Georgetown Journal on Poverty Law and Policy
Volume XXIX, Number 2, Winter 2022

Health Injustice in the Laboratories of Democracy

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Abstract

A growing majority of Americans support the implementation of a national single-payer healthcare program, also known as Medicare for All, which would shift payments for healthcare services to a single public payer and provide care based on need rather than ability to pay. However, legislators, scholars, and advocates have suggested state governments rather than the federal government should take the lead by implementing state-based single-payer programs. Dozens of single-payer proposals have been introduced in state legislatures across the country, and proposed legislation in Congress would remove the federal roadblocks to state-based single-payer's implementation. Proponents of state-based single-payer rely on the conventional wisdom that states—as the storied "laboratories of democracy"—can prove the concept of single-payer to other states, who will adopt it in time.

But, in taking the "laboratories of democracy" theory at face value, advocates of state-based single-payer ignore a number of realities fatal to the assumption that universal healthcare will come from the states. This Article argues state-based single-payer is not a stepping stone to health justice or the implementation of national single-payer and that it is, rather, a stumbling block that will worsen health inequities in the United States and ultimately make the implementation of a national single-payer system even less likely than it is now. In order to demonstrate this, I analyze the history of state government experimentation in healthcare to conclude the laboratories of democracy theory has been tested in the healthcare domain and failed, harming the nation's most vulnerable and historically oppressed people. Using the example of the Affordable Care Act Medicaid expansion, I discuss the historic and present antidemocratic state government resistance to programs that promote health justice, particularly when those programs would increase healthcare access for poor people and people of color. Furthermore, I employ a political theory analysis to conclude state-based single-payer is not an acceptable policy for the federal government to promote under a health justice framework. This is because the implementation of state-specific single-payer programs will worsen health disparities by weakening the bargaining power of existing federal programs such

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as Medicare and Medicaid and by fracturing a growing constituency in favor of single-payer, chilling popular momentum toward a national single-payer program.

I. INTRODUCTION

"... [I]n medicine the dream of reason has partially come true. But medicine is also, unmistakably, a world of power where some are more likely to receive the rewards of reason than are others."[1] The struggle for health justice in the United States is emblematic of U.S. politics. The struggle takes place between states and

1. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 4 (1982).

the federal government; between powerful lobbying behemoths and grassroots movements; and between profit-motivated companies and patients seeking care. Ever-increasing household healthcare expenses, including private insurance costs, result in health decline, debt, and bankruptcy. And those who receive means-tested public healthcare coverage are subject to marginalization and austerity. For these and many other reasons, a growing cross-demographic constituency supports a transition to a national single-payer healthcare program, sometimes referred to as "Medicare for All." A national single-payer program would make healthcare free at the point of service for all U.S. residents. It would make healthcare available based on need rather than ability to pay, and it would be a stepping stone to achieving health justice in the United States.

But as single-payer has grown in popularity, a number of scholars and single-payer proponents have suggested the United States should take a state-based rather than a national approach to achieving single-payer healthcare. There is even pending legislation in Congress that would remove major federal roadblocks to states implementing their own single-payer programs. Advocates of the state-based approach rely on the "laboratories of democracy" theory of federalism, arguing individual states should lead the way in proving the merits of single-payer, which would in turn create a model for broad adoption throughout the United States.[2] Although analysis of this shift to the laboratories approach has focused largely on what the federal government should do to enable states to conduct their own experiments with single-payer healthcare,[3] this Article takes a deeper look at whether relying on the states would be an abdication of a federal responsibility to promote health justice, and whether state-based single-payer is actually the stepping stone to health justice its advocates say it will be.

Unfortunately, however well-meaning the push for state-based single-payer may be, I conclude it is in fact a stumbling block rather than a stepping stone to national single-payer and, ultimately, to health justice in the United States. In Section II, I describe the basic contours of a national single-payer program based on current Congressional Medicare for All proposals and situate these proposals within a health justice framework. In Section III, I describe recent efforts toward state-specific single-payer programs and the legal theories—in particular the "laboratories of democracy" theory—underlying the efforts to shift the conversation from national to state-based single-payer. In Section IV, I undertake a historical and legal analysis of the history of states as laboratories of democracy in healthcare. Using the Affordable Care Act's Medicaid expansion as an example, I conclude the laboratories of democracy theory—as applied to healthcare—is largely mythic, as there is strong evidence state governments do not use

2. *See* New State Ice Co. v. Liebmann, 52 S. Ct. 371, 387 (1932) (Brandeis, J., dissenting) (coining the "laboratories of democracy" theory).

3. *See generally* Jonathan M. Kucskar, *Laboratories of Democracy: Why State Health Care Experimentation Offers The Best Chance to Enact Effective Federal Health Care Reform*, 11 J. OF HEALTH CARE L. & POL'Y 377 (2008) (arguing for the individual states to act as the "laboratories of democracy" for the federal government to model a national single-payer program on).

"innovation" in healthcare to promote health or meet the unique needs of their residents. In fact, state governments have often been the primary obstacles to democratic efforts to achieve health justice in the states. Finally, in Section V, I discuss the fundamental necessity of payer bargaining power in healthcare financing and explain how state-specific single-payer programs would worsen the state-by-state and regional disparities by weakening the bargaining power of federal programs like Medicare and Medicaid, which cover the nation's most vulnerable patients. I then employ a political theory analysis to explain how state-specific single-payer would fracture a growing national constituency, chilling popular momentum toward a national single-payer program. Therefore, I conclude, rather than being a positive or even neutral stepping stone toward national single-payer and health justice in the U.S., a state-specific single-payer approach is actually a stumbling block to national single-payer, and therefore, is an undesirable project when viewed through a health justice lens.

II. National Single-Payer Healthcare and Health Justice in the United States

Although a national-single-payer healthcare program—sometimes referred to as "Medicare for All"—has been on the national agenda for decades, it has received spikes in interest and coverage around the 2016 and 2020 U.S. general elections, as the public began to demand electoral candidates have a position on healthcare and increasingly supported the idea of a universal public healthcare program. A majority of Americans support a transition to a national single-payer program as an alternative to the United States' highly fragmented public-private healthcare financing system, in which healthcare is provided based on ability to pay rather than need.

From a health justice perspective, the need for and the merits of a national single-payer program seem clear. Health outcomes in the United States are deeply unequal, not just along race, class, and disability lines, but along regional lines as well. And the fragmented system undermines social solidarity and reinforces the idea that individuals, rather than systems, are "to blame" for poor health outcomes. This Section provides a setting for understanding the debate about state-specific single-payer programs by describing what national single-payer health care and health justice are, and by situating single-payer proposals within a health justice framework.

