



A Road Map to 'Single-Payer'

How States Can Escape the Clutches of the Private Health Insurance System

Acknowledgments

This report was written by Taylor Lincoln, Research Director of the Congress Watch division of Public Citizen, and edited by Congress Watch Director Lisa Gilbert, Congress Watch Health Care Counsel Dave Sterrett and Michael Carome, Director of Public Citizen's Health Research Group. Public Citizen's communications department provided invaluable proofreading and stylistic assistance.

Helpful comments were received from Don McCanne, Health Policy Fellow for Physicians for a National Health Program (PNHP) and past President of the group; Andrew McGuire, Executive Director of California OneCare; Deborah A. Richter, Chair of Vermont Health Care for All; and others.

About Public Citizen

Public Citizen is a national non-profit organization with more than 300,000 members and supporters. We represent consumer interests through lobbying, litigation, administrative advocacy, research, and public education on a broad range of issues including consumer rights in the marketplace, product safety, financial regulation, worker safety, safe and affordable health care, campaign finance reform and government ethics, fair trade, climate change, and corporate and government accountability.



Public Citizen's Congress Watch
215 Pennsylvania Ave. S.E
Washington, D.C. 20003
P: 202-546-4996
F: 202-547-7392
<http://www.citizen.org>

© 2013 Public Citizen.

Contents

INTRODUCTION	4
OVERVIEW	6
STEPS TO ENACTING A UNIFIED, UNIVERSAL HEALTH CARE SYSTEM	7
1. PASS A LAW	7
2. OBTAIN A WAIVER FROM THE AFFORDABLE CARE ACT	8
3. DEVELOP A STRATEGY TO INTEGRATE A STATE-COORDINATED SYSTEM WITH MEDICARE	9
4. INTEGRATE MEDICAID AND SCHIP WITH STATE SYSTEM	12
5. DETERMINE HOW TO DEAL WITH WORKERS' COMPENSATION HEALTH BENEFITS	13
6. ADDRESS OTHER FEDERAL HEALTH BENEFITS PROGRAMS	15
7. AVOID BEING STRUCK DOWN ON ERISA GROUNDS	16
8. DETERMINE HOW TO PAY FOR THE UNIFIED HEALTH CARE PROGRAM	18
CONCLUSION	20

Introduction

In 1962, the Canadian province of Saskatchewan instituted a government-funded system that provided universal health care services to its residents. Less than a decade later, Canada adopted the Saskatchewan model nationwide.¹

In the decades since, the Canadian system has become a target of U.S. conservatives, who have frequently accused it of failing to provide Canadians with adequate care. But Canadians themselves have never come to share the view that their system is inadequate.

On the contrary, Canadians consistently express high levels of satisfaction with their health care. They overwhelmingly indicate an opposition to switching to an American-style system, which forces most citizens to obtain health insurance to receive care and requires doctors to interact with a chaotic hodgepodge of private health insurance companies to be paid for their services.²

Numerous measures offer insight into why Canadians prefer their system. For instance, Canada spends just more than half as much per capita on health care as the United States. Yet the infant mortality rate in Canada is lower than in the United States and Canadians live longer, even though their smoking and drinking rates are higher.³

Political observers have long viewed it a quixotic pursuit to create a single-payer system in the United States, where health care policy is a political lightning rod. Consider, for instance, the ferocious level of opposition to the Patient Protection and Affordable Care Act of 2010 (hereinafter, "Affordable Care Act," or ACA), which did not even make significant changes to the structure of the existing system.

Despite conventional wisdom that the United States would never tolerate a single-payer system, Americans' actual views are closely divided. A December 2012 poll found that 40 percent of Americans favored a single-payer system and 44 percent opposed one.⁴ That single-payer could nearly break even is remarkable, given the incessant fear-mongering by conservatives about the supposed evils of a "government takeover" of health care. An earlier poll, conducted in 2006 by USA Today, ABC News and Kaiser Family Foundation,

¹ Elaine Bernard, *The Politics of Canada's Health Care System: Lessons for the U.S.*, RADICAL AMERICA (1993) at 3-4, <http://hvrld.me/10IYi7L>.

² See, e.g., *Is the U.S. Health Care System the "Envy of the World"? Not in Canada*, HARRIS INTERACTIVE (May 13, 2009), <http://bit.ly/P97Iiy>.

³ See 2012 Organisation for Economic Co-operation and Development Health Data, <http://bit.ly/10Sssk3>.

⁴ *40% Favor Single-Payer Health Care System, 44% Oppose*, RASMUSSEN REPORTS (Dec. 17, 2012), <http://bit.ly/TW4vGD>.

found that 56 percent of Americans favored a system providing for universal health care coverage.⁵

The Affordable Care Act sought to enable those who do not receive health insurance through their employer to be able to purchase insurance on their own for affordable rates (often with the assistance of subsidies) without suffering penalties for pre-existing conditions. But the ACA did not alter the regime of requiring providers to seek reimbursement from innumerable insurance companies and other sources, a process that exacts enormous administrative costs.

