JANUARY 2020

Current Federal Health Care Waiver Authorities Will Not Pave the Way for the New York Health Act

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Key Findings:

1. The New York Health Act presumes funds provided via Medicare, Medicaid, and the Affordable Care Act (together over ⅓ of all state health spending), can be folded into a state system for residents. Exempting current federal programs (and employer coverage) would undermine it, as NY regulates and controls very little of the overall insured population and associated medical service payments.

2. Existing federal waiver authorities provide states with circumscribed options for experimentation. However, these authorities are limited and conditional and do not allow for lump sum payments to the states to finance a single-payer program. Medicare in particular protects the entitlement rights of its enrollees, which precludes a single-payer design.

3. Vermont's unsuccessful effort to implement a single-payer program over the period 2011 to 2014 demonstrates that federal waiver authorities do not provide a ready mechanism for states to assume control over federal health dollars. Other states that pursue a single-payer agenda are likely to run into the same political and practical obstacles that forced Vermont's elected leaders to abandon their reform plan.

Single-Payer Legislation in New York

The primary campaign being waged amongst Democrats seeking the presidency in 2020 has surfaced an important debate about the viability of a single-payer health care system at the federal level. But the conversation about such reforms has not been limited to campaigns for federal office. In recent years, many Democratic candidates for state offices have responded to growing support for single-payer among party activists by pledging to support the concept if given the opportunity to do so.

New York's single-payer health reform proposal – the New York Health Act (NYHA) – has been filed in the state Assembly in every legislative session since 1992 and has been passed in that chamber three times in recent years.[1] While the legislation has not been taken up in the state Senate, 31 members of that chamber are currently co-sponsors of the bill.

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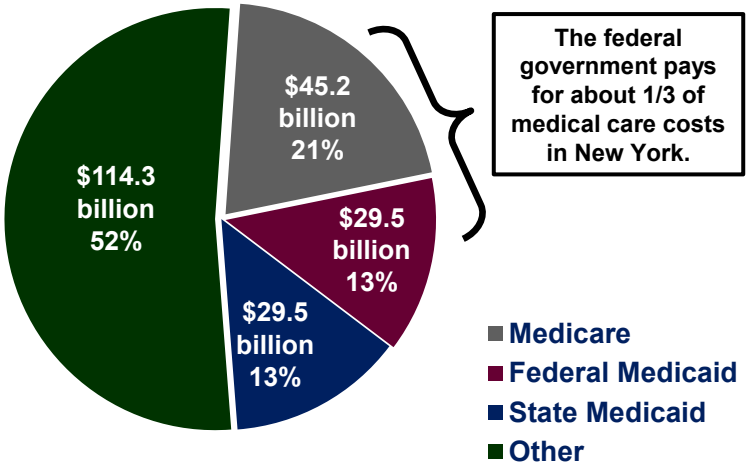
* *This analysis was commissioned by the New York Health Plan Association as part of an on-going effort to examine the implications of the New York Health Act. The views expressed are strictly those of the authors and not of the institutions with which they are affiliated. Neither the American Enterprise Institute nor the Hoover Institution hold institutional positions on policy issues.*

Under the NY Health Act, the state would set up an insurance plan for all New York residents, which would supplant most existing coverage, public and private. Employer-sponsored coverage would be allowed, but the imposition of a payroll tax to finance the single-payer program would likely lead most firms to drop their existing plans.[2] Providers of medical services would be paid based on rates set by the state, perhaps after a process of negotiation with organizations representing facilities and practitioners.

The legislation points toward comprehensive benefits, including dental and vision services, and also long-term care.[3] Consumers would pay no premiums for the coverage or cost-sharing when using services. It is expected that benefits provided by the program would far exceed those furnished through Medicare and Medicaid, as well as the essential health benefits provisions of the Affordable Care Act (ACA).

