STATE EFFORTS TO ENACT UNIVERSAL HEALTH CARE

For the Oregon Universal Access to Health Care Work Group 2018
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INTRODUCTION
This report summarizes recent state efforts to enact universal health care. It will review key policy decisions made in each state’s design and identify contributing factors that led to these efforts failing in their respective legislative assemblies.

The four most substantial state efforts in the past decade occurred in Vermont, Colorado, New York, and California. In 2011, Vermont adopted a law to create a single-payer health care system; the governor then oversaw the design of the single-payer system, but decided not to implement the proposal after the initiative failed to pass a subsequent funding bill. In 2016 Colorado voted on a constitutional amendment to create a single-payer system called ColoradoCare, which voters rejected. In both New York and California, elected officials recently introduced legislation in support of universal coverage, but the proposed legislation failed to pass both chambers and be signed into law. See pg. 8 for a comparison table of the four states.

SHARED CHALLENGES AND LESSONS
An examination of these efforts finds several shared challenges and lessons for states exploring universal coverage policies to consider:

Federal Employee Retirement Income Security Act (ERISA) makes the process significantly more complicated: all four initiatives proposed redirecting the money that public and private entities in the state are currently spending on health care into a new centralized system. The predominant approach would require large employers to heavily standardize their private insurance or mandate they buy the new public insurance for their employees. This approach is similar to how other industrialized countries have approached creating a universal system. However, federal ERISA prohibits states from pursuing these paths.1 As a result, all four plans relied on employer payroll taxes, which creates both political and financial issues.

Free-at-point-of-service results projected to increase utilization and higher than expected costs: currently, the United States health care system relies on out-of-pocket cost as a direct and indirect utilization management tool. All four proposals called for minimal or no cost-sharing. Furthermore, none of the four states’ proposals explicitly created a clear alternative form of utilization management. ColoradoCare proposed that individuals would have the “right to choose their

primary health care providers.”2 The Vermont plan referenced the possibility of a designated primary care provider to coordinate an individual's care, but the idea was not presented with sufficient detail such that it could be scored.3 This resulted in higher than expected costs in official estimates using current models. Such outcomes may create the need for higher tax rates or reductions in provider rates to offset additional health care expenditures. Researcher Jodi L. Liu with RAND Inc. highlights this dynamic. Specifically, Liu projects that a national single-payer system with minimal to no cost-sharing would increase national health care expenditures by $435 billion, annually, due to increases in utilization. This figure, however, does not factor in other savings and reduced costs related to administration, price changes, and implementation. A single-payer system with a cost-sharing structure modeled after federal Medicare may reduce national health care expenditures by $179 billion before incorporating other possible savings.4

**Long-term care expenditures excluded:** long-term care services are excluded in proposed coverage programs except in several instances for individuals who qualify under Medicaid.

**Multiple federal waivers:** all four states’ proposals require federal 1115 Medicaid Waivers, 1332 Waivers of the Affordable Care Act, and potentially, federal Medicare waivers. The potential challenge in obtaining a federal Medicare waiver has led states to explore options to keep individuals enrolled in Medicare (and TRICARE), and offer supplemental coverage. There is no guarantee federal waivers will be considered or approved.

**No true “single” payer proposal:** states are limited in their ability to repurpose federal health care funds, including redirecting federal financial resources tied to Medicare and TRICARE. Moreover, workers commute into states, individuals travel in and out of states, and states have limited to no discretion in enacting changes that impact ERISA-based insurance coverage in a state.

**Details matter:** the failure of the Colorado ballot measure was due in part to concerns about its specific design issues among possible supporters. For example, the cooperative which would run Colorado’s new health care plan had potentially unconstitutional rules governing the election of its board.5

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Legislation: House Bill 202 signed by the Governor Peter Shumlin (D) May 26, 2011.6

Design Overview: The act created Green Mountain Care, “a publicly financed health care program designed to contain costs and to provide comprehensive, affordable, high-quality health care coverage for all Vermont residents.”

The Green Mountain Care Board and the secretary of administration were tasked with developing a plan for how to run, structure, and design benefits packages, and get federal waivers for and finance the state’s universal health care plan, which the legislature would need to approve. The benefit package was to have an actuarial value of 87 percent. The Green Mountain Care Board would also oversee an all-payer rate-setting system modeled after Maryland’s rate-setting system.

Status: Signed into law by the Governor.

How the plan evolved: After the bill was approved, several changes were made to the basic design to include nonresident workers and increase the actuarial value of the program to 94 percent, resulting in increases in the overall cost.

The final report from the Governor indicated the health care program would require a 11.5 percent payroll tax and a sliding scale “public premium” range from 0-9.5 percent of income up to a maximum of $27,500 a year. The premium would be deductible from federal taxes according to the Internal Revenue Service. A supplemental insurance market would remain for dental and vision. It also indicated that creating a primary care gatekeeper model such as managed care might be necessary to manage costs.

