1st Reg. Sess. pt. A (Me. 2017) (§ 7506) (providing that "Healthy Maine serves as a secondary payor" and that the total of primary and secondary payments "may not exceed the amount that Healthy Maine would pay if it were the only payor").

88 *See id.* ("Healthy Maine may recover health care payments from any other collateral source, such as a health insurance plan, health benefit plan or other payor that is primary to Healthy Maine.").

89 For an example of a bill with a subrogation provision, see S. 810, 2011–2012 Leg., Reg. Sess. § 1 (Cal. 2011) (§ 140302(a)), which provides that

> [U]ntil such time as the role of all other payers for health care services has been terminated, costs for health care services shall be collected from collateral sources whenever health care services provided to an individual are, or may be, covered services under a policy of insurance, health care service plan, or other collateral source

would assume the employee's right to receive $800 from the employer plan and would pay the provider on the employee's behalf, then assess an $800 charge on the employer to pay back the state fund.[90] Under a secondary-payer provision, the employer plan must pay the $800 bill and the state single-payer plan is relieved of its obligation to pay.[91]

In proposals using a Type C—Assignment/Subrogation/Secondary-Payer model, if a patient has dual coverage in both the single-payer plan and another plan, such as employer-sponsored coverage, the single-payer plan is able to seek reimbursement from the other plan (the collateral source of coverage) for any services provided. In states where providers are permitted to bill collateral sources, the single-payer plan would just be responsible for patient cost-sharing and services not covered by the collateral source. Using the MRI example from above, the MRI provider could bill the patient's employer plan $800 for the MRI. If the patient had a $500 deductible under her employer plan, the patient would ordinarily owe $500 to the MRI provider. However, the state single-payer plan, which does not permit patient cost-sharing, would then function as supplemental coverage and pay the patient's $500 cost-sharing, and the employer would pay $300.[92] Thus, the assignment, subrogation, or secondary-payer provision saves the single-payer plan money by turning first to collateral sources of coverage,[93] which may reduce the amount of payroll or other taxes required to fund the single-payer program. It also contains an implied acknowledgement that employers may continue to offer coverage if they so choose. The circuitous inefficiency of these Type C pay-and-recoup provisions illustrate the contortions that ERISA forces states into. These provisions would be unnecessary if the state could simply mandate that employers offer coverage to employees through the state single-payer plan or cease

available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

90 *See, e.g.*, S. 2237, 2018 Leg., Reg. Sess. § 3 (authorizing the state single-payer plan's director to take "any action necessary" to recover these funds).

91 *See, e.g.*, H.R. 887, 128th Leg., 1st Reg. Sess. pt. A (Me. 2017) (providing that if the employer plan should have paid and did not, the state single-payer plan can pay and recoup the bill from the employer plan).

92 *See, e.g.*, S. 1014, 2017–2018 Gen. Assemb., Reg. Sess. §§ 503(c), 505, 506, 507 (Pa. 2018) (providing that the state plan is subrogated to and deemed an assignee of a participant's duplicate coverage, prohibiting providers from charging participants for cost-sharing, and not prohibiting providers from billing a participant's duplicate coverage).

93 *See, e.g.*, S. 1125, 91st Leg., Reg. Sess., § 3(3)(a) (Minn. 2019) (providing that "[t]he Minnesota Health Plan shall seek reimbursement from the collateral source for services provided to the individual . . . . Upon demand, the collateral source shall pay to the Minnesota Health Fund the sums it would have paid or expended on behalf of the individual for the health care services provided by the Minnesota Health Plan.").

providing employer-based coverage altogether because the possibility of dual coverage would be eliminated.

For administrative ease, however, providers may simply want to bill the single-payer plan for all services provided to dually covered patients, and the Assignment/Subrogation/Secondary-Payer provisions allow the single payer to pay the provider and then recover payment from the collateral source. This would allow the single-payer plan to recapture some of the employer expenditures: not what it spends on premiums, but the amount it pays in claims. The Assignment/Subrogation/Secondary-Payer model may be particularly useful to capture expenditures of out-of-state employers, who may not be subject to the state's payroll tax requirements.

Three states in our dataset—Ohio, Rhode Island, and Maine—had bills that combine Types B and C.[94] Ohio's single-payer bills contain provisions that require providers to seek payment only from the state single-payer plan, a provision subrogating the rights of the single-payer plan to all rights of a participant against a collateral source of payment, and a provision assigning from the participant to the single payer plan any rights to receive payment for services from any other source.[95] Combining Types B and C creates a mechanism to pull both employees and the employer expenditures into the single-payer plan: (1) participating providers are required to seek payment only from the single payer; (2) all services provided to state residents will be paid by the single payer at the established rates; and (3) if the patient is dually covered by an employer plan or other coverage, then the single-payer entity will seek reimbursement from the collateral source. In this way, the single-payer system can capture some of the employer expenditures on claims paid. For patients with dual coverage, it effectively transforms the single-payer plan into the billing agent of the provider. The employer can still pay claims to the single-payer plan if it elects to keep its private plan, but it may be easier and cheaper to simply stop covering the employees in that state and pay a payroll tax per employee instead. This model still relies upon a payroll tax or other way to capture the employer funds saved if an employer stops providing coverage to its employees, but it allows the single payer to capture health expenditures from third-party payers that continue to exist outside the single-payer system.[96]

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94 *See generally* H.R. 5611, 2019 Gen. Assemb., Reg. Sess. (R.I. 2019); H.R. 440, 132d Leg., Reg. Sess. (Ohio 2017); H.R. 962, 126th Leg., 1st Reg. Sess. (Me. 2013).

