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Single-Payer, Many Obstacles: Californian Health Care Reform

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Of the 25 wealthiest countries in the world, the United States is the only one without universal health care coverage.[2] California Senate Bill 562, known as the Healthy California Act, intended "to establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state," which would make it the first state to enact legislation guaranteeing universal health care. Support for single-payer health care has been growing among the Democratic base, and California has been identified as a laboratory for progressive health care policy aspirations. The California Senate passed SB-562 in June 2017, but it was stalled when Assembly Speaker Anthony Rendon (D-Paramount) shelved the bill for consideration in the Assembly. A cursory look at California politics makes this a surprising fate for single-payer health care: single-payer health care has support among 70 percent of Californians, including 58 percent who support SB-562 even after hearing arguments against it.[3] This report will detail the existing landscape of health care reform in California, explain the defeat of SB-562, and identify which political factors would have to change before single-payer health care could be enacted and implemented in California.

Single-payer health care replaces private health insurance companies with a publicly provided, tax funded health insurance plan guaranteed to the entire population. Unlike the British "single-provider" system, a single-payer system would leave health care delivery to the private sector.[4] However, "single-payer" in the United States has been used to describe various health

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[2] David De Ferranti and Julio Frenk, "Toward Universal Health Coverage," The New York Times, April 05, 2012, accessed November 30, 2017, http://www.nytimes.com/2012/04/06/opinion/toward-universal-health-coverage.html?_r=3.

[3] "Topline Results: California Statewide Survey," Healthy California Act, May 29, 2017, accessed November 28, 2017, http://www.healthycaliforniaact.org/wp-content/uploads/Topline-Results-Statewide-Survey.pdf.

[4] Jeanne Follman, "The Difference Between Single-Payer and Single-Provider Health Care," The Chicago Tribune, July 06, 2017, accessed November 29, 2017, http://www.chicagotribune.com/news/opinion/letters/ct-charlie-gard-single-payer-britain-20170706-story.html.

care plans.[5] Physicians for a National Health Program, for example, have proposed a single-payer system that would abandon copays, coinsurance, deductibles, and other out-of-pocket user payments known as "cost-sharing."[6] Writing in National Affairs, Kip Hagopian and Dana Goldman proposed a single-payer plan where "the deductible for each individual's policy would be means-tested."[7] In 2011, Vermont enacted legislation to establish a statewide single payer-system, which provided that health insurance will include "benefits that are actuarially equivalent to at least 87 percent of the full actuarial value of the covered health services."[8] In other words, Vermont residents would pay no more than 13 percent of their health care costs out-of-pocket.[9] Identifying the appropriate amount of cost sharing in a single-payer system is largely a question of how redistributive a policymaker or activist wants the system to be.[10] Including more cost sharing payments would reduce the taxes necessary to finance the system, making its economic impact less progressive. By reducing the portion of the system funded by taxes, cost sharing payments may also reduce the strain that a single-payer scheme puts on the rest of the economy.

An even greater point of departure in various American single-payer proposals is financing the program. ColoradoCare, a defeated initiative in Colorado's 2016 election cycle,

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[5] Jodi L. Liu and Robert H. Brook, "What is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S.," *Journal of General Internal Medicine* 32, no. 7 (2017), accessed November 29, 2017, doi:10.1007/s11606-017-4063-5.

[6] Natalie Shure, "Why Cost Sharing Should Be Abandonned," Physicians for a National Health Program, October 6, 2017, accessed November 29, 2017, http://www.pnhp.org/news/2017/october/why-cost-sharing-should-be-abandoned, and Liu and Brook.

[7] Kip Hagopian and Dana Goldman, "The Health-Insurance Solution," National Affairs, no. 13 (Fall 2012), accessed November 29, 2017, https://www.nationalaffairs.com/publications/detail/the-health-insurance-solution, and Liu and Brook.

[8] An Act Relating to a Universal and Unified Health System, H.202, Vermont. (2011).

