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**E Pluribus Saludem: How the States Will Bring Universal Single
Payer Health Care to America**

By: Charles D. Mueller

Part I: Introduction

Universal health insurance coverage has been a staple of progressive political movements since the early 20th Century.¹ In 1915 the American Association for Labor Legislation, a private organization of scholars, doctors, lawyers, and politicians, unveiled a standard health insurance bill that envisioned a state by state reform of health insurance to provide basic coverage to all low-income workers and their dependents.² An effort by the American Medical Association and recalcitrant state legislatures doomed this early effort but not before laying the groundwork for a legislative impetus, especially prevalent in progressive and labor groups, to enact some form of national healthcare reform.³

Universal, single payer health care, (Bernie Sanders' Medicare for All), is a system of health insurance that effectively replaces existing health insurance companies with a single, government run fund.⁴ It is publicly financed through taxes or premiums paid directly to the government and would provide basic benefits to all citizens.⁵ Proponents of single payer point to the societal benefits of ensuring every person has access to health care when they need it, and the added economic benefits of a streamlined system removed from the profit-driven world of

¹ *Chronology of Health Insurance Proposals 1915-76*, Social Security Administration, vol. 39 n. 7 35, July 1976, www.ssa.gov/policy/docs/ssb/v39n7/v39n7p35, last accessed 9/21/2017.

² *Id.*

³ *Id.* at 36.

⁴ William C. Hsiao et al., *What Other States Can Learn From Vermont's Bold Experiment: Embracing a Single-Payer Health Care Financing System*, 30 *Health Affairs* 1232, 1232 (2011); *Medicare for All: Leaving No One Behind*, BERNIESANDERS.COM, <https://live-bernieanders-com.pantheonsite.io/issues/medicare-for-all/>, last accessed 1/26/2018, (“[The] plan would create a federally administered single-payer health care program. Universal single-payer means comprehensive coverage for all Americans.”).

⁵ *Id.*

private health insurers.⁶ On the other hand, critics of single payer point to the massive public spending increases that such a program would require.⁷ The ACA, alone, cost a total of \$110 billion dollars in 2016. “Medicare for All,” however, could add \$18 trillion to the federal deficit over the next decade.⁸ This fundamental disagreement is what has stalled single payer health care on a national level.

The greatest strides in national health insurance reform in the 20th Century came in 1965 with the passage of Medicare and Medicaid, and then again in 1972, with the expansion of Medicare to the disabled and people suffering from other enumerated conditions.⁹ These programs created a foundation that allowed for the passage of the Patient Protection and Affordable Care Act (ACA) in 2010.¹⁰

Included within the ACA’s comprehensive language is a provision that allows states, with federal approval, to alter the requirements of the exchanges created by the bill and create their own, tailor-made programs while still utilizing federal funds available under the act.¹¹ These are known as section 1332 waivers.¹² As long as a State can demonstrate that their proposed plan is: 1) as comprehensive, 2) affordable, 3) will cover a comparable number of residents, and 4) will not negatively affect the federal budget as the ACA, they can make use of

⁶ *What is Single Payer?*, PHYSICIANS FOR A NAT’L HEALTH PROGRAM, <http://www.pnhp.org/facts/what-is-single-payer>, last accessed 11/10/2017.

⁷ Danielle Kurtzleben, *Sanders’ Proposals Would Add \$18 Trillion to Debt Over 10 Years*, NPR, May 9, 2016, <https://www.npr.org/2016/05/09/477402982/study-sanders-proposals-would-add-18-trillion-to-debt-over-10-years>.

⁸ FEDERAL SUBSIDIES FOR HEALTH INSURANCE FOR PEOPLE UNDER AGE 65: 2016 TO 2026, CONG. BUDGET OFFICE, March 24, 2016, <https://www.cbo.gov/publication/51385>; Gordon B. Mermin et al., *An Analysis of Senator Bernie Sanders’s Tax and Transfer Proposals*, TAX POLICY CENTER, May 9, 2016.

⁹ CMS’ PROGRAM HISTORY, CENTERS FOR MEDICARE AND MEDICAID SERVICES, 9/14/17, www.cms.gov/About-CMS/Agency-Information/History/index.html, last accessed 9/21/17.

¹⁰ *Id.*

¹¹ 42 U.S.C. § 18052

¹² *Id.*

these waivers.¹³ These waivers can be used for everything from setting up basic health care exchange structures, to creating high-risk pool and state-operated reinsurance programs.¹⁴ They can also be used as a vehicle for bringing comprehensive single-payer health care to reality.

This note will discuss how, through the funding structure of the ACA, and the use of section 1332 waivers, state legislatures in New York and California have begun to introduce and develop state-based comprehensive health coverage plans. Next, this note will assess what lawmakers in these states and others can learn from Vermont’s experience with Green Mountain Care. Finally, the note will conclude with a prospective look at the future of state based single payer healthcare.

Part II: The Key to Universal Healthcare, Section 1332 Waivers.

Section 1332 of the ACA provides states with the option to create innovative insurance structures to provide its citizens with access to high quality healthcare at affordable cost.¹⁵ The inspiration for this provision can be found in the Healthy Americans Act – a bill introduced in the United States Senate in 2007.¹⁶ Championed by Oregon Senator Ron Wyden, who filed the health reform proposal with Utah Senator Robert Bennett, the Wyden-Bennett bill sought “[t]o provide affordable, guaranteed private health coverage that will make Americans healthier...” and contained a provision to “empower states to innovate through waivers.”¹⁷ The waivers would allow for states compliant with the rest of the act to obtain waivers to certain structural

¹³ SECTION 1332: STATE INNOVATION WAIVERS, THE CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html, last accessed 11/10/2017.

¹⁴ *Id.*; “Reinsurance” is a transaction whereby a secondary insurer agrees to indemnify another party, usually another insurer, (the primary insurer), in order to reduce risk to the primary insurer.

¹⁵ 42 U.S.C. § 18052

¹⁶ Healthy Americans Act, S. 334 (110th)(1st session) Senate bill 334, Section 632.

¹⁷ *Id.*

requirements while maintaining coverage requirements.¹⁸ Senator Wyden would later sponsor an amendment inserting section 1332 into the ACA and borrowed much of the state innovation language from the Healthy Americans Act.¹⁹ The primary objective of the bill was to ensure universal healthcare coverage for all Americans.²⁰ To achieve this, the bill creates state-based risk pools to facilitate the coverage of sicker individuals without raising premiums.²¹ The plan involved a reform of the tax code and the distribution of federal subsidies so that by 2014, (assuming the bill was passed in 2008), the plan would be “budget neutral.”²² While the Wyden-Bennet bill eventually fell by the congressional wayside, facets of the plan would be the inspiration for the ACA’s landmark reforms.