The plan required a large bond offering to build up a sufficient financial reserve, equivalent to all of the state’s bonding capacity for 10 years. It was projected to be fiscally viable long-term if it was established, but required major new government spending.

The plan was estimated to produce modest net reductions in spending which would grow over time with $378 million in the initial five-year period. It was estimated, on net, to impact Vermont families

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6 H.202 (Act 48) An act relating to a universal and unified health system.
earning less than $150,000 by increasing their annual income, and those earning more than $150,000 would experience a decrease.\textsuperscript{7}

**Barriers to Enactment:** In December 2014, Governor Shulmin officially ended his effort noting a weaker than expected economy and lower than expected “other” sources of revenue made moving forward at that time financially problematic.\textsuperscript{8}

Governor Shulmin later commented that part of the reason he withdrew his plan is that he lost credibility with voters on health care. During this period, Vermont’s ACA Exchange went live and was highly dysfunctional. A poll from April of 2014 identified support for the plan at 40 percent in favor to 39 percent opposed. This was before the final report was released showing higher than expected costs.\textsuperscript{9}

**Follow up:** after not implementing single-payer legislation, the state began working on its voluntary “All-payer ACO” model overseen by the Green Mountain Care Board. The goal is to limit health care cost growth to no more than 3.5% in aggregate across all payers.

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**COLORADO - 2016**

**Legislation:** Amendment 64, Colorado Creation of ColoradoCare System Initiative.

**Design Overview:** Establish an elected 21-member board of trustees to run ColoradoCare, designed to function as a new public cooperative. ColoradoCare would have provided universal health care to residents in the state and operated all aspects of the state’s current health care programs. The plan would have been paid for with federal waivers and a 10 percent payroll tax combined with a 10 percent tax on other income. The benefit package was to have no deductibles and nominal co-pays. As a result, the ColoradoCare board would have a larger budget than the rest of the state government combined.

The board would have had the power to create new taxes to pay for the system on a special ballot. Individuals with voting authority on the board would technically be different from individuals able


to vote in a regular Colorado election. The initiative would have established a new government entity in Colorado.

**Status:** Put on the November 2016 ballot by citizens.

**Barriers to Enactment:** The measure lost on the November ballot with a vote of 21.23 percent yes to 78.77 percent no. The plan was challenged by financial concerns about raising new tax revenue but also encountered several technical and political issues.

The organization behind the measure failed to sufficiently build coalitions with potential allies to solicit input when drafting the measure. This resulted in several design issues around funding and how the new ColoradoCare board elections would be conducted, which divided even potential supporters of the measure. The organization did not know how the measure would interact with existing state constitutional amendments in a way that drew serious concerns and opposition.

The process in which ColoradoCare trustees would have been elected as well the governance of the new system generated significant legal and political issues. There were questions about whether such elections would be constitutional based on who would be allowed to vote and political concerns that opponents of the single-payer model would invest resources into non-partisan elections of board members.

Additional concerns focused on the proposed 10 percent tax and the issue of whether it would cover the projected spending while the law also prohibited the board from reducing benefits or increasing cost sharing for individuals. As a result, the plan may have required approval of additional tax increase votes by residents in future years. For these reasons and others, both U.S. Sen. Michael Bennet (D) and Gov. John Hickenlooper (D) opposed the measure.

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Design Overview: The bill aimed to establish the Healthy California program as an independent public entity not affiliated with an agency or department. The program was to be overseen by an unpaid executive board.

The proposal sought to cover every resident regardless of immigration status. The program prohibited any cost-sharing including no premiums, copays, deductibles, or other forms of out-of-pocket costs for individuals. The proposal covered a broad range of benefits including “chiropractic, vision, dental, ancillary health or social services previously covered by a regional center, skilled nursing facility care, and therapies shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective.”14

The plan would also effectively not engage in utilization management as a member could receive coverage from any participating provider. Such an approach raised questions as to how the state would address existing managed care systems and whether such models of care could continue.

The state’s legislative analysis indicated the program would cost $400 billion a year.15 Theoretically, if federal waivers were obtained, California would receive an estimated $200 billion from the federal government. Existing spending by individuals with private insurance was estimated to be approximately $100-$150 billion per year. In sum, it was estimated that the plan would require an additional $50-$100 billion in new revenue to finance the program. The bill contained no funding mechanism and it was projected to require a 15 percent payroll tax to pay for the program.16

Status: passed the State Senate.