The Affordable Care Act provides an opening for states to craft their own health care systems. It permits states to apply for an exemption from the act's requirements beginning in 2017. In order to receive a waiver, a state would need to demonstrate that its alternative proposal would meet the performance benchmarks of the Affordable Care Act.

The potential to receive a waiver from the ACA raises the possibility that a state could approximate the experiment with a single-payer system that Saskatchewan embarked on a half-century ago. The existence of federal programs, especially Medicare and Medicaid, prevents states from enacting pure single-payer systems on their own. But the flexibility of many federal programs permits the creation of systems that would capture many of the benefits promised by a single-payer system, particularly reducing administrative costs, increasing access to care and improving coordination of care.

If such a system were to generate enviable results upon implementation, other states, or even the entire federal government, might follow.

Vermont in 2011 passed legislation that called for it to create a "universal and unified health system."⁶ The pathway for Vermont to fulfill its vision will be challenging. Aside from obtaining a waiver from the mandates of the Affordable Care Act, Vermont will need to obtain waivers to permit federal programs, chiefly Medicare and Medicaid, to be integrated to the extent possible into its state-operated program.

Moreover, Vermont and any other states that set out to create unified systems will need to navigate a legal minefield arising from the 1974 Employee Retirement Income Security Act (ERISA), which forbids states from regulating employer benefits plans. A small body of case law provides grounds for cautious optimism that the hurdles of ERISA can be overcome.

Despite the challenges, the potential rewards are significant: affordable access to care for all, more comprehensive and better coordinated care, and overall cost savings.

⁵ Julie Appleby, *Universal Care Appeals to USA*, USA TODAY (Oct. 16, 2006), <http://usat.ly/11lemZZ>.

⁶ See Vermont Act 48 (2011), <http://bit.ly/UgO1Kz>.

Overview

The objective of this report is to outline steps that a state would need to undertake to develop a health care system that most closely resembles a government-administered single-payer system, such as is used in Canada. Because federal funding streams prevent a state from creating a pure single-payer system, we present a road map to a “unified, universal” system that would seek to come as close as possible to capturing the benefits that pure single-payer would offer.

This report’s scope is primarily limited to outlining the obstacles a state would face in implementing a unified, universal system. Aside from suggesting broad principles that are generally shared by single-payer advocates (such as ensuring comprehensive care for all and taking steps to control costs), we do not generally prescribe details about how a state might choose to design its system. Instead, this report is focused on providing guidance to state policy makers on their options to overcome circumstances that they cannot control so they can make decisions about the details that they can.

The findings of experts in Vermont are frequently cited herein. This is not meant as an endorsement of Vermont’s plan. Rather, these experts are cited because they have done significant work toward answering the questions that this report addresses.

Steps to Enacting a Unified, Universal Health Care System

This report outlines the obstacles that a state would have to overcome to create a unified, universal health care system. With the exception of the first step—to pass a law—these steps should be pursued concurrently.

1. Pass a law

The first step for a state to embark on the road to a unified, universal health care system is to pass legislation calling for the creation of such a system, as Vermont did in 2011.⁷ California's legislature in 2006 and 2008 passed bills to create a universal government-run system, although California Gov. Arnold Schwarzenegger (R) vetoed both bills.⁸

A state law expressing a policy of moving to a universal system would likely delegate many details to the officials in charge of enacting it, as was the case with Vermont's law. But such a law should include several principles, including:

1. The new system will provide comprehensive, universal care to the extent permitted under law;⁹
2. A state-chartered agency will receive funding to process and pay health care bills to the extent permitted by law;
3. The state will seek to the extent possible to integrate federally administered health benefits into its coordinated system and to recoup the money that the federal government would otherwise have spent on those benefits programs;
4. The state will have authority to set uniform prices for services and procedures, and to regulate capital expenditures, such as purchases of medical testing equipment;
5. The state legislature will set a total, statewide annual budget for health care expenditures.

⁷ See Vermont Act 48 (2011), <http://bit.ly/UgO1Kz>.

⁸ Aurelio Rojas, *Schwarzenegger Vetoes Universal Health Care*, THE SACRAMENTO BEE (Sept. 30, 2008).

⁹ At present, federal law does not permit illegal immigrants to participate in health care exchanges, as established by the Affordable Care Act. See, e.g., ALISON SISKIN, TREATMENT OF NONCITIZENS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE, CONGRESSIONAL RESEARCH SERVICE (March 22, 2011), <http://bit.ly/L1511g>. Such a prohibition appears to prevent a state from providing federally subsidized care to people who are not legal residents. It is possible that the passage of immigration reform legislation would remove this constraint.