While the creation of the state exchanges, essential health benefits, and the individual mandate surely garnered the most attention during the bill’s contentious passage, the provision for State Innovation Waivers in section 1332 of the bill may turn out to be the most significant. These waivers, first able to take effect on January 1, 2017, were designed to allow states, within the parameters set by the ACA, to create their own exchanges, insurance plans, coverage requirements, and other pertinent procedures and policies.²³ As of the time of writing, twenty-two states have passed or considered legislation that would seek to use these federal waivers.²⁴ The basic requirements of any state plan are that the proposal must be at least as 1) comprehensive, 2) affordable, 3) cover a comparable number of residents, and 4) not add to the

¹⁸ *Id.*

¹⁹ *State Health Coverage Innovation and Section 1332 Waivers: Implications for States*, Deloitte Center for Health Solutions, Health Policy Brief, 2016, www2.deloitte.com/content/dam/Deloitte/life-sciences-health-care/us-dchs-state-health-innovation.pdf, last accessed 9/21/2017.

²⁰ Edwin Park, *An Examination of the Wyden-Bennet Health Reform Plan*, Center on Budget and Policy Priorities, 9/24/2008, <https://www.cbpp.org/research/an-examination-of-the-wyden-bennett-health-reform-plan>.

²¹ *Id.*

²² *Id.*

²³ Richard Cauchi, *State Roles Using 1332 Health Waivers*, National Conference of State Legislatures, 9/14/17, www.ncsl.org/research/state-roles-using-1332-health-waivers.aspx.

²⁴ *Id.*

federal deficit.²⁵ This, along with the Trump administration's encouragement of state innovation, could lead to a sharp increase in waiver submissions coming from state governments.²⁶

The incentive behind the 1332 waivers is that they allow states to take advantage of federal funding for Medicare, Medicaid, and subsidies for those who purchase individual insurance under the ACA for use in a program that is state-designed. Therefore, a state can create its own set of coverage requirements, payment system, etc. and if it is compliant with section 1332, the state can direct those federal funds into the new program.

These section 1332 waivers are the key to state-organized comprehensive health coverage. Without the access to federal funds provided through the ACA and other programs like Medicare and Medicaid, the costs of a state run single payer system would be prohibitively expensive. That is, without the ability to integrate federal funding streams into the state systems, like section 1332 provides, there would be no feasible way for any state to self-fund a single-payer program without exorbitant tax hikes. In several states, legislation has already been introduced that works within the ACA's funding framework to create state-wide health plans that offer comprehensive coverage to residents.²⁷ In New York, New Jersey and Vermont, single-payer health care legislation has been introduced and passed in at least one of the houses of their respective legislatures.²⁸ Without a fully enacted state legislation, the application for a section

²⁵ *States See Opportunities for Flexibility in the ACA's Innovation Waiver Program*, Justin Giovannelli & Kevin Lucia, The Commonwealth Fund, Sep. 15, 2017, www.commonwealthfund.org/publications/blog/2017/sep/aca-innovation-waiver-program-flexibility, last accessed 9/21/17.

²⁶ *Id.*

²⁷ Cauchi, *Supra* note 23.

²⁸ *Id.*

1332 waiver will not be processed.²⁹ As of this writing, no state has submitted a single payer health care plan to the Secretary of Health and Human Services (HHS) for waiver approval.

Procedurally, the process is straightforward. It begins when states apply to the Department of Health and Human Services for a waiver of certain subsections of the ACA.³⁰ These applications must contain a copy of and a comprehensive description of the enacted state legislation, a plan for meeting the requirements of section 1332, a list of the sections of the ACA that the State seeks to waive, and all analyses, actuarial certifications, data, coverage targets, and other information in order to provide the Secretary with the necessary data to make a determination on the waiver.³¹ Once the application is deemed complete, there is then a mandatory public notice and comment period.³² The key first step to making use of the waiver program is the submission of state legislation, and that's where any analysis must begin, and that's where this paper will focus.³³

Any legislation that seeks to make use of the waivers must meet the requirements of section 1332(b).³⁴ The comprehensive coverage requirement mandates that the proposed plan would be at least as comprehensive in its coverage as the defined in section 1302(b) of the ACA.³⁵ The affordability requirement requires the plan to provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as the ACA.³⁶ The scope of coverage requirement mandates that the plan provide coverage to a comparable

²⁹ Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. 11,701, 11,701-11702 (Feb. 27, 2012) (to be codified at 45 CFR pt. 155).

³⁰ *Id.* at 11,701.

³¹ *Id.* at 11,702.

³² *Id.*

³³ *Id.* at 11,701.

³⁴ Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. at 11,702.

³⁵ *Id.* Section 1302(b) defines and lists “essential health benefits” for the purposes of coverage under Title I of the ACA.

³⁶ *Id.*

number of state residents as under the ACA.³⁷ The federal deficit requirement forbids any plan from increasing the federal deficit.³⁸ The legislation itself, combined with supporting actuarial, economic, and demographic evidence contained in each state’s application, is considered by HHS when analyzing section 1332 waivers.³⁹

Part III: The Legislation

Justice Brandeis once described the states of the union as the “laboratories of democracy...[able to] try novel social and economic experiments without risk to the rest of the country.”⁴⁰ In the push for state-based healthcare reform, this is a truism.

In April of 2006 the Commonwealth of Massachusetts enacted far-reaching health care reforms.⁴¹ The basic premise was a coverage requirement that would be enforced through state tax returns.⁴² Prior to the act, the state had begun requiring guarantee issue, whereby insurers have to issue to plans to eligible applicant regardless of health status, and community rating.⁴³ As part of the health reform, the state created the *Commonwealth Health Insurance Connector*, through which residents can access both subsidized and non-subsidized health insurance. If this sounds familiar that is not an accident.⁴⁴ Much of the basic structure of the ACA was based on the successful portions of the Massachusetts health reform.⁴⁵ It serves as an example for how state-created health reform can be exported and expanded nationwide.

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *New State Ice Co. v. Liebmann*, 285 U.S. 262, 387 (1932).