95 *E.g.*, H.R. 440, 132d Leg., Reg. Sess. § 1 (Ohio 2017) (§§ 3920.04(B)(15)(g), 3920.09(C)-(D), 3920.13).

96 As noted below in subsection II.A.3, however, application of these provisions to self-insured employer plans would be preempted.

A handful of bills only contain a Type C subrogation, assignment, or secondary-payer provision and no Funding Plan or Provider Restriction provisions.[97] A standalone Type C provision will do little to capture employer expenditures or move individuals into the single-payer plan and suggests that the state may anticipate the persistence of a multipayer system. Most of these Type-C-only plans provide for future development of the funding provisions, and such payroll or income taxes would do most of the work of moving people and funds into the state's plan. A standalone Type C provision, particularly secondary-payer, may even keep people in dual coverage longer than if they were paying for employer coverage that they rarely used (because the state plan would pay their claims). In some cases, other features suggest a standalone secondary-payer bill may not actually establish a single-payer system, but rather may establish a public option to compete with private plans without displacing private coverage altogether.[98]

A summary of the different types of mechanisms that state single-payer bills use to capture employer expenditures is listed in Table 1. The number of state proposals that contain each of the mechanisms (Types A, B, and C) are listed in Table 2. Note that proposals that feature more than one type of provision are counted more than once.

97 H.R. 316, 129th Leg., 1st Reg. Sess. (Me. 2019); S. 5222, 66th Leg., Reg. Sess. (Wash. 2019); H.R. 6285, 99th Leg., Reg. Sess. (Mich. 2018); H.R. 887, 127th Leg., 1st Reg. Sess. (Me. 2017); S. 631, 78th Leg., Reg. Sess. (Or. 2015).

98 For example, S. 5222 in Washington would allow employers that provide minimum essential coverage to employees to apply for an exemption from the payroll taxes to pay for the state plan. *See* S. 5222, 66th Leg., Reg. Sess. § 114(1) (Wash. 2019). Moreover, the bill does not contain a nonduplication provision and allows providers to continue to bill other payers. H.R. 6285 in Michigan creates a state plan that would be secondary to other coverage. H.R. 6285, 99th Leg., Reg. Sess. § 408(2)-(4) (Mich. 2018). Providers remain free to contract with and bill third-party payers, but only at rates less than the state plan's rates. *Id.* § 306(2). Employers may participate voluntarily. *Id.* § 202(1).

Table 1: Types of State Single-Payer Provisions

Type	Description
Type A – Funding Plan	Impose a payroll tax on employers and/or income tax on individuals to fund single-payer plan
Type B – Provider Restriction	Participating providers may only bill the single-payer system
Type C – Assignment/ Subrogation/Secondary Payer	Single payer can pay for services and seek reimbursement from other payers (pay-and-recoup provision)

Table 2: Number of State Single Payer Proposals by Type

Type	Proposals	# of Proposals	# of States
A (Funding Plan)	CA SB810, DE HB392, DE HB74, IA HF2352, IA HF96, IL HB207, IL HB311, IL HB942, IL HF2436, IL SB2177, MA HB1026, MA HB2987, MA SB501, MA SB515, MD HB1087, ME HP1026, MN SF8, MN SF912, MN SF2163, MN SF219, MN SF1125, NJ AB4945, NY AB5062, NYAB5248, NY AB5389, NY AB7860, NY SB4840, OH HB440, OH SB104, OHSB137, OH HB292, PA HB1688, PA HB2551, PA SB1014, PA SB400, RI HB5611, RI SB2237, RI SB 2824, SC SB786, VT HB202, WA HB1104, WA SB5224, WA SB5609, WA SB5741, WA SB5747	45	16
B (Provider Restriction)	CA SB562, FL SB1486, FL SB1872, IA HF2352, IA HF96, IL HB207, IL HB311, IL HB942, IL HF2436, IL SB2177, MA HB1026, MA HB2987, MA SB501, MA SB515, MD HB1087, MD HB1516, ME HP1026, ME HP962, NJ AB4945, NY AB5062, NY AB5248, NY AB5389, NY SB4840, OH HB287, OH HB440, OH SB104, OH SB137, OH HB292, RI HB5611, RI SB2237, RI SB2824, SC SB786, VT HB80, WA SB5957	34	14
C (Assignment, Subrogation, Secondary Payer)	ME HP1026, ME HP316, ME HP887, ME HP962, MI HB6285, MN SF8, MN SF912, MN SF2163, MN SF219, MN SF1125, OH HB287, OH HB440, OH SB104, OH SB137, OH HB292, OR SB631, PA HB1688, PA HB2551, PA SB1014, PA SB400, RI HB5611, RI SB2237, VT HB202, WA HB1104, WA SB5222	25	9