A. Medicare for All, Who Is Promoting It, and Why

An increasing majority of Americans across the political spectrum believes the federal government has a "responsibility to make sure all Americans have

health coverage."[4] And in 2020, 36% of Americans—a six-percentage point increase over the previous year—said healthcare coverage should be provided through a single national program.[5] The number of Americans supporting a national single-payer healthcare program, often referred to as "Medicare for All,"[6] eclipsed the numbers of both individuals who preferred a mix of public and private insurance programs and those who supported merely a continuation of existing Medicare and Medicaid.[7] Other polls have indicated majority support among both self-identified Republicans and Democrats for Medicare for All, with "[o]nly 20 percent of Americans say[ing] they outright oppose the idea."[8] It is unsurprising that Americans increasingly find the existing hybrid public-private health insurance system in the United States untenable and long for an alternative. A single-payer system provides healthcare based on need rather than

4. Bradley Jones, *Increasing Share of Americans Favor a Single Government Program to Provide Health Care Coverage*, PEW RSCH. CTR. (Sept. 29, 2020), https://www.pewresearch.org/fact-tank/2020/09/29/increasing-share-of-americans-favor-a-single-government-program-to-provide-health-care-coverage/. Discerning the precise amount of support for a national single-payer program is, admittedly, difficult. This is due both to the way polling is conducted on the issue and the frequent co-optation of and variations on terms like "Medicare for All" in electoral and lobbying platforms. *See* Ben Spielberg, *More Deceptive Reporting on Medicare for All*, PEOPLE'S POL'Y PROJECT (Feb. 5, 2019), https://www.peoplespolicyproject.org/2019/02/05/more-deceptive-reporting-on-medicare-for-all/ ("If you tell people that the policy will result in them losing their current insurance, paying higher taxes, and interacting with a bankrupt federal government, they're less likely to support it. If you tell people the truth, however – that public insurance in the United States is well-liked and more cost-efficient than private insurance, that other countries with similar systems spend way less money while covering a much higher percentage of their populations than we do, and that, under a Medicare For All system, most will get better coverage while paying less than they do today – people are on board."); Tim Higginbotham & Chris Middleman, *"Medicare-For-All" Means Something. Don't Let Moderates Water it Down*, VOX.COM (July 13, 2018), https://www.vox.com/the-big-idea/2018/7/13/17567952/medicare-for-all-centrists-copycat-plans-water-down-left-center-sanders ("In February, the Center for American Progress released a plan called 'Medicare Extra for All,' a particularly shameless attempt to co-opt Medicare-for-all's popularity. It would create a public option similar to what Krugman describes—it would allow people to buy into a public 'Medicare Extra' plan while leaving in place the privatized, multi-payer system that drives our health care struggles."). What is quite clear from polling, as explained in this Section, is a high level of dissatisfaction with private insurance and a persistent belief among a majority of Americans that the federal government has a responsibility to ensure people have healthcare.

5. Jones, *supra* note 4.

6. "Medicare for All" is a somewhat slippery term, but, as described *infra*, generally serves as a stand-in for a program that would move the United States healthcare financing system from a fragmented hybrid public-private risk-based system to a national single-payer that covers all residents (some proposals would only cover U.S. citizens) and eliminates out-of-pocket costs for patients. The term has come into popularity in the years since Michigan Representative John Conyers introduced the United States National Health Care Act—also known the Expanded and Improved Medicare for All Act—in 2003. Conyers introduced the bill annually between 2003 and his retirement in 2017, and support of the bill grew from an original twenty-five co-sponsors to 124. *See* H.R. 676, 108th Cong. (2003); *see also* H.R. 676, 115th Cong. (2017). The bill was renumbered, expanded, and re-introduced in 2019 by Representative Pramila Jayapal. H.R. 1384, 116th Cong. (2019).

7. Jones, *supra* note 4.

8. Yoni Blumberg, *70% of Americans Now Support Medicare-for-All—Here's How Single-Payer Could Affect You*, CNBC (Aug. 28, 2018), https://www.cnbc.com/2018/08/28/most-americans-now-support-medicare-for-all-and-free-college-tuition.html.

ability to pay, and that idea is appealing to Americans who increasingly find care costs unpredictable, prohibitive, and financially ruinous.

This Section briefly describes the current state of the U.S. healthcare financing system and sets out working definitions of terms like "single-payer healthcare" and provides an overview of the current proposals for single-payer healthcare in the United States. It also describes the ways in which a transition to a national single-payer system in the United States is a stepping stone on the path to achieving health justice. Although there are numerous proposals for single-payer healthcare in the United States and numerous worldwide models of national healthcare systems, only a basic understanding of the technicalities of a single-payer healthcare financing system is necessary to engage with my arguments. In this Article, single-payer healthcare means health coverage for all U.S. residents,[9] paid for by a single public payer regardless of means, and the elimination of deductibles, copays, and co-insurance. This would be a vast departure from the current public-private hybrid healthcare financing system, in which the provision of care is based on ability to pay for those who have private insurance coverage or on demonstration of deservingness (through means testing and determinations of disability) for those who have public coverage.

1. The Fragmented and Unequal U.S. Healthcare System

Healthcare costs—which also include the cost of health insurance—eat up an increasing portion of household budgets in the United States and medical bills are the number one cause of U.S. household bankruptcies.[10] Unsurprisingly, healthcare debt accounts for the largest portion of all U.S. debts in collection.[11] This is not because our healthcare has improved dramatically year by year or is provided more equitably to more people, or even because care itself always costs more. The primary reason for the more than 100% increase in household healthcare spending over the past four decades is primarily insurance costs (as distinguished

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9. I use the two most prominent single-payer proposals in Congress as guideposts for discussion of what single-payer healthcare would look like because they focus almost solely on changes to health *financing*. *See* Medicare for All Act of 2019, S. 1129, 116th Cong. (2019); Medicare for All Act of 2021, H.R. 1976, 117th Cong. (2021). These bills' general provisions—specifically, coverage for all U.S. residents in a non-means-tested regime, coverage of dental, vision, and long-term care, and the elimination of deductibles, copays, and co-insurance—describe the basic structure of a federal single-payer program and are used as a benchmark for the type of healthcare system single-payer advocates seek. Other national healthcare *delivery* models, such as the British National Health Service, are important to look to as models of healthcare solidarity and nationalized service provision and provider training, but their details go far beyond the financing changes involved in current proposals to shift the United States to a single-payer system. *See generally* Donald W. Light, *Universal Health Care: Lessons From the British Experience*, 93 AM. J. OF PUB. HEALTH 25 (2003) (discussing the history of the British National Health Service and the lessons the United States can learn from the British experience with healthcare reform).