⁴¹ *Massachusetts Health Care Reform: Six Years Later*, KAISER FAMILY FOUNDATION, May 2012, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8311.pdf>, last accessed 4/24/2018.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

Although the possibility of a true, single payer system nation-wide remains distant, lawmakers in New York, California, and Vermont have opened the doors of their respective legislative laboratories to the prospect.

The three bills share essential elements that, taken together, point to a future of healthcare that runs on a single payer model. The first common element is the streamlining of health insurance delivery through one, state-run agency.⁴⁶ This applies to both the receipt of funds and reimbursement to providers.⁴⁷ This is the essence of single payer – the channeling of all funds through one centralized administration. The second commonality is a stated goal to provide health insurance to all residents of the state, essentially providing comprehensive health insurance for all.⁴⁸ The third important commonality, and one that will be essential for any of these programs to succeed, is that each program will seek a section 1332 waiver allowing the state to reroute all federal funds through the single payer model.⁴⁹

Both the New York Health Act and the Healthy California Act would eliminate cost sharing by enrollees.⁵⁰ That is, the plan doesn't charge enrollees any co-pay or deductible.⁵¹ This is an extraordinary provision in each of these bills. The effects of this have been projected to increase utilization and eliminate out-of-pocket expenses.⁵² Importantly, it removes the financial

⁴⁶ A4738, Assemb. Reg. 2017-2018 Sess., Art. 51 §§ 5101-5102 (N.Y. 2017); S.B. 562, Leg., 2017-2018 Reg. Sess. § 2(2)(100610)(a) (Ca. 2017).

⁴⁷ A4738, Assemb. Reg. 2017-2018 Sess., Art. 51 §2(2) (N.Y. 2017); S.B. 562, Leg., 2017-2018 Reg. Sess. § 2(7)(3)(100657)(a-b) (Ca. 2017).

⁴⁸ A5062, Assemb. Reg. 238th Sess. 2014-2015 (N.Y. 2014), Memorandum in Support of Legislation (submitted in accordance with Assembly Rule III, § 1(f)); LEG. COUNSEL'S DIGEST, S.B. 562, Leg., 2017-2018 Reg. Sess. (Ca. 2017).

⁴⁹ A4738, Assemb. Reg. 2017-2018 Sess., (N.Y. 2017); S.B. 562, Leg., 2017-2018 Reg. Sess. § 2(7)(100650)(a) (Ca. 2017).

⁵⁰ A5062, Assemb. Reg. 238th Sess. 2014-2015 (N.Y. 2014), Memorandum in Support of Legislation (submitted in accordance with Assembly Rule III, § 1(f)); LEG. COUNSEL'S DIGEST, S.B. 562, Leg., 2017-2018 Reg. Sess. (Ca. 2017).

⁵¹ *Id.*

⁵² Gerald Friedman, *Economic Analysis of the New York Health Act* (Mar. 2015) (unpublished manuscript) (on file with the University of Massachusetts),

barriers to healthcare experienced by low-income enrollees, alleviates the financial burdens on low-income families who spend far more proportionately on healthcare expenses than other groups, and, in the case of the New York Health Act, would tax all income, instead of putting outsized pressure on wages and salaries as a classic income tax would.⁵³ However, this provision is one of the principal drivers of increased costs in single-payer plans. How the states plan on recouping and providing for these costs varies, and the plans' success depends on balancing the financial realities of providing for healthcare, adequately paying providers, and not overburdening the states' population with an oppressive tax regime.

New York

The New York Health Act has been proposed in the New York State Assembly every year since 1992.⁵⁴ The Democrats who have controlled New York State Assembly have passed the act four separate times, with a recalcitrant senate acting as spoiler to Assemblyman Richard Gottfried's mission of bringing comprehensive health care coverage to New York.⁵⁵ Recently however, Governor Andrew Cuomo has signaled support for single payer healthcare, both at the state and federal level.⁵⁶ If the GOP loses its hold on the New York State Senate, the New York Health Act may find its way to the Governor's desk and into state law. The act, due perhaps in part to its many trips through the Assembly and several edits and versions, is the basis on which

https://d3n8a8pro7vhmx.cloudfront.net/pnhpnymetro/pages/89/attachments/original/1425994768/Friedman_Fiscal_Study_New_York_Health_Act_FINAL_3-10-15_925_AM.pdf?1425994768, last accessed 11/7/2017.

⁵³ *Id.*

⁵⁴ A5062, Assemb. Reg. 238th Sess. 2014-2015 (N.Y. 2014), Memorandum in Support of Legislation (submitted in accordance with Assembly Rule III, § 1(f)). This memorandum was included on a previous version of the bill. For the purposes of this note, all citations not otherwise noted will be to A4738, the most recent version to pass through the Assembly.

⁵⁵ Lisa Herndon, *Klein Pushed to Take Action on Health Care Bill*, The Riverdale Press, Sep. 22, 2017, riverdalepress.com/stories/klein-pushed-to-take-action-on-health-care-bill,63521, last accessed 9/22/17.

⁵⁶ Matthew Hamilton, *Cuomo Signals Support for Single-Payer Health Care*, Times Union, Sep. 18, 2017, <http://www.timesunion.com/7day-state/article/Cuomo-signals-support-for-single-payer-health-care-12206177.php>, last accessed 11/7/2017.

other states are writing their own health legislation.⁵⁷ As such, it is useful to delve into the administrative structure, coverage requirements, financial scheme, and legislative animus of the bill to provide a lens through which other states' legislation may be viewed.

The stated purpose of the New York Health Act is to create a universal single payer health plan that provides comprehensive health coverage for all New Yorkers.⁵⁸ The New York State Assembly passed the most recent version of the bill in 2017.⁵⁹ The bill lays out the administrative and financial structure of the "New York Health" program – the state's single payer health care regime.⁶⁰ The plan would be funded through a New York Health Trust Fund that would serve as the clearing house for all funding sources and would be used solely to finance the program.⁶¹ As legislation, the bill serves to amend public health law and state finance law in order to effect the establishment of New York Health.⁶²

The administration of the plan is given over to a commissioner and a board of trustees.⁶³ The primary purpose of these officers is to ensure the establishment of New York Health and its continued operation under the law.⁶⁴ The board of trustees is comprised of twenty-six individuals appointed by the governor, and representative of health care providers, professionals, labor, and finance.⁶⁵ These stakeholders are tasked with implementing the provisions of the bill and have the power to both create and amend regulations in the execution of that duty.⁶⁶

⁵⁷ Herndon, *supra* note 55.

⁵⁸ A5062, memorandum, *supra* note 24.