2. Obtain a Waiver from the Affordable Care Act

The Affordable Care Act was the most sweeping overhaul of U.S. health care policy at least since the passage of the Social Security Amendments of 1965, which created Medicare and Medicaid. Among other things, the Affordable Care Act prohibited health insurance companies from rejecting applicants or discriminating on pricing based on pre-existing conditions. The law also required some people who do not receive health insurance through their employer to purchase individual policies or pay a fine, provided subsidies to help individuals with incomes of up to 400 percent of the poverty level purchase health insurance, and greatly expanded eligibility for Medicaid by including those whose incomes are up to 133 percent of the federal poverty level.¹⁰

The law's prescriptions would be a roadblock to states endeavoring to establish universal care systems but for its inclusion of a section permitting states to apply for a "waiver of all or any requirements ... with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017."¹¹

The criteria for receiving a state innovation waiver include demonstrating that a proposed alternative will provide coverage at least as comprehensive and as affordable as called for in the Affordable Care Act, that coverage will be provided to at least as many people as under the act, and not impose extra costs on the federal government.¹² The waiver provision calls for the federal government to make payments to the state equaling those that the government would otherwise have made pursuant to the Affordable Care Act.¹³

Conclusion: The standards called for in the waiver provision in the Affordable Care Act appear to be easily attainable by a state that wishes to establish a universal care system. Such a state system would almost certainly offer greater access to care and more comprehensive benefits than called for in the ACA. If a state is willing to provide these added services, the federal government should be willing to grant an ACA waiver.

¹⁰ See, *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAMILY FOUNDATION (July 2012), <http://bit.ly/17li01X>.

¹¹ The Patient Protection and Affordable Care Act, Public Law 111-148, Section 1332 (March 23, 2010), <http://1.usa.gov/gaf3kD>.

¹² *Id.*

¹³ *Id.*

3. Develop a Strategy to Integrate a State-Coordinated System With Medicare

Medicare is a federal program that provides nearly universal care to those 65 years of age and older and to those with long-term disabilities. Federal spending on Medicare accounts for about one-fifth of all health care spending in the United States.¹⁴

The existence of Medicare is both a blessing and an obstacle to the goal of achieving a state-run unified, universal health care system. On the plus side, Medicare embodies some of the core qualities that single-payer advocates desire: It offers universal care to those who are eligible and it is publicly funded. Single-payer advocates often refer to their idealized program as “Medicare for all” or “Improved Medicare for all.” The relative success of the Medicare program is one of the chief points that advocates make in support of creating a single-payer system for people of all ages.

Although far from perfect, Medicare has proven to be superior to private insurance in controlling costs.¹⁵ This success results from Medicare’s authority to use its market share to negotiate lower prices for doctors’ services (but not for prescription drugs) and from its ability to achieve lower administrative costs.

But because it is a federal program, Medicare poses challenges for would-be unified state systems. Most fundamentally, Medicare represents a major separate “payer,” thereby quashing the possibility of a state establishing a pure single-payer system.

Ideally, from a single-payer perspective, Medicare administrators would agree to furnish a grant to single-payer states in exchange for a promise to provide services at least as comprehensive as the Medicare program calls for. Such an arrangement would be similar to the waiver terms for the Affordable Care Act. But Medicare does not have authority to issue such a grant.

This leaves at least three ways in which a state focused on providing unified, universal care could choose to deal with Medicare.

¹⁴ See, e.g., *Biden Overstates Role of Medicare, Medicaid in U.S. Health Care Spending*, POLITIFACT (Feb. 14, 2010), <http://bit.ly/cuYdOz>.

¹⁵ Diane Archer, *Medicare Is More Efficient Than Private Insurance*, HEALTH AFFAIRS (Sept. 20, 2011), <http://bit.ly/rla7Ap>.

First, a state could simply operate its system side-by-side with Medicare, such that residents would transition from the state system to Medicare once they turn 65. But such an arrangement would forego many of the efficiencies promised by a coordinated system because doctors would still be forced to seek reimbursements from multiple sources, the prices of services would continue to vary, and benefit levels would be uneven.

As a second option, a state could seek alterations in the administration of Medicare services to permit billing and pricing for Medicare to be integrated with the state-directed system. The state would act as an intermediary between providers and Medicare, such that providers would submit bills to the state and the state, in turn, would settle up with Medicare.

