

December 2018

Single-Payer and Universal Coverage Health Systems: *Interim Report*

The 2018 Washington State Legislature directed the Washington State Institute for Public Policy (WSIPP)¹ to conduct a study of single-payer and universal health coverage systems. This interim report addresses several aspects of the study assignment.

We discuss universal health care coverage and policies that promote it in [Section I](#). [Section II](#) defines single-payer health care and examines how it differs from our current multi-payer system. [Section III](#) presents our examination of the effects of single-payer systems on health care costs. [Section IV](#) summarizes the challenges of implementing single-payer systems, and [Section V](#) reviews the characteristics of single-payer proposals in the United States. We conclude with a summary and next steps in [Section VI](#).

Our final report, due in June 2019, will address the remaining components of the study assignment. It will describe universal coverage and single-payer systems in other countries and review evidence regarding differences across high-income countries in health care costs, health outcomes, access to care, and equity.

Summary

Universal health coverage is a system where all people can obtain the necessary services to enhance their health without putting themselves through substantial financial hardship. In Washington State, about 400,000 residents remain uninsured. States have proposed a variety of policies to cover people who are uninsured, one of which is single-payer health coverage.

Under single-payer health care all residents are automatically enrolled in a single, publicly financed plan. Studies for other states suggest that a single-payer system may reduce health care costs. However, there is uncertainty over the magnitude and timing of these savings, and the savings would come at the expense of substantial disruption to insurance market employment and administrative jobs in hospitals and clinics.

Adopting a single-payer system requires a substantial shift in funding away from premiums and out-of-pocket spending to large new taxes. Funding proposals rely on using existing federal funds to help pay for the new system and gaining approval to do so is a major hurdle. There are also significant challenges arising from federal law regulating self-insured employer-sponsored insurance.

¹ The bill also directed the Washington State Office of the State Actuary to provide actuarial support for this study. See [Engrossed Substitute Senate Bill 6032, Section 106, Chapter 299, Laws of 2018](#). This support was provided by actuaries at Willis Towers Watson, under contract with the Office of the State Actuary.

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I. Universal Health Coverage

According to the World Health Organization (WHO), universal health coverage is a system where all people can use the necessary services to enhance their health without putting themselves through substantial financial hardship.² The WHO lists three objectives associated with universal coverage:

- 1) Equitable access to necessary services,
- 2) Service provision of sufficient quality to improve health conditions, and
- 3) Financial risk protection for patients.

Though the WHO's definition explicitly states that universal coverage entitles all people to health services, scholars have noted that attaining a 100% coverage rate would be difficult.³ However, as long as the proportion of uninsured is small relative to the rest of the population, a jurisdiction can still claim that its health care system provides universal coverage.⁴ No consensus threshold exists regarding the proportion of uninsured persons a jurisdiction can have while still claiming to provide universal coverage.

A recent study examined health care coverage and costs in 11 high-income countries—the United States, Japan, Germany, the United Kingdom, France, Canada, Australia, Netherlands, Sweden, Switzerland, and Denmark.⁵ Among these countries, only the United States did not have universal coverage.

² World Health Organization. [Universal health coverage](#).

³ Musgrove, P. (2010). The five Cs of universal health coverage. *Americas Quarterly*. 4(3), 48-53.

⁴ For example, in Germany's universal system approximately 0.1% of the population in 2015 was uninsured (OECD/European Observatory, 2015).

⁵ Pananicolos, I., Woskie, L., & Jah, A., (2018). Health care spending in the United States and other high-income countries. *JAMA*. 319(10), 1024-1039.

Legislative Assignment

\$100,000 of the general fund—state appropriation for fiscal year 2019 is provided solely for the Washington state institute for public policy to conduct a study of single payer and universal coverage health care systems. The institute may seek support from the office of the state actuary. The institute shall provide a report to the appropriate committees of the legislature by December 1, 2018. The study shall:*

- a) Summarize the parameters used to define universal coverage, single payer, and other innovative systems;
- b) Compare the characteristics of up to ten universal or single payer models available in the United States or elsewhere; and
- c) Summarize any available research literature that examines the effect of these models on outcomes such as overall cost, quality of care, health outcomes, or the uninsured.

Engrossed Substitute Senate Bill 6032, Section 606(15), Chapter 299, Laws of 2018.

*Due to prior research commitments, the WSIPP Board of Directors voted to move the final deadline of this study to June 30, 2019.

About 10% of U.S. residents do not have health care coverage. Uninsured rates in the other countries range from 0% to 0.2%. All of these other countries have an automatic or compulsory insurance enrollment process.⁶

The uninsured rate in Washington State declined from 14% in 2013 to under 6% by 2016, due largely to an expansion of Medicaid coverage under the Affordable Care Act (ACA) and access to ACA premium and cost-sharing subsidies through the state Health Benefit Exchange (the state's ACA marketplace for insurance coverage to individuals and families).⁷ Around 400,000 Washington residents remain uninsured.⁸

⁶ Ibid.

⁷ Yen, W. & Mounts, T. (2018). *Three years' ACA impact on Washington State's health coverage*. Washington State Office of Financial Management. Research Brief No. 86. January 2018.

⁸ Estimate based on the uninsured rate from Yen & Mounts (2018) and the state population estimate from the Washington State Office of Financial Management, *State of Washington Population Trends*. July 2018.

Nationally, among those who have remained uninsured:

- Many do not have coverage through their employer, are self-employed, are ineligible for Medicaid or Medicare, or do not qualify for ACA Marketplace (health insurance exchange) subsidies;
- Many choose not to purchase Marketplace insurance and cite high costs as the reason;
- Many are undocumented immigrants who are ineligible for Medicaid or Marketplace coverage; and
- Most are in low-income families and have at least one worker in the family.⁹

People who are uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases. When they do receive care, patients without insurance are usually billed for services and have to pay out-of-pocket. Medical bills often result in medical debts, and these debts account for about half of all bankruptcies. When patients are unable to pay, the costs become uncompensated care; covered by federal and state funds and by providers as charity care.¹⁰

Policies that Promote Universal Coverage

If achieving universal coverage is the goal, it would require three things:

- 1) Compulsion (a mandate) for everyone to participate,
- 2) Subsidies for those who cannot afford insurance, and
- 3) Guaranteed issue of insurance regardless of pre-existing conditions.¹¹

Policies related to both subsidies and mandates have been proposed in states across the country, though mandates are less popular among the public.¹² Beyond subsidies and mandates, other policy proposals have focused on extending coverage to populations not currently eligible for participation in public plans, creating new options in the individual market, and creating single-payer plans.

Mandating Insurance

Systems with voluntary health insurance face the problem of adverse selection, where people who want to buy insurance tend to be those who will be more costly to insure. Many younger, healthier (and thereby lower cost) individuals opt not to purchase insurance. An effective mandate expands the insurance pool, bringing lower cost members into plans, thereby lowering premiums.

⁹ Henry J. Kaiser Family Foundation. *Key Facts about the Uninsured Population*. November 29, 2017.

¹⁰ Ibid.

¹¹ Fuchs, V. (2018). Is single payer the answer for the US health care system? *JAMA*, 319(1); Rice, T., Unruh, L., van Ginneken, E., & Rosenau, P. (2018). Universal coverage reforms in the USA: From Obamacare through Trump. *Health Policy*. 122, 698-702.

¹² Ibid.

In December 2017, the U.S. Congress eliminated the individual mandate penalty, effective January 1, 2019. The Congressional Budget Office estimated that this would reduce health insurance enrollment by seven million in 2020 and increase premiums on the individual market by around 10%.¹³ Massachusetts, New Jersey, and Vermont have passed their own individual mandate laws in attempts to maintain enrollments and moderate premium increases. Other states, including Washington, are considering mandates.¹⁴

Increasing Subsidies

Another proposal is to use state funds to lower the cost of purchasing coverage in the individual market.¹⁵ This could involve offering state-funded subsidies to individuals who are currently ineligible under current income thresholds for marketplace subsidies. State subsidies could also be used to supplement federal Advance Premium Tax Credits (APTCs) to make coverage more affordable.

Extending Coverage to Undocumented Immigrants

Undocumented immigrants are not eligible to enroll in Medicaid or to purchase coverage through the ACA Marketplaces. In California, there are roughly three million people who are uninsured—almost two million of these are undocumented immigrants.¹⁶ Recent California legislative reports listed Medicaid coverage and Marketplace subsidies for income-eligible undocumented immigrants among potential options for moving toward universal coverage.¹⁷

Creating a Public Option

Among those without employer-sponsored insurance, some opt not to purchase coverage because of rising premiums in individual market.¹⁸ There have been proposals in several states to establish a public plan for individuals and small groups aimed at reducing the cost of individual coverage.

White and colleagues (2017) analyzed a potential public option for the Oregon Legislature.¹⁹ The proposed plan would be a state-administered option offered on the ACA Marketplace. It would be financed through premium payments by individuals, federal Advance Premium Tax Credits (APTCs), and federal payments for cost-sharing reduction subsidies (CSRs).

¹³ Liu, J.L., White, C., Nowak, S.A., Wilks, A., Ryan J., & Eibner, C. (2018). *An Assessment of the New York Health Act: A Single-Payer Option for New York State*, Santa Monica, CA: RAND Corporation, RR-2424-NYSHF.

¹⁴ Palanker, D., Schwab, R. & Giovannelli, J. (2018, June 14). *State efforts to pass individual mandate requirement aim to stabilize markets and protect consumers*. The Commonwealth Fund.

¹⁵ Bindman, A., Mulkey, M., & Kronick, R. (2018). Beyond the ACA: Paths to universal coverage in California. *Health Affairs*. 37(9), 1367-1374.

¹⁶ Legislative Analyst's Office. Financing Considerations for Potential State Healthcare Policy Changes. February 5, 2018.

¹⁷ Legislative Analyst's Office and Bindman, A., Mulkey, M., & Kronick, R. (2018). *A path to universal coverage and unified health care financing in California*. University of California San Francisco.

¹⁸ Premiums will rise 13.5% in Washington State's individual market in 2019 (Washington State Office of the Insurance Commissioner).

¹⁹ White, C., Eibner, C., Liu, J., Price, C., Leibowitz, N., Morley, G., . . . Meyer, J. (2017). *A comprehensive assessment of four options for financing health care delivery in Oregon*. RAND Research Report RR-1662-OHA.

White and colleagues find that the coverage impact of the public option would be limited because it would primarily affect the individual market, which insures only about 6% of Oregonians. They estimate that the number of uninsured would be reduced by 32,000, causing the uninsured rate to fall from 5.1% to 4.3%.²⁰ The public plan, however, could provide lower-cost coverage to enrollees.

Creating a Single-Payer System

Single-payer health care systems achieve universal coverage by design. All residents are automatically enrolled in a single, publicly financed insurance plan that provides comprehensive health care.

The next section of the report describes single-payer health care.

²⁰ Ibid.

II. Single-Payer Health Care

Although there is no consensus on a particular definition for single-payer health care, a recent review found that most definitions describe a system where only one entity collects funds and purchases health services for a specified population.²¹ In a single-payer health care system there is one government health plan that offers residents comprehensive coverage and does not compete with other insurers.

Single-payer is not synonymous with “socialized medicine.” Private providers play various roles in both single- and multi-payer systems. At one extreme, a country could have socialized medicine, a system in which the government pays for and directly provides health services (e.g., health providers are employees of the state health care system). The private sector plays a small role in socialized medicine. A well-known example of such a system is the United Kingdom’s National Health Service (NHS). In other single-payer systems, like Canada’s, the government pays for services that are delivered by mostly private providers.

Our current health care system in the United States is funded and administered through a wide array of public and private insurers. It is estimated that of the 7.4 million individuals who live in the state of Washington, 39% receive health care coverage through a government program (Medicaid or Medicare), 55% through private/commercial insurance, and 6% are uninsured ([Exhibit 1](#)).

There are many payers involved within each of these types of coverage. Within the private insurance market, 15 companies currently offer health insurance in Washington. Most of those covered by private insurance are in employer-sponsored plans ([Exhibit 1](#)). Employers may purchase coverage for their workers from an insurance carrier (a fully insured plan) or they may offer a self-insured plan. A self-insured plan is one in which the employer is responsible for all health care and administrative costs; employers bear the financial risk from unexpected high medical costs. In a fully insured plan, the insurance company is responsible for health care costs, and the employer pays premiums.

There are also multiple payers associated with public programs. Medicaid, which is funded by federal and state governments, provides health coverage to some low-income people, families with children, pregnant women, the elderly, and people with disabilities. Several managed care organizations (MCOs) now administer most of Medicaid coverage. Medicaid managed care provides for the delivery of Medicaid health benefits through contracted arrangements between state Medicaid agencies and MCOs.

Medicare, a federal program, provides health insurance to people age 65 and older, to people under age 65 with certain disabilities, and to people with end-stage renal disease (kidney failure). Within Medicare, beneficiaries are enrolled in either Traditional (fee-for-service) Medicare or privately administered Medicare Advantage plans. Medicare Advantage plans are

²¹ Liu, J., & Brook, R. (2017). What is single-payer health care? A review of definitions and proposals in the U.S. *Journal of General Internal Medicine*, 32(7), 822-31.

offered by private insurance companies that are approved by Medicare. In Washington, about a third of Medicare beneficiaries are in Medicare Advantage plans.²² Traditional Medicare beneficiaries may also purchase Medicare Supplement insurance to cover out-of-pocket costs.

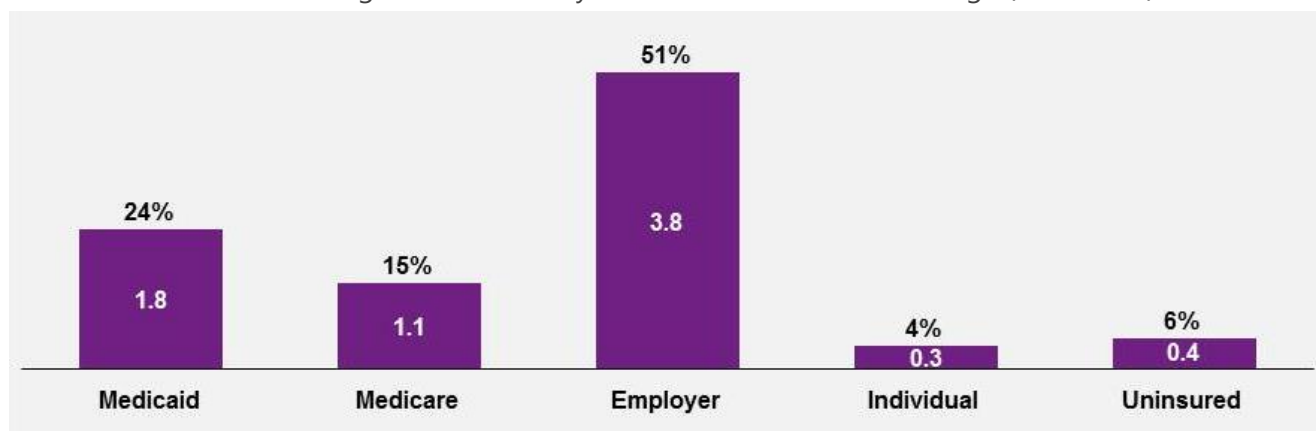
Under a single-payer plan, individuals with Medicaid, Medicare, employer-sponsored insurance, individual coverage, and those without insurance would all be enrolled in a single public plan. These other types of public and private insurance would cease to exist.

It is estimated that \$55.2 billion will be spent on medical care in 2018 for Washington residents. Spending levels vary by payer in our current system (see [Exhibits 2 & 3](#)). Just under half of all health care expenditures are paid for by Medicare and Medicaid. Single-payer proposals call for using these state and federal funds to help finance the single-payer plan. Gaining federal approval to do so is a significant challenge (discussed further in [Section IV](#)).

Employer-sponsored insurance accounts for almost half of total health expenditures. Under single-payer proposals, employer and individual premium payments and most out-of-pocket payments would be replaced by another source of funds—typically tax revenue, less any cost savings generated by a single-payer system.

Exhibit 1

Washington Residents by Source of Healthcare Coverage (in millions)



Notes:

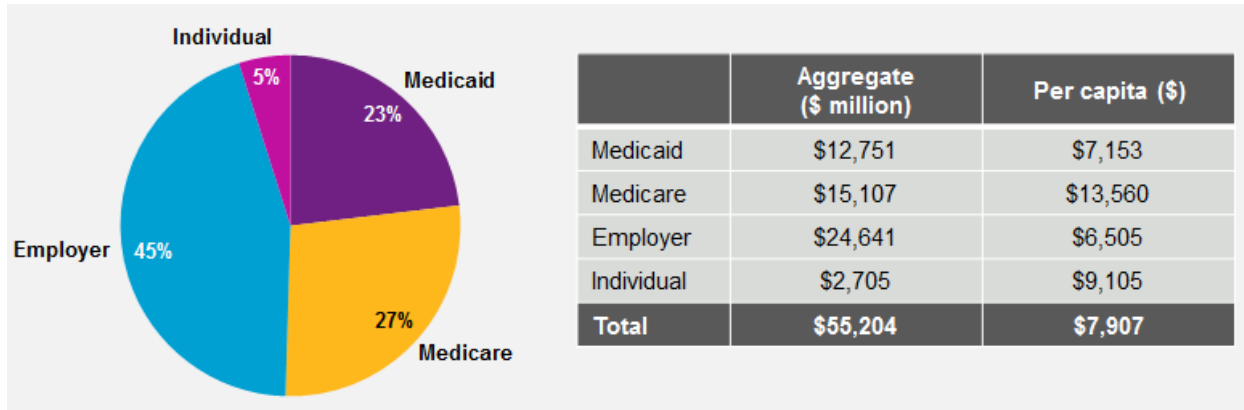
Source: Willis Towers Watson.

Data sources: The Washington State Office of the Insurance Commissioner (OIC), carrier reports for 2015; Centers for Medicare and Medicaid Services (CMS), state health expenditures data. Population estimates include adults and children in Washington.