⁵⁹ A4738, Assemb. Reg. 2017-2018 Sess., (N.Y. 2017).

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ A4738, Art. 51 §§ 5101-5102.

⁶⁴ *Id.*

⁶⁵ *Id.*, at § 5102(2)(A-C).

⁶⁶ *Id.*, at § 5102(1).

The New York Health Act provides for universal health insurance coverage for New Yorkers.⁶⁷ Under the Act, every resident of the state is eligible and entitled to enroll as a member.⁶⁸ It mandates comprehensive health care services to all members.⁶⁹ This includes any service that would be covered under the Child Health Plus, Medicaid, or Medicare programs.⁷⁰ Further, the coverage would extend to prescription drugs, rehabilitative care, dental, vision, and other medical services mandated by section 1302(b) of the ACA.⁷¹ The law mandates that no member will be required to pay any “premium, deductible, co-payment, or co-insurance under the program.”⁷² Members are also free to choose from any participating provider.⁷³

The New York Health Act provides for a true single payer program that is funded through a broad tax based on ability to pay, integrated with federal funding available through various federal programs.⁷⁴ The act aims to create a single trust fund through which all money will be funneled.⁷⁵ More specifically, the in-state revenue will be sourced from two “premiums,” which amount to taxes.⁷⁶ The first is a graduated tax on payroll and self-employed income, which the act likens to the Medicare tax.⁷⁷ The second is a progressive tax on income not already subject to the first tax. The levels of these “premiums” will be tied to enrollment and the anticipated federal revenue available.⁷⁸ In support of the bill, proponents point to projected

⁶⁷ *Id.*, at Art. 1 § 1(2).

⁶⁸ *Id.*, at § 5103(1).

⁶⁹ A4738, Assemb. 2017-2018 Reg. Sess., Art. 51 § 5104(1) (N.Y. 2017).

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.* at § 5104(2)

⁷³ *Id.* at § 5105(1)(B). Since the act also eliminates any other redundant insurance coverage in New York, it is a safe assumption that any qualified provider in New York would be considered a “participating” provider for the purposes of the act.

⁷⁴ *Id.* at § 2(2)

⁷⁵ *Id.*

⁷⁶ A4738, Assemb. 2017-2018 Reg. Sess., Art. 51 § 4(2) (N.Y. 2017).

⁷⁷ *Id.*

⁷⁸ *Id.*

savings through the elimination of inefficient administration costs associated with private insurance providers.⁷⁹ Additionally, the concentration of health insurance into the New York Health program will allow for enhanced bargaining power with pharmaceutical companies and providers.⁸⁰ A financial analysis of the plan projected that New Yorkers would “save \$45 billion in 2019 or nearly \$2200 per resident.”⁸¹

Broadly, the act finds authority under the New York state constitution. Article XVII provides that “the protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions in such manner and by such means as the legislature shall from time to time determine.”⁸² The language of the legislative intent is couched in broad, equitable terms.⁸³ It is presented as a response to continued inadequate coverage despite the ACA, and premised on the assertion that “all residents of the state have a right to health care.”⁸⁴ This is a theme that is woven throughout each of the states’ single payer health care legislations.

The New York Health Act clearly meets the necessary benchmark for obtaining a section 1332 state innovation waiver. The bill provides for comprehensive health care coverage surpassing what is included in section 1302(b) of the ACA.⁸⁵ In terms of affordability, there is no greater protection against excessive out-of-pocket expenses than a single payer system that

⁷⁹ Gerald Friedman, *Economic Analysis of the New York Health Act* (Mar. 2015) (unpublished manuscript) (on file with the University of Massachusetts), https://d3n8a8pro7vnm.cloudfront.net/pnhpnymetro/pages/89/attachments/original/1425994768/Friedman_Fiscal_Study_New_York_Health_Act_FINAL_3-10-15_925_AM.pdf?1425994768, last accessed 11/7/2017.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² N.Y.S. Const. Art. XVII.

⁸³ A4738, Assemb. 2017-2018 Reg. Sess., Art. 51 § 2(1) (N.Y. 2017).

⁸⁴ *Id.*

⁸⁵ *Id.* at § 5104(1).

includes no co-payments or deductibles.⁸⁶ While the “premiums” used to help fund the program will increase the tax burden on citizens, evidence points to an overall decrease in healthcare expenditures by members.⁸⁷ The coverage extends to all residents of New York, expanding the covered population from what the ACA mandated.⁸⁸ Finally, the act only seeks to use the Federal money already available through the ACA and other Federal programs by utilizing the section 1332 waiver.⁸⁹ The amount of funding would not increase, as the money would have been coming to in-state patients anyway, merely the path that those federal funds took to the market.

California

Amidst the GOP’s efforts during the summer of 2017 to repeal and replace the ACA, the California State Senate passed SB-562, The Healthy California Act.⁹⁰ In a contentious move, the Speaker of the State Assembly Anthony Rendon shelved the bill, calling it “woefully incomplete.”⁹¹ While the Assembly holds hearings to focus on improving access to health care in California, proponents of SB-562 are pushing for its introduction to the floor of the legislative body.⁹² The bill already has outspoken support among potential Democratic candidates for California’s 2018 gubernatorial elections.⁹³ Were Speaker Rendon to allow the legislative

⁸⁶ *Id.* at § 5104(2).

⁸⁷ Friedman, *supra* note 79.

⁸⁸ A4738, Assemb, 2017-2018 Reg. Sess., Art. 1 § 1(2).

⁸⁹ *Id.* at § 5109.

⁹⁰ Alexei Koseff, *Universal Health Care Debate Returns to California Capitol*, Sacramento Bee, Oct. 23, 2017, SACBEE.COM, <http://www.sacbee.com/news/politics-government/capitol-alert/article180305861.html>, last accessed 11/8/17.