Several provisions of law permit the federal government to provide waivers to states that would enable them to achieve this second option.¹⁶ Among the opportunities for flexibility, the Affordable Care Act created the Center for Medicare and Medicaid Innovation, which permits waivers for systems that promise to increase efficiency and improve the quality of care.¹⁷

“This type of waiver could be used alone, or in combination with other provisions, to align the Medicare payment and delivery requirements with Medicaid and create the basis for the single-payer or single ‘pipe’ system,” according to health care experts William C. Hsiao, Steven Kappel and Jonathan Gruber, the authors of a study commissioned by Vermont to explore methods to achieve a system of universal care for the state.¹⁸

Additional laws provide flexibility for Medicare administrators to permit a state to set prices for Medicare services.¹⁹ At present, Medicare reimburses at rates significantly less than those offered by private insurance. Establishing uniform rates would help simplify the billing process while enhancing fairness.

A third option for an aspiring single-payer state to deal with Medicare would be to become a Medicare Advantage provider. Medicare Advantage is a program in which insurers receive lump sum payments from Medicare in exchange for providing comprehensive Medicare services to enrolled patients.

¹⁶ See, Incentives For Economy While Maintaining or Improving Quality in Provision of Health Services, 42 USC §1395b-1, Contracts with Medicare Administrative Contractors, 42 USC § 1395kk-1 and THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, PUBLIC LAW 111-148, Section 3021 (MARCH 23, 2010), <http://1.usa.gov/gaf3kD>. See also, WILLIAM C. HSIAO, STEVEN KAPPEL AND JONATHAN GRUBER, ACT 128 HEALTH SYSTEM REFORM DESIGN ACHIEVING AFFORDABLE UNIVERSAL HEALTH CARE IN VERMONT (2011), at 15, <http://bit.ly/10bE9q3>. [HEREINAFTER *Hsiao et al.*]

¹⁷ See, The Patient Protection and Affordable Care Act, Public Law 111-148, Section 3021 (March 23, 2010), <http://1.usa.gov/gaf3kD>.

¹⁸ *Hsiao et al.*, *supra* note 16, at 15.

¹⁹ See, Social Security Act § 1814(b)3) and § 1833(a)(2).

Although Medicare Advantage insurers have traditionally been from the private sector, it is possible that a state health care system could qualify, said Robin Lunge, who is the director of health care reform in Vermont.²⁰ Conceivably, patients choosing to enroll in a state-run Medicare Advantage program would experience a seamless or near-seamless transition when they reached Medicare age. The state-administered health care program, meanwhile, would come much closer to realizing the goal of obtaining a lump-sum grant from Medicare.

Conclusion: An arrangement in which a state-coordinated system acts as the processor of Medicare bills and reimbursement rates are made uniform for all patients would reap many, though not all, of the advantages of a pure single-payer system. Such a system would appear to patients and providers to be integrated, but it would carry additional administrative costs for the state to submit claims to Medicare and distribute reimbursements to providers.

Achieving such an arrangement seems feasible under current law. Hsiao et al., the authors of the study outlining options for Vermont, share this view. “The outcome of any waiver negotiation is uncertain,” they wrote. “However, there is sufficient flexibility under federal law through administrative flexibility and waivers to achieve alignment in billing and other administrative functions.”²¹

The possibility of a state health care system becoming certified as a Medicare Advantage provider offers the potential to realize even greater efficiencies. Because enrollment in Medicare Advantage is a choice for beneficiaries, it would not be possible to compel Medicare patients to sign up for the state’s plan. But if the state plan offered appealing benefits and services, it might attract high rates of enrollment. Such a result could largely achieve the single-payer objective of merging Medicare and the state program.

²⁰ Taylor Lincoln, research director of Public Citizen’s Congress Watch division, interview with Robin Lunge, director of health care reform, Vermont Agency of Administration (May 23, 2013).

²¹ Hsiao et al., *supra* note 16, at 16.

4. Integrate Medicaid and SCHIP With State System

Another major federal health care program is Medicaid, which pays for care for people who have low incomes. An adjunct of Medicaid is the State Children's Health Insurance Program (SCHIP), a more generous program that provides care to children whose families have low incomes.

Medicaid is integral to the Affordable Care Act's goal of expanding access to health care. Under the ACA, individuals earning up to 133 percent of the poverty level will be eligible for Medicaid, provided that the state in which they live accepts the federal money to pay for the expansion.²²

The designers of statewide systems may find it easier to adapt Medicaid to their program than Medicare. This is because Medicaid already is administered by states and Medicaid's authorizing legislation provides a wide berth for state-level customization.

"The Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs," Medicaid's Web site states.²³ "The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as ... using innovative service delivery systems that improve care, increase efficiency, and reduce costs."

Vermont's policy leaders envision the state reimbursing providers at the same rates for treating Medicaid patients as for treating others, which would be a departure from the current system, in which Medicaid reimbursements are far lower.²⁴

As envisioned in Vermont, all patients would use smart cards at the point of service. The cards would embed information about which programs, such as Medicare or Medicaid, that a patient is enrolled in. While that information would be transmitted to the state claims

²² See, *Medicaid Expansion*, AMERICAN PUBLIC HEALTH ASSOCIATION (viewed on May 13, 2013), <http://bit.ly/198QTRI>.