10. Robert Buonaspina, *Now Is the Time for the NY Health Act*, LONG ISLAND PRESS (July 19, 2020), https://www.longislandpress.com/2020/07/19/now-is-the-time-for-the-ny-health-act/.

11. Sarah Kliff & Margot Sanger-Katz, *Americans' Medical Debts Are Bigger Than Was Known, Totaling $140 Billion*, N.Y. TIMES (July 20, 2021), https://www.nytimes.com/2021/07/20/upshot/medical-debt-americans-medicaid.html.

from care costs), "which have grown by 740% since 1984 . . . [with] the average American pa[ying] about $3,400 for insurance alone in 2018."[12] Despite the massive increase in household expenses on insurance, private health insurance—which covers slightly more than half of Americans, sometimes in concert with some form of public insurance[13]—covers an even smaller share of out-of-pocket healthcare expenses than it did a decade ago. "Employer-based [private] insurance for families costs about $20,576 this year, about a 5% increase from last year. Yet families are still on the hook for an average of $6,015 in out-of-pocket expenses, which is about a 71% increase over the past 10 years."[14] These increases have far outpaced the marginal wage increases of the past few decades, and healthcare costs even for insured people are overwhelming.[15]

The backdrop of a system that has become increasingly financially untenable is one in which health injustice is rampant. The U.S. infant mortality rate—a common indicator of population health—is seventy-one percent higher overall than the average of comparable countries, and infant mortality among Black and indigenous people far exceeds even the sobering national average.[16] U.S. life expectancy is higher for white people than Black and indigenous people, and—importantly—regional disparities persist even regardless of race. Among both white *and* Black Americans who live in the Southeast, for example, life expectancy is far lower than the national average.[17] As explained in far greater detail later, much of this is attributable to healthcare in the United States being—particularly for poor and disabled people—largely the domain of states against a backdrop of federal regulation.[18] Our healthcare system encounters—and reproduces—the outcomes of inequitable societal inputs. This includes a tendency in politics—sometimes intentional and sometimes unconscious—to blame poor, disabled, and Black people and other people of color for their own health outcomes rather than focusing on the fact that they have worse access to comparably inferior

12. Megan Leonhardt, *Americans Now Spend Twice As Much on Health Care As They Did in the 1980s*, CNBC (Oct. 9, 2020), https://www.cnbc.com/2019/10/09/americans-spend-twice-as-much-on-health-care-today-as-in-the-1980s.html.

13. *U.S. Healthcare Coverage and Spending*, CONG. RSCH. SERV. (Jan. 26, 2021), https://fas.org/sgp/crs/misc/IF10830.pdf.

14. Leonhardt, *supra* note 12.

15. Melissa B. Jacoby, *The Debtor-Patient in Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453, 458 (2004) ("Nearly forty percent of insured joint filers owed money to health providers, a rate that is higher than for uninsured filers.").

16. *See* Rabah Kamal, Julie Hudman & Daniel McDermott, *What Do We Know About Infant Mortality in the U.S. and Comparable Countries?*, PETERSON-KAISER FAM. FOUND. HEALTH SYS. TRACKER (Oct. 18, 2019), https://www.healthsystemtracker.org/chart-collection/infant-mortality-u-s-compare-countries/#item-start.

17. David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Nov. 18, 2021) at 4, https://www.commonwealthfund.org/sites/default/files/2021-11/Radley_racial_ethnic_equity_state_scorecard_r.pdf.

18. *See, e.g.*, Randall R. Bovbjerg, Joshua M. Wiener & Michael Housman, *State and Federal Roles in Health Care: Rationales for Allocating Responsibilities*, *in* FEDERALISM & HEALTH POLICY 30–32 (John Holahan, Alan Weil & Joshua M. Wiener eds., 2003).

care because of historic and current oppressive structures in healthcare and healthcare financing.[19] Regional health inequalities also then, unsurprisingly, map onto issues such as school segregation,[20] income,[21] and economic mobility.[22] The overlap in these disparities demonstrates that there are *structural* bases for health inequities in the United States, and a single-payer healthcare system is one way to target such deeply structural problems. Viewing healthcare reform proposals through a health justice lens is an important step toward targeting these structural problems.

B. Health Justice as a Legislative and Policy Priority

Healthcare reform in the United States should seek primarily to promote health and health justice,[23] and a national single-payer program is a stepping stone toward health justice primarily because it would remove a primary access barrier—costs to patients—that prevents many people in the United States from achieving health.[24] But what is health justice? At its root, health justice is a state of equity in which the health system works alongside community members to envision an environment that promotes health rather than destroying it or subordinating it to non-health concerns, such as profit or social control.[25] It is about ensuring that all people, regardless of their socioeconomic background or

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19. *See* Ibram X. Kendi, St*op Blaming Black People for Dying of the Coronavirus*, ATLANTIC (Apr. 14, 2020), https://www.theatlantic.com/ideas/archive/2020/04/race-and-blame/609946/; *see generally* Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 7 (2016).

20. Reed Jordan, *America's Public Schools Remain Highly Segregated*, URB. INST. (Aug. 26, 2014), https://www.urban.org/urban-wire/americas-public-schools-remain-highly-segregated.

21. Andy Kiersz, *America Is the Land of Unequal Opportunity. These 13 Maps Show How Class, Education, and Health Inequities All Intersect—With Nonwhite, Rural Areas Hit Especially Hard*, BUSINESSINSIDER.COM (Apr. 30, 2021), https://www.businessinsider.com/us-maps-show-overlapping-inequities-2021-4.

22. *Id.*

23. As opposed to, say, protecting the profits of insurance companies or subsidizing the private market for the market's sake, or promoting other social goals such as increases in employment.