Supporters of the New York single-payer plan argue it is affordable because federal funds now used to finance Medicare, Medicaid, and the coverage subsidies provided by the ACA will be redirected to the single-payer program. As shown in Chart 1, federal expenditures finance approximately one-third of medical care spending in the state, with the state share of Medicaid covering another 13%.

Chart 1:
Sources of Payment for Personal Medical Care in New York State, 2016



Source: "An Assessment of the New York Health Act: A Single-Payer Option for New York State," Jodi I. Liu, et. al., RAND Corporation, 2018, p. 79. https://www.rand.org/content/dam/rand/pubs/research_reports/RR2400/RR2424/RAND_RR2424.pdf. Expenditure estimates include costs for structures and equipment.

While the federal government is indeed spending substantial sums on medical services in New York, those funds are not easily placed under the control of the state. There are several provisions in current federal law that might be used by New York to seek greater control over the existing funding streams, but these provisions are not free from complications or requirements that make adoption of a clean version of a single-payer scheme by any state highly unlikely. It

is possible to envision New York pursuing options that would partially align the existing federal programs with the single-payer concept, but even these approaches would be very complicated to secure in federal waiver requests and likely would involve compromises that call into question the rationale for merging the programs at all.

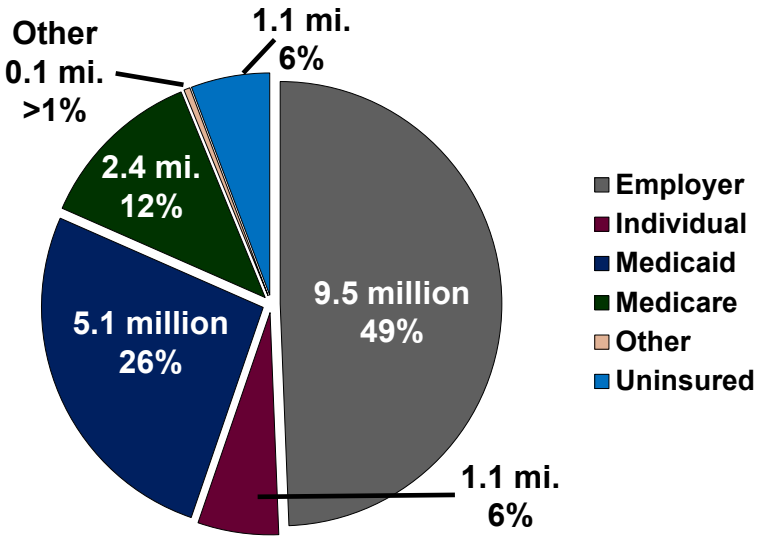
This paper discusses some of the challenges and issues that advocates of single-payer reform in New York are likely to face if they choose to repurpose federal dollars in their effort to dramatically remake the health care system in the Empire State.

The State Single-Payer Coverage Dilemma

Proponents of NYHA advocate including all residents in the program, regardless of current insurance status. That means the legislation assumes Medicare, Medicaid, the individual health insurance market, and job-based coverage will be subsumed into the larger, state-run single-payer system.

The desire to make the new state-run scheme as expansive as possible is understandable because the existing sources of coverage are so large that leaving them out would reduce the political salience of the single-payer project. As shown in Chart 2, in 2017, fully 87 percent of New York residents were enrolled in Medicare, Medicaid, or job-based plans.[4] Exempting this coverage would reduce the reach of single-payer to just the individual market and the uninsured, and thus make it more difficult for advocates to argue that it would have a transformative effect on costs.