²² Centers for Medicare and Medicaid Services. (2018, April). [Medicare Enrollment Dashboard](#).

Exhibit 2

Health Care Expenditures in Washington in 2018



Notes:

Source: Willis Towers Watson.

Totals include claims/premiums; payer administration costs and individual out-of-pocket costs (deductibles, copays, etc.); hospitalization; physician and nursing care; prescription drugs; medical equipment; and supplies.

These figures do not include the cost of care for uninsured individuals. It is likely that care cost for uninsured individuals adds another \$2-\$4 billion to the aggregate annual spending in Washington.

Data sources: The Washington State Office of the Insurance Commissioner (OIC), additional data statement forms; Centers for Medicare and Medicaid Services (CMS) state health expenditures data; Willis Towers Watson 2018 Financial Benchmarks Survey; and the Washington Health Benefit Exchange monthly enrollment reports.

Exhibit 3

Administration Costs and Out-of-Pocket Spending in 2018 (in millions)

	Plan payments to providers*	Payer administration	Individual out-of-pocket payments to providers**	Total
Medicaid	\$12,016	\$735	\$0	\$12,751
Medicare	\$11,817	\$236	\$3,054	\$15,107
Employer	\$19,541	\$1,650	\$3,450	\$24,641
Individual	\$1,615	\$214	\$876	\$2,705
Total	\$44,989	\$2,835	\$7,380	\$55,204

Notes:

Source: Willis Towers Watson.

* Plan payments to providers include provider administration costs.

** Includes all deductibles, copays, premiums, etc. Additionally includes payments by Medicare Supplement plans.

The administrative rate for Medicare (2%) corresponds to administrative costs in Traditional Medicare. Actual administrative costs for all of Medicare are higher than shown here due to higher administrative costs of Medicare Advantage plans.

The administrative rate for Medicaid (about 6%) corresponds to only the administrative costs for the sponsoring state and federal agencies. Total administrative costs would also include the administration provided by the MCOs, where applicable, which is not included here.

Data sources: The Washington State Office of the Insurance Commissioner (OIC), additional data statement forms; Centers for Medicare and Medicaid Services (CMS) state health expenditures data; Willis Towers Watson 2018 Financial Benchmarks Survey; the Washington Health Benefit Exchange monthly enrollment reports; Kaiser Family Foundation; and MACPAC.gov.

Of those who receive coverage through an employer, about three in ten receive coverage through an insured plan and about seven in ten receive coverage through a self-insured plan.²³ Federal law (the Employee Retirement Income Security Act) shields self-insured plans from state regulation, and this poses another challenge to implementing state single-payer plans (discussed more in [Section IV](#)). Employers will be keenly interested in whether they are being relieved of the health insurance cost for their employees, and if they are taxed to cover the single-payer program cost, how that tax compares to their prior insurance spending.

In Washington State, and across the nation, an insured person's benefit level varies significantly depending on their current program and payer. Benefit levels are the net amounts paid by the sponsors of the insurance, after removing premium contributions by covered individuals and out-of-pocket costs. Medicaid enrollees, for example, pay no premiums and have minimal out-of-pocket costs; their benefit level is close to 100%. Those insured through their employer realize about a 72% benefit level and those who purchase individual coverage have a benefit level of 35% on average, which varies depending on ACA premium subsidies (see [Exhibit 4](#)).

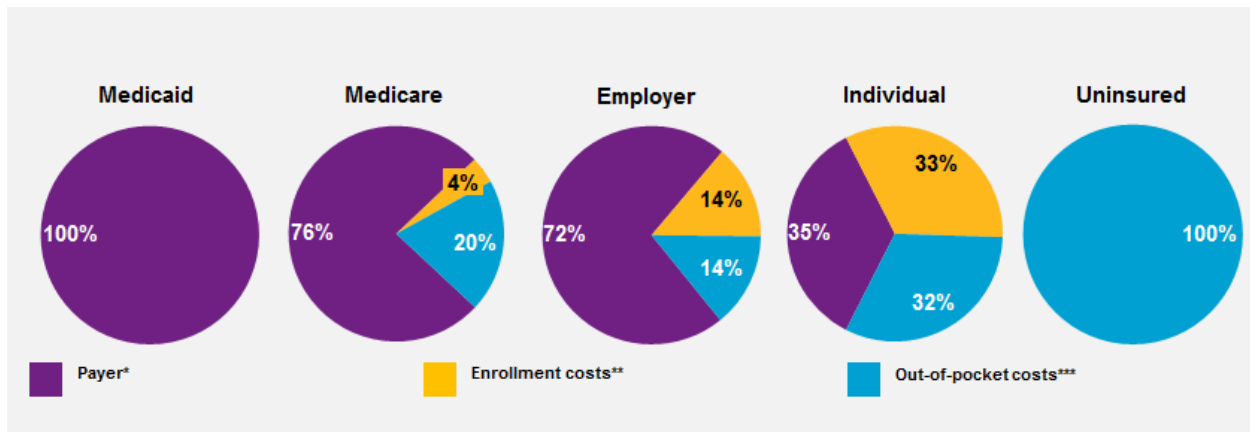
Moreover, there is substantial variation in benefit levels across employer-sponsored plans. Employers in Washington tend to provide higher benefit levels than the national average ([Exhibit 5](#)). However, there is significant variation across employers in the state. See examples in [Exhibit 5](#) for the Public Employees Benefits Board plans and two sample employers in the state.

Under single-payer, all enrollees receive a uniform benefit level. Premiums and out-of-pocket costs are reduced or eliminated across the board. This is not to say that all residents gain equally from single-payer. Premiums and out-of-pocket costs are replaced by some form of taxes, and the specific nature of these taxes and prior benefit levels determine which households will pay more or less under single-payer.

²³ Willis Towers Watson estimate based on analysis of total population data for the state of Washington as well as analysis of OIC carrier reports.

Exhibit 4

Benefit Levels in Washington



Notes:

Source: Willis Towers Watson.

* Payer cost includes the net amount paid by the sponsor of the insurance after covered individuals pay a portion of the premium. In the case of those purchasing individual insurance, the "payer cost" represents the average amount of ACA premium subsidies, which vary significantly by person according to their level of household income.

** Enrollment costs include the premium paid by the covered individual for the insurance.

*** Out-of-pocket costs are paid directly by the covered individual (deductible, copays, and coinsurance).

Individual cost-sharing does not include out-of-pocket subsidies for those qualifying under the Affordable Care Act (ACA).

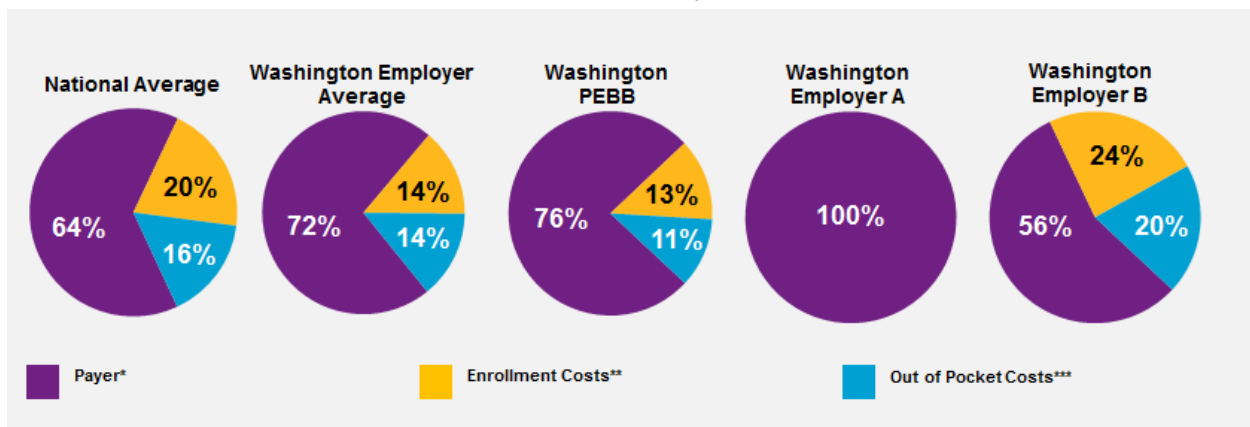
Medicare information does not account for Medicare Supplement plans; that is, the costs covered by Medicare Supplement plans are shown here as part of the out-of-pocket costs.

Amounts shown are for an average covered individual; out-of-pocket costs vary based on health care services used by each covered individual.

Data sources: The Washington State Office of the Insurance Commissioner (OIC), additional data statement forms; Willis Towers Watson 2018 Financial Benchmarks Survey; and the Washington Health Benefit Exchange monthly enrollment reports.

Exhibit 5

Benefit Variation across Employer-Sponsored Plans



Notes:

Source: Willis Towers Watson.

* Payer cost includes the net amount paid by the sponsor of the insurance after covered individuals pay a portion of the premium.

** Enrollment costs include the premium paid by the covered individual for the insurance.

*** Out-of-pocket costs are paid directly by the covered individual (deductible, copays, and coinsurance).

Data sources: Willis Towers Watson 2018 Financial Benchmarks Survey.

Single-Payer Pros and Cons

In moving from the status quo to a single-payer health system, there are a wide variety of possible benefits and consequences.²⁴ Advocates cite potential advantages of single-payer health care systems, such as:

- More equal and universal provision of health care;
- Reduced plan and provider administrative costs;
- Centralized administration; and
- Greater bargaining power in negotiations with drug and device manufacturers, hospitals, and physicians.

Critics point out potential disadvantages, including:

- Public concerns over higher taxes, government control, excessive rationing, and bureaucratic inefficiency;
- Reduced patient choice;
- Potential adverse effects on medical and pharmaceutical innovation;
- Substantial implementation challenges;
- Significant disruption to employment in the insurance market;
- Reduced staffing levels and/or compensation among providers;
- Possible underfunding by the government;

- Increased service “congestion” (e.g., longer wait times for appointments, more stringent referral requirements, etc.); and
- Potential concerns among employers depending upon how single-payer tax financing is structured.

In the national debate over single-payer health care plans, controlling costs has received the most attention. Proponents predict substantial cost savings from adopting a single-payer strategy. Opponents argue these savings are overstated and would be difficult to realize. [Section III](#) discusses the potential impacts of single-payer on health expenditures. We will review evidence for single-payer effects on access to care, health equity, and health outcomes in our final report due to the legislature by June 30, 2019.

²⁴ Blewett, L. (2014). *Single payer health care systems*. State Health Access Data Assistance Center (Presentation to Minnesota Medical Association, August 19, 2014).

III. Potential Single-Payer Effects on Health Care Costs

The United States spends more on health care than other countries. Among the 11 high-income countries examined by Papanicolas and colleagues (2018), the U.S. is an outlier on costs. We spend almost 18% of Gross Domestic Product (GDP) on health care. The average across the other ten countries is 11%.²⁵ Single-payer proposals attempt to mitigate factors that contribute to higher spending in this country.

Some components of single-payer proposals, such as universal coverage, would increase health care expenditures. Other aspects, such as lower administrative costs and reduced provider payments, would act to lower expenditures. The overall impact of single-payer depends on the relative sizes of these and other effects.

Adopting single-payer is expected to increase health expenditures by:

- Providing coverage to the previously uninsured;
- Reducing cost-sharing among enrollees; and, in some proposals,
- Providing more comprehensive benefits (e.g., vision and dental).

Potential reductions in health care system costs could be achieved by:

- Reducing plan administrative costs by shifting out of private into public coverage;
- Negotiating reductions in the prices of pharmaceuticals, medical devices, and provider services; and
- Other potential cost reductions facilitated by centralized single plan administration, such as a reduction in the use of lower value health care services.

We reviewed studies that estimate the effects of national and state single-payer proposals on health care costs. These analyses make different assumptions regarding the magnitude of the effects listed above, and produce varying estimates for the overall impact of single-payer on costs. A brief summary of findings is given below, drawn from analyses of Senator Bernie Sanders' "Medicare for All" proposal as well as state initiatives in California, New York, and Oregon.²⁶ First, we consider the channels through which single-payer coverage increases health expenditures.

²⁵ Papanicolas et al. (2018).

²⁶ The national single-payer studies include Friedman (2013, 2016), Holahan et al. (2016), Thorpe (2016), and Liu (2016). California studies include Senate Committee on Appropriations (2017), Legislative Analyst's Office (2018), and Pollin et al. (2017). New York studies are by Friedman (2015) and Liu et al. (2018). The Oregon study is by White et al. (2017). See reference list for full citations. We also include a discussion of Vermont's single-payer proposal.

How Single-Payer Plans Would Increase Costs

Increased Coverage

Studies start with an estimate of total health care spending under our current system (the status quo), assuming that the Affordable Care Act remains in place. They then add the estimated cost of covering those currently without insurance, who would automatically be enrolled under single-payer. Most single-payer proposals we examined extend coverage to undocumented immigrants.

The estimated increase in health expenditures depends upon the uninsured rate, the current level of spending on health care services for those without insurance (through out-of-pocket, public funding, and uncompensated care), and the increase in health care service utilization among those currently without insurance after they obtain coverage. When individuals gain health insurance, they tend to increase their utilization.²⁷

Reduced Cost Sharing by Enrollees

Cost sharing (out-of-pocket cost) is determined by a plan's level of copay, coinsurance, deductible, and out-of-pocket maximum. The actuarial value of a plan is a measure of cost sharing for an average enrollee. It is the percentage of total average costs for covered benefits that a plan will pay. The actuarial value for "Silver" plans on the ACA Marketplace, for example, is 70%. Traditional Medicare's actuarial value is about 80%, and it is typically 86% for employer-sponsored plans in Washington. Single-payer proposals usually require

modest or no patient cost sharing. Actuarial values for the single-payer proposals we examined generally range from 98% to 100%.

When cost sharing falls, people tend to use more health care services and total health care expenditures increase. Estimates for the size of these increases vary across studies ([Appendix II](#)).

Comprehensive Benefits

Single-payer proposals usually cover the ten ACA essential health benefits.²⁸ Some would cover additional benefits, such as dental and vision. Studies estimate the additional costs of these services. Proposals do not typically include coverage of long-term care, at least initially, but some specify that this coverage be considered in the future.

Covering persons who are uninsured, reducing cost sharing, and expanding covered benefits will increase the demand for health care services. Estimates vary across studies, ranging from 6% to 18% growth in utilization (see [Appendix II](#) for more detail).

It is not clear to what extent the increased demand for health care services can actually be met, given demands already placed on providers. Some recent studies have examined this issue.²⁹ They project expenditures to rise but to a lesser extent

²⁷ For discussions see White et al. (2018), Liu (2016), and Liu et al. (2018).

²⁸ These include ten service categories that health insurance plans must cover under the Affordable Care Act. Essential Health Benefits include outpatient care, hospitalization, emergency care, maternity and newborn care, mental health and substance disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision).

²⁹ See White et al. (2018) and Liu et al. (2018).

than demand for services.³⁰ As a result, congestion is predicted to increase, resulting in impacts such as longer wait times for appointments, more stringent prior authorization, and changes in referral requirements.

Universal coverage, reduced cost sharing, and more generous benefits act to increase health expenditures. These increases could be offset by potential savings related to plan administration, pharmaceutical costs, provider payments, and the opportunity for greater efficiency facilitated by centralized system administration.

How Single-Payer Might Reduce Costs

Plan Administration Costs

Administrative costs are higher in private insurance plans than in Medicare. A greater proportion of the commercial insurance premium dollar goes toward administrative costs today, and this is a potential source of savings in moving to a single-payer system (see [Exhibit 6](#)). Plan administrative costs include eligibility determination, enrollment, developing and maintaining health care provider networks, billing, claims payment, and other insurance-related costs. Private insurer administration also includes marketing, care management, and profits or surplus.

Medicare and Medicaid programs have two layers of administrative costs. [Exhibit 6](#) reports the administrative costs for health plans in 2018. The administrative cost rate for Traditional Medicare is about 2%. Actual

administrative costs for all of Medicare are higher due to higher administrative costs in Medicare Advantage plans. The reported Medicaid administrative rate of 6% reflects state and federal administrative costs. It does not include the additional administrative costs of managed care organizations (MCOs) that administer much of Medicaid coverage.

Studies base their estimates of administrative savings on comparisons of administrative costs between Medicare and private insurance or comparisons between administrative costs in the United States versus other countries (often Canada).³¹

There is debate over what level of administrative costs is feasible under single-payer, and assumptions vary. Some studies assume the single-payer plan administration rate to be around 2%, based on the rate for Traditional Medicare. Others assume rates of around 6%, reflecting a blend of Traditional Medicare and Medicare Advantage plans. Note that administrative costs in other high-income countries average around 3%.³²

Pharmaceutical Drug Prices

Drug costs are higher in the United States than in other countries. Papanicolas and colleagues (2018) estimate that per capita spending on pharmaceuticals was about \$1,450 in the U.S. versus an average of \$750 across high-income countries. This is true despite our greater use of generic drugs.³³

³⁰ For example, Liu et al. (2018) estimate that under the New York Health Act demand for hospital care would increase by 10% and for physician services by 15%. However, they estimate that actual increase in utilization would only be half as large as demand.