⁹¹ *Id.*

⁹² *Id.*

⁹³ Ben Deci, *Health Care is Hot Topic at Gubernatorial Debate*, FOX 40, Oct. 22, 2017, <http://fox40.com/2017/10/22/health-care-is-hot-topic-at-gubernatorial-debate/>, last accessed 11/8/2017.

process to proceed, strong support among California progressives could see the Healthy California Act passed into law.⁹⁴

Sponsored by Senators Ricardo Lara and Toni Atkins, the bill seeks to create the Healthy California program to comprehensive, universal, single payer health care coverage to all residents of the state.⁹⁵ The Healthy California program precludes any other carrier from offering redundant coverage within the state.⁹⁶ Facially, the Healthy California Act hews closely to its New York counterpart in terms of administrative and financial structure. The bill would create the “Healthy California” program as the single payer insurance provider for the state of California.⁹⁷ All funds would be funneled through the Healthy California Trust Fund and medical providers paid out of this same trust.⁹⁸

The administration of the program is delegated to the Healthy California Board.⁹⁹ The Board is governed by an executive board that consists of nine members, appointed by the Governor, Senate Committee on Rules, and the Speaker of the Assembly.¹⁰⁰ All of which must have demonstrated expertise in health care and at least having one representative each from registered nurses, the general public, labor, and medical providers.¹⁰¹ The board under the Healthy California Act has broad administrative powers to effectuate the Healthy California program.¹⁰²

⁹⁴ *New Poll: 70% of Californians Support CA Medicare for All Bill*, CALIFORNIA NURSES ASS., NATIONAL NURSES UNITED, May 31, 2017, <http://www.nationalnursesunited.org/press/new-poll-aeu-70-californians-support-ca-medicare-all-bill>.

⁹⁵ LEG. COUNSEL’S DIGEST, S.B. 562, Leg., 2017-2018 Reg. Sess. (Ca. 2017).

⁹⁶ S.B. 562, Leg., 2017-2018 Reg. Sess. § 2(2)(100612)(g) (Ca. 2017).

⁹⁷ *Id.* at § 2(2)(100610)(a).

⁹⁸ *Id.* at § 2(7)(2)(100655)(a).

⁹⁹ *Id.* at § 2(2)(100610)(a).

¹⁰⁰ *Id.*

¹⁰¹ S.B. 562, Leg., 2017-2018 Reg. Sess. § 2(2)(100610)(c)(A-B).

¹⁰² *Id.* at § 2(2)(100612)(a).

The Healthy California Act covers “all medical care determined to be medically appropriate by the member’s health care provider.”¹⁰³ The list of covered medical care under the Healthy California Act includes all essential health benefits as defined by section 1302(b) of the ACA, all services otherwise covered under Medicaid and Medicare, and includes a long list of explicitly mandated coverages.¹⁰⁴ The act goes further to enumerate many therapeutic treatments and explicitly leaves the door open for further development of the mandated covered benefits.¹⁰⁵ Every resident of the state of California is eligible and entitled to enroll as a member under the program, and no member is required to pay any fee, premium, copayment, or deductible in relation to medical services or program enrollment.¹⁰⁶

The funding structure of the Healthy California Act is not developed within the text of the bill. While the bill does provide for the application to “all federal waivers” in order to utilize federal moneys for the plan, there is no plan for generating income in-state.¹⁰⁷ Rather there is an expression of intent on the part of the Legislature to “develop a revenue plan...” and ensure that money is placed within the Healthy California Trust Fund.¹⁰⁸ Like the New York Health Act, the immense bargaining power of a state based single payer program would likely allow for favorable negotiations with pharmaceutical companies, health systems, and other medical providers, thus keeping costs down. The California Senate Appropriations Committee estimated the cost of the program at \$400 billion, with \$200 billion of that expected to come from the “revenue plan” that has yet to be developed.¹⁰⁹ This punts the issue and leaves the creation of the

¹⁰³ *Id.* at § 2(4)(100630)(a) (CA. 2017).

¹⁰⁴ *Id.* at § 2(4)(100630)(b)(1-34).

¹⁰⁵ *Id.* Acupuncture is a mandated health benefit, at (b)(23).

¹⁰⁶ *Id.* at § 2(3)(100620)(a)(b)(1-2).

¹⁰⁷ S.B. 562, Leg., 2017-2018 Reg. Sess. § 2(7)(100650)(a) (Ca. 2017).

¹⁰⁸ *Id.* at § 2(7)(3)(100657)(a-b).

¹⁰⁹ S. COMM. ON APPROPRIATIONS, S.B. 562, 2017-2018 Reg. Sess. (Ca. 2017).

funding scheme to the political process.¹¹⁰ Because the establishment of in-state funding sources is left to the future, there is the very real possibility that, despite the passage of the bill, the Healthy California program never gets off the ground.¹¹¹

There has been some scholarly research completed on the financial implications of the Healthy California Act, and proposals for how the state could generate enough income to establish the plan.¹¹² In a paper published by the University of Massachusetts' Political Economy Research Institute, savings under the plan are found in administration, pharmaceutical pricing, fee structures for service providers, and elimination of inefficiencies associated with the current service structure amount to a net savings of 10 percent over the existing system.¹¹³ Furthermore, the paper suggests a duo of taxes on business receipts and sales.¹¹⁴ On average, the average California family will see savings of 2.6-9.1 percent of income.¹¹⁵ While the Pollin report shows significant upside to the Healthy California program, no mention of this is made within the act or its legislative materials.

The Healthy California Act, as it stands today, fails to meet the benchmark requirements for section 1332 waivers due to its lack of certainty around funding sources. Clearly, the bill meets and surpasses the coverage requirements as articulated by section 1302(b).¹¹⁶ The bill also ensures that members to Healthy California would not be subject to any excessive out of pocket costs, at least in terms of direct payments to providers.¹¹⁷ The plan offers coverage to all

¹¹⁰ S.B. 562 Leg., 2017-2018 Reg. Sess. § 2(9)(100670)(a).

¹¹¹ *Id.*

¹¹² POLLIN ET AL., ECONOMIC ANALYSIS OF THE HEALTHY CALIFORNIA SINGLE-PAYER HEALTH CARE PROPOSAL (SB-562), 2-3, POLITICAL ECONOMY RESEARCH INSTITUTE, UNIVERSITY OF MASSACHUSETTS AMHERST, (2017) (hereinafter the "Pollin report").

¹¹³ *Id.*

¹¹⁴ *Id.* at 3.

¹¹⁵ *Id.* at 4.

¹¹⁶ S.B. 562, Leg., 2017-2018 Reg. Sess. § 2(4)(100630)(a-b) (Ca. 2017).

¹¹⁷ *Id.* at § 2(3)(100620)(a)(b)(1-2).

residents of California, thus meeting the scope of coverage requirement as well.¹¹⁸ Where the bill falls short is the Federal deficit question. There is little in the bill to assuage the fears of creeping costs. This is because if the plan is going to pool all federal funding with in-state funding streams, the plan still must cover all residents up to the standards of the ACA, Medicaid, Medicare etc. If the funding of the additional coverage is uncertain, then there is a significant risk that federal funds will make their way to covering residents outside the intent of that federal program. If California legislators could include within their plan elements from the Pollin report, it would go a long way to grounding the funding structure of the Healthy California Act in terms more palatable to HHS. The bill, if passed as is, would not likely be deemed “complete” for the purposes of section 1332 waivers.