24. *See* Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, 337 (2015) ("The preponderance of the evidence clearly indicates the urgent need for robust measures that address the deleterious effects of economic, societal, cultural, environmental, and social conditions, as well as the policies and legal systems that have devastating effects on health. This knowledge of social determinants of health should be integrated into the policy-making and judicial decision making processes. Policies, laws, and social structures must anticipate, and be designed to mitigate, the effects of socioeconomic inequality and the social determinants of poor health."). *See also* Keegan Warren-Clem, *"Unnecessary, Avoidable, Unfair, and Unjust": (En)gendered Access to Care in the PPACA Era and the Case for A New Public Policy*, 13 IND. HEALTH L. REV. 119, 125 (2016) [hereinafter Warren-Clem] ("[H]ealth care is expensive, and so much so that traditionally the two most widely accepted measures of access to care are the status of healthcare insurance coverage and financial barriers.").

25. *See* Warren-Clem, *supra* note 24, at 123 (noting the World Health Organization—since the 1940s—has defined health "as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'").

standing, receive quality healthcare[26] in a way that promotes "physical, mental, and social well-being."[27] Equity is not a corollary or optional consideration in healthcare. "Health protection," the ultimate goal of any healthcare system, encapsulates "equity—timely access not linked to employment status or ability to pay" and "financial protection against catastrophic health expenditure" among other key parameters that should drive political decisions about which type of healthcare system to construct to best promote the health of a population.[28]

A primary feature of programs that promote health justice is the elimination of means-testing in healthcare financing.[29] Means-testing creates healthcare programs that only cover specific populations and have income or other qualification requirements and is itself an obstacle to health justice.[30] It not only eliminates

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26. I eschew the popular framing of "access" to healthcare when discussing the right to healthcare. Access is an amorphous political term that rarely describes the same thing. For example, a person may be perceived as having "access to care" simply because they have some kind of health insurance coverage, regardless of whether they can actually afford their care at the point of service. *See* BOWEN GARRETT & ANUJ GANGOPADHYAYA, WHO GAINED HEALTH INSURANCE COVERAGE UNDER THE ACA, AND WHERE DO THEY LIVE? 3 (URB. INST., 2016), https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf ("Repeal of the ACA without new policies capable of maintaining the coverage gains achieved since 2010 would result in millions of Americans, of all ages and backgrounds and in all states, losing health insurance along with the access to health care and financial protections it affords."). Sometimes the "access" is a rhetorical flourish that could be eliminated altogether. *See also* Stasha Smiljanic, *How Many Americans Are Uninsured (2021),* POLICYADVICE.NET (June 27, 2021), https://policyadvice.net/insurance/insights/how-many-uninsured-americans/ ("Reports indicate that in 2016, roughly 1 out of 10 Americans did not have access to health insurance yet, meaning that roughly 91.5% of Americans were enrolled with a health insurance provider."). The former example is more insidious because it obscures a number of factors standing in the way of true "access," such as out-of-pocket and at-the-point-of-service costs that prevent many individuals from seeking healthcare (i.e., limiting access). A right to healthcare, rather than seeking to achieve "access" prevents blame-shifting for poor outcomes to patients rather than to healthcare systems as a whole.

27. Warren-Klem, *supra* note 24, at 123.

28. P. Petrou et al., *Single-payer or a Multipayer Health System: A Systematic Literature Review*, 163 PUB. HEALTH 141, 142 (2018).

29. *See* M.R. Groff, *Keeping America: Wealth Concentration and the Need for Repaired Revenues and Basic Income*, 34 QUINNIPIAC PROB. L.J. 367, 395 (2021) (noting that means-testing subjects poor Americans to "slow-moving government bureaucracies [which] add unnecessary costs to government administration and create stigmas which cause additional and unnecessary harm"). Groff describes means-testing for poor people's programs as a policy that "embrace[s] rather than eschew[s] wealth concentration," and therefore limits full political participation of those who do not hold wealth because "today's policies force our poorest neighbors to prove their poverty, sometimes monthly, before receiving meager, subsistence-level income, housing, food, or healthcare support." *Id.* at 396.

30. Notably, even some healthcare reforms of recent decades have effectuated moderate shifts away from what Matthew B. Lawrence refers to as "morality testing" and into a more purely means-testing regime. For example, the shift to slightly more broad-based income eligibility for Medicaid under the ACA allowed single, non-disabled adults (not previously defined as part of the "deserving poor") to receive Medicaid. *See* Matthew B. Lawrence, *Against the "Safety Net"*, 72 FLA. L. REV. 49, 56–57 (2020). Still, even Medicaid remains unavailable to groups such as non-citizen migrants and prisoners. *See generally id.* at 56 n.30; Mira Edmonds, *The Reincorporation of Prisoners into the Body Politic: Eliminating the Medicaid Inmate Exclusion Policy*, 28 GEO. J. ON POVERTY L. & POL'Y 279, 283 (2021). These exclusions illustrate the general problem with means-tested programs as opposed to universal programs; this problem is further discussed in remainder of this Section.

certain groups of people from consideration for public benefits altogether, but it also creates barriers for people who *are* putatively eligible for programs, resulting in under-utilization of benefits[31] and churn (the process of "beneficiaries moving in and out of . . . coverage," resulting in "delayed care, and less preventative care").[32] A particularly absurd illustration of how means-testing promotes churn and undermines continuity of care is Medicaid's "spend down" rule, under which "the medically needy may qualify for Medicaid benefits if they incur medical expenses, i.e., 'spend down,' in an amount that reduces their income to the eligibility level."[33] Once the spend down requirement is met in a given month, a medically needy individual can receive Medicaid coverage only for the remainder of that month,[34] meaning individuals repeatedly find themselves in and out of coverage. These barriers are outputs of a system that uses insurance and ability to pay rather than need as a gatekeeper to care. Under a single-payer system, no individual's healthcare coverage would be subject to a day-to-day eligibility determination.

Because health outcomes—and the U.S. healthcare and healthcare finance system as a whole—are inextricably intertwined with other social issues, researchers often point to "social determinants of health" as causes of health disparities in the United States. The U.S. Centers for Disease Control and Prevention (CDC) define "health disparities" as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."[35] Furthermore, the CDC confirms that "health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources."[36]

Health justice describes an absence of disparities,[37] and a national single-payer program, which signals universal deservedness across the population and makes care free at the point of service, is a step toward addressing health

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31. For example, approximately six million Medicaid-eligible people in the U.S. do not actually receive Medicaid. Louise Radnofsky, *Millions Eligible for Medicaid Go Without It*, WALL ST. J. (Jan. 31, 2016), https://www.wsj.com/articles/millions-eligible-for-medicaid-go-without-it-1454277166.