²³ *Section 1115 Demonstrations*, MEDICAID.GOV (viewed on May 13, 2013), <http://bit.ly/IATwm0>. See also, *Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation; Final Rules*, 77 FEDERAL REGISTER 11678 (Feb. 27, 2012), <http://1.usa.gov/13eOsYf>.

²⁴ Taylor Lincoln, research director of Public Citizen's Congress Watch division, interview with Robin Lunge, director of health care reform, Vermont Agency of Administration (May 23, 2013).

processor, providers would be largely unaware and unconcerned about the patient's enrollment in Medicaid or other programs.²⁵

"Basically Medicaid can be integrated into a single-payer system pretty much seamlessly," Robin Lunge, the coordinator of health care reform in Vermont, told Public Citizen.²⁶

In their review of options for Vermont, Hsiao et al. also expressed confidence that the state would be able to shape the Medicaid program to suit its broad objective of a unified system. "In summary, there is great flexibility in Medicaid and SCHIP through waivers, which would allow the state to align benefits, payment methods, and other administration," they wrote.²⁷

Conclusion: The Medicaid hurdle appears to be surmountable.

5. Determine How to Deal With Workers' Compensation

Health Benefits

Workers' compensation is a system that operates under the auspices of state laws that provides health care coverage and compensation for lost wages to employees who are injured on the job. Employees, meanwhile, are prohibited from suing their employer to seek compensation for injuries, except under extraordinary circumstances.

Private insurance companies administer most states' workers' compensation systems.²⁸ Some states administer a fund themselves. In most cases, employers pay premiums based on their claims history to insurance companies or to state funds. Some employers provide self-insured workers' compensation benefits. Health care provided pursuant to workers' compensation accounts for a small percentage of overall care. In Vermont, for instance, workers' compensation is responsible for about 2 percent of health care spending.²⁹

There are various alternatives for how to deal with workers' compensation in the context of a unified state health care system.

First, the ostensibly simplest solution would be to have the state system fulfill the health care needs arising from workplace injuries. But this approach is hindered by characteristics

²⁵ *Id.*

²⁶ *Id.*

²⁷ Hsiao et al., *supra* note 16, at 17.

²⁸ See, e.g., ROBIN LUNGE, DIRECTOR OF HEALTH CARE REFORM, (VERMONT) AGENCY OF ADMINISTRATION, INTEGRATION OR ALIGNMENT OF VERMONT'S WORKERS' COMPENSATION SYSTEM WITH GREEN MOUNTAIN CARE IN ACCORDANCE WITH ACT 48, SECTION 8(B) (Jan. 15, 2013), at 15, <http://bit.ly/ZVh3ku>.

²⁹ *Id.*, at 4.

of workers' compensation that distinguish it from other health care services. For instance, workers' compensation is viewed as providing an incentive to employers to provide safer workplaces, as employers with more claims are assessed higher premiums. Some have speculated that completely integrating the health care component of workers' compensation into a single-payer system could reduce or eliminate the deterrents instilled in conventional workers' compensation programs.³⁰

Also, health benefits that are provided pursuant to workers compensation are at times more comprehensive and costly than under private health insurance because the program involves a goal of returning the injured person to work as rapidly as possible.³¹ A state system likely would not provide this enhanced level of benefits.

Further, because workers' compensation benefits include both health care and compensation for lost wages, workers' compensation insurers may be unwilling to continue offering their services if they are forced to cede the health care component, which allows them to monitor employees' recoveries.³²

A second option (which would apply to states that currently use private insurance companies to administer their programs) would be for states to convert entirely to a publicly administered system. This would facilitate accomplishing the objective of creating a unified system but would constitute a major change for a state. But the minority of states that already operate their own workers' compensation systems should have little trouble aligning their workers' compensation benefits with a unified health care system.

A third and more modest option would be to have the state serve as an intermediary between health care providers and workers' compensation health insurance companies in a manner similar to the way that this paper suggests that a state might seek to integrate Medicare and Medicaid with its health care system.

Conclusion: Because workers' compensation is operated by the states, states have the power to integrate their program into a unified health care system. The minority of states that already operate their own systems would be well positioned. States that currently use private insurance could choose to convert their entire workers' compensation system to a state-operated program to facilitate integration.

States that do not want to overhaul their workers' compensation program should be able to devise a system that captures many of the benefits of a single-payer system by having the state serve as a hub that would accept claims from providers and submit them to private

³⁰ *Id.*, at 7.

³¹ *Id.*, at 3.

³² *Id.*, at 11.

insurers for reimbursement. This would constitute an additional step compared to an entirely integrated system, but would be far more efficient than requiring providers to interact directly with private insurers.

