

A Perspective on the Relationship Between National and State Single Payer Work Steffie Woolhandler, M.D., & David Himmelstein, M.D.

Virtually all single payer supporters aspire to a nationwide reform. Absent a national solution, many regions with the gravest problems in access to care will lag further and further behind. Living in New York or Massachusetts doesn't lessen our sense of responsibility for millions in the deep South and other "red state" areas for whom national legislation is the only realistic option for health care progress.

Yet with the Congress currently tied in knots, prospects for the passage of a national single payer bill are dim for the next few years. Meanwhile, in a number of states the political environment offers more openings for single payer work, in no small part due to years of work by local PNHP members and other activists. These efforts are educating and pressuring many state legislators, and even governors, to embrace single payer – at least rhetorically. We outline below our views of the opportunities and obstacles to state-based work.

Opportunities:

1. In some locales, the apparently lower bar to state single payer legislation is facilitating mobilization of activists who might be daunted by the scale and seemingly dim prospects for Congressional action.
2. State-based efforts empower local leadership. Such local leadership is critical to development of a nation-wide movement.
3. Media outlets are often more willing to cover state-based efforts, both because they view such efforts as more feasible and because attention to local issues and personalities is a central focus of local media.
4. State legislators and local politicians who become single payer supporters influence, and sometimes themselves, become Congresspeople and Senators.
5. State programs can be tailored to address local problems, e.g. thorny rural health issues.
6. Some feel that a state program may avoid some of baggage of Washington-based lobbying and rule making. The ACA, flawed at the outset, has been further compromised in HHS' rule making process, which has bent to corporate pressures.
7. Many point to the Saskatchewan example of state- (or province-) level reform that served as a springboard to national legislation.

Obstacles:

- 1- Federal waivers are required to include Medicare, Medicaid and SCHIP enrollees in a state single payer. While HHS can grant Medicaid and SCHIP waivers, an act of Congress is required for a Medicare waiver.

2- Leaving Medicare outside of the single payer funding stream makes it impossible to realize many cost savings possible under a true single payer reform. Hospitals can't be paid global budgets, precluding the elimination of their wasteful per-patient billing apparatus; health planning via control of new capital investments is obstructed; and Medicare-paid for-profit HMOs, dialysis facilities, hospices, home care agencies etc. will continue to distort the system.

3- Waivers are not without risk. We fear that conservative forces in red states may take advantage of loosened federal restrictions on Medicaid, and particularly Medicare, to further undermine these programs. For instance, while Massachusetts was able to secure a progressive Medicaid waiver to help fund care of the uninsured, Arkansas took advantage of this process to fully privatize its Medicaid program.

4- It's not clear how – absent an act of Congress - a state program could fully integrate federal workers and military personnel and retirees covered by Tricare. As with Medicare, maintaining these separate funding streams sacrifices most administrative cost savings.

5- In some states, many people cross state borders to work and get medical care, greatly complicating the design of state-based programs.

6- The political power of corporations is highly portable. While national insurers, drug firms and billionaire conservative activists often stand back in earlier stages of state single payer efforts, as a state moves closer to implementation we can expect a massive influx of outside funding for efforts to disrupt it. Hence, the advantage of a locally progressive political climate is likely to erode as a movement gets closer to binding legislation.

7- State (but not federal) programs must skirt the federal ERISA law that prohibits state regulation of employee benefits, i.e. to ban private coverage that duplicates the single payer coverage. Such duplicate private coverage erodes political support for continued adequate funding of the public system, and encourages the development of two-class care.

8- While the Saskatchewan example is inspiring, its applicability in the U.S. context is questionable. The division of powers under the Canadian Constitution reserves most responsibility for health care to the provinces; the Canadian Federal government exercises leverage almost exclusively by offering the provinces funding. Hence, Saskatchewan faced few federal hurdles to implementation.

9- Applying the term "single payer" to a state program compromised by corporate and federal government interference risks sullyng the public image of such reform.

In sum, we believe that state-level work offers a valuable opportunity to educate and mobilize for single payer. But we're also convinced that a fully workable state program is not possible without explicit Congressional endorsement, or at least acquiescence. Hence a continuing focus on national-level work is essential, not only to save Texas, but to allow real progress in Vermont.