[9] Chapin White, Christine Eibner, Jodi L. Liu, Carter C. Price, Nora Leibowitz, Gretchen Morley, Jeanene Smith, Tina Edlund, and Jack Meyer, "A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon," RAND Corporation, 2017, accessed January 31, 2018, http://www.oregon.gov/OHA/HPA/Documents/Four-Options-Financing-Health-Care-Delivery-Report.pdf

[10] Katarzyna Kolasa and Marta Kowalczyk, "Does Cost Sharing Do More Harm or More Good? - A Systematic Literature Review," BMC Public Health 16, no. 992 (September 15, 2016), doi:10.1186/s12889-016-3624-6.

would have financed a statewide single-payer system through a 10 percent payroll tax, split between employers and employees.[11] The progressive-leaning think-tank Growth & Justice proposed a state single-payer scheme for Minnesota financed, in part, by $0.05 tax per drink on spirits, wine, and beer, a $1 per pack tax on cigarettes, and an 81.3 percent tax increase on all other tobacco products.[12] The remainder of the financing would be funded by a combination of payroll and income tax hikes.[13] Senator Bernie Sanders's (I-VT) 2017 bill "To establish a Medicare-for-all national health insurance program" does not include any specific plan to pay for the national health care system but instead was accompanied by a white paper from Sanders's staff providing several financing options should the main bill be passed.[14] The variation between different plans necessitates an intimate understanding of the existing health care and economic environment of any jurisdiction considering single-payer.

California's health care system has historically been geared towards ensuring care for the most vulnerable groups. As far back as California's founding, the Pauper Act of 1855 required county governments to provide support and care for poor Californians, but the obligation generally exempted health care.[15] In 1935, the California State Legislature passed an evolved

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[11] John Ingold, "ColoradoCare Measure Amendment 69 Defeated Soundly," The Denver Post, November 09, 2016, accessed November 29, 2017, http://www.denverpost.com/2016/11/08/coloradocare-amendment-69-election-results/.

[12] John Sheils and Megan Cole, *Cost and Economic Impact Analysis of a Single-Payer Plan in Minnesota: Final Report*, 542055 (The Lewin Group, 2012), http://growthandjustice.org/images/uploads/LEWIN.Final_Report_FINAL_DRAFT.pdf, and Beth Hawkins, "Growth & Justice Lays Out Its Case For Minnesota Single-Payer Health Care," MinnPost, March 29, 2012, accessed November 29, 2017, https://www.minnpost.com/health/2012/03/growth-justice-lays-out-its-case-minnesota-single-payer-health-care.

[13] Sheils and Cole.

[14] S. 1804, 115th Cong. (2017 https://www.congress.gov/bill/115th-congress/senate-bill/1804/text, *Options to Finance Medicare for All*, (Senator Bernie Sanders of Vermont, 2017), https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?inline=file, and Jordan Weissmann, "Bernie Sanders' Single-Payer Proposal Ignores the Hardest Thing About Single-Payer," Slate Magazine, September 13, 2017, accessed November 29, 2017, https://slate.com/business/2017/09/bernie-sanders-single-payer-proposal-ignores-the-hardest-thing-about-single-payer.html.

[15] Deborah Reidy Kelch, *Caring for Medically Indigent Adults in California: A History*, (The California HealthCare Foundation, 2005),

version of the same provision as Section 17000 of the Welfare and Institutions Code, which is still in place.[16] Section 17000 provides, "every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."[17] In that year, city and county governments were providing more than 23 percent of Californian hospital beds while the same figure was less than 16 percent nationally, indicating an early commitment to the state's role in ensuring citizens' health. [18] Section 17000 maintains relevance in Californian health care policy to this day.[19]

In practice, California's primary means of providing health care to the poor is the California Medical Assistance Program, known as Medi-Cal. Medi-Cal is registered as part of the national Medicaid system, but it varies substantially from other states' Medicaid programs.[20] For example, Medi-Cal spends the most of any statewide Medicaid program in the country,[21] but it also spends the fourth least of any state per enrollee.[22] California also has a uniquely robust

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http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaringForMedicallyIndigentAdults.pdf

[16] Michael R. Cousineau and Robert E. Tranquada, "Crisis & Commitment: 150 Years of Service by Los Angeles County Public Hospitals," American Journal of Public Health 97, no. 4 (April 2007), accessed November 29, 2017, doi:10.2105/ajph.2006.091637.