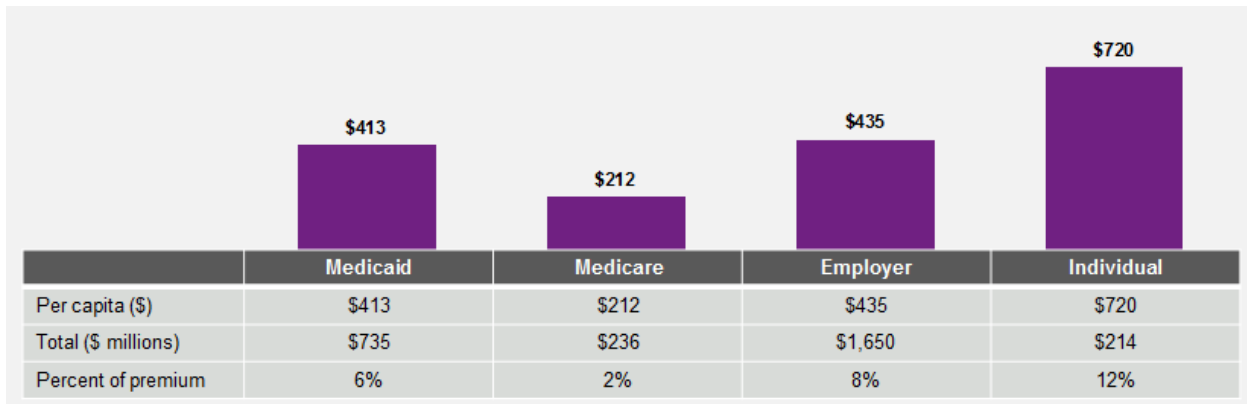
³¹ See Liu (2016) for a comprehensive list of studies used to estimate savings from plan administrative costs, provider administrative costs, drug prices, and provider payments (given in table 3.5, page 75).

³² Papanicolas et al. (2018).

³³ Ibid.

Exhibit 6

Plan Administration Costs in 2018



Notes:

Source: Willis Towers Watson.

The administrative rate for Medicare (2%) corresponds to administrative costs in Traditional Medicare. Actual administrative costs for all of Medicare are higher than shown here due to higher administrative costs of Medicare Advantage plans.

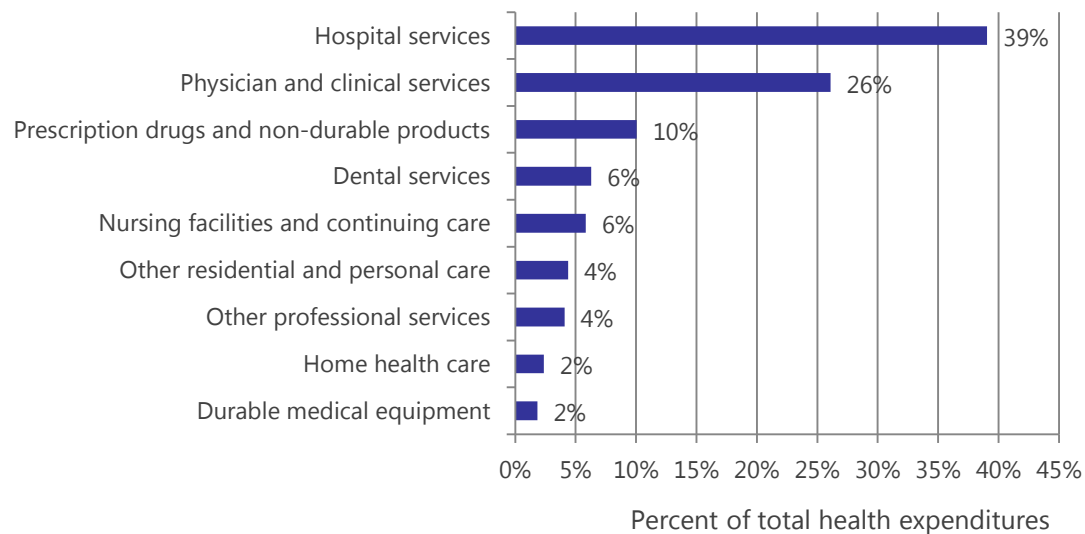
The administrative rate for Medicaid (about 6%) corresponds to only the administrative costs for the sponsoring state and federal agencies. Total administrative costs would also include the administration provided by the MCOs, where applicable, which is not included here.

The employer administration rate (8%) includes both insured and self-insured plans. Self-insured plans tend to have lower administrative costs due to economies of scale and lower risk premiums.

Data sources: The Washington State Office of the Insurance Commissioner (OIC), additional data statement forms; Willis Towers Watson 2018 Financial Benchmarks Survey; Kaiser Family Foundation; MACPAC.gov.

Exhibit 7

Health Expenditures by Service Category



Note:

Source: CMS 2014 Health Expenditures by State of Residence.

Negotiated reductions in drug prices may be a potentially large source of system savings. In Washington State about 10% of total health care expenditures go toward retail sales of prescription drugs (see [Exhibit 7](#)). Note that this percentage does not include the drugs provided in hospital care or administered in a physician's office.

Some single-payer studies do not consider potential reductions in negotiated pharmaceutical prices. Others assume price reductions of 30% to 38%.

Provider Payments

Almost 40% of all health care expenditures go toward paying for services provided by hospitals (see [Exhibit 7](#)). This includes room and board for inpatient stays, ancillary services, resident physician care, inpatient pharmacy, and other services. Payments to hospitals cover the costs of employee salaries, supplies, equipment, facility costs for outpatient use of the hospital including emergency departments and surgical centers, and contribute to profits or margins.

The next largest expenditure category is services provided in offices and clinics operated by doctors. Physician and clinical services also include services rendered by doctors in hospitals, if the physician bills independently for those services. These payments cover salaries for doctors, clinical staff, and administrative staff and other practice expenses.

Provider payment rates vary substantially across payers in our current system. Private insurers pay providers at much higher rates

than Medicare.³⁴ Medicare pays more than Medicaid. Medicaid rates can vary for facilities and professionals who see a disproportionate share of Medicaid (and Medicare) populations. One consequence of these rate differentials is that some Medicaid enrollees have less access to specialty services.³⁵

Under a single-payer system, there would be a single set of payment rates. Some studies assume that single-payer payment rates would be set to a weighted average of current rates across payers: thus total payments to providers would not change. However, revenues would increase for providers who served patients formerly covered by Medicaid and decrease for those who primarily served patients with commercial coverage.

Other studies assume that provider payment rates would fall to somewhere between Medicare and commercial rates, and some assume provider payment rates would fall to the level of Medicare fee-for-service rates.³⁶ Providers would have to decide how to respond to lower payment rates by reducing staffing levels, compensation, and/or equipment.

Reduced administrative burden on providers is one rationale for lowering provider

³⁴ For example, Ginsburg (2010) examined commercial payment rates to hospitals and physicians within eight local markets across the country. Average inpatient hospital rates of four large insurers ranged from 147% to 210% of Medicare. Average physician rates were within 20% of Medicare rates in most geographic areas. Ginsburg, P. (2010). *Wide variation in hospital and physician payment rates evidence of provider market power*. Research Brief No. 16, Center for Studying Health System Change.

³⁵ Rosenbaum, S. (2014). Medicaid payments and access to care. *New England Journal of Medicine*, 371(2345-2347).

³⁶ See, for example, Liu (2016), White et al. (2018), and Liu et al. (2018).

payments. Under single-payer, the administrative burden on providers from dealing with multiple payers would be reduced. Provider administrative costs would decline, though the savings would come at the expense of lost administrative jobs in hospitals, clinics, and offices.

Administrative costs consume roughly 25% of hospital and physician group revenues; about a half of this cost is due to billing and insurance-related tasks.³⁷ Provider administrative costs are relatively high in the United States. Hospital administrative costs in Canada, for example, are half that of the U.S.³⁸

The majority of studies we reviewed include savings from reductions in administrative costs among providers. Assumptions vary, but estimates suggest potential savings of around 10% for payments to hospitals and physicians (see [Appendix II](#)).

Some studies also predict additional savings due to slower growth in health expenditures over time, reflecting growth rate differentials between public programs versus private insurance or between the United States and other countries.³⁹

³⁷ Himmelstein, D., Jun, M., Busse, R., Chevreul, K., Geissler, A., Jeurissen, P., . . . Woolhandler, S. (2014). A comparison of hospital administrative costs in eight nations: US costs exceed all others by far. *Health Affairs*, 33(9), 1586-94; Levitt, L. (2018). *The cost of administering health care*. Presentation to the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage. January 17, 2018.

³⁸ Ibid.

³⁹ See Liu et al. (2018) and Friedman (2013, 2015).

Overall Single-Payer Effect on Health Care Costs

We examined studies of national single-payer proposals and state proposals in California, New York, and Oregon. These studies reach different conclusions regarding the effect that single-payer plans would have on total health care costs, even when the studies address the same proposal (see [Exhibit 8](#)).

One study estimated that health care expenditures would increase by 15% under single-payer. However, most studies predict single-payer would reduce total costs. One cluster of studies estimates cost reductions of 1% to 5%. Another cluster of estimates are in the range of 10% to 15% reductions.

In Washington State, we currently spend around \$55.2 billion for health care annually ([Exhibit 2](#)). If we apply the range of estimates found in the studies we examined, the implications for health care spending in Washington could vary greatly. Consider the following:

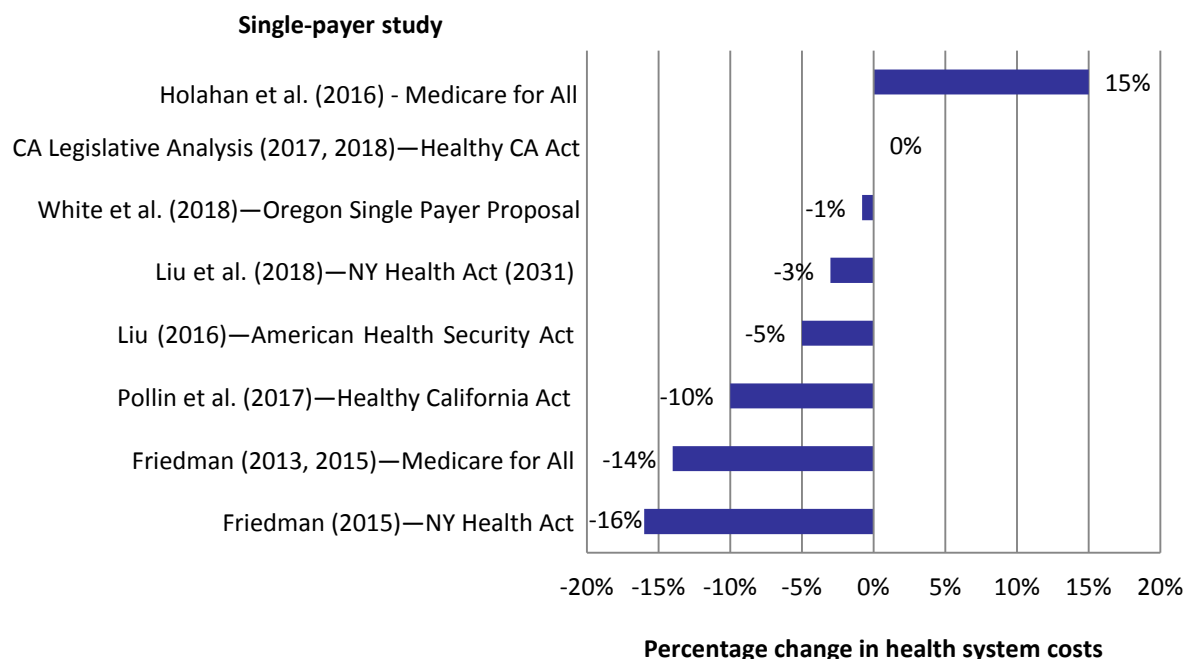
- A 15% increase in total expenditures would represent an additional \$8 billion in spending.
- No change in total health expenditures (a 0% change), means that costs associated with insuring 400,000 additional residents and increased utilization among the insured would be offset by single-payer cost savings.
- A 3% reduction in total expenditures, given total health care costs in Washington, would save \$1.65 billion.
- A 15% reduction in total expenditures would save \$8 billion.

The different estimates across studies are due to different assumptions regarding feasible cost savings under single-payer health care. To illustrate this point, consider the study by Liu and colleagues (2018) for the New York Health Act. The authors' baseline assumptions are that provider payments are set to the average of current rates across payers, the plan administration rate is 6%, and drug prices are 10% below Medicare rates. Using these assumptions, they predict a 3% decline in total expenditures by 2031. The authors also estimate a scenario with a 5% reduction in provider payment rates, 3% plan administration costs, and Medicaid drug prices (which are 34% lower than Medicare). In this scenario, health care costs would decline by 15%.⁴⁰

In order to put these findings into perspective, we estimate that health care spending in the United States would have to fall by 30% in order to be in line with other countries that have GDP per capita over \$50,000.⁴¹ None of the studies we reviewed predict single-payer impacts that large.

Exhibit 8

Single-Payer Effects on Health Care System Costs: Percentage Change in Health Care System Spending Relative to Status Quo



⁴⁰ Liu et al. (2018).

⁴¹ This estimate is based on data reported by Papanicolas et al. (2018). The other three high GDP countries include Sweden, Switzerland, and Denmark.

Critique of Single-Payer Studies

There is substantial uncertainty over the size of single-payer effects on health care costs, as evidenced by the wide range of estimates given above. Assumptions vary regarding feasible reductions in administrative costs, pharmaceutical prices, and provider payments.

Another source of uncertainty is that the potential effects of single-payer may be different in state versus national initiatives. An individual state may have less negotiating power with pharmaceutical and device manufacturers than the federal government. States may also be constrained by potential migration of providers, e.g., if provider payments were reduced under a state single-payer plan, affected providers may leave that state.

There is also uncertainty over the timing of these effects. The studies typically do not provide much insight concerning how long it would take to achieve substantial cost savings, if cost savings are predicted.

Finally, there is uncertainty regarding the size of potential single-payer effects not explicitly included in these studies.⁴² Single-payer plans may promote the use of cost-effective medicine through more effective payment incentives, firmer budget constraints, or system-wide quality of care guidelines.

Utilization of some costly services is higher in the United States than other countries—advanced imaging (MRIs and CTs), high rates of total knee replacements,

hysterectomies, cesarean deliveries, cataract surgery, coronary artery bypass, and coronary angioplasty. Moreover, the costs of these services are higher in the U.S.⁴³

There have been efforts in Washington State to reduce utilization of some these services. The Health Technology Assessment (HTA) program at the Washington State Health Care Authority, for example, makes decisions regarding which medical devices, procedures, and tests to pay for with state health care dollars. Washington's BREE Collaborative, a partnership among public and private stakeholders, has developed guidelines for different surgical procedures, treatments, and end-of-life care. Single-payer centralized administration may extend these decisions and guidelines more broadly across our health care system.

Single-Payer Financing

In order to fund state single-payer plans, proposals assume that federal and state health care spending would be pooled. These funds include:

- Federal funding for Medicaid, Marketplace subsidies, outlays for Medicare, health benefits for federal workers, veterans programs, and
- State funding for Medicaid.

Additional funds would be required to replace employer and household premium payments and out-of-pocket spending, less any attributed single-payer cost savings. Proposals specify a variety of taxes to provide these funds—payroll taxes, gross receipts tax on businesses, sales taxes, income taxes, and taxes on non-payroll

⁴² Only one study, Pollin et al. (2017), explicitly assumes savings from reduced system inefficiencies.

⁴³ Papanicolas et al. (2018) and Fuchs (2018). See Papanicolas et al. (2018) for additional citations.

income (dividends, interest, and capital gains). Under the current system, premium contributions and out-of-pocket spending are substantial. The required new tax revenues would also be substantial ([Appendix III](#)).

Economists have raised two points regarding this shift away from premiums to taxes. First, households ultimately pay for health care through taxes, premiums, out-of-pocket expenses, and foregone earnings. The costs of “employer-sponsored insurance” ultimately fall to workers. In a competitive labor market, payments by employers for health benefits will be offset by reductions in average wages or other benefits.⁴⁴ The increasing cost of health care has been one factor contributing to relatively flat real wages for 30 years.⁴⁵

Second, some proposals we reviewed call for financing through progressive taxes. In the studies which estimate total health care costs to decline, household payments also decline on average. However, due to proposed progressive tax rates, some studies predict relatively large reductions in health care costs among lower-income households and higher costs for the highest income households.⁴⁶

⁴⁴ White et al. (2017) and Baicker, K., & Chandra, A. (2008). Myths and misconceptions about U.S. health insurance. *Health Affairs*, 27(6), w533-w543.

⁴⁵ Emanuel, E., & Fuchs, V. (2008). Who really pays for health care? The myth of ‘shared responsibility’. *JAMA*. See Emanuel & Fuchs (2008) for citations on the health cost-wage tradeoff.

⁴⁶ See, for example, Liu et al. (2018) and White et al. (2017).

IV. Implementation Issues

Any state single-payer proposal will need to navigate existing federal legislation related to Medicaid, Medicare, and the Affordable Care Act (ACA). Another, perhaps lesser known law—the Employee Retirement Income Security Act of 1974 (ERISA)—is a critical factor in implementation of a single-payer proposal.

Medicare, Medicaid, and the ACA have statutory waiver options that states could request in combination to pursue universal health care or design a single-payer system. These waivers could potentially allow states to pool federal ACA Marketplace subsidies, federal contributions to Medicaid and the Children’s Health Insurance Program (CHIP),⁴⁷ and Medicare funds to help finance a single-payer plan. When states are awarded these federal funds in full or in part, they are said to receive pass-through funding. [Exhibit 9](#) summarizes these waivers, and a detailed overview of each is provided in [Appendix I](#).

The process of applying for waivers, however, poses challenges. Applications can be long and resource intensive.⁴⁸ Ultimately, waivers are granted at the discretion of the Health and Human Services (HHS) Secretary. Further, each waiver is limited in scope and would need to be utilized in combination with other waivers to achieve a single-payer system.

⁴⁷ CHIP covers children whose families earn too much to qualify for Medicaid. See [HealthCare.gov](https://www.healthcare.gov). [The Children’s Health Insurance Program \(CHIP\)](#).

⁴⁸ For example, 1332 waiver applications must contain actuarial analyses and certifications; economic analyses and associated data and assumptions; as well as ongoing implementation targets; among other requirements. See [Application, Review, and Reporting Process for Waivers for State Innovation Final Rule, February 27, 2012](#).