Barriers to Enactment: Assembly Speaker Anthony Rendon decided to keep the bill in committee saying, “SB 562 was sent to the Assembly woefully incomplete. Even senators who voted for SB 562 noted there are potentially fatal flaws in the bill, including the fact it does not address many serious issues, such as financing, delivery of care, cost controls, or the realities of needed action by the Trump Administration and voters to make SB 562 a genuine piece of legislation.”17

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15 Office of Senate p. 11
Polling on the bill might have also played a role. A survey conducted by the Public Policy Institute of California from May 2017 found 65 percent of adults initially supported SB 562, but support dropped to 42 percent when told the program would require raising taxes.\textsuperscript{18}

\textbf{New York - 2017}

**Legislation:** Assembly Bill 4738 Amended, New York Health Act

**Design Overview:** Establish the New York Health program in which all residents could enroll in and be overseen by a board of Trustees composed of government officials and representatives from the health care industry. New York’s proposal offered comprehensive benefits that included rehabilitative, dental, vision, and hearing. There would be no co-pays, deductibles, or other cost-sharing, and everyone would have a primary care practitioner. The bill provided no specific utilization management plan.

If passed, the law would have required the governor to later submit a revenue plan to the legislature. The revenue plan was to be based on a progressive graduated payroll tax and a progressive graduated tax on taxable income not subject to payroll taxes.\textsuperscript{19}

**Status:** The Senate version did not make it out of committee.

**Barriers to Enactment:** Expected opposition in the Senate to the general concept behind the legislation prevented a more in-depth discussion of the policy details.


\textsuperscript{19} New York State Assembly. A04738. Retrieved March 24, 2018 \url{http://assembly.state.ny.us/leg/?default_fld=&bn=A04738&term=2017&Summary=Y&Actions=Y&Text=Y&Votes=Y}
<table>
<thead>
<tr>
<th>VERMONT</th>
<th>COLORADO</th>
<th>CALIFORNIA</th>
<th>NEW YORK</th>
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<tr>
<td><strong>Eligibility</strong></td>
<td>All Vermont residents except Medicare or TRICARE. Non-residents who commute into Vermont to work for Vermont businesses.</td>
<td>All Colorado residents except those covered by Medicare and TRICARE. ColoradoCare would have been a supplemental care for TRICARE and Medicare. ColoradoCare would have also offered a Medicare Advantage plan.</td>
<td>All resident of California. Seniors would have been required to enroll in Medicare Parts A, B, and D.</td>
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<td><strong>Benefits</strong></td>
<td>Primary, preventive, mental health, and chronic care. Hospitalization, rehabilitation, labs, prescription drugs. Dental and vision for children. No dental and vision for adults or long-term care for people who don’t qualify under Medicaid.</td>
<td>Primary, preventive, mental health, chronic care. Primary, preventive, mental health, and chronic care. Hospitalization, rehabilitation, labs, prescription drugs. Dental and vision for children. No dental and vision for adults. At least long-term care for people who don’t qualify under Medicaid.</td>
<td>&quot;All services covered by Medi-Cal, Medicare, the essential health benefits, and all health plan/insurance mandated benefits. Benefits required include chiropractic, vision, dental, ancillary health or social services previously covered by a regional center, skilled nursing facility care, and therapies shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective.&quot;</td>
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<td><strong>Affordability/ Cost-sharing</strong></td>
<td>Minor cost-sharing coverage (94 percent actuarial value insurance).</td>
<td>No cost-sharing.</td>
<td>No cost-sharing.</td>
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<td><strong>Administration</strong></td>
<td>The Green Mountain Care Board (five members nominated by a committee and appointed by the Governor) would oversee a program operated as a public-private partnership between the state of Vermont and a strong private sector partner under either a “designated public utility” or a “designated facilitator” model.</td>
<td>ColoradoCare would have been run as a cooperative. It would have been controlled by a 21-member board of trustees elected in special non-partisan co-op elections that would be separate from regular state government elections.</td>
<td>Healthy California would have been an independent public entity run by a nine-member board.</td>
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<td><strong>Financing</strong></td>
<td>11.5% payroll tax, sliding scale “public premium” up to 9.5% Adjusted Gross Income, some cost-sharing, existing state funds and federal waiver funds.</td>
<td>10% payroll tax and 10% non-payroll income premium, existing state funds and federal waiver funds.</td>
<td>SB 562 provided no financing mechanism beyond existing state funds and federal funds. Officials estimated it would require a 15% payroll tax.</td>
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<td><strong>Unique Challenges</strong></td>
<td>Concerns about generating sufficient reserves to launch the program. Lack of credibility after failure of state-run exchange. Difficulty securing federal waivers. Higher than expected costs of projects.</td>
<td>Outside independent analysis projected tax revenue could be insufficient.</td>
<td>Lack of defined financing plan. Would require the issue to be placed on the ballot to exempt it from existing constitutional requirements.</td>
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