[17] California Welfare and Institutions Code, Div. 9 Public Social Services, Part 5 County aid and Relief to Indigents, Ch. 1 General Provisions, [17000 - 17030.1], http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=17000.

[18] Kelch.

[19] Abbi Coursolle, "California's Safety Net Law and Low Income Health Programs," National Health Law Program, September 01, 2012, accessed November 29, 2017, http://www.healthlaw.org/issues/california/health-reform/californias-safety-net-law-and-low-income-health-programs#.Wh7rU7Q-fBJ.

[20] "Medi-Cal: The Basics," Disability Benefits 101, October 27, 2017, accessed November 29, 2017, https://ca.db101.org/ca/programs/health_coverage/medi_cal/program.htm.

[21] "Total Medicaid Spending," Kaiser Family Foundation, 2016, accessed March 26, 2018, https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Medicaid%20Spending%22,%22sort%22:%22desc%22%7D

[22] "Medicaid Spending per Enrollee (Full or Partial Benefit)" Kaiser Family Foundation, 2014, accessed March 26, 2018, https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-

system of Federally Qualified Health Centers (FQHCs). FQHCs, which qualify for federal reimbursement under Section 330 of the Public Health Service Act, are outpatient clinics that offer means-tested fees to people below 200 percent of the federal poverty line.[23] California's 118 FQHCs are the most, in absolute terms, of any state.[24]

Medi-Cal has grown significantly in the past decade. Using funding from the Affordable Care Act (ACA), California expanded Medi-Cal to cover nearly all nonelderly adults with incomes at or below 138 percent of the federal poverty line.[25] In 2010, the federal Centers for Medicare & Medicaid Services also approved California's proposal to make major structural changes to Medi-Cal under Section 1115 of the Social Security Act, which empowers the Secretary of Health and Human Services to waive specific provisions of major health and welfare programs.[26] The waiver increased funding and administrative flexibility to implement programs to improve health services funding and delivery, which California used for two purposes.[27] First, Medi-Cal transitioned from a fee-for-service model, in which the state pays providers directly for Medicaid enrollees' fees, to a managed care model, in which the state pays fees to a managed care plan for all Medicaid enrollees. [28] As a result, Medi-Cal now functions

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enrollee/?currentTimeframe=0&sortModel=%7B%22colId%22:%22All%20Full%20or%20Partial%20Benefit%20Enrollees%22,%22sort%22:%22desc%22%7D

[23] *Federally Qualified Health Center*, (Medicare Learning Network, 2017), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf

[24] Snyder et al. The state with the second most FCHQs is Texas, with 64. Again, see Snyder et al.

[25] *The California Health Care Landscape*, (Kaiser Family Foundation, 2015), https://www.kff.org/health-reform/fact-sheet/the-california-health-care-landscape/

[26] Peter Harbage and Meredith Ledford King, *A Bridge to Reform*, (California HealthCare Foundation, 2012), http://www.chcf.org/publications/2012/10/bridge-to-reform, and Elizabeth Hinton, et al, *Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape of Approved and Pending Waivers*, (Kaiser Family Foundation, 2017), https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-a-look-at-the-current-landscape-of-approved-and-pending-waivers/

[27] Hazelton PT, Steward WT, Collins SP, Gaffney S, Morin SF, Arnold EA (2014) California's "Bridge to Reform": Identifying Challenges and Defining Strategies for Providers and Policymakers Implementing the Affordable Care Act in Low-Income HIV/AIDS Care and Treatment Settings. PLoS ONE 9(3): e90306. https://doi.org/10.1371/journal.pone.0090306

[28] "Provider Payment and Delivery Systems," MacPac, accessed November 29, 2017, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems.