Vermont: The Cautionary Tale of Green Mountain Care

The experience of Vermont’s Green Mountain Care serves as a valuable lesson for state governments. Passed amidst much fanfare and with the overwhelming support of legislators and residents in Vermont, financial uncertainty and political complications have since stalled the program indefinitely.¹¹⁹ The text of the legislation is similar in tone and intent to the Healthy California Act and the New York Health Act.¹²⁰ The legislation was supported by similar groups, health care professionals, progressives, and human rights advocates.¹²¹ The law even also sought

¹¹⁸ *Id.*

¹¹⁹ John E. McDonough, *The Demise of Vermont’s Single-Payer Plan*, 372 NEW ENG. J. MED. 1584, 1584 (2015).

¹²⁰ H. 202, Leg., 2011-2012 Reg. Sess. § 1(a) (Vt. 2011); LEG. COUNSEL’S DIGEST, S.B. 562, Leg., 2017-2018 Reg. Sess. (Ca. 2017); A4738, Assemb. Reg. 2017-2018 Sess., Art. 1 § 1(2) (NY 2017) (stating the intent to create a fair, universal system of healthcare for all residents of the state).

¹²¹ Joe VerValin, *The Rise and Fall of Vermont’s Single Payer Plan*, CORNELL POLICY REV. (Jul. 13, 2017), <http://www.cornellpolicyreview.com/rise-fall-vermonts-single-payer-plan/>, last accessed 11/10/17.

to make use of the section 1332 waivers available through the ACA.¹²² Where the law differs from the New York Health Act is Green Mountain Care's fatal ambiguities and vagueness – the same criticism leveled at the California Health Act.¹²³

The story of Vermont's Green Mountain Care begins with the election of Democrat Peter Shumlin to the governor's office in 2010.¹²⁴ Shumlin had run on a platform of bringing single-payer health care to Vermont.¹²⁵ As a reaction to what proponents of single-payer saw as unacceptable compromises of the ACA, the Vermont state legislature passed Act 128- establishing a Health Care Reform Commission to design a path forward and towards universal health care for Vermonters.¹²⁶ The Commission hired Harvard health economist William Hsiao, who had previously aided the government of Taiwan in their transition to single-payer, to create a report detailing the administrative and financial contours of single-payer health care in Vermont.¹²⁷ Elements of this report would later be used by Governor Shumlin in his campaign to pass single payer legislation.¹²⁸ However, citing the political danger of explicitly detailing a financial plan in regards to the new healthcare system, the final version of the bill left that portion of the plan purposely vague.¹²⁹ The final version of the bill, Act 48, was signed into law in 2011.¹³⁰

¹²² H. 202, Leg., 2011-2012 Reg. Sess. § 2(a) (Vt. 2011).

¹²³ McDonough, at 1584; Koseff, *supra* note 65.

¹²⁴ Joe VerValin, *The Rise and Fall of Vermont's Single Payer Plan*, CORNELL POLICY REV. (Jul. 13, 2017), <http://www.cornellpolicyreview.com/rise-fall-vermonts-single-payer-plan/>, last accessed 11/10/17.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ William C. Hsiao et al., *What Other States Can Learn From Vermont's Bold Experiment: Embracing a Single-Payer Health Care Financing System*, 30 *Health Affairs* 1232, 1233 (2011).

¹²⁸ Joe VerValin, *The Rise and Fall of Vermont's Single Payer Plan*, CORNELL POLICY REV. (Jul. 13, 2017), <http://www.cornellpolicyreview.com/rise-fall-vermonts-single-payer-plan/>, last accessed 11/10/17.

¹²⁹ *Id.*

¹³⁰ H. 202, Leg., 2011-2012 Reg. Sess. (Vt. 2011).

The bill begins by demonstrating legislative intent to create “universal access and coverage for high-quality, medically necessary health services for all Vermonters.”¹³¹ In pursuit of this goal, the legislature created Green Mountain Care.¹³² Just as the New York Health and Healthy California programs, Green Mountain Care would serve as the program through which health care reform was created and administered.¹³³ Rather than a true single-payer program, Green Mountain Care would offer some large employers the opportunity to opt out of the program.¹³⁴ Additionally, the plan was envisioned as a public-private single payer system, one of many plans available on the exchange marketplace created by the ACA.¹³⁵

The design of the plan was provided to the Green Mountain Care Board. The Board is comprised of five members and tasked with overseeing the design of Green Mountain Care.¹³⁶ This included all negotiations surrounding the costs of healthcare, coverage, benefits, and premiums.¹³⁷ A separate nominating board is established that nominates Board members to be appointed by the governor with no specific requirements for the board’s background, or qualifications.¹³⁸

The law mandates a wide range of medical services to be covered by the plan.¹³⁹ All Vermont residents would be eligible for coverage.¹⁴⁰ It includes all “primary care, preventive

¹³¹ *Id.* at sec. 1(a)(1).

¹³² *Id.*

¹³³ *Id.*

¹³⁴ Jessica Marcy, *Vermont Edges Toward Single Payer Health Care*, Kaiser Health News, Oct. 2, 2011, khn.org/new/Vermont-single-payer-health-care, last accessed 11/10/17.

¹³⁵ Hsaio, *supra* note 127, at 1235.

¹³⁶ An Act Relating to a Universal and Unified Health System, H.202, Leg., 2011-2012 Reg. Sess. sec. 3 (Vt. 2011) (amending 18 V.S.A. ch. 220 § 9374(a)(1)).

¹³⁷ *Id.* at § 9375(b).

¹³⁸ *Id.* at § 9374. The absence of mandated health care professionals and other stakeholders is a lesson already learned by other state’s legislation, the New York Health Act and Healthy California Act mandate that the governing board be sourced from these populations.

¹³⁹ *Id.* at § 1825(a)(1).

¹⁴⁰ *Id.* at sec. 1(a).

care, chronic care, and hospital services” that would have been included in the earlier Catamount Health plan.¹⁴¹ It also mandates that coverage is not limited by pre-existing conditions.¹⁴² Coverage of dental, vision, hearing, and long-term care are left to the board’s discretion whether to include in the plan or not.¹⁴³ The board under this scheme had both a mandate to provide comprehensive coverage and a vast amount of power over what “comprehensive” meant.