The discussion that follows summarizes potential legal and financial barriers that any state proposing a single-payer system would face with respect to Medicaid, Medicare, the ACA, and ERISA. We also discuss potential ways to work around these barriers.

[Medicaid & Medicare](#)

As discussed in [Section II](#), the current U.S. health care system is funded and administered through a wide array of both public and private insurers. A single-payer health care system, however, would offer just one comprehensive benefit plan to all residents. Beneficiaries of government programs, including Medicaid and Medicare, would not be distinguished from other beneficiaries. As displayed in [Exhibit 1](#), approximately 39% of Washington residents receive coverage through a government program.

Many state single-payer proposals plan to redirect federal Medicaid and Medicare funds to a single state pool in order to finance expanded coverage (see [Appendix III](#)). This state fund would be administered by a new state authority or board authorized to spend health care funds. To achieve this, states will seek exemptions from federal regulations related to Medicaid and Medicare to the extent that they do not jeopardize access to those funds.

Exhibit 9

Overview of Relevant Federal Laws and Waivers

Legislation	Waiver or demonstration authority	Summary
Patient Protection and Affordable Care Act (2010), Section 1332	State Innovation Waiver, aka 1332 Waiver or State Relief and Empowerment Waiver*	Effective January 1, 2017, allows for waiver of ACA requirements such as qualified health plans and marketplace rules. Permits states to request subsidy pass-through funding. Requires that four protective guardrails be met.
Social Security Act, Section 1115	Medicaid Demonstration Waiver, aka 1115 Waiver	Allows for waiver of Medicaid Section 1902 provisions while testing innovative ways to serve beneficiaries. Since the 1990s, states have used such waivers for broad purposes.
Social Security Amendments of 1967, Section 402(b)	Medicare Waiver, aka 402(b) Waiver	Allows for departures from Medicare payment rules in pursuit of improved efficiency of Medicare service provision.
Social Security Act, Section 1115A	Center for Medicare and Medicaid Innovation (CMMI)	The 2010 ACA established the Center for Medicare and Medicaid Innovation (CMMI) with the authority to test innovative health care payment models that could lower Medicare, Medicaid, and/ or CHIP funding.
Employee Retirement Income Security Act	No existing waiver	Blocks states from regulating employer-sponsored health care.

Notes:

*In October 2018, the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of the Treasury released new guidance regarding 1332 waivers. In brief, the guidance aims to “loosen excessive restrictions” and provide “increased access to affordable private market coverage,” among other initiatives. The guidance indicated that these waivers are now also referred to as State Relief and Empowerment Waivers. See the CMS Fact Sheet and Appendix I for additional detail.

ACA = Patient Protection and Affordable Care Act. CHIP = Children’s Health Insurance Program.

Medicaid

States have the freedom through Section 1115 waivers to access federal Medicaid funding for innovative design, a feature many states have long utilized (see [Exhibit 9](#) and [Appendix I](#) for additional detail).⁴⁹ Historically, states have used such waivers to expand eligibility, restructure the process of enrollment, establish long-term services and supports, or otherwise alter benefits and cost-sharing.⁵⁰

It is questionable whether a Section 1115 waiver could be used to amend Medicaid financing rules such that federal expenditures would flow to a single state fund. Currently, federal Medicaid dollars are awarded as matching funds (FMAP rates)⁵¹ for approved state expenditures, a formula set in statute. States must track both Medicaid eligibility determination and expenditures in order to access these

⁴⁹ For an overview of current waivers, see the Kaiser Family Foundation. (2018). [Section 1115 Medicaid demonstration waivers](#).

⁵⁰ The Commonwealth Fund. (2018). [1115 Medicaid Waivers: From Care Delivery Innovations to Work Requirements](#).

⁵¹ The Federal Medical Assistance Percentage (FMAP) is the federal government’s share in state Medicaid expenditures. The remainder is covered by states. Nationally in FY2019, the FMAP ranged from 50% to 76.39% of state Medicaid expenditures. In Washington, between FY2014 and FY2019, the rate has consistently been 50%. See Mitchell, A. (2018). [Medicaid’s Federal Medical Assistance Percentage \(FMAP\)](#). Congressional Research Service, Washington: DC.

federal funds. Redirecting those funds to a state pool would require a change to this funding formula. Because the funding formula is contained in a section of the Social Security Act that is outside the scope of the 1115 waivers,⁵² decoupling Medicaid funding from the concept of federal matching funds would require a change to federal statute.⁵³

However, a report by Manatt Health and the California Health Care Foundation suggests states could potentially use a Section 1115 waiver to move away from tracking expenditures on a per-enrollee basis so long as states continue to track state spending and contribute their share of Medicaid funding per the FMAP rules. States could instead negotiate capped funding with the Centers for Medicare & Medicaid Services (CMS).⁵⁴ In this scenario, HHS would set a per capita spending cap on federal Medicaid contributions.

States could also choose to preserve the matching payment structure as it currently exists by continuing to operate Medicaid in the background of a single-payer system.⁵⁵ In other words, a state could continue to track eligibility and expenditures for its Medicaid program in a purely administrative manner. This would allow the state to

continue to access federal Medicaid dollars while simplifying the waiver process.

Finally, CMS will not approve any Section 1115 waivers that fail to ensure Medicaid beneficiaries will not experience a reduction in benefits or an increase in cost sharing.⁵⁶

Medicare

As discussed, state single-payer proposals may seek to divert Medicare funding to a pooled state fund. Per [Exhibit 8](#), there are two pathways for states to make changes to Medicare. Section 402(b) of the Social Security Amendments of 1967 authorizes the secretary of HHS to waive Medicare payment rules for demonstrations.⁵⁷ Alternatively, the Center for Medicare & Medicaid Innovation (CMMI) may also grant states authority to test innovative models within Medicare, Medicaid, and CHIP populations.

While states often make changes to their Medicaid programs, Medicare changes are infrequent. Only two states have received permission to involve Medicare in health care system changes.⁵⁸ Maryland received a Medicare waiver beginning in 1974, which allowed the state to create an all-payer hospital rate-setting system.⁵⁹ Vermont received permission from CMS to allow Medicare to participate in the state's all-

⁵² These waivers technically apply to only Section 1902 of the Social Security Act, which contains eligibility and benefits provisions. Under different administrations, CMS has broadened the provisions of federal Medicaid statute that can be waived. For an overview, see Kaiser Family Foundation. (2017, October 25). [How Medicaid Section 1115 Waivers are evolving: Early insights about what to watch](#). [press release].

⁵³ White et al. (2017).

⁵⁴ Manatt Health. (2018). [Understanding the rules: Federal legal considerations for state-based approaches to expand coverage in California](#).

⁵⁵ Ibid.

⁵⁶ Manatt Health (2018) and White et al. (2017).

⁵⁷ Social Security Amendments of 1967, Pub. L. No. 90-248, Section 402, 42 U.S.C. Section 1395b-1. See Appendix II for an overview of this demonstration authority.

⁵⁸ White et al. (2017).

⁵⁹ In an all-payer system, each provider receives the same reimbursement per service regardless of the payer. Payers include private health insurance, employer-sponsored insurance (including self-insured), Medicare, Medicaid, and uninsured patients. See National Conference of State Legislators. (2018). [Equalizing health provider rates: All-payer rate setting](#). and Centers for Medicare & Medicaid Services. [Maryland All-Payer Model](#).

payer system beginning in 2017.⁶⁰ In this arrangement, Vermont sets monthly fees that commercial insurers, Medicare, and Medicaid will pay to providers.

Both cases are limited to changes to provider payments. States were not authorized to control Medicare eligibility or determine benefits.⁶¹ Neither state was awarded pass-through funding for Medicare enrollees, meaning they did not receive permission to route federal funds into a state health care program. Ultimately, the HHS Secretary does not have authority to redirect federal Medicare funding streams to states.⁶² The limited nature of these Medicare demonstrations suggests it would be difficult to make the broader changes to Medicare that single-payer would require.⁶³

Similar to the Medicaid workaround, rather than attempting to route Medicare funds into a state health care program, states could pursue mandatory enrollment of eligible individuals into Medicare programs.⁶⁴

⁶⁰ Centers for Medicare & Medicaid Services. [Vermont All-Payer ACO Model](#).

⁶¹ White et al. (2017).

⁶² Cubanski. (2018). *Presentation to California State Assembly Select Committee on Health Care Delivery Systems and Universal Coverage*.

⁶³ The ACA also included a demonstration program related to individuals who are dually eligible for both Medicare and Medicaid. Under the demonstration, a limited number of states were given the opportunity to share Medicare savings that resulted from implementation of programs designed specifically for this population. Washington State has participated in the demonstration and received Medicare shared savings funds (See Centers for Medicare and Medicaid Services. (2018, October 5). [Financial Alignment Initiative \(FAI\)](#)).

⁶⁴ Manatt Health (2018).

[The Affordable Care Act \(ACA\)](#)

A single-payer health system would alter components of the Affordable Care Act (ACA). The Section 1332 waiver (see [Exhibit 8](#)) permits some changes to the ACA, including the replacement of marketplaces with a single plan. States could use the same waiver to collect pass-through funding for ACA premium tax credits to low-income individuals and families purchasing insurance through health insurance exchanges.⁶⁵ In other words, states can opt to directly receive the total amount in federal funds that would have subsidized low-income individuals and families purchasing insurance through a marketplace. States could instead route these funds into a state health program.

The 1332 waiver allows these changes so long as states can ensure they continue to meet clear standards (commonly known as “the four guardrails”) regarding comprehensiveness of benefits and beneficiaries, affordability, and budget neutrality.⁶⁶

As of October 2018, eight states (Alaska, Hawaii, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin) have received 1332 waivers.⁶⁷ However, all of these waivers concern federal pass-through funding for reinsurance programs, which aim to lower premiums by making high-risk individuals⁶⁸ less risky to insurers.⁶⁹ It

⁶⁵ Kaiser Family Foundation. (2018, August 23). [Tracking Section 1332 State Innovation Waivers](#).

⁶⁶ See Appendix I.

⁶⁷ Kaiser Family Foundation. (2018, August 23). [Tracking Section 1332 State Innovation Waivers](#).

⁶⁸ For example, individuals with a pre-existing condition may be considered high-risk. See Healthcare.gov. [High-Risk Pool Plan \(State\)](#).

remains to be seen whether CMS will approve pass-through funding for policies other than reinsurance. Further, 1332 waivers may come into conflict with ERISA, which is discussed below and in [Appendix I](#).

In the preceding discussion, we point to the various waivers that could potentially be used to make exception to federal law. In addition to the issues already addressed, it has been suggested that establishing a single-payer or universal health-care system by relying on waivers or demonstrations represents a departure from the intent of those programs. In general, waivers seek to test time-limited, innovative ideas rather than institute permanent change.⁷⁰ Implementing a single-payer health care would involve a system-wide transformation.

[The State-Based Universal Health Care Act of 2018](#)

There are efforts to change federal regulations in order to facilitate implementation of state universal health care systems. The State-Based Universal Health Care Act of 2018 (H.R. 6097), proposed by Congresswoman Pramila Jayapal would replace the ACA's 1332 State Innovation Waiver with a "Waiver for State universal health care." This single waiver would be approved at the discretion of the HHS Secretary and would give states authority to waive components of multiple

federal laws, including the ERISA preemption provision.⁷¹

The bill provides for federal pass-through funding from federal programs, stating that the Secretary "shall provide for an alternative means by which the aggregate amount of [Federal health funds] shall be paid to the State for purposes of implementing the State plan under the waiver."⁷²

By streamlining changes to federal law and access to pass-through funding into a single waiver process, this bill addresses the legal and financial barriers to universal or single-payer systems raised above. It leaves a great deal of discretion to states as to the design of health care systems, requiring only that 95% of the population of participating states have access to health care within five years. So long as they achieve universal coverage, states would have the option to establish single-payer systems, or to pursue other initiatives that may involve coordination with private entities.

[Employee Retirement Income Security Act of 1974 \(ERISA\)](#)

The Employee Retirement Income Security Act of 1974 (ERISA) establishes regulatory standards for private-sector employee benefits, including health care.⁷³ ERISA has generally proved an obstacle to health reform because it bars states from

⁶⁹ Reinsurance programs waive the ACA requirement that all market enrollees be part of a single risk pool. They create state-operated programs that reinsure insurers for high-risk individuals, with the goal of lowering premiums and expanding coverage. See the National Conference of State Legislators. (2018, October 22). [State roles using 1332 Health Waivers](#).

⁷⁰ Cubanski (2018).

⁷¹ Jayapal, P. (2018, June 11). *In Seattle, Rep. Jayapal unveils state-based universal health care act*. [press release].

⁷² The State-Based Universal Health Care Act of 2018 (H.R. 6097).

⁷³ The most current guidance on ERISA is available from the National Association of Insurance Commissioners (NAIC). While under revision, it is publicly available. NAIC. (2018). [Health and welfare plans under the Employee Retirement Income Security Act](#). Washington, DC.

regulating employer-sponsored plans (ERISA plans). In short, when states attempt to regulate employer group health care plans, state law is “preempted” or replaced by federal law.⁷⁴

A distinction is made between self-insured ERISA plans and fully insured employer group health plans. States have authority to regulate the health insurance plans that are purchased by employers under the ERISA “savings clause.”⁷⁵ However, ERISA plans that self-insure are exempt from state regulation.⁷⁶ In Washington State, about 70% of residents with employer-sponsored coverage (roughly 2.75 million Washington residents) are in self-insured plans ([Section II](#)).

Because the statutory guidance around ERISA health plans is brief,⁷⁷ the law’s scope has largely been established through case law. Due to ambiguity in this case law and changes in interpretation of ERISA by federal courts over time, there are likely to be ERISA-based challenges to state single-payer plans.⁷⁸ (See [Appendix II](#) for a more detailed discussion of ERISA and case law.)

According to the National Academy for State Health Policy (NASHP), states have the authority to tax and regulate traditional insurers and the

products they sell to employers.⁷⁹ However, states cannot regulate or directly tax ERISA plans, mandate that employers sponsor insurance,⁸⁰ or indirectly impose substantial changes to such plans. States cannot force employers to discontinue self-insured plans. Many employers may choose to do so under a single-payer system but some could use ERISA to challenge a state single-payer initiative. In particular, challenges could arise due to payroll tax financing and multi-state employment.

If confronted with single-payer universal coverage and the need to increase payroll taxes to fund the coverage, self-insured employers may argue that they are forced to discontinue their health plans or modify them to a significant extent. This would open up single-payer plans to challenges under ERISA.⁸¹

Employers may decide to discontinue self-insured health care coverage under single-payer. However, this would create challenges for firms with out-of-state employees. It may be more difficult for firms to continue offering coverage to these workers. For example, given a reduction in the size of their risk pools, firms may need to purchase fully insured plans for their out-of-state employees.⁸²

There are no waivers for ERISA, and only one federal exemption has ever been issued—to Hawaii in 1983—with regards to a law that the state had passed just prior to the passage of ERISA.

⁷⁴ For a concise overview of ERISA in the context of health system transformation, see Center for Disease Control and Prevention. [Public health law](#).

⁷⁵ See Appendix I for additional detail.

⁷⁶ 29 U.S.C. section 1144(b)(2)(B).

⁷⁷ In statute, ERISA explicitly requires only that employers disclose to employees information about the health plans and that employers uphold fiduciary responsibility in managing plans. See Francis, L. (2017, September 21). [ERISA and Graham-Cassidy: A disaster in waiting for employee health benefits and for dependents under 26 on their parents’ plans](#). [blog post]. Petrie-Flom Center: Harvard Law School.

⁷⁸ Liu et al. (2018).

⁷⁹ Butler, P.A. (2000). [ERISA Preemption Manual for State Health Policymakers](#). Washington (DC): Alpha Center.

⁸⁰ Note that an employer mandate is permissible at the federal level. The ACA’s employer shared responsibility provisions (aka “the employer mandate” or “the pay or play provisions”) require large employers to meet minimum essential coverage or make a payment to the IRS.

⁸¹ White et al. (2017) and Liu et al. (2018).

⁸² Liu et al. (2018).

V. Single-Payer Proposals in the United States

No state has yet successfully implemented a single-payer system, but many proposals have been put forth. Published reviews have identified the following common characteristics among single-payer proposals in the United States.⁸³

- Single-payer plans would provide comprehensive benefits.
- Plans would include little or no cost sharing.
- Patients would be free to choose providers, though in some cases choice is only for primary care physicians and referrals are required for specialty care.
- Private insurance would be limited to supplemental coverage for benefits not offered by the plan.
- Payment models vary, including fee-for-service, capitation, and global budgets for total expenditures.
- Prescription drug formularies and thresholds for administrative costs are often included.

We summarize selected recent single-payer proposals below—Senator Bernie Sanders’ “Medicare for All” at the federal level and state initiatives in California, Vermont, Oregon, and New York. Please see [Appendix III](#) for more detailed descriptions of proposal characteristics.

We also summarize estimates of the effects these proposals would have on health care costs by discussing some of the research described in [Section III](#) in more detail. The

studies are difficult to compare directly, as they all use different assumptions and different approaches to estimating changes in projected costs. [Appendix II](#) contains more detailed summaries of individual studies.

Medicare for All

Senator Bernie Sanders proposed a national single-payer plan during his 2016 presidential campaign. The following discussion is based on that proposal and his more recent Medicare for All Act of 2017. Key plan characteristics⁸⁴ include:

- A single, federally administered plan would replace other existing coverage, except for Veterans Health Insurance and Indian Health Service.
- Coverage would be provided for all residents of the United States.⁸⁵
- There would be no cost sharing.
- The plan would provide comprehensive benefits—hospital; ambulatory services; primary and preventive services; prescription drugs, medical devices, and biological products; mental health and substance abuse treatment; lab and diagnostics; comprehensive reproductive; maternity and newborn; pediatrics; and dental and vision.
- Long-term care for seniors and people with disabilities would

⁸³ Liu & Brook (2017) and Blewett (2014).