like a Health Management Organization (HMO). Second, the state offered counties an opt-in program to create Low-Income Health Programs (LIHPs) with federal matching funds. LIHPs cover low-income individuals not otherwise eligible for Medi-Cal, with more limited benefits and means tested eligibility varying from county to county.[29]

California's embrace of health care reform during the Obama administration was not limited to Medi-Cal; it also included a broader effort to extend health insurance to the previously uninsured. After the federal government enacted the ACA in 2010, California became the first state in the country to create a statewide health care exchange.[30] Created by Senate Bill 900 and Assembly Bill 1602, signed by then-Governor Arnold Schwarzenegger, and known as Covered California, the exchange functions as a marketplace for individuals who do not have access to another source of affordable coverage to purchase individual coverage directly from insurers.[31] Covered California also offers tax credits to people with incomes above Medi-Cal eligibility but below 400 percent of poverty, and cost-sharing subsidies to those with incomes up to 250 percent of poverty.[32] In total, 87 percent of Covered California enrollees receive some kind of health care subsidy.[33]

Since the ACA went into effect, California has seen increased health insurance enrollment. Prior to ACA implementation, Californian's uninsured rate steadily rose for two

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[29] Hazelton.
[30] Victoria Colliver, "Health care exchange will offer policies," SFGate, June 30, 2012, accessed November 30, 2017, http://www.sfgate.com/health/article/Health-care-exchange-will-offer-policies-3675063.php.
[31] Phil Daigle, "Schwarzenegger Signs Landmark Health Care Legislation," California Health Benefit Advisors, September 30, 2010, accessed November 30, 2017, https://www.cahba.com/blog/2010/09/schwarzenegger_signs.html, and "The California Health Care Landscape."
[32] "The California Health Care Landscape."
[33] Laurel Beck, "The Affordable Care Act in California," Public Policy Institute of California, January 2017, accessed November 30, 2017, http://www.ppic.org/publication/the-affordable-care-act-in-california.

decades,[34] ultimately amounting to 14 percent of the national uninsured population.[35] In all, California's uninsured rate hovered near 20 percent during the 1990s and 2000s before ACA implementation.[36] The percentage of uninsured Californians has fallen by 54 percent, sitting at 11 percent of working-age adults in 2016.[37] The rise in insurance coverage was fueled by a 7 percent increase in individually purchased insurance paired with a 5 percent increase in Medi-Cal enrollment.[38] At the beginning of the 2017 open-enrollment period, 1.3 million Californians were insured under Covered California, in addition to an estimated 400 thousand Californians who signed up between then and February 2017.[39]

Despite these reductions in the uninsured rate, some Californians believe that the only sufficient state health care reform is a full single-payer system, leading to the introduction of Senate Bill 562 in 2017. Also known as the Healthy California Act, the bill proposed an extraordinarily generous version of the single-payer system, including full state payment for inpatient, outpatient, emergency services, dental, vision, mental health, nursing home care, and more.[40] Moreover, it did not require any co-pays or deductibles, and barred private insurers from

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[34] Paul Fronstin, “California’s Uninsured: Treading Water,” (California Health Care Foundation, December 2012), https://www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaUninsured2012.pdf
[35] “The California Health Care Landscape.”
[36] Chris Nichols, “True: California’s uninsured rate has hit 'historic low',” Politifact, January 19, 2017, accessed December 2, 2017, http://www.politifact.com/california/statements/2017/jan/19/jerry-brown/true-californias-uninsured-rate-has-hit-historic-l/.
[37] "Impact of the Affordable Care Act in California," Latino Physicians of California, December 26, 2016, accessed November 30, 2017, http://latinophysiciansofca.org/impact-affordable-care-act-california/, and Soumya Karlamangla, "If Obamacare is Repealed, California Has the Most to Lose — Putting the Insured on Edge," Los Angeles Times, November 13, 2016, accessed November 30, 2017, http://www.latimes.com/local/california/la-me-obamacare-trump-california-20161110-story.html.
[38] Paul Fronstin, *California’s Uninsured: As Coverage Grows, Millions Go Without,* (California Health Care Foundation, 2016), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaliforniaUninsuredDec2016.pdf
[39] Paul Sisson, "California Reaches Record High Obamacare Enrollment," San Diego Union Tribune, February 07, 2017, accessed November 30, 2017, http://www.sandiegouniontribune.com/news/health/sd-me-health-0208-story.html.
[40] Dylan Scott, "California's single-payer plan costs $400 billion - twice the state's entire budget," Vox, May 22, 2017, accessed November 30, 2017, https://www.vox.com/policy-and-politics/2017/5/22/15676782/california-single-payer-health-care-estimate.