Regardless of the structure, a state offering universal care to residents would need to take precautions to ensure that care rendered as a result of workplace injuries is properly billed as workers' compensation, such that employers are held accountable for the expenses. Otherwise, employers could escape paying their share simply by instructing injured employees to seek care pursuant to the benefits they enjoy as state residents.

6. Address Other Federal Health Benefits Programs

Aside from Medicare and Medicaid, numerous federal programs provide health care benefits. These include health plans for federal civil servants, uniformed service members and military veterans.

Integrating these programs into a unified state system will be challenging. A state may be able to enhance efficiency by interposing itself as a claims processor between providers and insurers, as suggested elsewhere in this paper regarding Medicare and Medicaid.

It also is conceivable that a state-operated health care program could apply to become an insurer for federal employees.³³ On behalf of federal employees who choose the state-operated option, the federal government would pay the state the same premiums as it would otherwise have paid to private health insurance companies.

Some federal programs may not lend themselves to integration with a state system. For instance, the U.S. Department of Veterans Affairs provides direct services to eligible patients. It is difficult to imagine how the VA's services would fit within a unified state system.

Conclusion: As with Medicare and Medicaid, a state should be able to act as a claims processor for care rendered to most federal employees, and thereby realize enhanced efficiencies. If a state were able to become an approved insurer to provide federal health benefits, that would offer the potential for a significantly greater level of integration. But it may not be possible to integrate some federal benefits programs into a state system.

³³ Taylor Lincoln, research director of Public Citizen's Congress Watch division, interview with Robin Lunge, director of health care reform, Vermont Agency of Administration (May 23, 2013).

7. Avoid Being Struck Down on ERISA Grounds

The federal Employee Retirement Income Security Act of 1974 (ERISA) regulates employer-provided benefits, particularly concerning retirement and health care plans. The law is vexing for states that seek to alter their health care systems because ERISA's mandates "supersede any and all state laws" on employee benefit plans.³⁴

The implications of ERISA are complicated and remain the source of much conjecture. Much of what has been determined about how the law works in the real world is a product of court opinions, some of which are conflicting. For the most part, ERISA has been interpreted as prohibiting state laws from dictating the composition of health care benefits that employers must offer.

But, pursuant to the McCarran-Ferguson Act of 1945, states retain the explicit authority to regulate "the business of insurance."³⁵ This authority appears to give states leeway to regulate the conduct of health insurance companies (but not to dictate businesses' choices in purchasing products from those health insurance companies).³⁶

Further complicating matters, states' prerogative to regulate insurance does not permit them to interfere in the health care plans of businesses that self-insure their health care benefits.³⁷ Nearly 60 percent of U.S. businesses that offer health insurance benefits are self-insured, according to a 2012 report of the Employee Benefit Research Institute.³⁸

The restrictions in ERISA combined with the prevalence of self-insured businesses create dilemmas for states that seek to transition to unified, universal systems. How can a state attract patients currently covered by self-insurance programs into its system? And how can it devise a revenue model to fund a single-payer system without running aground of ERISA?

One proposed financing system for a unified, universal state-coordinated system would be to impose a payroll tax. A payroll tax appears to be well-suited to fulfilling the objectives of a unified system because it would provide an enticement to employers to drop their own plan if they are separately paying into the state system.

³⁴ See, Other Laws, 29 U.S.C., § 1144.

³⁵ See, Declaration of Policy, 15 U.S.C. § 1011.

³⁶ See, e.g., *Hsiao et al.*, *supra* note 16, at 11.

³⁷ *Id.*, at 9.

³⁸ PAUL FRONSTIN, SELF-INSURED HEALTH PLANS: STATE VARIATION AND RECENT TRENDS BY FIRM SIZE, EMPLOYEE BENEFIT RESEARCH INSTITUTE (November 2012), <http://bit.ly/Wv8Otd>.

But use of a payroll tax is potentially risky for the same reason. A court could determine that such a tax would give businesses no practical choice but to drop their self-insured plan because they (or their employees) would simultaneously be required to pay to participate in the state-operated health care system. As such, a court could rule that a payroll tax to fund a health care system would violate ERISA.

Alternatively, a state could impose a payroll tax in a manner that would exempt self-insured employers. But such a “pay or play” strategy, which most single-payer advocates oppose on policy grounds, could also face legal jeopardy. In 2006, a federal court voided a Maryland law that required employers to offer either a certain level of benefits or pay a levy to the state. The court determined that the choice presented employers with an “irresistible incentive” to alter their benefits offerings, and thus constituted an intrusion on ERISA.³⁹

A broad-based income tax that avoided mention of ERISA to finance a state-run system appears likely to pass legal muster because it would be imposed on residents, not businesses. But an income tax could face resistance from the members of the public because of its potential to reduce their take-home pay. In theory, any income tax to fund public health care would be roughly cancelled out by higher salaries. That is, employers would pass on their savings from avoided health insurance premiums to their employees. But while the income tax would be certain, the expected commensurate increase in salaries would remain speculative at the outset.