⁸⁴ [Medicare for All: Leaving No One Behind](#) (Medicare for All Act of 2017: [Executive Summary](#)).

⁸⁵ The proposal does not explicitly address undocumented immigrants, but it does extend coverage to “all residents.”

continue as it is currently covered by Medicaid.

- Patients would be able to choose a health care provider.

The findings from studies projecting the long-term cost impact of Medicare for All vary more than for any other proposal.

Friedman (2013, 2015) estimated that the Sanders plan would extend coverage to 29 million residents, remove all cost sharing, and reduce health care expenditures by 14% relative to the current system between 2017 and 2026.⁸⁶ However, under a different set of assumptions, Holahan and colleagues (2016) estimated that the plan would increase total system costs by 15% over the same period. Holahan and colleagues predict larger cost increases from covering those without insurance and eliminating cost sharing. They also assume lower savings from reduced pharmaceutical prices, provider payments, and expenditure growth over time.⁸⁷

Liu (2016) analyzed another national proposal, the American Health Security Act (S. 1782, 113th Congress). This proposal is similar to Medicare for All, but it does not extend coverage to undocumented immigrants. The study estimates that the Act would increase coverage by 16 million people and reduce health care costs by 5%. Liu estimates expenditures to increase by about 18% due to increased coverage and lower cost sharing. These cost increases would be more than offset by savings associated with plan and provider administrative cost reductions, lower drug costs, and reduced provider payments.⁸⁸

⁸⁶ Friedman (2013, 2015).

⁸⁷ Holahan et al. (2016).

⁸⁸ Liu (2016).

New York Health Act

The New York Health Act of 2018, under consideration by the New York State Legislature, would create a single-payer health care system in the state.

Key plan characteristics⁸⁹ include:

- A state sponsored single-payer plan would replace other types of coverage (conditional on federal waivers).
- All residents, including undocumented immigrants, would be covered.
- Benefits would include those covered by Medicare, Medicaid, and the ACA essential health benefits.
- There would be no cost sharing.
- Enrollees would have a care coordinator.
- Long-term care would not be covered initially, though it could be considered later.
- The payment method would be fee-for-service; other methods could be considered.
- Payment rates would be set to ensure “adequate and accessible supply” of services.
- Private insurance cannot offer the same benefits covered under the state plan.

Two studies of the New York Health Act came to somewhat different conclusions.

Friedman (2015) estimated that coverage would be extended to 1.3 million residents,

⁸⁹ New York Assembly Bill A5062A, An act to amend the public health law and the state finance law, in relation to enacting the “New York health act” and to establishing New York Health.

and total health care system spending would be reduced by 16% relative to the status quo, due to significant reductions in provider and plan administrative costs and prescription drug costs.⁹⁰ Liu and colleagues (2018) assumed smaller reductions in administrative costs and drug prices and estimated that annual total health care spending would be reduced by 1% in 2022. Liu and colleagues also projected that cost savings would increase over time, and annual spending would be 3% lower by 2031.⁹¹

Healthy California Act

The California Senate approved the Healthy California Act (Senate Bill 562) in June of 2017. The act, which would have established a single-payer system in California, did not receive a vote in the state Assembly.

Key plan characteristics⁹² include:

- Coverage is extended to all California residents.
- Benefits include inpatient and outpatient care, dental and vision care, mental health and substance abuse treatment, and prescription drugs. Members are entitled to “all medical care determined to be medically appropriate by the member’s health care provider.”
- Long-term care would not be covered initially but would be considered at a later date.
- There would be no cost sharing.
- Any licensed provider who is legally allowed to practice in California can participate in the program.
- Members are allowed to receive services from any participating provider of their choice. They are not required to seek referrals before visiting a participating provider.
- Care coordination services must be provided to members.
- Private insurers are prohibited from providing coverage for services already covered in the statutory plan.
- Private insurers are permitted to offer complementary coverage, which would provide benefits that are excluded in the statutory plan.
- Plan representatives will engage in “good faith negotiations” to establish “reasonable rates” for health care services and prescription and non-prescription drugs.
- Payment rates would be set to ensure “adequate and accessible supply” of services.
- Utilize a fee-for-service payment method “unless and until” the board decides to implement a different policy.
- Some entities, such as group practices or other types of integrated delivery systems, can elect to receive a capitated or noncapitated operating budget.
- Prohibit payments to for-profit providers to compensate for profits, return on investments, or tax payments.
- Prohibit balance billing.
- Authorize funding for retraining of workers in the health insurance industry who would no longer be employed under the Healthy California Act.

⁹⁰ Friedman (2015).

⁹¹ Liu et al. (2018).

⁹² The Healthy California Act 2017 SB-562.

Two studies of the Healthy California Act reached somewhat different conclusions.

California legislative staff estimated that coverage would be extended to three million California residents. The analysis concluded that cost savings from administrative efficiencies and reduced provider payments would be largely offset by the increased cost of covering those without insurance and increased utilization.⁹³ Pollin and colleagues (2017) estimated that total health costs would be reduced by 10%, driven by larger assumed reductions in plan and provider administrative costs, pharmaceutical costs, and provider payments. In addition, Pollin and colleagues assumed reductions in system inefficiencies, such as unnecessary services, inefficient service delivery, and missed opportunities for prevention.⁹⁴

Oregon Single-Payer

The Oregon legislature asked researchers at the RAND Corporation to examine options for health care financing reforms. One option was to establish a single-payer system in the state. Key plan characteristics⁹⁵ include:

- A single, state-administered plan would cover all residents of Oregon, including undocumented immigrants.
- The plan would cover the ACA essential health benefits for all and Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children.

- The plan would not cover institutional long-term care.
- Cost sharing would be low; no cost sharing for residents with incomes under 250% federal poverty level and 4% for those above this threshold.
- There would be no premiums.
- Employers that currently provide health benefits would be required to pass back any savings in the form of increased wages.

The RAND researchers found that the proposed plan would slightly reduce total health system costs. White and colleagues (2017) estimated that coverage would increase by 215,000 people. Due to offsets from reductions in plan administrative costs and reduced provider payments, the authors estimated that total health care system spending would decrease by 1%. The authors did not assume any reductions in drug costs.⁹⁶

⁹³ California Senate Committee on Appropriations (2017); Legislative Analyst's Office (2018).

⁹⁴ Pollin et al. (2017).

⁹⁵ White et al. (2017).

⁹⁶ Ibid.

Vermont Green Mountain Care

The Vermont Legislature enacted single-payer legislation (Act 24, Green Mountain Care) in 2011. The initial legislation did not propose how the plan would be financed but directed that a plan be developed. Initial estimates suggested substantial cost savings from the plan. Subsequent studies predicted lower savings. Financial plans were also revised to reflect lower than expected available federal funds and larger proposed reductions in cost sharing. Ultimately, state agency analysis estimated the plan would require raising payroll taxes by 11.5% and income taxes by up to 9%. In December 2014, Vermont Governor Peter Shumlin decided not to continue with the plan.⁹⁷ Key plan characteristics⁹⁸ included:

- Undocumented immigrants would not be allowed to participate.
- Cost sharing was to be moderate. The plan was to have an actuarial value of at least 87%.⁹⁹
- Comprehensive benefits, offering at least the federally required ten ACA essential health benefits and could expand to include dental, vision, hearing, and long-term coverage in the future.
- No restrictions on health care provider participation.
- Members could choose their primary care provider.
- Members are not required to terminate any forms of existing coverage and may choose to keep any existing supplemental insurance.
- Payments should “be consistent with efficiency, economy, and quality of care” and allow health care professionals to provide “effective and efficient health services that are in the public interest.”
- Payments should also eliminate cost shifting and ensure residents have access to services and that services are distributed equally.
- If appropriate, the board may decide to pay health care professionals on a fee-for-service basis. However the board could invoke other payment methods including, but not limited to, global payments, global budgets, risk-adjusted capitated payments, bundled payments, or setting cost-containment targets.
- Other cost-containment mechanisms include using drug formularies, administration simplification, and malpractice reform.

⁹⁷ Weiner, J., Rosenquist, R., & Hartman, E. (2018). *State efforts to close the health coverage gap. Issue Brief 2*.-2018. Leonard Davis Institute of Health Economics, University of Pennsylvania; Troy, T. (2017). *A move to single-payer health care? Implications for Employer-Sponsored Care*. American Health Policy Institute.

⁹⁸ Vermont General Assembly, Vermont Health Reform Law of 2011, Act 48.

⁹⁹ Ultimately the plan’s actuarial value increased to 94%. Troy (2017).

Three studies of the Green Mountain Care plan found that the plan would reduce health care costs to varying degrees. Hsiao and colleagues (2011) estimated that the plan would achieve 8% to 12% cost savings in the short term and 25% savings in the long term (2015-2024).¹⁰⁰ Unlike other estimates we have discussed in this section, these are gross savings and do not net out the increased cost of covering people without insurance and reducing cost sharing.

Two other studies came to very similar conclusions. One, by the University of Massachusetts Medical School and Wakely Consulting Group (2013), estimated cost savings of 1.5% between 2017 and 2019.¹⁰¹ The other, an analysis by the State of Vermont (2014) estimated cost savings of 1.6% over five years.¹⁰²

¹⁰⁰ Hsiao, W., Knight, A., Kappel, S., Done, N. (2015). What other states can learn from Vermont's bold experiment: embracing a single-payer health care financing system. *Health Affairs*. 30(7), 1232-1241; McDonough, J. (2015). The demise of Vermont's single-payer plan. *New England Journal of Medicine*, 372(17), 1584-1585.

¹⁰¹ University of Massachusetts Medical School and Wakely Consulting Group. 2013. State of Vermont Health Care Financing Plan Beginning Calendar Year 2017 Analysis. Report prepared for the Vermont Agency on Administration.

¹⁰² Cited in McDonough (2015).

VI. Summary

Universal health care is a system where all people can use the necessary services to enhance their health without putting themselves through substantial financial hardship.

The uninsured rate in Washington State is under 6% and about 400,000 Washington residents remain uninsured.¹⁰³ In order to promote universal coverage, some states have considered insurance mandates, extending Medicaid and Marketplace coverage to undocumented immigrants, state-funded subsidies to lower the cost of coverage in the individual market, and a public plan for individuals and small groups.

Single-payer health care systems achieve universal coverage by design. All residents are automatically enrolled in a single, publicly financed insurance plan that provides comprehensive health care. Under single-payer plans, individuals with Medicaid, Medicare, employer-sponsored insurance, individual coverage, and those without insurance would all be enrolled in a single public plan. These other types of public and private insurance would cease to exist.

Advocates cite potential advantages of single-payer health care systems including more equal and universal provision of health care, cost savings through reducing plan and provider administrative costs, and greater bargaining power in negotiations with drug and device manufacturers, hospitals, and physicians.

Critics point out potential disadvantages, including public concerns over higher taxes, government control, excessive rationing of care; implementation challenges; significant disruption to employment in the insurance market and lost jobs among administrative staff in hospitals and clinics; possible underfunding by the government; and adverse effects on medical and pharmaceutical innovation.

Among the potential benefits, controlling costs has received the most attention. Proponents predict substantial cost savings for adopting single-payer health care. Opponents argue these savings are overstated and would be difficult to realize.

Adopting a single-payer system would increase health expenditures by extending coverage to the previously uninsured, reducing cost-sharing among enrollees, and providing more comprehensive benefits.

On the other hand, a single-payer system could decrease health expenditures by reducing plan and provider administrative costs, negotiating reductions in the prices of pharmaceuticals and medical devices, reducing payments to providers, and realizing other potential cost reductions facilitated by single plan administration.

Assumptions regarding the relative magnitudes of these effects vary, as do estimates for the overall effect of single-payer plans on total health care expenditures. Some studies predict total costs to rise and others estimate substantial cost savings.

¹⁰³ Estimate based on the uninsured rate from Yen & Mounts (2018) and the state population estimate from the Washington State Office of Financial Management. (2018, July). [State of Washington Population Trends](#).

Single-payer proposals also differ in regard to implementation details related to controlling costs, such as how provider payment rates are to be set. So, there is substantial uncertainty over how large single-payer effects on health care costs would be. There is also uncertainty over the timing of these effects.

Among the studies we reviewed, estimates ranged from a total expenditure increase of 15% to an expenditure decrease of 16%. Most studies predict single-payer plans would reduce total costs. One cluster of studies estimates cost reductions of 1% to 5%. Another cluster of estimates are in the range of 10% to 15% reductions.

Single-payer funding proposals rely on pooling federal health care spending to help pay for state plans. Gaining federal approval to do so would be a major challenge. State single-payer initiatives could also face challenges under the federal law regulating employee benefits (ERISA).

Additional funds would be required to replace employer and household premium payments and out-of-pocket spending, less any attributed single-payer cost savings. Proposals specify a variety of taxes to provide these funds—payroll taxes, gross receipts tax on businesses, sales taxes, income taxes, and taxes on non-payroll income (dividends, interest, and capital gains).

VI. Next Steps

The forthcoming final report will provide additional commentary on U.S. initiatives, describe universal coverage and single-payer systems in other countries, and summarize the evidence regarding differences across high-income countries in health care costs, utilization of services, quality of care, access, and equity.

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Appendices

Single-Payer and Universal Coverage Health Systems: *Interim Report*

Appendices

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I. Overview of Relevant Laws and ERISA

Overview of Relevant Laws and Waivers

Creating a legal pathway to implementing a state-based single-payer system would require the use of multiple waivers in conjunction to navigate federal law related to Medicaid, Medicare, and the Affordable Care Act (ACA). The various waivers as well as ERISA are briefly summarized below.

State Innovation Waivers (Affordable Care Act Section 1332)

Section 1332 of the ACA permits states to apply for a State Innovation Waiver (1332 waiver) of ACA provisions in pursuit of alternatives to standard marketplace coverage. The waivers became available January 1, 2017 and are valid for a period of five years. The Secretary of Health and Human Services (HHS) and the Secretary of the Treasury approve waiver proposals at their discretion. ACA requirements eligible to be waived include qualified health plans (QHBs); essential health benefits (EHBs); rules around cost sharing and premium tax credits for marketplace plans; metal tiers of coverage; and standards for health insurance marketplaces. States may use this waiver to request subsidy pass-through funding, equivalent to the sum of premium tax credits and cost-sharing reductions states would otherwise be eligible to receive in federal funding.¹⁰⁴

Requirements related to Medicaid and Medicare cannot be waived with a 1332 waiver. Any application for a 1332 waiver must meet four guardrails designed to protect beneficiaries from any negative impacts resulting from a change in coverage. Compared to default coverage under the ACA, waivers must (1) cover at least as many state residents, (2) be at least as affordable in terms of premiums and cost sharing (e.g., deductibles and co-pays), and (3) provide benefits that are at least as comprehensive as the state's essential health benefits benchmark plan.¹⁰⁵ Waivers also (4) must not increase the federal deficit.

In response to a 2017 executive order,¹⁰⁶ the Centers for Medicare & Medicaid Services (CMS) and the Department of the Treasury released new guidance regarding 1332 waivers in October 2018.¹⁰⁷ Reflecting new changes, this guidance indicated that these waivers are now also referred to as "State Relief and

¹⁰⁴ Section 1332(b)(1) of the ACA, codified at 42 U.S.C. Section 18052(b)(1).

¹⁰⁵ The ACA requires plans in the individual and small group markets to meet a set of minimum requirements across ten categories. States designate one plan to be a benchmark plan, from which essential benefits are derived (all individual and small group plans in the state must offer at least the benchmark's benefits). In Washington State, the benchmark plan is Regence BlueShield Regence Direct Gold+ for the 2017-19 biennium. See Kaiser Family Foundation. (2018). *Essential Health Benefit (EHB) Benchmark Plans, 2017-2019*.

¹⁰⁶ In October 2017, President Trump issued Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States."

¹⁰⁷ To view the guidance, see Department of the Treasury & Department of Health and Human Services. (2018, October, 24). [State relief and Empowerment Waivers](#).

Empowerment Waivers.” The guidance gives new interpretation on how states can meet the four guardrails discussed previously. In brief, states will have more opportunity to satisfy the four guardrails due to a shift in emphasis from ensuring coverage to ensuring *access* to coverage. This frees up states to seek waivers that would result in less comprehensive or less affordable coverage relative to the ACA.¹⁰⁸

The guidance also addresses the fact that previously, 1332 waivers were effectively limited to state reinsurance programs. To achieve new flexibility, the guidance identifies five principles that the Secretaries will consider favorably in reviewing applications.

These five principles include:

- 1) Increasing access to competitive private market coverage over public coverage through the use of Association Health Plans (AHPs)¹⁰⁹ and short-term, limited-duration insurance (STLDIs);¹¹⁰
- 2) Encouraging sustainable spending growth by offering cost-effective coverage through actions such as reducing state-level regulation that reduces market choice and competition;
- 3) Fostering state innovation;
- 4) Empowering low-income individuals to purchase private coverage by providing financial assistance; and
- 5) Promoting consumer-driven health care through the provision of resources and information that facilitates the purchase of private insurance coverage.

Medicaid Waivers (Social Security Act Section 1115)

Section 1115 of the Social Security Act permits the HHS Secretary to waive certain provisions of the federal Medicaid statute so that states may test innovative ways to serve beneficiaries. Historically, states have used such waivers to expand eligibility, restructure the process of enrollment, establish long-term services and supports, or otherwise alter benefits and cost-sharing.¹¹¹ In general, waivers must be budget neutral. Washington State currently has an 1115 waiver in place—the Medicaid Transformation Waiver.¹¹²

Medicare Waivers (Social Security Amendments of 1967, Section 402(b))

The HHS Secretary has the authority to grant demonstration waivers under Section 402(b) of the social Security Amendments of 1967. These waivers allow for departures from Medicare payment rules in pursuit of improved efficiency of Medicare service provision.