32. SARAH SUGAR ET AL., U.S. DEP'T OF HEALTH & HUM. SERVS., ASSISTANT SEC'Y FOR PLAN. & MGMT., MEDICAID CHURNING AND CONTINUITY OF CARE: EVIDENCE AND POLICY CONSIDERATIONS BEFORE AND AFTER THE COVID-19 PANDEMIC 1 (Apr. 2021), https://aspe.hhs.gov/system/files/pdf/265366/medicaid-churning-ib.pdf.

33. Atkins v. Rivera, 477 U.S. 154, 154 (1986) (citing 42 U.S.C. § 1396a(a)(17)).

34. Eliot Abarbanel, *A Practical Guide to Medicaid and Medicare*, J. DUPAGE CNTY. BAR ASS'N, https://www.dcba.org/mpage/vol170605art1 (last visited Apr. 7, 2022).

35. *Health Disparities*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/healthyyouth/disparities/index.htm#:~:text=Health%20disparities%20are%20preventable%20differences,experienced%20by%20socially%20disadvantaged%20populations (last visited Apr. 7, 2022).

36. *Id.*

37. "Health disparities do not refer generically to all health differences, or even to all health differences warranting focused attention. They are a specific subset of health differences of particular relevance to social justice because they may arise from intentional or unintentional discrimination or marginalization and, in any case, are likely to reinforce social disadvantage and vulnerability. Disparities in health and its determinants are the metric for assessing health equity, the principle underlying a commitment to reducing disparities in health and its determinants; health equity is social justice in

disparities. Health justice requires far more, of course, but removing a primary barrier to healthcare—costs—moves the needle, as does the creation of a universal program in which everyone has a vested interest. For policy and law to promote health justice, we must create "a regulatory and jurisprudential approach that consistently and reliably considers the health ramifications of judicial and legislative decision making."[38]

Health justice is also promoted when programs are universal, and thus less subject to political whims after their implementation; this advantage is somewhat separate from the advantage that accrues directly to individuals under a universal program and is more of a program-level advantage that promotes longevity and improvement. The stability and universality of a public program like single-payer promotes health justice in multiple ways. The more people who benefit from a program, the more politically popular it becomes, thus making it incredibly politically risky to undermine or cut back on the program.[39] Take, as an example, the top issue of U.S. voters in the 2020 election: preventing cuts to Social Security benefits.[40] Of course, Social Security benefits are not truly universal, in that individuals must accrue enough work credits to obtain Social Security Retirement benefits in old age. However, Social Security benefits are entitlements for those eligible and 46.7 million retirees (about one-seventh of the U.S. population) and their dependents currently receive Retirement,[41] with tens of millions more counting on the benefit in the future.[42] Even if an individual's positive attitude toward a

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health." Paula A. Braveman et al., *Health Disparities and Health Equity: The Issue Is Justice*, 101 AM. J. PUB. HEALTH S149, S150 (2011).

38. Benfer, *supra* note 24, at 337.

39. *See* Luke Darby, *Why Are So Many Democrats Opposed to Universal Programs?*, GQ (Dec. 12, 2019), https://www.gq.com/story/means-testing-democrats ("SNAP is what's known as a 'means tested' program, meaning that people are only eligible for it if they meet set income requirements and other criteria. Medicaid, the federal program that provides health care to millions of people living in poverty, is another means tested program. This is in contrast to 'universal' programs, like libraries, fire departments, and public schools—everyone in America, regardless of how much or how little money they make, has a right to use these resources. Often, universal programs are massively popular. A Pew Research study from this past summer, for example, found that a staggering 74 percent of Americans oppose any cuts to Social Security. Since universal programs are harder to cut, conservatives frequently target ones with means testing."); Bryce Covert, *Why Americans Love Social Security*, N.Y. TIMES (Dec. 19, 2019), https://www.nytimes.com/2019/12/19/opinion/democrats-green-new-deal.html ("But there are administrative costs that come with delineating who gets benefits and who doesn't. Programs that are narrowly targeted can be less effective. And, most important for presidential candidates, they lack political support. Universal programs, on the other hand, not only cultivate strong support but also tend to get recipients more politically involved. Social Security is an exemplar universal program. We all contribute to it, we all rely on it, and its broad scope has given it equally broad appeal and strength.").

40. Lorie Konish, *Preventing Social Security Benefit Cuts is a Top Priority for Americans in 2020 Election, Survey Finds*, CNBC (Aug. 19, 2020), https://www.cnbc.com/2020/08/19/preventing-social-security-benefit-cuts-is-a-top-priority-in-2020-election.html.

41. U.S. SOC. SEC. ADMIN., FACT SHEET SOCIAL SECURITY (2020), https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf.

42. *See* Mark Miller, *Social Security: Where Do the 2020 Candidates Stand?*, N.Y. TIMES (Feb. 7, 2020), https://www.nytimes.com/2020/02/07/business/social-security-2020-candidates.html ("No topic is more important than Social Security to the well-being of today's older voters—and younger workers

universal benefit is somewhat selfishly based on the benefit to oneself, he still has an interest in the maintenance of the program because it improves his own livelihood; the same cannot always be said of means-tested programs largely viewed as a "safety net" for the benefit of "other" people.[43] The universality of a program like single-payer, then, is a hallmark of health justice promotion because it promotes its own preservation through the creation of a large and diverse constituency of beneficiaries.

C. Single-Payer as a Stepping Stone to Achieving Health Justice

A single-payer system would, of course, not cause health justice to materialize immediately in the United States, but single-payer is a *means* to achieving health justice in a number of ways. First, and most straightforwardly, single-payer begins to address health disparities by removing one of the primary obstacles to care—cost—from the equation. Costs are a barrier to healthcare for both insured and uninsured people,[44] meaning even primary and preventive care are largely out of the reach of people who cannot afford the high out-of-pocket costs now associated with healthcare. This often leads people who need complex chronic care, or even simple primary care, to rely on emergency rooms and urgent care when health problems come to a head.[45] These individuals and families have less access to the kind of personalized primary care that improves health outcomes and prevents emergencies. When a patient is making the choice between a routine checkup or an appointment to address a persistent but non-emergency health issue and paying for necessities like rent, food, or transportation, health concerns get pushed to the back burner until they balloon into emergencies. And, of course, when making that choice, the current healthcare system lends itself to information asymmetry—few people can predict the actual cost of a healthcare

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who will come to rely on the program. Nearly all Americans pay into the program and can expect to receive a benefit. It is the largest retirement income source for a majority of older households.").