Chart 2:
Sources of Insurance Coverage in New York State, 2017



Source: Kaiser Family Foundation, "Health Insurance Coverage of the Total Population." https://www.kff.org/other/state-indicator/total-population/?dataView=0&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

While there are opportunities in current federal law to pursue experiments and waivers in

both Medicare and Medicaid, the lack of flexibility of federal rules creates barriers to state-based single payer programs. Further, the federal government has never used these provisions of current law to approve inclusion of all or parts of the major public insurance programs in anything nearly as sweeping as the New York Health Act. The barriers to inclusion of Medicare and Medicaid in the state's single-payer scheme are legal, practical, and political all at once.[5]

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Major Conceptual Impediments to State-Sponsored Single-Payer Plans

The NYHA, like single-payer bills introduced in other states, contemplates institution of a fully state-administered system unrestrained by the rules and requirements of Medicare and Medicaid as they exist today. The starting assumption is that the state plan will take control of the existing federal funds deployed through Medicare and Medicaid in something like a fixed block grant, which the state can use as it sees fit to finance the new, state-administered insurance plan. The reality is that federal law does not provide a ready pathway for state-initiated single-payer plans.

The first and most basic problem for single-payer advocates is that there is no existing authority in current law that would allow the federal government to send its combined financial commitment in Medicare and Medicaid to the states in the form of a block grant or something similar. There are existing authorities that allow states to submit proposals and applications for using federal funds in ways that are outside of the normal program rules, but those authorities come with substantial requirements, caveats, and administrative complexity, creating a series of piecemeal approvals that would require periodic reauthorization. In addition, it is far from certain that federal officials will agree to any proposed plans submitted by the states, and they are under no obligation to approve state requests under current law provisions, or even to process them in a timely manner.

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A second conceptual roadblock is the design of the Medicare program. Under current law, employees and their employers pay taxes on earnings that creates entitlement to benefits in the Hospital Insurance (Part A) program for workers when they reach age 65. Further, persons eligible for benefits under Part A can opt to get supplemental medical coverage under Part B of Medicare by paying a monthly premium. Enrollment in Part B is strictly voluntary.

The New York Health Act, if Medicare is subsumed into it, would upend this longstanding framework and create potential inequities. Workers in New York would continue to pay the Part A payroll tax, like workers in all other states, but they would no longer become entitled to Medicare benefits administered by the federal government. Among other things, they would lose certain rights that are available to current Medicare enrollees, including the right to get their benefits from private insurers through the Medicare Advantage program. They would also lose the option to enroll in Part B when they turn 65. In a single-payer plan, Medicare beneficiaries would lose the right to access services using the payment structure of Medicare and would instead have to rely on whatever payment system is put in place by the state.

Single-payer advocates have suggested that the New York Health Act will provide even more generous benefits to the elderly than Medicare, and so losing the entitlement to the federally-administered program should not be considered a setback. However, that is an assertion that has not yet been tested, and workers who have paid taxes on their wages have earned an entitlement under federal law that comes with established rights, principles, and access to a highly popular health care coverage program. It is highly unlikely that the federal government will walk away from its obligations to Medicare-eligible individuals in New York based on a state request, or that Medicare-eligible state residents will be eager to forgo the Medicare entitlement they earned with their tax payments when they learn of the practical consequences of a purist version of single-payer reform.

A third impediment is the financing structure of the Medicaid program as redirecting federal health care funds comes with restrictions and limitations. Current federal law uses a matching payment system to finance services for Medicaid-eligible beneficiaries. States make eligibility determinations within the boundaries of federal law, and the federal government pays for a percentage of the costs incurred in providing services to those patients. No provision of existing federal law explicitly allows this "matching system" to be altered in any fundamental way, even with waiver authority. Consequently, many analysts have argued that it is not possible for the federal government to provide financing to the state in a form that differs from the matching payment system.[6] As such, there is an expectation that states must always maintain an eligibility system for Medicaid that allows for the separate tracking of expenses that can be used to draw down matching funds from the federal government. This structure, and especially the requirement to maintain accounting for Medicaid funds separate and apart from other health spending, runs counter to the concept of a single-payer system, such as the one proposed in New York, as a unitary eligibility and benefit system.