Center for Medicare & Medicaid Innovation Demonstration Projects

The Affordable Care Act established Section 1115A of the Social Security Act, creating the Center for Medicare & Medicaid Innovation (CMMI) or Innovation Center. CMMI’s directive is to test “innovative payment and service delivery models to reduce program expenditures... while preserving or enhancing the quality of care.”¹¹³ Examples of Medicare models include medical homes, bundled payment models, and accountable care organizations (ACOs). All 50 states have at least one of these models.¹¹⁴ CMMI is also authorized to directly award state agencies or other organizations with grants to develop innovative models.

¹⁰⁸ For an overview of the changes in interpretation and implications, see Keith, K. (2018, October 23). [Feds dramatically relax Section 1332 Waiver guardrails](#). [Blog post]. Health Affairs.

¹⁰⁹ AHPs allow employers to band together to purchase health coverage. See [Keith \(2018, October 23\)](#).

¹¹⁰ See Internal Revenue Service, Employee Benefits Security Administration, & Department of Health and Human Services. (2018, October, 2). [Short-Term, Limited-Duration Insurance](#).

¹¹¹ The Commonwealth Fund. (2018). *1115 Medicaid Waivers: From Care Delivery Innovations to Work Requirements*.

¹¹² Washington State Health Care Authority. [Medicaid transformation](#).

¹¹³ Centers for Medicare & Medicaid Services. [About the CMS Innovation Center](#).

¹¹⁴ For an overview, see Kaiser Family Foundation. (2018, February 27). [“What is CMMI?” and 11 other FAQs about the CMS Innovation Center](#).

The HHS Secretary has the authority to expand CMMI demonstration projects directly to Medicaid, Medicare, and CHIP, so long as they satisfy two criteria: reducing spending while preserving or improving quality.

The Employee Retirement Income Security Act of 1974 (ERISA)

ERISA establishes regulatory standards for private-sector employee benefits, including health care. Because the statutory guidance around ERISA health plans is brief,¹¹⁵ the law's scope has largely been established through case law. Three clauses in particular establish the extent of ERISA's authority.

Preemption Clause

ERISA's preemption clause states that the regulation of employer-sponsored health care plans is the exclusive domain of federal law and not subject to state regulations.¹¹⁶ The goal of ERISA preemption, according to court interpretation, "was to avoid a multiplicity of regulation in order to permit nationally uniform administration of employee benefit plans."¹¹⁷

Savings Clause

ERISA recognized the historic role of states in the regulation of their insurance markets through the savings clause.¹¹⁸ This clause reserves to the states the right to regulate health insurance plans sold in their state. The Supreme Court has stated that ERISA is not meant to "displace general healthcare regulation."¹¹⁹ State laws regulating insurance, banking, or securities are not subject to federal preemption (and are thus "saved"). Generally, states can set minimum standards for health plan benefits, financial solvency, and consumer protections and mandate coverage of certain services.¹²⁰

Deemer Clause

Despite the authority afforded states in the savings clause, there is one major caveat. ERISA plans that self-insure are completely exempt from state regulation.¹²¹ The deemer clause creates a distinction between self-insured ERISA plans, which states cannot regulate, and fully insured health plans, over which states can exercise traditional regulatory authority. There is, however, one exception to the deemer clause. A 1983 amendment to ERISA (the Erlenborn-Burton Amendment) gives states full authority to regulate self-funded association health plans (AHPs). Recently issued federal AHP rules affirmed the state's authority.¹²²

¹¹⁵ In statute, ERISA explicitly requires that employers disclose to employees information about the health plans, and that employers uphold fiduciary responsibility in managing plans. See Francis, L. (2017, September 21). [ERISA and Graham-Cassidy: A disaster in waiting for employee health benefits and for dependents under 26 on their parents' plans](#). [blog post]. Petrie-Flom Center: Harvard Law School.

¹¹⁶ ERISA's preemption clause states: "the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." See 29 U.S.C. section 1144(a).

¹¹⁷ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 657 (1995) ("Travelers").

¹¹⁸ ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

¹¹⁹ *Travelers*, 514 U.S. at 658.

¹²⁰ For a concise overview of ERISA in the context of health system transformation, see Center for Disease Control and Prevention. [Public health law](#).

¹²¹ 29 U.S.C. section 1144(b)(2)(B).

¹²² In October 2017, President Trump issued Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States." This Order directed the Secretary of Labor to consider expanding the definition of "employer" under ERISA section 3(5) and also to consider ways to expand access to health care by broadening the availability of association health plans (AHPs). In AHPs, multiple employers band together to purchase insurance. In June of 2018, the Department of Labor issued a new rule with guidance around AHPs. For a summary, see Cousart, C. (2018, June 26). [The new association health plan rule: What are the issues and options for states](#) [blog post]. National Academy for State Health Policy.

Historically, courts have determined state laws to be preempted by ERISA, if they “refer” to ERISA plans or “relate” to plans by causing structural or administrative impacts on them. According to the National Academy for State Health Policy (NASHP)¹²³ states generally do have the authority to perform the following activities:

- Tax and regulate traditional insurers and the products they sell to employers,
- Engage in hospital rate-setting (regulate the rates hospitals charge insurers), and
- Potentially tax health care providers.

By contrast, it is suggested that states cannot mandate that employers sponsor insurance¹²⁴ or indirectly impose substantial changes to such plans.

However, courts have not always been consistent in their interpretation of ERISA preemption, and there is ambiguity around what qualifies for preemption.¹²⁵ The viability of some health reform initiatives against ERISA remain unclear, or would need to be considered on an individual basis. Examples include pay-or-play laws or imposing employer tax credits for health coverage.¹²⁶ Stop-loss insurance policies might expand the pool of employers with self-funded ERISA plans, which states cannot regulate. Pay-or-play laws are discussed below.

ERISA and Single-Payer

In reviewing a challenge to a single-payer proposal, consideration would be given to the extent that an employer has any real choice in whether to continue to offer benefits and the extent to which the operation and substance of their group health plan is affected.

Pay-or-Play Schemes and Payroll Taxes

States could attempt to sidestep ERISA by partially funding single-payer through a payroll tax, or establishing a pseudo-single-payer system with a pay-or-play system.

In pay-or-play, employers failing to meet minimum benefit requirements¹²⁷ must contribute towards coverage in the form of a tax. In the ERISA context, a pay-or-play scheme arguably falls within a state’s authority to tax and regulate insurance. However, if “paying” represents a substantial enough cost to effectively incentivize employers to modify their benefit plans, the scheme could be deemed in violation of ERISA.¹²⁸ A payroll tax could be challenged on the same grounds. If faced with contributing to employee

¹²³ Ibid.

¹²⁴ Note that an employer mandate is permissible at the federal level. The ACA’s employer shared responsibility provisions (a.k.a “the employer mandate” or “the pay or play provisions”) require large employers to meet minimum essential coverage or make a payment to the IRS.

¹²⁵ For example, while the Fourth Circuit court held that a Maryland pay-or-play law was preempted, the Ninth Circuit held that a similar San Francisco law was not preempted. The differing results were likely due to the fact that the Maryland law applied to just one employer, while the San Francisco law applied to multiple. See Butler, P.A. (2006). ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland “Fair Share Act” Court Decision. *AcademyHealth*; Jacobson, P.D. (2009). [The role of ERISA preemption in health reform: Opportunities and limits: Executive summary](#). *The Journal of Law, Medicine & Ethics*, 37(2_suppl), 86-100.

¹²⁶ Self-funded employer plans purchase stop-loss policies to protect themselves from catastrophic loss. Under such arrangements, employers do not assume complete liability for losses; rather, the insurance company becomes liable after a specified threshold. In 2017, the House passed a bill, H.R.1304 - Self-Insurance Protection Act, which if enacted would exclude stop-loss policies from ERISA preemption. This legislation would prevent smaller employers from creating self-insured policies with supplemental stop-loss insurance in order to attain ERISA preemption protection (see Gluck, A.R., Hoffman, A.K., & Jacobsen, P.D. (2017). ERISA: A bipartisan problem for the ACA and the AHCA. *Health Affairs Blog*). In April 2017, the bill was received in the Senate and referred to the Committee on Health, Education, Labor, and Pensions.

¹²⁷ Minimum benefits could be defined in a variety of ways. They might consist of required benefits or cost sharing standards, an actuarial value for benefit, or a percentage of compensation, such as through a payroll tax. Kaiser Family Foundation. (2009 May). [Explaining health care reform: What is an employer “Pay-or-Play” requirement?](#) [issue brief].

¹²⁸ Hsiao et al. (2011).

benefit plans and paying a tax to fund public benefits, employers are likely to abandon their ERISA plans or be forced to modify them to such an extent that interferes with uniform national administration.¹²⁹

These issues were illustrated by a federal district court's 2006 striking down of Maryland's Fair Share Act, which would have required large employers to spend a minimum of 8% of payroll on employee health care or pay the difference to the state's Medicaid fund.¹³⁰ Calculations indicated the law would have affected just one employer: Wal-Mart. The court ruled that because it would be in Wal-Mart's best interest to restructure its health benefits¹³¹ rather than pay into Medicaid, it was preempted on the basis of disrupting uniform national administration.¹³² The legality of payroll taxes or pay-or-play schemes will likely depend on the size of the imposed assessment.¹³³

ERISA and 1332 Waivers

ERISA preemption challenges would also come into play for a state attempting to use a 1332 State Innovation Waiver (1332 waiver) to implement a single-payer system. These waivers must establish coverage that meets four guardrails of the ACA, including offering coverage as least as comprehensive as that available under the ACA. To ensure compliance with this guardrail, states would likely need to regulate ERISA plans. However, self-insured plans cannot be forced by states to alter their benefits, administration, or structure.¹³⁴

The recent guidance¹³⁵ on 1332 waivers issued by CMS, the Department of Health and Human Services, and the Department of the Treasury may avoid this issue. The guidance (discussed above) effectively makes it easier for states to meet the ACA guardrails by expanding what qualifies as affordable and comprehensive coverage. For example, under the new guidance states no longer need to ensure residents will at least have the equivalent of "minimum essential coverage" under the ACA. Instead, broader forms of health insurance can satisfy the coverage requirement.¹³⁶

¹²⁹ Ibid.

¹³⁰ Butler (2006).

¹³¹ The court noted Wal-Mart would be forced to "segregate a separate pool of expenditures for its Maryland employees and structure its contributions – and employees; deductibles and co-pays – with an eye to how this will affect the Act's 8% spending requirement." See [Retail Industry Leaders Association v. James D. Fielder, Jr., No. 06-1840, United States Court of Appeals for the Fourth Circuit](#).

¹³² Ibid.

¹³³ For an overview of state health plans challenged by ERISA, see National Conference of State Legislatures. (2008 July). [Healthy San Francisco Health Plan challenged under ERISA guidelines](#).

¹³⁴ Tumber (2015). The ACA's 2017 State Innovation Waiver: Is ERISA a roadblock to meaningful healthcare reform. *U Mass Law Review*, 10, 388.

¹³⁵ See Department of the Treasury. [State Relief and Empowerment Waivers](#).

¹³⁶ Keith (2018, October 23).

II. Single-Payer Studies

National Proposals

Exhibit A1

American Health Security Act

Liu (2016)—American Health Security Act (S. 1782, 113 th Congress)	
Time frame	2017
Status quo	Coverage and total system costs under the current system (ACA).
Increase in coverage	16 million
Status quo rate of uninsured	9%
Single-payer uninsured rate*	4%
Total percent change in spending	
Percent change in total spending: Base scenario (actuarial value 98%)	-5.0%
Percent change in total spending: Higher cost sharing scenario (actuarial value of 78%)	-30.1%
Components of change in spending	
Percent change in total spending due to increased coverage and lower cost sharing (base scenario)	17.8%
Assumptions	All citizens and legal residents are enrolled in plan; undocumented immigrants are not covered. Base scenario assumes minimal cost sharing.
Percent change in total spending due to lower plan and provider administrative costs	-13.7%
Assumption	Administrative savings are based on the median estimate from available studies. Declines in administrative costs are 70% for insurers, 36% for hospitals, and 30% for physicians.
Percent change in total spending from reduced pharmaceutical costs	-6.8%
Assumption	Drug costs are reduced 38%.
Percent change in total spending from reduced provider payments	-5.2%
Assumption	Provider payments are reduced 7%.
Financing	Pool existing federal and state health care funding; graduated income tax from 2.2% to 5.2%, plus 5.4% surcharge on high earners; 6.7% payroll tax paid by employers; 0.2% securities transaction tax.
Additional assumptions	Total single-payer expenditures also include \$28 billion for start-up costs and \$43 billion for transition costs.

Notes:

Total spending refers to total system costs, which include both health care expenditures and administrative costs.

* The American Health Security Act (S. 1782, 113th Congress) is similar but not identical to Senator Sanders' Medicare for All plan—undocumented immigrants are not covered.

The high cost sharing scenario has an actuarial value (78%) similar to Traditional Medicare.

The model forecasts an increase in wages of \$1,420 per worker from wage pass through as employers reduce spending on health benefits.

The incidence of the employer payroll tax is assumed to fall on employees in impact analysis.

Exhibit A2
"Medicare for All"

Friedman (2013, 2015)—"Medicare for All"	
Time frame	2017-2026
Status quo	Coverage and total system costs under the current system (ACA).
Increase in coverage	29 million (2017)
Percent change in total spending	
2017	-8.0%
2017-2026	-14.0%
Note	Cost savings increase over time, from 8% in 2017 to 18% in 2026.
Percent change in total spending due to increased coverage, lower cost sharing, and Medicaid rate parity	
Percent change	12%
Assumptions	Assumes people without insurance currently spend 55% as much on health care as do the insured; spending increases to only 80% of the average after gaining coverage due to younger age distribution of people without insurance.
	Removing cost sharing is assumed to increase utilization of personal health expenditures by 5%.
	Estimates include additional expenditures from increasing Medicaid provider payment rates.
	Estimates also include transition costs (e.g., retraining for displaced workers).
	Plan actuarial value of 98%
Percent change in total spending due to lower plan and provider administrative costs, lower drug costs, and slower growth in health expenditures	
Percent change	-20% (2017 approximate)
Assumptions	Single-payer plan administration cost is 2% (slightly above Traditional Medicare). This generates savings of 6% of total national health expenditures.
	Provider administrative costs are reduced to Canadian levels; generating cost savings equal to 7% of national health expenditures (9.4% savings for hospital care and 10.7% for physician and clinical services).
	Reduces U.S. drug prices to average for Organization for Economic Co-operation and Development (OECD) countries and pharmaceutical spending declines by 37.5%.
	Spending after 2017 is assumed to increase by less 1.1% less than CMS projects. This reflects the difference between health care inflation for private insurance and Medicare. It also reflects the differential in health care inflation between Canada and the U.S.
Financing	Financing per Senator Sanders' "Medicare for All: Leaving No One Behind" proposal includes: 6.2% income-based health care premium paid by employers; 2.2 % income-based premium paid by households; progressive income tax; and capital gains tax.

Exhibit A3
"Medicare for All"

Holahan et al. (2016)—Sanders "Medicare for All"	
Time frame	Estimates for 2017 and ten-year period (2017-2026)
Status quo	Coverage and total system costs under the current system (ACA).
Increase in coverage	28.3 million (2017)
Status quo rate of uninsured	10.4%
Percent change in total health care spending	
2017	15.9%
2017-2026	15.0%
Note	Holahan et al. (2016) included costs of long-term services and supports (LTSS) in their estimates. LTSS coverage is not included in the more recent Medicare for All Act of 2017, and these costs are excluded in the estimates reported here.
Percent change in total spending on acute care for the nonelderly	
2017	22.9%
2017-2026	22.1%
Assumptions	Additional spending on the nonelderly are due to expansion in coverage, elimination in cost sharing, and more comprehensive benefits (e.g., dental, vision).
	There is no cost sharing (actuarial value of plan 100%).
	Providers are paid at Medicare rates, except for hospital care which is paid at 100% of costs.
	Pharmaceutical payments are reduced to 25% below Medicare drug payment rates.
	Assumes lower growth rate in health expenditures (0.5% age points below current CMS estimates) due to stronger negotiating power of single purchaser; reflects difference between spending growth in U.S. versus other OECD countries.
	Assumes plan administrative costs of 6% of claims, based on CMS measure for the entire Medicare program (Traditional and Medicare Advantage).
	Does not incorporate potential provider administrative savings into estimates but study does reduce provider payments to Medicare rates.
	Assumes that not all the increased demand for services can be met in the short run due to supply constraints.
	Spending for those insured under current law are expected to rise from \$1,705 billion to \$1,970 billion (a 16% increase).
	Spending for the uninsured rises from \$61.6 billion to \$166 billion (a 169% increase).
	Spending for undocumented immigrants increases from \$34.4 billion to \$77 billion (a 124% increase).
Percent change in total spending on acute care for those otherwise enrolled in Medicare	
2017	3.8%
2017-2026	3.6%
Assumptions	Expenditures increase due to induced utilization from elimination of cost sharing, more comprehensive benefit package, and increased hospital payment rates (Medicare rates estimated to cover only 89% of hospital costs).

	<p>Additional spending on those otherwise enrolled in Medicare is the net effect of:</p> <ul style="list-style-type: none"> • A \$24.9 billion decrease in Medicare prescription drug spending, • An offsetting increase in Medicare drug spending of \$17 billion due spending for those that do not currently have drug coverage, • Additional hospital spending of \$25.3 billion from rate adjustment, and • Additional spending of \$21.1 billion due to removal of cost sharing under the status quo.
Additional note	Study conducted by team at the Urban Institute.