Despite the foregoing concerns, many experts believe that a payroll tax would survive an ERISA challenge. Patricia A. Butler, who has written extensively on the ERISA implications relating to state health care plans, told consultants exploring options for Vermont that a payroll tax should pass muster because “both taxation and health care financing are exercises of traditional state authority that a court should not presume Congress intended to preempt” and “a payroll tax is not substantively different from other revenue sources that could be used to fund a single-payer system such as income taxes or other assessments.”⁴⁰

But Butler separately has acknowledged that “There are no guarantees about how a court will analyze a state law.”⁴¹

Phyllis Borzi, assistant secretary of Labor for the Employee Benefits Security Administration in the U.S. Department of Health and Human Services, offered a stronger

³⁹ PATRICIA A. BUTLER, INCLUDING EMPLOYER FINANCING IN STATE HEALTH REFORM INITIATIVES: IMPLICATIONS OF RECENT COURT DECISIONS (January 2009), at 4, <http://bit.ly/18GqSIP>.

⁴⁰ *Hsiao et al.*, *supra* note 16, at 10.

⁴¹ PATRICIA A. BUTLER IMPACT OF THE MARYLAND “FAIR SHARE ACT” COURT DECISION, NATIONAL ACADEMY FOR STATE HEALTH POLICY (November 2006), at 11, <http://bit.ly/13tGHBh>.

affirmation of a state's ability to fund a health care system by taxing employers. "Clearly ERISA is not an impediment for states that choose to levy a fee or tax on all employers and to then use the funds to subsidize health care coverage expansions. In such a situation, the regulated entity is the employer, not the employer plan," she told Vermont's consultants.⁴²

Robin Lunge, Vermont's health care reform coordinator, expressed similar confidence with regard to both an income tax and a payroll tax. "It doesn't make sense to me that ERISA could preempt a state's right to tax. We feel pretty good about that," Lunge told Public Citizen.⁴³

In support of the positions put forth by Butler, Borzi and Lunge, a U.S. Appeals Court in 2007 upheld a San Francisco ordinance that required employers of certain sizes to spend \$1.17 to \$1.76 per hour per employer hour on health care. But that decision came after the ordinance was struck down by a U.S. District Court.⁴⁴

Conclusion: Much like the individual mandate in the Affordable Care Act that was eventually upheld in a narrow decision by the U.S. Supreme Court, most any single-payer design choice would likely be at risk of being struck down by an ERISA challenge unless the Congress passes an amendment to pave the way for a state experiment.

Proposals that impose levies on all residents or employers (or both) may be more likely to survive than those that impose "pay or play" requirements on employers. Across-the-board levies also would better serve the objectives of a unified, universal system.

Because of the risks that ERISA poses, states that pursue universal care systems should include alternative funding mechanisms in their implementing legislation in case their first choice is struck down by a court.

8. Determine How to Pay for the Unified Health Care

Program

Most health care services in the United States are billed either to private insurance companies, federal government programs, directly to patients, or to a combination of these sources. A unified, state-coordinated system would shift the costs for a sizeable share of health care services to the state government.

⁴² *Hsiao et al., supra* note 16, at 10.

⁴³ Taylor Lincoln, research director of Public Citizen's Congress Watch division, interview with Robin Lunge, director of health care reform, Vermont Agency of Administration (May 23, 2013).

⁴⁴ PATRICIA A. BUTLER, INCLUDING EMPLOYER FINANCING IN STATE HEALTH REFORM INITIATIVES: IMPLICATIONS OF RECENT COURT DECISIONS (January 2009), at 3, <http://bit.ly/18GqSIP>.

A unified, universal system is likely to end up costing less overall while providing much more than a state's current system. For instance, an analysis conducted for Vermont by the University of Massachusetts Medical School Center for Health Law and Economics projected savings of about \$35 million (out of total health care expenses of \$5.9 billion) in 2017, when Vermont aims to convert to a universal care system.⁴⁵ Such lower costs would come despite the new system providing care to many more people, and providing more comprehensive benefits to almost everybody.

But, despite these benefits, a transition from private insurance would require increasing revenue on a scale that would appear at first blush to be jarring to a state's economy. Consider the University of Massachusetts analysis of how to fund a unified, universal system in Vermont. It assumed that payments from the federal government and other existing sources would cover \$4.3 billion of Vermont's \$5.9 billion in annual health care costs. That would leave about \$1.6 billion to be financed.⁴⁶ Vermont's total projected revenue for 2013, in contrast, is only \$1.5 billion.⁴⁷

The study's authors enumerated about \$1.2 billion in revenue the state currently loses due to tax deductions, otherwise known as tax expenditures. The authors suggested that Vermont should contemplate reducing those deductions to pay for its health care plan.