Vermont's Green Mountain Care Initiative: A Case Study

Nearly a decade ago, Vermont aggressively pursued implementation of a single-payer program for state residents. The state legislature approved a bill in 2011 that set in motion implementation of the plan – called Green Mountain Care – provided that certain conditions were met in the ensuing years. After a substantial investment of state resources pursuing the concept, Democratic Governor Peter Shumlin decided to terminate the project in December 2014.[7]

The objectives of Vermont's aborted single-payer effort closely resemble those of the New York Health Act. The overall goal was comprehensive, state-administered coverage that was to become the de facto insurance plan for all (or nearly all) state residents. Vermonters would have paid a tax, called a "public premium," to partially finance the program's expenditures. Employer plans would not have been prohibited, but enrollment in job-based coverage would not have exempted workers from paying taxes to finance the single-payer plan. Unlike the New York Health Act, Green Mountain Care would have imposed modest cost-sharing on consumers when they used services (cost-sharing was planned to cover 6 percent of the overall cost of coverage). The planned benefits covered by Green Mountain Care insurance were more modest than the list included in the New York Health Act. All primary and preventive services were covered, along with all necessary acute care services (including emergency care) to treat medical conditions. Children were to get vision and dental care, up to age 21. Long-term care was excluded, as were vision and dental services for adults.

Vermont's experience with Green Mountain Care provides insights into the difficulty any state, including New York, will face when pursuing a similar, single-payer program. In particular, Vermont was forced to make compromises with respect to Medicare and Medicaid that called into question th why it was pursuing a single-payer structure at all.

MEDICARE. Although Green Mountain Care was billed as a single-payer plan, it explicitly exempted Medicare – the largest single insurer – from inclusion in the program (retired military enrolled in TRICARE were also exempt). All Medicare beneficiaries would have remained in their existing coverage, and they were exempted from the planned tax to finance Green Mountain Care too. All of the private supplemental policies that wrap around Medicare would have been allowed to continue operating in the state as well.

MEDICAID. The planned benefits under Green Mountain Care were more modest than that offered to Vermont Medicaid beneficiaries. For instance, Vermont's Medicaid program pays for transportation services and generally does not require cost-sharing from participants. To ensure Medicaid beneficiaries would not lose services, Vermont was planning to maintain an enrollment process that would allow for separate identification of residents eligible for Medicaid.[8] The separate tracking of expenses would have continued as well in order to draw down matching federal funds. In other words, although Medicaid was said to be subsumed into Green Mountain Care, the program would have continued as a separate insurance plan within the larger state-run plan.

With Medicare exempt and Medicaid operating as it always had previously, the state was left with trying to finance the program from taxes imposed on a smaller subset of state residents. Cost estimates produced at the time showed the tax on employers would have been 11.5 percent of payroll, with workers paying another 9.5 percent.[9] In the end, the governor chose to terminate the program rather than continue pursuing a concept that was non-viable both politically and financially.

Potential Waiver Options, and Their Limitations

Current federal law provides four separate authorities, summarized in Chart 3, which might be used by New York and other states to pursue health coverage agendas that move in the direction of a single-payer program. Each of these authorities has features that limit their usefulness to the advancement of a single-payer system in New York.

CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI)

The ACA created a new waiver authority (section 1115A of the Social Security Act) for testing payment models in Medicare and Medicaid, under the auspices of CMMI. The authority is fairly broad. CMMI can approve projects that alter how Medicaid and Medicare pay for services so long as the new payment models do not reduce benefits for program enrollees, or lower the quality of the services provided to them. The basic orientation of the authority is to test approaches that hold the promise of both cutting expenses for the federal government while maintaining or improving the quality of care provided to patients. Each demonstration approved by CMMI is to be evaluated on this basis.

Although CMMI's waiver authority is broad, it is not unlimited. For Medicaid, CMMI can only waive provisions related to requirements for providing uniformity of benefits statewide, processes for establishing payment rates for services provided in facilities, and managed care requirements. That leaves many program provisions in place (including the requirement to make federal payments on a matching rate basis).