State Proposals

Exhibit A4

Oregon

White et al. (2017)—Oregon Single-Payer proposal	
Time frame	2020
Status quo	Coverage and total system costs under the current system (ACA).
Increase in coverage	215,000
Status quo rate of uninsured	5%
Percentage change in total spending	
Percent change	-0.8%
Increases in spending due to single-payer	
Percent change in total spending due to increased coverage and lower cost sharing (base scenario)	5% to 6%
Assumptions	Coverage is extended to all permanent Oregon residents, including undocumented immigrants.
	Model estimates that adding coverage for undocumented immigrants adds roughly \$800 million to total costs (2.2 % of total system costs).
	No cost sharing for residents with incomes under 250% of FPL; 4% cost sharing for those above 250% (actuarial value 96%).
	Increased coverage and reduced cost sharing would increase health expenditures by 12%. However, modelling assumes that the full increase in demand is not met due to supply constraints in short run.
Decreases in spending due to single-payer	
Percent change in total spending due to lower plan administrative costs	-1.7%
Assumption	Insurer administrative costs are reduced by 22% due to moving enrollees from private to public management.
Percent change in total spending from reduced pharmaceutical costs	0.0%
Assumption	No savings are assumed from reduced pharmaceutical costs.
Percent change in total spending from reduced provider payments	-4% to -5%
Assumptions	Provider payment rates for hospitals, physicians, and other clinicians set 10% below status quo (lower than commercial, higher than Medicare). The 10% reduction based on comparisons with national averages.
	Average hospital payment rates relative to Medicare decline from 1.30% (status quo) to 1.17% under single-payer plan.
	Average physician and other clinical payment rates relative to Medicare decline from 1.19% (status quo) to 1.07% under single-payer plan.
	No savings are explicitly linked to reduced provider administrative costs.
Notes	Reducing provider payment to Medicare fee-for-service rates would reduce total system costs by \$3 billion (8.2%).

Notes	In general, for each percentage point decrease in average provider payment rates, the total cost of the single-payer plan falls between \$150 and \$200 million in 2020.
Financing	Pool existing federal and state health care funding; increase state income tax revenues by 83%; new payroll tax on mid- and large-size firms (6.5% paid by employers with 20 or more workers).

Notes:

Total spending refers to total system costs, which include both health care expenditures and administrative costs.

The plan does not cover institutional long-term care.

Employers currently providing health benefits would be required to pass back savings to workers through increased wages.

Exhibit A5

California

California Senate Committee on Appropriations (2017) & Legislative Analyst's Office (2018)— Healthy California Act	
Time frame	2017
Status quo	Coverage and total system costs under the current system (ACA).
Increase in coverage	3 million (2017) Current uninsured rate of 7%
Average annual expenditures under single-payer plan	
2017	\$400 billion
2017-2026	\$2,470 billion
Assumptions	Assumes administrative costs would be less than 10% of total expenditures; based on existing California Medicaid system.
	Provider payments set at Medicare rates.
	Health care service utilization levels are 10% above levels for fee-for-service Medicaid.
	Cost savings are largely offset by increased cost of covering the uninsured and increased utilization of services.
Financing	Assumes \$200 billion state and federal health care funding available for plan.
	An additional \$200 billion in tax revenues are required. Estimates that the following would raise an additional \$200 billion in revenues: <ul style="list-style-type: none"> • A payroll tax with a rate of 14% to 15%, • A gross receipts tax on business sales of 5%, or • A 3.7 % increase in property taxes; bringing the average rate to 5%.

Exhibit A6
California

Pollin et al. (2017)—Healthy California Act	
Time frame	2017
Status quo	Coverage and total system costs under the current system (ACA).
Increase in coverage	2.7 million (2017)
Percent change in total health care system costs	
2017	-10.1%
Percent change in total spending over status quo due to increased coverage and lower cost sharing	
Percent change	9.6%
Assumptions	Cost of covering people without insurance increases expenditures by 4.3%. Average expenditure for a person without insurance is about half that for a person with insurance. Expenditure for a person without insurance approximately doubles under plan, after factoring in age distribution of people currently without insurance.
	Removing cost sharing increases expenditures by 5.4%. Assumes 36% of the insured population is underinsured (high deductibles and out-of-pocket expenses); removing their cost sharing increases spending by 15%.
Percent change in total spending relative to status quo due to lower plan and provider administrative costs, lower drug costs, and lower payment rates	
Percent change	-19.7%
Assumptions	Reduced plan and provider administrative cost savings reduce total expenditures by 6.7%. Plan administration assumed to be 5%. Assumes hospital and physician administrative costs are reduced by 50%.
	Providers are paid at Medicare rates, reducing total expenditures by 2.9%.
	Pharmaceutical costs are reduced by 30%, lowering total expenditures 3.4%.
	Assumes an additional 5% reduction in total expenditures due to reduced system inefficiencies—unnecessary services, inefficient delivery, and missed prevention.
Financing	Estimates that \$106 billion in new funding is required.
	Proposes a gross receipts tax of 2.3% on all businesses and a sales tax of 2.3%.

Exhibit A7

New York

Liu et al. (2018)—New York Health Act			
Time frame	2022-2031		
Status quo	Coverage and total system costs under the current system (ACA).		
Increase in coverage	1.4 million		
Status quo rate of uninsured	7%		
Estimated single-payer effects: 2022			
Change in total system costs (health care and administration)	-1%		
Change in spending components			
Percentage change in medical care*	6%		
Percentage change in prescription drugs and devices	2%		
Percentage change in health plan administration	-42%		
Percentage change in provider administration	-8%		
Estimated single-payer effects: 2031			
Change in total system costs (health care and administration)	-3%		
Change in spending components			
Percentage change in medical care*	3%		
Percentage change in prescription drugs and devices	2%		
Percentage change in health plan administration	-43%		
Percentage change in provider administration	-10%		
Alternative scenarios			
Total system costs relative to status quo (percent change)	2022	2031	
Baseline assumptions	-1%	-3%	
Provider payments set 5% below status quo in 2022	-4%	-6%	
Plan administrative rate 3%	-4%	-6%	
Plan drug prices equal to Medicaid	-5%	-10%	
Combined lower provider payments, administrative rate, and drug prices	-12%	-15%	
Assumptions and notes			
<p>* Medical care includes hospital care, physician and clinical services, other professional services, dental and other health and personal care.</p> <p>The increase in health expenditures is due to increased enrollment and elimination of cost sharing.</p> <p>Single-payer provider payment rates are set to the status quo average across payers.</p> <p>Provider payments grow more slowly under single-payer. The growth rate is assumed to be the same as for public health care programs.</p> <p>Provider revenues are 2% higher than status quo in 2022. In 2031, they are 1% below status quo.</p> <p>The plan administration rate is 6%. Provider administrative costs are reduced by 13% based on the median estimate from the literature (savings of 13% for physicians, 12% for hospitals).</p> <p>Prescription drug prices are set 10% below Medicare. (Medicaid pays about 34% lower than Medicare; private insures pay about 22% more than Medicare.)</p> <p>Cost sharing is minimal (actuarial value 98%).</p> <p>Payment method is fee-for-service.</p> <p>Wage pass back is assumed in the analysis (employers adjust wages based on the difference between their prior health care contributions and new payroll taxes to maintain worker total compensation).</p> <p>The modelling accounts for supply constraints. Authors project the demand for hospital care to increase by 10% and for phvsician services by 15%. but they estimate that the increase in services will only be half as large as the demand.</p>			

Financing	Two new progressive state taxes are proposed: 1) Payroll tax jointly paid by employers (80%) and employees (20%) and 2) A tax on non-payroll income.
	Progressive payroll tax rates range from 6% to 18%; non-payroll tax rate ranges from 6% to 19%.
	Revenue analysis assumes use of all federal and state health care funds.

Exhibit A8

New York

Friedman (2015)—New York Health Act	
Time frame	2019
Status quo	Coverage and total system costs under the current system (ACA)
Increase in coverage	1.3 million
Change in total spending relative to status quo	
Percent change	-16%
Spending increases due to single-payer (percent of status quo total spending)	
Universal coverage	1.4%
Increased utilization	3.9%
Medicare & Medicaid rate equity	3.8%
Unemployment insurance and retraining costs	0.1%
Total increase in spending	9.2%
Assumptions	The estimate for the cost of covering the uninsured assumes: per capita health expenditures among uninsured are 55% that for total population; after gaining coverage the formerly uninsured cost 85% as much as currently insured due to younger age structure.
	Increased utilization estimate is based on the experience in Canada with establishment of universal coverage.
	Rate equity increases costs for those formerly covered by Medicare by \$3.8 billion; \$6.9 billion increase for those formerly covered by Medicaid.
Savings due to single-payer (percent of status quo total spending)	
Health provider administration	-7%
Prescription drug and device prices	-6%
Plan administration	-10%
Reduced fraud	-2%
Total cost reductions	-25%
Notes	Plan administrative rate is 1.8% (based on Medicare fee-for-service).
	Plan negotiates 37% reduction in drug prices.
	Provider administrative cost reductions are taken from studies; 9.1% savings for hospitals and 11.7% savings for physicians.
	Reduced fraud is due to lower possibility of duplicate billing and simplified bill tracking.
Financing	Assumes federal and state health care funding available for the plan; required additional revenues are \$91.3 billion.
	Additional revenues raised through: 1) Progressive payroll assessment and 2) Progressive assessment on dividends, interest, and capital gains.

III. Single-Payer Proposals

Exhibit A9
"Medicare for All"

Objectives	Program design & governance	Benefits	Financing
Creates a federally administered single-payer health care program.	Little specified except that the system would be single-payer and federally administered.	Benefits include: -Hospital services (inpatient & outpatient), -Ambulatory care, -Preventive care, -Emergency care, -Primary care, -Prescription medications, -Chronic disease management, -Vision, hearing, and oral health care, -Mental health and substance abuse services, -Reproductive, maternity, and newborn care (including abortion), -Medical equipment & supplies, -Biological products, -Laboratory and diagnostic services, -Pediatrics, and -Long-term care for seniors and people with disabilities will continue to be provided by Medicaid.	<u>New taxes:</u> 1) Employers pay a 6.2% income-based health care premium, and 2) Households pay a 2.2% income-based premium. <u>Adjusted taxes:</u> <i>Income tax rates include:</i> 37% on income between \$250,000 - \$500,000, 43% on income between \$500,000 - \$2 million, 48% on income between \$2 million - \$10 million, 53% on income above \$10 million. <i>Capital gains and dividends:</i> taxed the same as work income. <i>Estate tax:</i> inheritance over \$3.5 million will be taxed. <i>Limit tax deductions:</i> alternative minimum tax (AMT), personal exemption, itemized deductions. <i>Health-related tax expenditures:</i> eliminates employer-based insurance tax break and other tax breaks.
Seeks to give health care access to all Americans.			
Eligibility			
All residents are eligible	Not enough available information to determine if citizens are barred from purchasing private insurance.		
Provider characteristics	Fee setting	Payment policy	Quality & provider standards
Patients can choose to see any provider.	Government will negotiate for lower prices.	Provider payment rates bargained by government.	The federal government can make investments to ensure a sufficient supply of providers and access. Does not provide detail as to the investments.
Cost containment	Cost sharing		
The Urban Institute* notes that the plan seeks to lower administrative costs.	No cost sharing.		

Notes:

Source: Medicare for All: Leaving No One Behind (n.d.). Retrieved from <https://live-berniesanders-com.pantheonsite.io/issues/medicare-for-all/>, and S. 1804 – Medicare for All Act of 2017, 115th Congress. Retrieved from <https://www.congress.gov/bill/115th-congress/senate-bill/1804>.

* Holahan et. Al. (May, 2016). The Sanders Single-Payer Health Care Plan. The Urban Institute. Retrieved from <https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending>.

Exhibit A10

Healthy California Act; California SB 562

Objective	Program design & governance	Benefits	Financing
Creates Healthy California (Healthy CA) program to deliver all coverage to residents.	Creates the Healthy California Board (the Board) to govern the program, made up of nine members with expertise in health care. The Board will establish the Healthy CA program. Directs the Secretary of California Health and Human Services to establish a public advisory committee to advise the Board on all matters of policy for Healthy CA.	Benefits include: -Inpatient & outpatient medical services, -Diagnostic imaging & laboratory services, -Equipment & appliances (e.g., prosthetics, hearing aids, etc.), -Inpatient & outpatient rehabilitation, -Emergency transportation & care, -Transportation to health care services for low-income and/ or disabled individuals, -Preventative care, -Hospice & skilled nursing facility care, -Home health care & assisted living, -Mental health & substance abuse services, -Dental & vision, -Prescription drugs, and -Prenatal, postnatal, & pediatric care. Also includes other therapies shown by the National Institutes of Health and the National Center for Complementary and Integrative Health to be safe and effective (e.g., case management or adult day care). Benefits shall also include all health care services required to be covered under the following non-exhaustive list: -The state's CHIP, -Medi-Cal,** -Federal Medicare, and -Essential health benefits mandated by the ACA as of January 1, 2017. Carriers may offer benefits to cover health care services that are not offered to individuals under the program (complimentary insurance).	<u>Use of existing revenue sources.</u> Creates the Healthy California Trust Fund. Federal funding would fold into this fund. Waivers will be sought allowing existing federal funds and subsidies to be deposited in the trust fund, including but not limited to: -Medicare, -Medi-Cal (federal & state portions), -Federal Employee Health Benefits Program, -Federal ESI Tax Subsidies (eliminates state and local ESI tax subsidies), and -Affordable Care subsidies. The board and program may change some regulations and requirements for federal health programs to increase available funding under current law. The legislature intends to: -Develop legislation for a revenue plan, consulting with appropriate officials and stakeholders and -Develop legislation requiring the deposit of all state revenues for the program.
Eligibility	The Board will administer Medicare in the state, become a provider of Medicare Part B (supplemental coverage), and provide premium assistance drug coverage for Medicare D members. Members will be encouraged to find a care coordinator.* Any licensed and qualified health care provider can provide services within the state. The board will decide standards and payment methodologies for out-of-state providers delivering services to Healthy CA members. The bill prohibits private insurers from providing coverage for services already covered in the statutory plan. Private insurers are permitted to offer complementary coverage, which would provide benefits that are excluded in the statutory plan.		
All state residents are eligible. Eligibility of undocumented immigrants not mentioned, but states Healthy CA will not disclose personally identifiable information, such as immigration status, for law enforcement purposes. The board will develop proposals for benefits for retirees who are no longer living in the state.			

Provider characteristics	Fee setting	Payment policy	Quality & provider standards
<p>Both private not-for-profit and for-profit "entities" allowed.</p> <p>Members choose any participating provider from which to receive services.</p> <p>Members do not need a referral from care coordinator to see an eligible provider.</p>	<p>Board determines a "reasonable" rate for providing efficient care. Board engages in "good faith negotiations" with representatives to establish rates for health care services, prescription, and non-prescription drugs.</p> <p>Participating Providers cannot charge higher rates to patients or a third party.</p> <p>Rates should encourage efficient provision and adequate/accessible supply of services.</p> <p>Payment methodologies and rates shall include a distinct component of reimbursement for direct and indirect graduate medical education.</p>	<p>Fee-for-service "unless and until" the board establishes a different method.</p> <p>Care coordination is not fee-for-service.</p> <p>Providers are reimbursed only if the member is enrolled with a care coordinator at the time of service delivery.</p> <p>Integrated health care delivery systems, [defined as 'a provider organization that...is fully integrated operationally and clinically to provide a broad range of health care services'], essential community providers, and group medical practices can choose to receive a capitated operating budget or non-capitated operating budget that pays for services.</p> <p>Payments to for-profit entities "will not be calculated to accommodate the generation of profit, revenue for dividends, or other return on investment or the payment of taxes that would not be paid for a not-for-profit entity."</p>	<p>Board sets standards for care coordinators and health care organizations (HCOs). Board will create requirements and standards for the following:</p> <ul style="list-style-type: none"> -Scope, quality, and accessibility of services, -Relations between HCOs or providers and members, -Relations between HCOs and providers such as regulations that promote: <ul style="list-style-type: none"> -Simplification, transparency, uniformity, and fairness in administrative responsibilities, -In-person care, efficient and effective services, quality assurance, and public wellness, -Eliminating health disparities, -Nondiscrimination of members (Unruh Civil Rights Act), -Accessibility of care, including those with a disability or language barriers, -Providing services with cultural competence -Participating providers are required to share information necessary for reviewing utilization, quality, cost containment, and accessibility. <p>To maintain approval, care coordinators and HCOs must renew status per Board requirements and provide the Board with data for an evaluation of quality, outcomes, and cost.</p>
Miscellaneous	Cost sharing		
<p>The act does not prohibit, require, or limit any employment benefits.</p>	<p>Members will not have to pay any premium, copayment, coinsurance, deductible, or any other forms of cost sharing. No enrollment or membership fee.</p>		

Notes:

Source: [The Healthy California Act 2017 SB-562](#).

* Care coordination includes managing, referring to, locating, coordinating, and monitoring health care services for the member to assure that all medically necessary health care services are made available to and are effectively used by the member in a timely manner, consistent with patient autonomy. A care coordinator may be a health care practitioner, a health care organization, or entity licensed to provide care (e.g., long-term care).

**Medi-Cal = the state's Medicaid program.

The Board = The Healthy California Board. Healthy CA = Healthy California. HCO = Health care organization.