providing coverage for services offered under the state plan, including senior citizens' Medicare.[41] Patients would not need referrals to see eligible providers.[42] All residents, regardless of immigration status, would qualify for its coverage.[43] SB-562's administration would be put in the hands of a small governing body.[44] The Governor, the Senate Committee on Rules, and the Speaker of the Assembly would appoint members of a 9 person board that includes at least one representative of the following groups: nurses, the general public, a labor organization, and the medical provider community.[45] This board would conduct negotiations with the federal government and private health care providers, authorize expenditures to pay program expenses, and determine when individuals may begin enrolling in the program, among several other powers outlined in the Act.[46] The board, broadly, "shall have all powers and duties necessary to establish and implement Healthy California."[47]

Economic review of the bill was mostly positive. The bill's main sponsor, National Nurses United, commissioned a study from the Political Economy Research Institute (PERI) at the University of Massachusetts-Amherst, which predicted positive results.[48] PERI predicted that

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[41] Tom Blackwell, "How Canadian politicians, doctors and bureaucrats fueled a California push for single-payer health care," National Post, April 30, 2017, accessed November 30, 2017, http://nationalpost.com/health/how-canadian-politicians-doctors-and-bureaucrats-fueled-a-california-push-for-single-payer-health-care, and George Skelton, "California state senators passed a single-payer healthcare bill, but it's going nowhere fast," Los Angeles Times, June 5, 2017, accessed November 30, 2017, http://www.latimes.com/politics/la-pol-sac-skelton-single-payer-bill-20170605-story.html.

[42] Melanie Mason, "What would single-payer healthcare look like in California? Lawmakers release new details," Los Angeles Times, March 30, 2017, accessed November 30, 2017, http://www.latimes.com/politics/essential/la-pol-ca-essential-politics-updates-what-would-single-payer-look-like-in-1490888709-htmlstory.html.

[43] Taryn Luna, "Government-run universal health care wins vote in California Senate," Sacbee, June 1, 2017, accessed November 30, 2017, http://www.sacbee.com/news/politics-government/capitol-alert/article153931299.html.

[44] Mason.

[45] Margaret Emerson, "Answers for questions about California single-payer plan," Times-Standard, July 13, 2017, accessed November 30, 2017, http://www.times-standard.com/article/NJ/20170713/LOCAL1/170719907.

[46] The Healthy California Act, SB 562, California. (2017).

[47] Ibid.

[48] "6 big questions hanging over California's single-payer bill," KPCC, August 18, 2017, accessed November 30, 2017, http://www.scpr.org/programs/take-two/2017/06/06/57207/6-big-questions-hanging-over-california-s-single-p/.

the Healthy California Act would reduce "net overall costs by about 8 percent relative to the existing system," causing "health care spending for middle-income families [to] fall by between 2.6 – 9.1 percent of income."[49] Even for low-income families currently insured by Medi-Cal, it forecasted reductions in "health care costs as a share of income by 5.5 percent in moving from Medi-Cal to Healthy California."[50]

The projected benefits were not limited to the common man. Despite their lobbying efforts against it, the business community was also predicted to be a winner under the Healthy California Act.[51] Pollin's research anticipated benefits to businesses of all sizes:

> Small firms that have been providing private health care coverage for their workers will experience a 22 percent decline in their health-care costs as a share of payroll. The small firms that have not provided coverage will still make zero payments for health care under Healthy California through their gross receipts tax exemption. Medium-sized firms will see their health care costs fall by between 6.8 and 13.4 percent as a share of payroll relative to the existing system. Firms with up to 500 employees will experience a 5.7 percent fall, and the largest firms, with over 500 employees, will experience a 0.6 percent fall as a share of payroll relative to the existing system.[52]