It is also clear from the CMMI statute that a comprehensive single-payer scheme was not one of the models the waiver authority was designed to set in motion. The law includes a list of potential demonstration ideas, and one item on that list is a test of a state-based "all-payer" payment system. There is no mention of a single-payer program, however. Moreover, CMMI has never come close to approving a demonstration on the scale of the New York Health Act. Instead, the authority is used mainly to test payment modifications in Medicare that do not alter how the program is financed, or change how beneficiaries access services.

SECTION 402(A) WAIVERS

Section 402(a) of the Social Security Amendments of 1967 (as amended) allows the Secretary of Health and Human Services to waive certain unspecified provisions of both Medicare and Medicaid to assess alternative methods for paying for various medical care and related services.[10]

The statute specifically cites the possibility of using negotiation as a possible concept for testing and evaluation. This authority is sometimes cited as a possible key to unlocking Medicare funds for a single-payer scheme, but that is a flawed interpretation of the statute. The law allows the Secretary to waive provisions of Medicare law to test whether alternative "methods of payment or reimbursement" would improve the efficiency of the program. There is nothing in this waiver authority that would allow the Secretary to force Medicare beneficiaries in a particular state to accept enrollment in a single-payer plan in lieu of their entitlement to Medicare coverage. Consequently, this authority has very little to offer in terms of subsuming Medicare in the New York Health Act.

SECTION 1115 WAIVERS

Many states have utilized the existing authority provided in the Social Security Act to pursue waivers in the Medicaid program. Section 1115 allows the Secretary of Health and Human Services to waive many provisions of current Medicaid law, including provisions which limit federal matching payments to a list of covered services. States have used this authority to pursue substantial modifications of the program, including more expansive eligibility rules, additional benefits beyond those required by Medicaid law, and use of private managed care entities to deliver services to eligible patients.

However, this authority does not allow the federal government to provide funding to states separate from a matching rate structure. States may request caps on the total amount of matching payments (as was the case in a waiver approved for Rhode Island) but that is not the same as providing block grant-like funding that is untethered to services provided to eligible individuals.[11] Consequently, section 1115 would not allow a state to discontinue its Medicaid eligibility tracking systems, or to terminate its system of separately accounting for Medicaid-related expenses.

Section 1115 does not specifically require budget neutrality as a condition of federal approval of state waiver requests, but the long-standing practice of the executive branch (dating back to 1983 and maintained in the ensuring years under both Democratic and Republican administrations) is to impose that condition.[12] This requirement reinforces the convention that Medicaid spending must continue to be tracked and accounted for separate and apart from other coverage in the state, which substantially complicates the single-payer project.

Federal Medicaid spending requires matching funds from the state, too, and it is both sources of funding that need to be separately identified and applied to authorized expenditures for the program to meet federal legal requirements. In a sense, then, it is the entirety of the state's Medicaid budget – some $60 billion in 2016, according to the RAND analysis of NYHA – that would be difficult to redirect in a flexible and unencumbered manner into a single-payer fund to be used with wide discretion by state authorities.

SECTION 1332 WAIVERS

Under the ACA, states can request section 1332 waivers to alter certain provisions of current law related to regulation and subsidization of the individual and small group insurance markets. In particular, section 1332 allows states to request altering the insurance rules established in the ACA, and to request using the federal funds dedicated to premium credits, small employer tax credits, and cost-sharing subsidies in a manner that differs from the conditions stipulated in federal law. To gain federal approval, states must submit supporting information that demonstrates their alternative insurance plans will meet four conditions: (1) the benefits in the new insurance arrangement will be at least as comprehensive as those provided in the ACA; (2) the state plan will not increase the financial burden on program enrollees; (3) the state plan will not increase the number of residents who do not enroll in health insurance; and (4) the state plan will not increase the federal government's costs.