Unlike the New York Health Act or the Healthy California Act however, these would not be free for Vermont residents.¹⁴⁴ Instead, a cost-sharing scheme was put in place that closely mirrors the “platinum” levels of the ACA.¹⁴⁵ This means that members would be subject to out-of-pocket expenses of around 13 percent of their medical expenses.¹⁴⁶ The rationale for this being that total coverage would result in a much more expensive program for the state to finance.¹⁴⁷ The Hsaio report specifically states that the total coverage of medical expenses was politically unpalatable to the business community while its exclusion from the law drew the ire of single payer advocates.¹⁴⁸

As noted, the law left much of the funding structure to be determined by the board and legislature.¹⁴⁹ The Green Mountain Care Fund was to be the single source to finance the plan.¹⁵⁰ All money authorized by the general assembly, (any new taxes established to fund the plan), and,

¹⁴¹ *Id.* Catamount Health was an earlier reform initiative passed in Vermont in 2006, described as a “comprehensive insurance package.” Catamount Health Insurance, Reg. H-2006-01 (Vt. Sep. 8, 2006).

¹⁴² *Id.* at § 1825(a)(4)(B).

¹⁴³ An Act Relating to a Universal and Unified Health System, H.202, Leg., 2011-2012 Reg. Sess. sec. 3 (Vt. 2011) (amending 18 V.S.A. ch. 220 § 1825(a)(3)).

¹⁴⁴ *Id.* at § 1825(a)(3).

¹⁴⁵ Hsaio, *supra* note 127, at 1235.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ VerValin, *supra* note 122; An Act Relating to a Universal and Unified Health System, H.202, Leg., 2011-2012 Reg. Sess. sec. 9(a) (Vt. 2011).

¹⁵⁰ *Id.* at sec. 4 (amending 18 V.S.A. ch. 220 § 1829(a))

assuming waivers could be attained, received by the federal government from federal health programs would be deposited in the fund.¹⁵¹

In the creation of funding plans, the law does lay out some requirements.¹⁵² Factors ranging from the effects on the retirement plans of Vermonters to how to maximize the flow of federal funds to the state would have to be considered.¹⁵³ The plan was due to be submitted to the legislature on January 15, 2013.¹⁵⁴ The Hsaio report included within it a plan to generate enough revenue and save the state money under the plan.¹⁵⁵ Hsaio's team laid out a funding plan that estimated employers would save \$260 per employee and on average Vermonters would save \$370 per household.¹⁵⁶ Key to this plan were adjustments to the payroll taxes of the state.¹⁵⁷ A flat rate would be placed on all wages, split 75 percent and 25 percent between employer and employee.¹⁵⁸ The savings would be found as the difference between old premiums and the new payroll taxes and reduced administrative costs associated with streamlining the health care delivery system.¹⁵⁹

Before assessing why Green Mountain Care fell apart, it is useful to run it through the same test of 1332 compatibility as New York Health and Healthy California.¹⁶⁰ Although not nearly as wide-ranging as the California and New York plans, Green Mountain Care is as

¹⁵¹ *Id.* at § 1829(b).

¹⁵² *Id.* at sec. 9(b).

¹⁵³ *Id.*

¹⁵⁴ *Id.* at sec. 9(a).

¹⁵⁵ Hsaio, *supra* note 127, at 1235-1237.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ This is especially true due to the plan's reliance, as any state based single payer plan under the ACA, on federal funds to operate. At least one scholar points to the failure of federal funding levels to increase as expected as a reason for the plan's collapse (*see* McDonough, at 1584).

comprehensive as the ACA.¹⁶¹ This is due to the services already covered by Catamount Health in the state and the provision against excluding members based on pre-existing conditions.¹⁶² The affordability of the plan is arguable as out-of-pocket expenses are not excluded.¹⁶³ While they do comport with the “platinum” level of the ACA, tax hikes and other expenses could put the plan’s actual costs to the individual member above what the ACA would require. The plan covers a comparable number of state residents because Green Mountain Care is a plan available to all residents in Vermont.¹⁶⁴

In terms of being budget neutral on the federal deficit, Green Mountain Care would likely have the same issues raised by the California plan above. Without actuarial and economic evidence showing otherwise, HHS is unlikely to approve so vague a funding structure. Vermont never submitted Green Mountain Care to HHS for approval, but had it done so in the law’s current form, it is not likely to have gained approval for a section 1332 waiver.

In the end, Green Mountain Care was abandoned by Governor Shumlin due to “the risk of economic shock...”¹⁶⁵ As noted, federal revenues from Medicaid and the ACA failed to meet projected amounts over the period from 2011-2014.¹⁶⁶ Further, Shumlin raised the actuarial value of the plan, (the amount that the plan would cover rather than out of pocket expenses), from 87

¹⁶¹ An Act Relating to a Universal and Unified Health System, H.202, Leg., 2011-2012 Reg. Sess. sec. 3 (Vt. 2011) (amending 18 V.S.A. ch. 220 § 1825(a)(1)); *see also Id.* at § 1806(b)(1)(A) requiring any qualified health plan to cover the essential health benefits required by section 1302(a) of the ACA.

¹⁶² *Id.*

¹⁶³ *Id.* at § 1825(a)(3).

¹⁶⁴ *Id.* at sec. 1(a).

¹⁶⁵ McDonough, *supra* note 119, at 1584-1585

¹⁶⁶ *Id.*

percent to 94 percent.¹⁶⁷ These factors, along with the Vermont legislature's inability to create a viable tax plan to fund the plan, dimmed its financial prospects considerably.¹⁶⁸

To add to this, the Governor found himself in a politically toxic situation just as the law was to take effect.¹⁶⁹ He had barely fended off a Republican challenger in the 2014 gubernatorial election and by that same year, public and legislative support for single payer had waned significantly.¹⁷⁰ Facing the prospect of introducing a new tax plan to support Green Mountain Care to a hostile public and a legislature acutely conscious of the plan's potential political toxicity, the plan was abandoned.¹⁷¹

Part IV: Lessons Learned and the Future of Single Payer

A poll conducted during the summer of 2017 by Pew Research shows that 33 percent of Americans want a single national government program.¹⁷² This increases to 52 percent when asking Democratic voters.¹⁷³ The Republican party's efforts to create national health care reform in their own image has led to a surge of support for these state-led single payer programs.¹⁷⁴ Besides California and New York, bills have been introduced in twenty-four other states at one time or another.¹⁷⁵ With the GOP controlling the levers of government on a federal level, single-

¹⁶⁷ *Id.* Raising the actuarial value, while reducing the direct costs to the individual, increases the cost to the plan itself. This shift in cost-sharing drastically increased the forecasted cost of the plan to the public at large, and thus the amount that would have needed to be raised through taxes or other means.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ McDonough, *supra* note 199, at 1585.