43. *See* Lawrence, *supra* note 30, at 52 ("[T]he conception of laws as lying dormant, ready to spring into action as a net for any person in need of rescue, obscures the important, ongoing role that law plays in shaping the social determinants of health and structural determinants of inequality that put some people and not others in need of rescue in the first place.").

44. *See* Leonhardt, *supra* note 12.

45. *See* U.S. Dep't of Health and Hum. Serv. Off. of the Assistant Sec'y for Plan. and Evaluation, Trends in the Utilization of Emergency Department Services, 20092018, at 12 (2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265086/ED-report-to-Congress.pdf ("There are a number of reasons an individual might seek care at an ED, even in cases that may not appear to be emergencies. One is insurance coverage, or lack or coverage. In the United States, EDs are required to stabilize all patients under the Emergency Medical Treatment & Labor Act (EMTALA), regardless of their ability to pay, though they are able to be billed for those services afterwards. Another reason may be accessibility issues or convenience. If there is not adequate or accessible primary care or preventive care, for instance, patients may need to rely on the ED."). *See also* Elena Renken, *As Out-Of-Pocket Health Costs Rise, Insured Adults Are Seeking Less Primary Care*, NPR (Feb. 3, 2020), https://www.npr.org/sections/health-shots/2020/02/03/801351890/as-out-of-pocket-health-costs-rise-insured-adults-are-seeking-less-primary-care (describing a study which found "[a]dults with commercial health insurance are visiting primary care providers less often than they did about a decade ago").

encounter, and many cannot risk being saddled with an unexpected bill.[46] A national single-payer program that provides healthcare free at the point of service would eliminate these out-of-pocket cost strains and worries, and promote health justice by eliminating cost considerations from people's decisions to seek care.

More importantly, though, a universal program like single payer promotes health justice by changing our social notions of who "deserves" healthcare, social notions currently reinforced by the hybrid unequal system of care in the United States.[47] For example, racialized social ideas about healthcare are reinforced through a system that provides disparate coverage, but these biases stand to be dampened by a shift to single-payer. "Through Black health gains via universal healthcare . . . the (often unstated) myth that White people 'earn' their high rates of positive health status and outcomes relative to Black people, by virtue of some attention to care to their bodies and minds that other groups, including Black people, do not employ, would fall."[48] In this way, a single-payer system—by providing care based on need rather than ability to pay—contributes to a sense of social solidarity that had been undermined and combatted by existing health finance policy. As a beneficiary of Britain's NHS put it:

> I think it's also a great pleasure certainly to me, you walk into a room in your surgery. And it's full of all sorts of people . . . . I wouldn't like to be thrown out of a place because I wasn't rich enough. But I also don't want to be in a place which everybody poorer than me is not getting access.[49]

Although means-testing typically reproduces these social notions of deservingness or lack thereof in subtler ways than "throwing one out" of a hospital, moving beyond means-testing is a key tool in health justice promotion.

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46. Lunna Lopes, Audrey Kearney, Liz Hamel & Mollyann Brodie, *Data Note: Public Worries About and Experience with Surprise Medical Bills*, KAISER FAM. FOUND. (Feb. 28, 2020), https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/ ("About two-thirds of Americans say they are either 'very worried' (35%) or 'somewhat worried' (30%) about being able to afford unexpected medical bills," topping the list of the public's worries about household expenses).

47. *See, e.g.*, Alan Mozes, *More Evidence Minorities in U.S. Get Poorer Hospital Care*, U.S. NEWS & WORLD REP. (Oct. 6, 2011), https://health.usnews.com/health-news/managing-your-healthcare/healthcare/articles/2011/10/06/more-evidence-minorities-in-us-get-poorer-hospital-care (describing study).

48. Ampson Hagan, *How Medicare for All Challenges our Ideas of Black Deservingness*, SOMATOSPHERE (May 27, 2019), http://somatosphere.net/2019/how-medicare-for-all-challenges-our-ideas-of-black-deservingness.html/; *see also* Lawrence, *supra* note 30, at 55 (noting one prevailing notion of the "safety net" conceives of "programs providing cash or in-kind support directly to the 'deserving poor'—that is, those who, through no 'fault' of their own, are young, sick, incapacitated, or otherwise dependent").

49. Libby Watson, *Bernie Sanders' Brother on Healthcare*, SICK NOTE (July 7, 2021), https://www.sicknote.co/p/bernie-sanders-brother-on-healthcare.

To illuminate the meaning of health justice and how single-payer might promote it, it is worth examining why the United States government—unlike more than seventy countries in the world that provide universal healthcare—has been so resistant to single-payer despite popular calls for such a program. As Ampson Hagan puts it, "[the] U.S. healthcare debate is hardly just about health. Healthcare, representing a politics by other means, helps determine the socio-political and economic futures of women, Black people, and Black *women*, beyond the intrinsic health outcomes it directly produces . . . ."[50] The system, in other words, reinforces and perpetuates ideas about who deserves care and who is to blame for their own health outcomes. Hagan adds that "[a] Medicare For All program may prompt us to examine notions of merit and deservingness that have up to now, been deployed to entrench racial inequality within existing American social structures."[51] Such a reexamination would be incredibly threatening to other oppressive structures in the U.S., where, "[w]hile other nations focused on access and equality, our deep-seated attachment to America's racial hierarchy tied us to a health care system encompassing racial disparities by design."[52] That is, a national single-payer program, through the implication that all U.S. residents deserve healthcare, upsets and undermines a history of U.S. public policy enforcing an oppressive racial and class order.[53] As discussed in more detail later, this is starkly illustrated in how states have administered federal public healthcare programs.[54] "When we hone in on the demographics of the American populace and think critically about who is currently underserved by the current medical system in the U.S., and who stands to benefit from an improved and more accessible system," it becomes clear "the healthcare debate has come to resemble a proxy war of sorts, pitting social welfare proponents against capitalist hawks who believe in little government and every man for himself."[55]

Additionally, related to its elimination of out-of-pocket costs and private intermediaries, a single-payer system also builds a more equitable health finance

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50. Ampson Hagan, *How Medicare for All Challenges our Ideas of Black Deservingness*, SOMATOSPHERE (May 27, 2019), http://somatosphere.net/2019/how-medicare-for-all-challenges-our-ideas-of-black-deservingness.html/.