The Trump Administration recently revised Obama-era guidance relating to Section 1332 to emphasize that states requesting waivers under this section of the ACA should describe how their proposal will promote private market coverage, "encourage sustainable spending growth," and "promote consumer-driven health care." Proposals that advance these priorities, amongst others, will be looked upon most favorably by the Administration.[13] These factors weigh strongly against the use of a Section 1332 waiver to advance a single-payer health reform proposal.

This authority arguably provides the states with the best shot at accessing funds in a flexible manner for a single-payer program. A state submitting single-payer system plans could receive funding from the federal government that is equal to what would have paid directly to beneficiaries in the ACA exchange, and the state would have complete control over the use and distribution of those funds.

Although this funding is flexible and potentially available to the states (notwithstanding the recent HHS guidance), it is a small portion of overall health spending. According to RAND, in 2022, federal spending on ACA subsidies would be just 4 percent of total federal spending in NY for medical care.[14]

A further complication for New York is its adoption of the Basic Health Program (BHP) option provided in the ACA. BHP allows states to set up a state-run insurance option for households with incomes above Medicaid eligibility and below 200 percent of the Federal Poverty Level (FPL). BHP can be used to provide an insurance option that differs from the plans offered on the ACA exchange and also to persons residing legally in the U.S. who are nonetheless ineligible for premium credits and cost-sharing assistance in the exchanges.[15] Two states – Minnesota and New York – have elected to set up insurance plans under the BHP authority. New York's BHP option provides insurance to 790,000 enrollees in 2019.[16] The Centers for Medicare and Medicaid Services (CMS) denied a request by Minnesota to provide additional flexibility for its BHP program through a section 1332 waiver, as the ACA did not include BHP in the list of program spending provisions specifically covered by the waiver option. Consequently, it is not clear that New York's BHP program could be included in a 1332 waiver request. The state might be able to work around this limitation by moving the population covered in the BHP program into regular exchange coverage.[17]

Chart 3:
Federal Waiver Authorities and Their Limitations

Waiver Authority	Description	Limitations
Section 1115A of Social Security Act	• Provision of the Affordable Care Act (ACA) that created the Center for Medicare and Medicaid Innovation • Broad authority to test new payment methods to cut federal costs without harming quality	• Law explicitly mentions allowing all-payer plans, although such plans would be hard to enact on a budget-neutral basis • Nothing in the authority allows for block granting Medicaid or revoking choices available to Medicare beneficiaries
Section 402(a) of the Social Security Amendments of 1967	• Provision allows for testing of new methods for paying providers in Medicare	• The authority does not allow states to assume control over Medicare program spending
Section 1115 of the Social Security Act	• States can request waivers of various provisions of Medicaid law to allow for testing of new models of coverage and payment	• Section 1115 does not allow for waiving of the federal matching rate structure for financing Medicaid, which precludes lump sum payments and necessitates maintenance of separate Medicaid accounting
Section 1332 of the Affordable Care Act	• Allows states to request federal funds used to pay premium credits and cost-sharing subsidies in an alternative form	• This is the most flexible authority and would allow a state to receive these funds in lump sums • However, this authority applies only to ACA-financed spending, which is small relative to Medicare and Medicaid

Additional Questions and Issues

Beyond the primary avenues for seeking waivers from the federal government, the New York Health Act raises other issues and questions that deserve clarification.

WHAT WOULD HAPPEN TO NEW YORK'S EXISTING MEDICAID WAIVERS?

As of 2019, New York has eight waivers that have been approved by CMS and are operational.[18] Many of these waivers were developed in order to provide tailored benefits to particular subpopulations of the program. For instance, New York has a waiver that allows the state Medicaid program to finance extensive additional services for residents age 18 and older who have significant brain injuries, including respite services for their regular caregivers, environmental modifications to their homes, transportation services, and much else. The state also has a waiver allowing it to provide benefits well beyond those traditionally covered by Medicaid to children under age 21 who have significant disabilities. These populations need extensive medical and social support, which is now being provided through service providers who otherwise would not exist if the Medicaid waiver were not in place. In all likelihood, the New York Health Act would be forced to make accommodations for these populations by maintaining the waiver programs. This is one more reason why it would be all but impossible to actually subsume Medicaid into the larger single-payer scheme.