On the whole, the PERI analysis predicted that while SB-562's single-payer system would be expensive, its cost in taxes would ultimately be cheaper than the costs that Californians currently pay to private insurers. The study did not, however, analyze the effects of SB-562 on employment.[53]

In contrast to PERI's optimistic forecasting, several competing analyses have pointed to potential drawbacks in the bill. As a result of its effective abolition of the private insurance

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[49] Robert Pollin, et al, *Economic Analysis of the Healthy California Single-Payer Health Care Proposal (SB-562),* (Political Economy Research Institute, 2017), https://www.peri.umass.edu/media/k2/attachments/PollinZetZalZECONOMICZANALYSISZOFZCAZSINGLE-PAYERZPROPOSAL---5-31-17.pdf
[50] Pollin.
[51] Julie A. Trager, "Universal health care turns out to be good for business," San Diego Union Tribune, June 15, 2017, accessed November 30, 2017, http://www.sandiegouniontribune.com/opinion/commentary/sd-utbg-universal-healthcare-california-20170614-story.html.
[52] Pollin.
[53] Ibid.

industry, and therefore all the jobs it creates directly and indirectly, the California Association of Health Underwriters, which opposed SB-562, predicted the bill would eliminate 500,000 jobs.[54] Critics also argue that the bill's fee-for-service model of paying doctors, in which doctors and hospitals get paid by the government based on how many patients they receive or procedures they perform, may drive up net health care spending as it incentivizes doctors to provide more, rather than better, care.[55] Combined with SB-562's elimination of all out-of-pocket expenses for patients, it would therefore incentivize both health care providers and consumers to maximize total care provided and received.[56] Other hidden costs of the bill include developing information technology to run the program, which a California Senate Committee on Appropriations analysis estimated is likely to be in the billions.[57]

However, in understanding why SB-562 failed despite its broad popular support and mixed economic analysis, it is useful to understand what was *not* in the bill. Namely, the bill failed to specify how the single-payer system would be financed.[58] That is, it proposed replacing the payments that Californians currently make to private insurers with payments in the form of taxes but did not identify what those taxes would be. Just to study the bill, PERI had to invent a tax plan for SB-562 in which they proposed "two new taxes to generate the revenue required to offset the loss of private insurance spending: a gross receipts tax of 2.3 percent and a sales tax of

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[54] Toni Vranjes, "What Are the Prospects for Single-Payer Health Care in California?" Society for Human Resource Management, July 21, 2017, accessed November 30, 2017, https://www.shrm.org/resourcesandtools/legal-and-compliance/state-and-local-updates/pages/single-payer-health-care-in-california.aspx.
[55] Melanie Mason, "What would California's proposed single-payer healthcare system mean for me?" Los Angeles Times, June 1, 2017, accessed February 5, 2018, http://www.latimes.com/politics/la-pol-sac-single-payer-explainer-20170601-htmlstory.html
[56] Ibid.
[57] Brendan McCarthy, "SB 562 (Lara) – The Healthy California Act," Senate Committee on Appropriations, April 17, 2017, accessed November 30, 2017, http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml
[58] Matthew Yglesias, "It's time for Democrats' wonk class to write some single-payer plans," Vox, August 29, 2017, accessed November 30, 2017, https://www.vox.com/policy-and-politics/2017/8/29/16196608/wonks-single-payer.

2.3 percent."[59] However, the Senate Committee on Appropriations estimated that if the bill was financed "through a new payroll tax (with no cap on wages subject to the tax), the additional payroll tax rate would be about 15 percent of earned income."[60] Regardless, any analysis of the bill is necessarily speculative and incomplete; the way that California would actually finance its health care system if SB-562 was enacted is entirely ambiguous.