"A fundamental restructuring of Vermont's revenue system should be considered strategically given the potentially important interplay between funding [universal care] and possible reforms to Vermont's tax code," the authors wrote.⁴⁸

The paper by Hsiao et al. on alternatives for Vermont to achieve universal care recommended instituting payroll taxes ranging from 12 to 17 percent, mostly paid by employers.⁴⁹

Although significant, the practical effects of such a payroll tax could be softened by at least two factors. First, a compulsory payroll tax would entail employers sending roughly the same amount to the state health care agency as they otherwise would pay to health insurance companies. Thus, their bottom line would be largely unaffected.

⁴⁵ UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL CENTER FOR HEALTH LAW AND ECONOMICS AND WAKELY CONSULTING GROUP INC. STATE OF VERMONT HEALTH CARE FINANCING PLAN BEGINNING CALENDAR YEAR 2017 ANALYSIS (Prepared for Vermont Agency of Administration) (Jan. 24, 2013), at xi, <http://bit.ly/17ZmaFz>

⁴⁶ *Id.*, at 66.

⁴⁷ *Table 1A – State of Vermont Legislative Joint Fiscal Office* (January 2013), <http://bit.ly/12CCtXN>.

⁴⁸ UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL CENTER FOR HEALTH LAW AND ECONOMICS AND WAKELY CONSULTING GROUP INC. STATE OF VERMONT HEALTH CARE FINANCING PLAN BEGINNING CALENDAR YEAR 2017 ANALYSIS (Prepared for Vermont Agency of Administration) (Jan. 24, 2013), at xv, <http://bit.ly/17ZmaFz>.

⁴⁹ *Hsiao et al., supra* note 16, at viii.

Second, a state intent on converting to a single-payer system would likely enjoy a head start in transitioning people off of private health insurance because about 10 percent of the nation's civilian employees work for state and local governments.⁵⁰ Governmental jurisdictions that share the objectives of a single-payer system should be willing participants in the transition.

Conclusion: Converting the portion of health care funding that is currently paid to private insurance companies to a government-funded alternative would represent a major shift, even though the overall costs may be less than under the current system. The critical factor in designing a state-administered system would be to make sure that the shift in costs occurs in the least disruptive manner possible.

A payroll tax paid entirely or primarily by employers may offer the potential for the least disruptive transition. In theory, employers would simply end up paying a state fund roughly the same amount of money that they currently pay to insurance companies. Employees, meanwhile, would trade in their private insurance coverage for access to the state plan. The use of a payroll tax would rely on its surviving potential challenges on ERISA grounds, as discussed above.

Conclusion

A state's effort to enact a unified, universal health care system would require overcoming significant legal and logistical hurdles, but would offer enormous potential dividends.

Existing federal law appears to provide flexibility to overcome many challenges by permitting alignment of the billing systems for federal programs with a state system. The obstacles posed by the Employee Retirement Income Security Act of 1974 are perhaps most vexing because most any design could be subject to court challenge, although there is reason for optimism that a well-crafted law would survive an ERISA challenge.

Implementing a unified state system once a design strategy is finalized would be a major technical challenge, primarily in the area of information technology. A well-operated system would involve a claims hub that would rely on significant automation to process billing submissions.

⁵⁰ The civilian labor force in July 2010 was 153.6 million, according to the Bureau of Labor Statistics. State and local governments employed 16.6 million full-time equivalent workers in 2010, according to the U.S. Census Bureau. *See, Employment Situation*, U.S. Bureau of Labor Statistics (Aug. 6, 2010), <http://1.usa.gov/178GRSL> and *State and Local Governments Employ 16.6 Million Full-Time Equivalent Employees in 2010*, United States Census (Aug. 30, 2011), <http://1.usa.gov/mU3v6S>.

But achieving such a system promises economic and health benefits that would far outweigh the costs of the initial investment. Having a streamlined billing system should begin to reduce administrative overhead costs, which have been estimated to account for about one-third of all health care expenditures.⁵¹ Achieving significant administrative savings would help pay for access to care for those who are currently uninsured, and for more comprehensive care for nearly everybody.

Aside from reduced administrative costs, a unified system promises cheaper and more effective care by offering greater access to preventive care, reduced costs for most procedures and tests, and the potential for significantly increased coordination among providers. Finally, institution of a unified, universal system would address a major moral shortcoming in our society: that the ability to receive essential health care largely depends on one's economic wherewithal, and that those of lesser means are often forced to make agonizing choices between their physical and financial well-being.

⁵¹ Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 THE NEW ENGLAND JOURNAL OF MEDICINE 768 (Aug. 31, 2003), <http://bit.ly/K3Osw>.