51. *Id.*

52. Bobbi M. Bittker, *Racial and Ethnic Disparities in Employer-Sponsored Health Coverage*, 45 HUM. RTS. MAG. (Sept. 8, 2020), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/health-matters-in-elections/racial-and-ethnic-disparities-in-employer-sponsored-health-coverage/.

53. For a description of how non-universal programs reproduce discriminatory social processes, *see* Leslie London, Chuma Himonga, Nicole Fick & Maria Stuttaford, *Social Solidarity and the Right to Health: Essential Elements for People-Centered Health Systems*, 30 HEALTH POL'Y AND PLAN. 938, 940 (2015) ("An individual solution, framed as an individual entitlement, may reinforce the unfair social relations that generated inequity in two ways. Firstly, it may shift attention away from the social solutions needed to remedy the problems of group discrimination . . . Secondly, it may allow claims for individual entitlements to be met in ways that undermine public health efforts to address population-wide priorities, thereby increasing inequalities in some contexts.").

54. *See infra* Section III(A).

55. Hagan, *supra* note 50. However, as discussed later, *federal* healthcare payers do have a history of using their power to lessen health disparities caused by the *states*. *See infra* Section V(D).

system by removing the insurance company-provider mismatches that prohibit individuals and families from seeking the most appropriate care due to insurance network limitations and restrictions on covered care. Right now, each private insurance company makes private decisions about when, where, how, and how much people can seek care, and these rationing decisions are based on profit motivation and financial risk assessment, rather than on what a patient's provider deems medically necessary. As explained in greater detail later, public health programs are required to give far more deference to providers' recommendations.[56]

Finally, a single payer that covers all U.S. residents is far better positioned to bargain not just for better prices, but for higher standards of care, than individual private insurance companies, and even the current large federal payers. The ability of a large single payer to bargain with providers, manufacturers, and suppliers is unmatched in the current private-public hybrid U.S. healthcare system. This bargaining power inheres in the public as well. A single-payer healthcare program weaves together a single cross-demographic interest group (the U.S. resident population) out of currently disconnected constituencies and disease-specific advocacy groups. This increases the bargaining power of the public as to the healthcare payer, promoting greater accountability of the payer to patients than is present in the current system, particularly among patients with private insurance who must face down private insurance companies on their own through individualized advocacy and appeals. Essentially, single payer is a proposal that, through a fundamental shift in healthcare financing, prioritizes and promotes health justice. And, in the inequitable U.S. healthcare system, supporters of reform must key in on whether and how reforms will promote health justice rather than continuing the process of expanding health coverage piecemeal, while maintaining an untenably unjust and fragmented system.

Beyond the more obvious effects on individual and family budgets, a national single-payer program lays the groundwork for healthcare solidarity across the population. By eliminating means-testing and creating a universal program that covers all residents—and thus signaling universal deservingness—the terrain of health struggle is changed in a way that allows for more mass organizing around health justice demands. When everyone benefits, everyone has something to lose, and it becomes less and less politically viable to eliminate programs the closer those programs come to being universal. Currently, patient power is widely dispersed, and grows even more so after every effort to provide healthcare or insurance coverage to some new specific group succeeds.

For example, the Affordable Care Act (ACA), emblematic of the dispersal of political power attendant to the typical healthcare reform pathway in the United States, created new sets of interest groups invested in preserving the specific provisions that benefitted them. But because the healthcare coverage "provided" by the ACA and the changes it made were not universal, it left people with

56. *See infra* Section V.

preexisting conditions to advocate for that provision, middle-class people to advocate for middle-class private insurance subsidies, and so on. In essence, instead of creating a constituency to support the ACA or further reform, the ACA created many divided constituencies with different and sometimes competing interests. As lawmakers and courts began chipping away at the ACA, even its popular provisions lacked mass organizing around them.[57] One provision of the ACA that has stood the test of time is its requirement that insurers do not discriminate against people with preexisting conditions.[58] This provision's survival is no surprise. It was the provision that affected the most people of any ACA provision —one in every two non-elderly Americans by official estimates[59]—and its beneficiaries included Americans across the political and demographic spectrums. Lawmakers could never repeal the provision because it would have required them to anger a large constituent group that crossed the boundaries of the very constituencies they often play against one another in order to achieve electoral victories.[60]

There are many obstacles to achieving universal public programs in the United States. The stigmatization of social welfare and the dividing up of the population into deserving and undeserving groups is socio-politically constructed at the highest levels of welfare policy.[61] This paradigm is entrenched, but social attitudes favoring policies such as national single-payer healthcare demonstrate it is not for inherent lack of public desire that these programs do not exist.[62] Rather, the failure to achieve universal healthcare in the U.S. is a systemic and socially constructed problem. A national single-payer healthcare program has recently gained traction at the federal and state levels,[63] laying the foundation for health solidarity across the population and an opportunity to achieve a measure of health justice in the United States. Unfortunately, efforts at single payer have stalled in

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57. *See, e.g.*, Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 Geo. L.J. 1471 (2020) (documenting the legal challenges to the Affordable Care Act in the ten year period from the ACA's enactment in 2010 until 2020).

58. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §1201, 124 Stat. 119 (2010).

59. *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform*, CTRS. FOR MEDICARE AND MEDICAID SERVS., https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/preexisting (last visited Apr. 7, 2022).

60. *See* Margit Sanger-Katz, *No. 1 Aim of Democratic Campaign Ads: Protect Pre-existing Conditions*, N.Y. TIMES (Sept. 17, 2018), https://www.nytimes.com/2018/09/17/upshot/democrats-campaign-ads-pre-existing-conditions.html ("In 2010, Mr. Manchin's pro-West Virginia iconoclasm meant standing up to his party's leadership. Now, it means protecting a core provision of the Affordable Care Act. The words "Affordable Care Act" don't appear in the ad—neither does Obamacare. But the Manchin campaign has bet big that health care politics in the state have changed. Instead of vowing to repeal part of Obamacare, he's promising to protect its most popular provision."). *See also infra* Section IV (discussing the splitting of constituencies as a political strategy).

61. *See, e.g.*, Covert, *supra* note 39.

62. *See, e.g.*, Blumberg, *supra* note 8.

63. *See generally* HEALTHCARE-NOW, https://www.healthcare-now.org/legislation/state-single-payer-legislation/ (last visited Apr. 7, 2022) (supporting a database detailing nineteen states, including Iowa, Ohio, and South Carolina, that have or are currently considering state single payer legislation); *supra* note 6 (discussing federal efforts to enact single payer since 2003).