Exhibit A11

Vermont's Green Mountain Care; Act 48 (2011)

Objectives	Program design & governance	Benefits
<p>Declares access to high-quality health care a responsibility of the state.</p> <p>Establishes a universal, publicly financed health coverage program (Green Mountain Health Care or GMC) for all Vermont residents.</p> <p>GMC will operate as a public-private partnership between the state of Vermont and a strong private sector partner.</p>	<p>Establishes <u>Green Mountain Care Board (GMCB)</u>, which will operate as a partnership with consumers, employers, health care professionals, hospitals, and the state and federal government.</p> <p><i>Board membership:</i> There will be a chair and four members. Up to nine positions from the department of banking, insurance, securities, and health care administration will be transferred to the GMCB.</p> <p><i>Board duties:</i> The GMCB will oversee the health care payment and service delivery reform. The GMCB sets a three-year budget for GMC.</p>	<p>The legislature intends to provide a plan with at least an actuarial value of 87%.</p> <p>Services Covered include:</p> <ul style="list-style-type: none"> -Primary care, -Preventive care, -Chronic care, -Acute episodic care, -Hospital services, and -The services covered in the lowest cost plan by private insurers in the small group market on January 1, 2011.
Eligibility		
<p>All Vermont residents are eligible.</p> <p>In accordance with federal law, the health benefit exchange can offer:</p> <ul style="list-style-type: none"> -Benefits to individuals and employers not considered "qualified" according to ACA requirements and as defined in Act 48, -Medicaid benefits to eligible individuals, -Medicare benefits to eligible individuals, and -Benefits to state and municipal employees. <p>Non-residents will be billed for services received in Vermont.</p> <p>GMC will contract with "outside entities" to establish mechanisms for members to receive necessary services while temporarily out of the state.</p> <p>Requests a report summarizing potential costs for providing GMC to undocumented immigrants.</p>	<p>Prior to implementation, the Board must confirm:</p> <ul style="list-style-type: none"> -Coverage for each resident will be provided at an actuarial value of at least 80%, -The program will not negatively impact Vermont's economy and financing is sustainable, -Any anticipated reduction in administrative costs, -Cost-containment efforts will reduce per capita health spending, and -Reimbursement levels will aim to recruit & retain quality health care professionals. <p>Establishes <u>Vermont Health Benefit Exchange (HBE)</u>.</p> <ul style="list-style-type: none"> -The commissioner will try to contract with at least two insurers if at least two insurers are interested in participating in the HBE. - Multi-state plans will also have the opportunity to participate in the exchange as required by the ACA. -The HBE shall establish a navigator program to assist individuals and employers in enrolling. <p>The Secretary of Administration will make recommendations on the following:</p> <ul style="list-style-type: none"> -Methods and statutory changes for integrating Medicaid, Medicare, private insurance, associations, state employees, and municipal employees into the Health Benefit Exchange and GMC. -Whether private insurers should be allowed to provide supplemental insurance or through Green Mountain Care. <p>GMC enrollees may elect to maintain supplemental health insurance.</p>	<p>The GMCB will consider whether to include dental, vision, hearing, and long-term care.</p> <p>Benefits for Medicaid, CHIP, or Medicare eligible individuals will include those benefits guaranteed by law and any additional GMC benefits.</p>

Provider Characteristics	Financing	Fee Setting
Vermonters will be able to choose their providers.	<p>GMC will use a "single payment system" to provide health benefits.</p> <p>Two financing plans will be prepared for the appropriate committees:</p> <ul style="list-style-type: none"> -One plan will recommend financing mechanisms for coverage without receiving a Section 1332 ACA* waiver, and -One plan will recommend financing mechanisms for achieving a public-private universal health care system and recommendations on providing coverage to nonresidents employed by Vermont businesses. <p>Pursuant to these requirements, the following financing mechanisms were introduced in a 2014 report.**</p> <p><u>Use of existing revenue sources</u></p> <p><i>Federal revenues.</i> Under the ACA Section 1332 waiver, Vermont would receive pass-through funding equal to the aggregate amount of the premium tax credits and cost-sharing reduction payments that would have otherwise been paid under the ACA. The government would continue receiving matched state Medicaid funding.</p> <p><i>State revenues.</i> Existing state revenue funding Medicaid will fund GMC. However, a reduction in Medicaid funds is expected due to the elimination of the following:</p> <ul style="list-style-type: none"> -Tax on private health insurance claims and -Employer assessment on employers not providing coverage, with uninsured employees, with employees on Medicaid, or employees purchasing coverage through Vermont Health Connect.^ <p><u>New revenue sources.</u> GMC taxes would replace private insurance premiums. Two sources comprise these taxes.</p> <p><i>Payroll tax.</i> An 11.5% rate on wages up equal to or less than \$200,000 would be imposed, deductible from federal wages. Self-employed Vermonters would be exempt from this tax.</p> <p><i>Public premium.</i> This replaces private insurance premiums. It is calculated as a percentage of AGI corresponding to federal poverty level (FPL) brackets. The minimum contribution begins where Medicaid eligibility ends, at 138% FPL (tax=2.5% AGI); the maximum is 9.5% of AGI at the 400% FPL level. Taxpayers above 400% FPL pay a flat \$27,500 maximum tax.</p>	<p>The GMCB will set "reasonable rates" for health care professionals and other actors in the health care system. The board will facilitate the negotiation process for rate setting.</p> <p>Changes in payment rates must be included in an annual report to the legislature.</p> <p>In determining rates the GMCB will consider:</p> <ul style="list-style-type: none"> -Legitimate cost differences of services and -The supply of health care professionals in underserved areas. <p>The commissioner of banking, insurance, securities, and health care must receive approval from the GMCB before approving a general health policy rate increase. The commissioner will determine whether rates are:</p> <ul style="list-style-type: none"> -“Affordable;” -Promoting high quality; -Promoting access; and -Just, fair, and equitable. <p>The commissioner has the authority to refuse rates.</p>
Cost Sharing		
<p>The GMCB will consider:</p> <ul style="list-style-type: none"> -Whether or not to implement cost sharing, -Whether cost-sharing should be "income-sensitized,” -The relationship between cost-sharing and access to care, and -Waiving cost-sharing requirements for primary, preventive, and palliative care and some cases of chronic care. 		

Other cost containment strategies & utilization management	Payment policy
<p>The Health Benefit Exchange may consider mechanisms to simplify and unify administrative procedures for health insurers and other entities offering health services. These mechanisms could include:</p> <ul style="list-style-type: none"> -Contracting with a single entity for administration and management of plans, -Requiring particular software for administrative work, or -Requiring insurers to conform to a set of standards. <p>In offering qualified health plans, insurers must:</p> <ul style="list-style-type: none"> -Use a uniform enrollment form and descriptions provided by commission of health access and commissioner of banking, insurance, securities, and health care; -Obtain premium approval through a rate review process; -Submit appropriate documentation justifying premium increases prior to implementation. <p>To contain costs, GMC will:</p> <ul style="list-style-type: none"> -Provide incentives to avoid preventable health conditions and avoid unnecessary emergency room visits. -Utilize innovative payment methods, -Encourage managing health services through the Blueprint for Health, and -Reduce administrative costs. <p><u>Single formulary.</u> The Department of Vermont Health Access (DVHA) ^^ will provide:</p> <ul style="list-style-type: none"> -Recommendations for a single prescription drug formulary for all payers with some variations for Medicaid members, -Mechanisms for negotiating prices with the single formulary, and -Management rules "aligned with Medicare to the extent possible, to minimize administrative burdens and promote uniformity of benefit management." <p><u>Prior authorization.</u> The GMCB will consider compensating providers for completing prior authorization requests and exempting some services from requiring prior authorization commissioner will determine whether rates are:</p> <ul style="list-style-type: none"> -“Affordable;” -Promoting high quality; -Promoting access; and -Just, fair, and equitable. <p>The commissioner has the authority to refuse rates.</p>	<p>GMCB will oversee payment reform. In doing so, it will consider the following payment methods:</p> <ul style="list-style-type: none"> -Cost containment targets, -Global payments, -Global budgets, -Risk-adjusted capitated payments, -Bundled payments, and -Fee for service, among others. <p>Service paid through capitation should be “broad and comprehensive.” Examples include:</p> <ul style="list-style-type: none"> -Prescription drugs; -Diagnostic services; -Acute and sub-acute home services; -Hospital, mental, and substance abuse health services; and -Services from a licensed practitioner.

Quality & provider standards	Miscellaneous
<p>The Exchange will assign a quality and wellness rating for each plan offered.</p> <p>The Exchange will provide consumers and professionals with satisfaction surveys or other evaluation tools to inform necessary stakeholders of performance</p> <p>Plans can only be on the Exchange after the Commissioner has decided that offering the plan "is in the best interest of individuals and qualified employers," a decision based on based on affordability, quality, accessibility, and promotion of wellness and prevention.</p> <p>Qualified health plans for the Exchange must:</p> <ul style="list-style-type: none"> -Meet established requirements regarding prevention, quality, and wellness, including: <ul style="list-style-type: none"> -Standards for marketing practices, -Providers in underserved areas, -Services to promote access for underserved individuals or communities, -Quality improvement, -Information on quality measures for performance, and -Include joint quality improvements activities with other plans. -Meet the standards for participation in Blueprint for Health,^{^^^} -Meet ACA requirements for deductibles (at least silver level coverage) <p>Health insurers must:</p> <ul style="list-style-type: none"> -Use a uniform enrollment form, -Abide by the insurance and consumer requirements, including: <ul style="list-style-type: none"> -Be approved by the premium rate review process and -Offer at least one silver level plan; -Premium prices cannot vary depending on who sells the plan, and -If requested, insurers must offer information on cost sharing amounts to consumers. <p>The Commissioner and other health care groups will develop community reports that compare hospitals across quality and financial indicators.</p> <p>Gives responsibility to the Board of Nursing, Board of Medical Practice, and the Office of Professional Regulation for reviewing and recommending changes of regulations and procedures that could be contributing to primary care shortages.</p>	<p>Questions will be added to a household health insurance survey for the Department of Banking, Insurance, Securities, and Health Care Administration can determine how many respondents moved to Vermont for health services.</p> <p>Establishes efforts to create a health care workforce development strategic plan that would include recommendations regarding:</p> <ul style="list-style-type: none"> -Capacity issues of healthcare workforce and delivery system; -Education, training, recruitment and retention of health care professionals; -Factors hindering recruitment and retention; and -Availability of state and federal funds for workforce development.

Notes:

Source: [An act relating to a universal and unified health system Act 48](#).

* For an explanation of Section 1332 Waivers, see Appendix II.

** See Office of Governor Peter Shumlin. (2014). [Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System](#). This report fulfilled the 2011 law's requirement that the Executive Branch develop a plan for financing and operating GMC. However, this report followed the governor's announcement that GMC was not financially feasible. Thus, while the report explains the financing plan for funding GMC, it was never adopted.

[^] [Vermont Health Connect](#) is the state's health insurance marketplace, or exchange, created per the ACA.

^{^^} The [Department of Vermont Health Access \(DVHA\)](#) is responsible for the management of Vermont's publicly funded health insurance programs.

^{^^^} [Blueprint for Health](#) is a statewide, community-led initiative made up of a network of medical homes, community health teams, and other programs.

AGI = adjusted gross income. GMC = Green Mountain Care. GMCB or "the Board" = Green Mountain Care Board. "The Exchange" = Vermont Health Exchange.

Exhibit A12

New York Health Act; New York Assembly Bill A5062A

Objective	Program design & governance
<p>This bill would create a universal single-payer health plan, the New York Health Program (the program), to provide comprehensive health coverage for all New Yorkers.</p>	<p>The <u>Commissioner of Health</u> (the Commissioner) does the following:</p> <ul style="list-style-type: none"> -Establishes and implements an enrollment period, -Establishes regulations for recognizing and paying out-of-state providers delivering out-of-state services for members, -Approves and makes regulations or amendments for enforcement of the program, and -Can regulate eligibility requirements, increase benefits for federally matched programs, or restructure cost sharing.
Eligibility	
<p>All residents are eligible for coverage.</p> <p>Every resident of New York state can enroll without a fee "regardless of age, income, wealth, employment, or other status."</p> <p>A resident is defined as follows: "an individual whose primary place of abode is in the state, without regard to the individual's immigration status, as determined according to regulations of the Commissioner."</p> <p>Services are paid for only if provided to an enrolled member or an eligible resident who has not had a reasonable amount of time to enroll.</p>	<p>The Commissioner shall contract with not-for-profit organizations to:</p> <ul style="list-style-type: none"> -Assist consumers in selecting a provider or health care organization, -Assist health care providers to participate in the program, and -Provide care coordinator** assistance to individuals and entities providing or seeking to provide care coordination services. <p>Establishes the <u>New York Health Board of Trustees</u> (the Board). The Board is comprised of 29 trustees appointed by governor. Of those, 19 appointments are based on community representation (i.e. physicians, hospitals, health care advocacy, etc.), and ten appointments are based on legislative recommendations.</p> <p>The Board meets at least four times per year without compensation and create proposals for future coverage of: long-term care, retiree health benefits, and workers' compensation benefits.</p> <p>Establishes <u>Regional Advisory Councils</u>. Each Council will be comprised of at least 27 members. Of those, nine will be appointed by the governor, and the remainder will be appointed by the governor on the recommendation of legislative leadership.</p> <p>The Councilmembers represent different health care communities (e.g., advocacy groups, health care organizations, and hospitals, etc.). Duties of the Council include:</p> <ul style="list-style-type: none"> -Promoting public knowledge of services, -Adopting/revising a health improvement plan published on the website, -Publishing annual reports on the website, -Identifying gaps in care, and -Holding at least four public hearings per year. <p>Members eligible for Medicare shall enroll in Parts A, B, & D. Premium assistance will be available to eligible members for Part D under the federal Social Security Act.</p> <p>Creates a temporary commission for implementation.</p>

Benefits	Financing	Fee setting	Payment policy
<p>Health plan provides "comprehensive health coverage" including benefits from:</p> <ul style="list-style-type: none"> -Existing federal programs, -Insurance law, -Civil service law, and -Benefits added later to the program. <p>The program will cover temporary and emergency services to eligible individuals who have not had a reasonable time to officially enroll.</p> <p>Future additions to coverage include:</p> <ul style="list-style-type: none"> -Long-term care (proposal to be developed within five years) and -Folding in of retiree benefits and workers' compensation. <p>Health Care Organizations (HCOs) will be responsible for part of all of a member's entitled services.</p>	<p><u>New revenue.</u> Two new taxes, called premiums, will be established and phased-in gradually.</p> <p><i>Payroll premium.</i> All income subject to the Medicare tax will be subject to this premium. This will be set as a percentage of income, with higher %ages for higher income brackets (progressively graduated). In this scenario,</p> <ul style="list-style-type: none"> -The employer pays 80% of premium (though they have the option to pay 100% of premium), -The employee pays 20% of premium, and -Self-employed individuals pay 100% of premium. <p><i>Non-payroll premium.</i> This taxes upper-bracket income not subject to the payroll premium, such as interest, dividends, and capital gains. This premium is also progressively graduated.</p> <p>Provisions are made for cross-border employees.</p> <p><u>Existing revenue.</u> Premium revenues will be deposited in the New York Health trust fund. State monies that already fund organizations or programs providing health care services would go into the trust fund.</p> <p>The state will apply to deposit in the state treasury federal payments for federal programs funding for health care services, including Medicare, Medicaid, and Family Health and Child Health Plus. These payments also include funds in lieu of tax credits, cost-sharing subsidies, and small business tax credits.</p>	<p>The plan will engage in "good faith negotiations" collectively with representatives of health care providers to set rates and establish new payment methodologies.</p> <p>Payment rates will be "reasonable... [for] the cost of efficiently providing the health care service."</p> <p>Providers cannot charge in excess of negotiated fees for service delivery.</p> <p>Payment rates will be set to ensure an "adequate and accessible supply" of services.</p> <p>"Payment methodologies and rates shall include a distinct component of reimbursement for direct and indirect graduate medical education."</p>	<p>The plan would develop alternative payment methods to replace fee-for-service. Suggested alternative methods include global or capitated payments to dis-incentivize overutilization and control administrative expenses.</p> <p>However, services will be provided on a fee-for-service bases "until and unless" the Board establishes a different method.</p> <p>Care Coordination* is not fee-for-service.</p> <p>Maintains competition by allowing New York Health to offer and provide different terms and conditions to different providers</p>

Cost sharing	Provider characteristics	Quality & provider standards	Other cost containment strategies & utilization management
Members do not have to pay premiums, deductibles, co-payments, or co-insurance.	<p>Members choose their qualified provider, assuming provider is willing and available. Members have the right to change their care coordinator.</p> <p>Members can choose to receive services from approved HCOs.</p>	<p>The Commissioner shall establish standards for the program and for providers, including standards for the</p> <ul style="list-style-type: none"> -Scope, quality and accessibility of services, -Relations between organizations and providers, and -Credentialing and participating methods of payments. 	<p>Data from care coordinators and providers will be used to evaluate cost and quality of services.</p> <p>Participating providers may need to submit records for analysis of cost containment, accessibility, utilization, and quality assurance.</p> <p>Each Regional Advisory Council will adopt or revise a "community health improvement plan" that should promote knowledge of available services and appropriate utilization.</p>
Miscellaneous	Referrals are not required to receive services.	These standards include will promote:	
Establishes a job training and assistance to those affected by the health plan.	An HCO is a not-for-profit or governmental entities that is approved by the Commissioner that is an accountable care organization or a Taft-Hartley fund.	<ul style="list-style-type: none"> -Simplification, transparency, and ...fairness in credentialing and participation; -Care coordination quality assurance and appropriate use of technology; -Elimination of disparities; -Non-discrimination; and -Accessibility for those with a disabilities and language barriers as well as in the form of culturally competent provision of services. 	
	HCOs must maintain commissioner approval by renewing its status and providing required data for evaluation.		
	Private insurance can still operate but cannot offer the same benefits covered under the New York Health Program.	All entities must meet same requirements regardless of "profit" status.	
	Employers or universities can offer private benefits to out-of-state employees and their dependents.	Bans agreements that would limit participation, reimbursement, or scope of provided services.	
	Care coordinators are approved by the program based on procedures and standards developed by the Commissioner.	Care coordinators must renew their status and provide data for quality, outcomes and cost evaluation.	

Notes:

Source: [Assembly Bill A5062A](#).

The Commissioner = The Commissioner of Health. Council(s) = Regional Advisory Council(s). The Board = The New York Health Board of Trustees. HCO = Health care organization.

** Care coordination includes managing, referring to, locating, coordinating, and monitoring health care services for the member to assure that all medically necessary health care services are made available to and are effectively used by the member in a timely manner, consistent with patient autonomy. A care coordinator may be a health care practitioner, a health care organization, or entity licensed to provide care (e.g., long-term care).

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