The failure of SB-562 to identify a complimentary tax scheme is especially troubling given its high price. The Committee on Appropriations analysis predicted "total annual costs of about $400 billion per year, including all covered health care services and administrative costs, at full enrollment."[61] PERI, on the other hand, estimated, "The overall annual costs of this single-payer system for California would be $331 billion as of 2017."[62] Additionally, PERI proposes that the state would seek federal waivers to repurpose "the same public health care revenue sources that are presently providing about 71 percent of all health care funding in the state," including Medi-Cal and Medicare, which if granted would cover all but $106 billion of SB-562's cost. Again, however, SB-562's financing is not even identified in its own text, and for reasons described below, the waiver scheme would almost certainly be unsuccessful.

In the most literal sense, SB-562's inability to pay for itself is the primary reason that it failed. After passing the Senate in a 23-14 vote, Assembly Speaker Anthony Rendon decided to shelve the bill from consideration because, "SB 562 was sent to the Assembly woefully incomplete...it does not address many serious issues, such as financing, delivery of care, cost

[59] Pollin.
[60] McCarthy.
[61] McCarthy.
[62] Pollin.

controls, or the realities of needed action by the Trump administration and voters to make SB 562 a genuine piece of legislation."[63]

However, the complicated business of why SB-562 failed to include these details is not just about politicians' reluctance to vote for a tax increase. Proposition 98 is the first underlying reason that SB-562 failed to provide its own financing mechanism. Put on the 1988 ballot by the initiative process and approved by 50.7 percent of Californian voters, Proposition 98 mandates annual Californian budgets pass three tests.[64] First, the budget must allocate at least 40 percent of General Fund revenue to K-14 education.[65] Second, schools must receive at least as much as they received from state and local sources in the prior year, adjusted for enrollment growth and inflation.[66] Third, and infrequently applicable, in fiscal years during which inflation growth exceeds per capita General Fund revenues by more than 0.5 percent, the education funding floor is determined by the growth in per capita General Fund revenues.[67] The legislature can suspend Proposition 98 for a single year by a two-thirds vote, but the budget then must increase funding over time until funding returns to where it would have been under Test 2 absent a suspension.[68]

Proposition 98 puts California in a budgetary straightjacket when considering any high cost legislation. The Committee on Appropriations analysis makes this clear:

> "There are several provisions of the state constitution that would prevent the Legislature from creating the single-payer system envisioned in the bill without voter approval...In the context of Proposition 98, the term "General Fund" revenue refers to state tax revenues, not simply revenues that are deposited in the state's General Fund. Any taxes

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[63] Melanie Mason, "California Assembly Speaker Anthony Rendon shelves single-payer healthcare bill, calling it 'woefully incomplete'," Los Angeles Times, June 23, 2017, accessed November 30, 2017, http://www.latimes.com/politics/la-pol-sac-single-payer-shelved-20170623-story.html.
[64] Nirupama Jayaraman, *School Finance in California and the Proposition 98 Guarantee,* (California Budget Project, 2006), http://calbudgetcenter.org/wp-content/uploads/0604_prop98.pdf.
[65] Ibid.
[66] Jayaraman.
[67] Ibid, and "Proposition 98 Primer," Legislative Analyst's Office, February 2005, accessed November 30, 2017, http://www.lao.ca.gov/2005/prop_98_primer/prop_98_primer_020805.htm.
[68] Jayaraman.

> raised to support this bill would be considered the proceeds of taxes and would be subject to the requirements of Proposition 98. Since it would be infeasible to dedicate one-half of the new revenues for this program to education (or to raise twice the amount needed for the bill), the voters would need to exempt the tax revenues generated to fund this bill from the requirements of Proposition 98."[69]

In other words, if SB-562 had included a funding mechanism, whatever revenue it collected would be considered part of the same General Fund that Proposition 98 mandates is allocated at least in half to education. Moreover, the analysis suggests that Proposition 98 would be applied to this new tax scheme on an individual level, so that at least half of the revenue that the new tax alone collects goes to education. Thus, without some new, voter-approved measure to amend or repeal Proposition 98, California would be forced to tax for a single-payer system at double the rate that it actually requires,[70] meaning that the cost savings upon which PERI built the case for SB-562 would vanish.