IS MARYLAND'S ALL-PAYER RATE SETTING SYSTEM A RELEVANT PRECEDENT?

Maryland has operated a federally-approved all-payer rate setting program since 1977. A provision enacted by Congress in 1980 gave the state a statutory basis to continue the program without annual consultations with the federal government. In more recent years, the program

has fallen within the demonstration authority at CMS and is now operated as an innovation waiver approved by CMMI. Maryland uses its authority to impose a system of regulated payments on hospital systems and other providers that are more uniform across payers than would otherwise be the case. The program requires hospital systems to conform to these payment rules when providing services to patients covered by all employer-sponsored plans, commercial insurance, Medicare, and Medicaid.

New York could pursue an all-payer design as a CMMI demonstration project. It would allow it to have more control over provider payments (particularly for facilities) than it does today.

However, an all-payer system is not likely to be easier to impose than a single-payer plan. One major impediment is that commercial rates, which are relatively high today, would likely fall, while payments by Medicare and Medicaid would rise. Hospitals and physicians would strenuously object to a simple lowering of commercial payments to the levels paid by public insurance. However, setting all-payer rates that are higher than what Medicare and Medicaid pay today would almost certainly increase costs for the federal government, and thus violate the budget neutrality requirement of CMMI demonstrations.[19] Further, if Medicaid were forced to pay more for hospital services, New York's share of program costs, which is generally 50 percent of what Medicaid spends on services, would rise under an all-payer scheme rather than fall, and thus leave the state with fewer available resources to pursue its single-payer agenda.

COULD THE STATE SPONSOR A MEDICARE ADVANTAGE PLAN?

It is sometimes suggested that states seeking to implement a single-payer scheme could effectively include the Medicare program in the overall program by sponsoring a Medicare Advantage (MA) plan.[20] Medicare Advantage is currently the private insurance option in Medicare; beneficiaries can opt to get their entitlement from an MA plan in their market area, or remain in the traditional fee-for-service program, which is managed by the federal government. Currently, MA plan sponsors are private insurers, employers, or unions, but it seems possible that a state could apply to CMMI to offer an MA plan as a demonstration project. However, unless the state's proposal suggested termination of all other MA offerings, Medicare beneficiaries would retain their right to sign up with plans of their choosing. Consequently, even if the state of New York sponsored an MA plan, it would not be guaranteed that it would attract enrollment of all state residents eligible for the program. Moreover, the state would be required to take on substantial insurance risk, and to compete with other MA offerings. The state would also be required to build a network of participating providers, which would limit its ability to impose payment rates that are below those paid by competing plans. Although there may be valid reasons to study the effects of a state-sponsored MA plan on the market, there is no reason to expect such a plan would lead to a large shift in the direction of a single-payer program.

COULD A STATE OFFER MEDICARE WRAPAROUND COVERAGE?

Single-payer advocates have suggested that a state might offer wraparound coverage to supplement the benefits provided for under the Medicare program. Such coverage would be similar to the wrap-around coverage offered by private plans that provide enrollees with additional financial protections, such as coverage for out-of-pocket expenses, including deductibles and co-payments. While a state could attempt to provide additional financial benefits to Medicare enrollees (notwithstanding any program coordination difficulties), such coverage would be limited in scope to beneficiaries in the Medicare program and would be of little utility in an effort to migrate the state to a single-payer health care system.

Square Pegs and Round Holes

The New York Health Act was written to provide a vision for what a single-payer system would look like if it were established in an environment of no impediments or constraints to how it is designed. But New York, like every other state, already has a mature insurance system that is the product of the rules and incentives previously established in both federal and state laws.