¹⁷² Jocelyn Kiley, *Public Support for "Single Payer" Health Coverage Grows, Driven by Democrats*, Pew Research Center, June 23, 2017, <http://www.pewresearch.org/fact-tank/2017/06/23/public-support-for-single-payer-health-coverage-grows-driven-by-democrats/>, last accessed 11/10/2017.

¹⁷³ *Id.*

¹⁷⁴ Barret Newkirk & David Robinson, *Some States See Opportunity for Single-Payer Health Care*, USA TODAY NETWORK, June 28, 2017, <https://www.usatoday.com/story/news/politics/2017/06/28/single-payer-health-insurance/434353001/>, last accessed 11/10/2017.

¹⁷⁵ *Single Payer Legislation*, HEALTHCARE-NOW!, <https://www.healthcare-now.org/legislation/>, last accessed 11/10/2017.

payer health care is likely to come from the success of a state based effort rather than federal legislation.

The legislatures of New York and California will have the opportunity to pass comprehensive single payer healthcare. If they are successful, it would be a stunning leap into the experiment begun by Vermont in 2011. The question of the plans' success in implementation will heavily rely on whether the state governments have learned from the lessons of Green Mountain Care. For an answer, one only need to look to the language of the respective legislation. The New York Health Act is meticulous in its administrative procedures and exact in its financial forecasting: the bill has been forged and revised through the legislative process. The Healthy California Act on the other hand, suffers from much of the same ambiguity and uncertainty that doomed Green Mountain Care. Without a funding structure that is mandated in the bill, and given the ability to change and adapt later, any single payer plan has a hard road to success. An informational campaign must be waged to educate citizens and lawmakers on the economic, social, and financial implications of the plan. Support for its implementation must be broad based and sustained to ensure success over the long road of change: this is nearly impossible to do when the plan itself contains ambiguities.

If state based single payer healthcare is coming, it will likely come first in New York. The success there will be combination of legislative fastidiousness and widespread support. A major factor will also be the continuation of federal funding available to states. In estimates of the estimations of the overall budget, \$152 billion would still be coming from the federal government.¹⁷⁶ This requires the application for and HHS acceptance of all applicable waivers for the plan. If the New York Health Act passes in its current form, this is not an unlikely

¹⁷⁶ Friedman report, *supra* note 79.

scenario. The proposed plan easily fits within the requirements for section 1332 waivers. It is a comprehensive plan, covering the spectrum of medical services for all New York residents. The plan requires that no New Yorker pay any out-of-pocket costs, and, if the actuarial analyses bear out, will not impact the federal deficit negatively. In fact, the Friedman report suggests a proportional decrease in federal spending after the plan is put into place thanks to administrative economies.¹⁷⁷

For California, the road ahead is less certain. Certainly, there is support within the state for single payer health care. Were it not for Speaker of the State Assembly Anthony Rendon, the bill may have passed in the summer of 2017. The irony is, it may be that Speaker Rendon's apprehension leads to the bill's eventual passage and the successful application for a 1332 waiver. The key issue is the uncertainty surrounding the financing of the plan. Just as Vermont left the financing details to a future date, so does the Healthy California Act. Speaker Rendon's delaying of the bill now gives proponents of the plan an opportunity to work out the details of a funding structure. Health care reform is a highly politicized and contentious issue. Any attempt to pass meaningful legislation is the result of a years-long build-up of support, funding, and political capital. The key to passing legislation that works is not simply railroading what amounts to a statement of intent through a state legislature, rather it is to pass a bill that is the product of careful consideration and attention to detail. The New York Health Act has been introduced, rejected, and revised dozens of times since 1992, and the legislation reflects that kind of sweat equity. The Healthy California Act simply does not.

¹⁷⁷ *Id.*

The biggest question remaining is how the federal government will administer the granting of waivers going forward.¹⁷⁸ The Trump administration, while signaling that more control must be given to the states, has explicitly called for the repeal of the ACA and withdrawn support for the waiver system.¹⁷⁹ Recently Iowa’s request for a waiver was put on hold after the President reached out to HHS.¹⁸⁰ Oklahoma also withdrew its application for a waiver after complaints that HHS was intentionally stalling the process.¹⁸¹ Without the funding available through the waiver system, it is unlikely that any state, even those as large as California and New York, would be able to sustain a single payer system.

Notwithstanding Senator Bernie Sander’s resurgent “Medicare for All” campaign, federal legislation instituting universal, single payer health care coverage remains remote.¹⁸² The opportunity exists however for these state governments to press ahead. There certainly is precedent for state-based health care reform going national.¹⁸³ Perhaps the road to national health care leads through Albany or Sacramento.

¹⁷⁸ The legislation grants the Secretary of HHS the full discretion to grant waivers in 42 U.S.C. § 18052(b). This power however has been further delegated to CMS and the Department of the Treasury to administer. *See* Delegation of Authorities, 76 Fed. Reg. 53,903, 53,903-4 (Aug. 30, 2011). For a more detailed treatment of the discretion power of the agencies involved in administering the waiver *see* Elizabeth Y. McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 OHIO ST. L.J. 1099 (2017).

¹⁷⁹ Juliet Eilperin, *As ACA enrollment Nears, Administration Keeps Cutting Federal Support of the Law*, THE WASHINGTON POST, Oct. 5, 2017, https://www.washingtonpost.com/politics/as-aca-enrollment-nears-administration-keeps-cutting-federal-support-of-the-law/2017/10/05/cc5995a2-a50e-11e7-b14f-f41773cd5a14_story.html?utm_term=.3069e95406d5.

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² Bernie Sanders, *Why We Need Medicare for All*, THE NEW YORK TIMES, Sep. 13, 2017, <https://www.nytimes.com/2017/09/13/opinion/bernie-sanders-medicare-single-payer.html>.

¹⁸³ Jessica Taylor, *Mitt Romney Finally Takes Credit for Obamacare*, Oct. 23, 2015, NPR, <https://www.npr.org/sections/itsallpolitics/2015/10/23/451200436/mitt-romney-finally-takes-credit-for-obamacare>, last accessed 11/10/2017.