Several workarounds to Proposition 98 have been suggested, but none of them are currently feasible. First, suspending Proposition 98 with a two-thirds vote would merely kick the can down the road. Because suspensions must be compensated for once they expire, the legislature would have to continue to suspend the mandate every single year, and if a year ever came when the legislature did not have the votes to re-suspend, education spending would have to immediately account for the massive backfill that had been accumulating up to that point. This would leave California sitting on a budgetary landmine.

Second, as Rendon alluded to above, the waiver-based proposal to fund most of a single-payer plan is unrealistic. The infeasibility of the proposed waiver scheme is the second major reason that SB-562 failed. One would not expect the Trump administration to sign off on the necessary Health and Human Services waivers, as described above, that would enable a

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[69] McCarthy.
[70] McCarthy.

Californian plan to socialize statewide medicine. Moreover, while a waiver program exists for Medicaid, no actual mechanism currently exists in federal law to shift Medicare funding to the states.[71] Again, the current Congress would not be inclined to pass legislation to fix this hurdle and bankroll California's transition to single-payer. Finally, the Employee Retirement Income Security Act (ERISA) provides for the federal government the exclusive authority to regulate the employer health plans that single-payer would shift to the state.[72] Thus, ERISA means Congress would have to enact some new legislation authorizing California to shift all its resident's employer health plans to Healthy California's public system, which is unforeseeable. SB-562's only means of making itself affordable is politically infeasible.

For these reasons, Proposition 98 and issues of federalism make funding a statewide single-payer system effectively impossible. If California funds the system by itself, Proposition 98 requires it to be taxed so exorbitantly that it would not be worth the savings. On the other hand, if California does not fund the plan itself, it falls prey to a hostile political balance of power in the federal government.

SB-562 did not fail because of insufficient public support, lobbyist pressure, or moderate Democrats' reluctance to move to the left. While activists may glorify the fight for Californian hearts and minds, the real battle for single-payer lies in a combination of targeted and policy-oriented efforts.

The only path to a statewide single-payer system in California must include the following steps. First, if California single-payer advocates are serious about getting it enacted, they should

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[71] Dayen.
[72] Michael Hiltzik, "The challenges in setting up a California single-payer system are daunting - but not insurmountable," Los Angeles Times, May 26, 2017, accessed November 30, 2017, http://www.latimes.com/business/hiltzik/la-fi-hiltzik-single-payer-20170526-story.html.

not run to the most radical proposal conceivable, as SB-562 represented.[73] Future single-payer legislation would be more workable if it included features that would reduce cost to the state and kept some cost on patients. For example, a Medicare-modeled system of cost-sharing and supplemental private insurance rather than SB-562's total abolition of both, and a Canadian-modeled scale of benefits, which does not cover dental, mental health, vision care, and nursing home services,[74] rather than SB-562's extremely expansive coverage, would prove less expensive and therefore more feasible. Second, Healthy California supporters must put an initiative on the ballot to amend Proposition 98 to exempt health care taxing and spending from the definition of the General Fund. Alternatively, because an initiative to overturn Proposition 98 entirely might attract a broader array of interest groups' support, activists could advance its total repeal. Third, California single-payer advocates both in and out of office should cultivate relationships and influence in Washington, D.C. Progressives can be targeted to support legislation and waivers that enable Healthy California on the grounds that California is a laboratory of democracy for progressive health care reform that will later enter the national conversation. Conservatives can be targeted to support the same measures in the name of federalism, using arguments employed to defend September 2017's Graham-Cassidy amendment in favor of California's own interest in state managed, rather than nationalized, health care reform. Fourth, and only once the previous three actions are taken, supporters of Californian single-payer should advance a comprehensive health care reform bill that includes a funding mechanism, most likely similar to the one proposed by PERI.

[73] Yglesias.
[74] Blackwell.

An idealistic goal in and of itself, universal health care can only be achieved through a realistic plan. The Healthy California Act was not one; single-payer healthcare may be implemented in California if the plan for it is.