In particular, Medicare, Medicaid, and the Employee Retirement Income Security Act (ERISA) are largely responsible for how the vast majority of Americans get their health insurance. The laws establishing these insurance arrangements were not written to accommodate states wishing to establish single-payer programs. The waiver provisions that are embedded in Medicare and Medicaid, while affording some flexibility, do not allow states to do away with the eligibility and accounting rules which ensure these programs retain their integrity as separate sources of insurance protection as contemplated in federal law.

Medicare, Medicaid, and ERISA are largely responsible for how the vast majority of Americans get their health insurance. The laws establishing these insurance arrangements were not written to accommodate states wishing to establish single-payer programs.

Although there is some authority in existing federal law to provide states greater control over existing funding streams, implementing a single-payer program at the state level would require a much broader authority for experimentation than is provided in current federal law.

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Endnotes

1 *Liu, Jodi L., et. al., "An Assessment of the New York Health Act," RAND Corporation, 2018. https://www.rand.org/content/dam/rand/pubs/research_reports/RR2400/RR2424/RAND_RR2424.pdf.*

2 *Liu, 2018.*

3 *Campaign for New York Health, Frequently Asked Questions. https://www.nyhcampaign.org/faq.*

4 *Kaiser Family Foundation, "Health Insurance Coverage of the Population." https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

5 *This paper provides an analysis of the complexities associated with assuming Medicaid, Medicare, and the ACA subsidy system can be redirected to the state's single-payer scheme. States also face hurdles when trying to bring employer plans regulated under ERISA into state-administered single-payer plans. However, the issues associated with ERISA and employer coverage are beyond the scope of this paper.*

6 *See Sachs, Rachel and Nicole Huberfeld, "The Problematic Law and Policy of Medicaid Block Grants," Health Affairs Blog, July 24, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190722.62519/full/.*

7 *Shumlin, Peter. "Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System," December 2014. https://hcr.vermont.gov/sites/hcr/files/pdfs/GMC%20FINAL%20REPORT%20123014.pdf.*

8 *Shumlin, 2014.*

9 *McDonough, John, "The Demise of Vermont's Single-Payer Plan," New England Journal of Medicine, April 23, 2015. https://mfprac.com/web2019/07literature/literature/Misc/SinglePayerVermont_McDonough.pdf.*

10 *Section 402(a) of the Social Security Amendments of 1967 (as amended). https://www.ssa.gov/OP_Home/comp2/F090-248.html.*

11 *Miller, Edward Allen, et. al., "Medicaid Block Grants: Lesson from Rhode Island's Global Waiver," Robert Wood Johnson Foundation, June 2013. https://www.shadac.org/sites/default/files/publications/RI_Global_Waiver_Brief_FINAL.pdf.*

12 *Dobson, Alan, et. al., "The Role of Federal Waivers in the Health Policy Process," Health Affairs, Winter 1992. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.11.4.72*

13 *"State Relief and Empowerment Waivers," 83 FR 53575, October 24, 2018.*

14 *Liu, 2018.*

15 *For a description of the Basic Health Program option, see Tolbert, Jennifer et. al., "Improving the Affordability of Coverage through the Basic Health Program in Minnesota and New York," Issue Brief, Kaiser Family Foundation, December 2016. http://files.kff.org/attachment/Issue-Brief-Improving-the-Affordability-of-Coverage-through-the-Basic-Health-Program-in-Minnesota-and-New-York.*

16 *New York State of Health, "2019 Open Enrollment Report," May 2019. https://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202019%20Open%20Enrollment%20Report_0.pdf.*

17 *This possibility is mentioned on p. 17 of Liu et. al. (RAND).*

18 *Medicaid.gov State Waiver List. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.*

19 *Budget neutrality of these demonstrations is required by section 1115A(b)(3) of the Social Security Act. https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm.*

20 *Campaign for New York, Frequently Asked Questions: Federal Waivers. https://d3n8a8pro7vhmx.cloudfront.net/pnhpnymetro/pages/4148/attachments/original/1529527348/Federal_Waivers_FAQ.pdf?1529527348.*