

Questions from Maine's Rep. Charles R. Priest

1. How do state single payer bills deal with ERISA?

When we wrote the Washington Health Security Trust (WHST) proposed legislation, we specifically set up funding for the Trust as a tax on employers' payrolls. There is precedent for taxing payrolls to pay for the public welfare. (Labor and Industries coverage for injuries to workers is a good example.) Employers are not prevented for providing whatever benefits, including private health insurance (or even self-insuring), they wish, but they will still be obligated to pay the payroll tax to support the WHST. It's a lot like public vs. private schools: everyone pays taxes to support the public schools, but you can send your kid to private school if you wish and can pay the tuition. In reality, few employers will be so blinded by ideology that they will pay for private health insurance once the WHST is established and works.

Of course, the right wingers will challenge the WHST in federal court using ERISA, but we think the law can withstand the challenge.

2. What are the pros and cons of individual premiums versus employer and employee deductions?

Ah! I can tell you aren't from Washington State! We have a fierce opposition to an income tax in our state, built into the state's constitution. Technically, a 1% income tax can be levied without a constitutional amendment, but any and all taxes recently attempted have been shot down by 2-1 margins in referendums. Never mind that a constitutional amendment to set up an income tax has failed several times (and not just recently) by similarly huge margins. Therefore, in writing the WHST we tapped individuals by calling the monthly payment a "premium", and setting it at a flat price.

States that already have an income tax would be wise to use this approach to funding part of a single payer system, as the tax can be made much more sensitive to each individual's ability to pay. Still, an employer payroll tax should fund part of the system, mostly because historically employers have funded the majority of health insurance coverage in the United States, and there is no assurance that if they were taken off the hook completely they would pass on the savings to their employees.

When we wrote the WHST we tried to set up a funding mechanism that would tap the three main sources of existing funding for health care: individuals, employers, and government. (Note that state law can only affect local and state governments, not the federal government – at least without its permission.) We tried to set the amounts to roughly reflect the proportions each group is currently paying.

3. Does anyone have any financial projections for single payer in any state?

We did do an economic feasibility study in 1999 when we were writing the WHST. Trouble is, such numbers are rapidly out of date, making it a constantly moving target. We thought we got our legislature to do such a study 4 years ago, but those opposed to any reform made the wording in the law requisitioning the study to be something like: “a single payer system like Canada’s”. Mathematica was hired to study 3 other incremental proposals and the single payer proposal as above (not the WHST) without any more guidance. So Mathematica’s single payer report put the entire financing of health care into the state budget, didn’t propose raising any tax revenue to support it, and the cost (surprise!) was overwhelming.

Dr. Hsiao’s work for Vermont may have included what it would cost to implement a true single payer system.

4. You didn’t ask, but here is a list of the hurdles a state law would have to jump over in order to implement a true single payer system.

- Challenges in federal court under ERISA (discussed above)
- Integration of Medicare enrollees into the state system
- Integration of Medicaid eligibles into the state system
- Integration of federal employees into the state system
- Getting labor unions’ Taft-Hartley trusts integrated into the state system
- Integration of Indian Health Services into the state system. Note that tribes are not willing to let the federal government out of its treaty obligations regarding provision of health care.
- Integration of Veterans Administration eligibles into the state system
- Military personnel and their dependents. Note that active military should probably still receive medical coverage through the military system, but retirees and families should be integrated into the state system
- Incarcerated persons. The state is responsible for health care for prisoners in local and state prisons, but federal prisoners should also be integrated into the state system.

Federal cooperation would be required to fold these populations into a state’s single payer system in order to attain all the efficiencies of administration, pricing, record-keeping, and standard-setting that make a single payer system able to provide top quality health care while controlling costs. Some of these populations are small, and the system would work even if they were not included, but Medicare, Medicaid, and Taft-Hartley trusts cover a substantial portion of the population of any state.