Congress in recent years despite the broad public support such a program enjoys. In the absence of movement on single-payer at the federal level, a number of U.S. states have considered state-based single-payer systems in the hope that our storied "laboratories of democracy" can take up the mantle of health justice.[64]

III. The Push for State-Based Single-Payer Healthcare

Before turning to my argument that state-level single-payer systems will undermine rather than advance health justice, I will detail the conventional wisdom espoused by policymakers and advocates: that Congress should act to clear the roadblocks to state-level single-payer to create a legal path for states to serve as "laboratories of democracy" where the merits of single-payer will be proven to other states. Multiple state governments have demonstrated a willingness to move forward with some popular state-level single-payer efforts.[65]

Scholars and advocates have, therefore, proposed that Congress act to exempt state-level single-payer from the Employee Retirement Income Security Act of 1974 (ERISA)—in particular, ERISA's prohibition on state regulation of employer-based insurance, which covers just under half the U.S. population.[66] Because ERISA currently prohibits states from regulating employer insurance, it is almost certainly impossible any state could bring all of its residents under a single-payer system without running afoul of federal law.[67] But there is a pending proposal in the U.S. House of Representatives to provide the very ERISA exception these states would need.[68] Although some advocates of state-based single-payer are in support of a national program and see states as the proper site of initial implementation and experimentation, some outright prefer the state-specific approach. Congressional leaders who oppose national universal programs have expressed a preference for states to go it alone. For example, Speaker of the House Nancy Pelosi supports individual states creating working models to test them before considering a national Medicare Single Payer Health Care System.[69]

This state-based approach coming from Congress comports with and relies on traditional notions of federalism and the states as "laboratories of democracy."[70] However, examination of the history and uses of state experimentation in

64. Healthcare-Now, *supra* note 62; *see infra* Section III.

65. *See* Healthcare-Now, *supra* note 63.

66. *See* Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Pa. L. Rev. 389, 448-56 (2020) (arguing for Congress to "add a statutory waiver provision to ERISA" to clear the path for state single payer programs).

67. *See, e.g.*, *id.*

68. *See* State-Based Universal Health Care Act of 2021, H.R. 3775, 117th Cong. (2021). *See* Press Release, Congressman Ro Khanna, Release: Khanna Reintroduces Universal Health Care System at State Level (June 8, 2021), https://khanna.house.gov/media/press-releases/release-khanna-reintroduces-universal-health-care-system-state-level; *see also infra* note 87.

69. Buonaspina, *supra* note 10.

70. *See* Hannah J. Wiseman & Dave Owen, *Federal Laboratories of Democracy*, 52 U.C. Davis L. Rev. 1119, 1119 (2018) ("Facilitating state policy experimentation is an oft-cited justification for the United States' federalism system. Despite growing recognition of risk aversion, free riding, and other

healthcare reveals that the laboratories of democracy theory, as applied to the provision of healthcare, has only worsened state-by-state and regional healthcare disparities in the United States. Instances where such reform policies have unambiguously improved health outcomes and saved money have universally not resulted in the adoption of successful "lab-tested" policies throughout the country. This Section provides an overview of efforts toward state-level single-payer and describes how the "laboratories of democracy" theory undergirds those efforts. Rather than critiquing any individual state's proposals or critiquing the House proposal for state single-payer on its merits, my goal is to illustrate the ways in which calls for state-based single-payer erroneously rely on the acceptance of the theory of laboratories of democracy. In the following Section, I turn to a discussion of the myriad problems with applying the conventional assumptions of the laboratories theory to single-payer healthcare experimentation.

A. Recent State-Based Efforts Toward Single-Payer

Although popular media has followed single-payer healthcare financing as a matter of national policy surrounding major national elections, there is much action at the state level receiving far less attention and scrutiny until recently.[71] Advocates of an improved healthcare system have hailed states as the potential drivers of health justice and called for states to implement their own single-payer programs, and have even touted state-based single-payer programs as a *better* way to promote health justice than a national program.[72] And state legislators have demonstrated a desire to experiment with single-payer.[73] "The volume of state-level interest in single-payer, as measured by proposed state legislation and local resolutions,[74] has been substantial. From 2010, when the ACA was enacted,

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disincentives to state-led experimentation, the mythology of state laboratories still dominates the discourse of federalism.").

71. Perhaps unsurprisingly, a Google trends search for the phrase "Medicare for All" reveals a peak in interest leading up to the U.S. Presidential election in 2020. *See* GOOGLE TRENDS, MEDICARE FOR ALL, https://trends.google.com/trends/explore?date=today%205-y&geo=US&q=medicare%20for%20all (last visited Apr. 7, 2022).

72. *See* Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 OHIO ST. L.J. 843, 847 (2018) ("What role can progressive states play in making health justice a reality? At a time when the Trump Administration and the Republican majority in Congress are undermining the fragile gains of the ACA through partial repeal and litigation while simultaneously attacking older federal commitments embodied in the Medicaid program, state governments are facing tough choices . . . . I focus particularly on the efforts of states to succeed where federal reformers have failed by adopting a state-level public option or single-payer health care system. Although state-level public-option and single-payer health plans face significant obstacles, many believe they are more feasible than federal reforms. Moreover, I argue, state-level single-payer health care may be preferable from a health justice perspective because it holds greater promise for integrating health care, public health, and social safety net program goals to achieve better health for all.").

73. *See* Fuse Brown & McCuskey, *supra* note 66, at 391; Wiley, *supra* note 72, at 874–75.

74. This section discusses proposals for state-specific single-payer, but some state and local governments have taken a different approach more aligned with the claims in this Article by adopting resolutions in support of national single-payer rather than locating such calls within the state. MEDICARE FOR ALL RESOLS., https://www.medicare4allresolutions.org/is-a-local-resolution-already-underway-in-

through 2019, legislators in twenty-one states have proposed sixty-six unique single-payer bills."[75] The COVID-19 pandemic revived calls for state-based single-payer,[76] especially in hard-hit states like New York.[77]

State-level single-payer proposals have not simply languished in legislative committees and have not been the domain of just a small group of committed healthcare advocates or so-called "progressive" or "blue" states; the legislation is not "purely symbolic or precatory."[78] For example, in 2006, the California legislature passed a state single-payer bill and only a gubernatorial veto prevented the country from seeing one of the world's largest economies attempt to implement a state-based single-payer system.[79] And single-payer legislation has been introduced in states with a wide variety of demographic makeups and perceived political leanings, including Florida, South Carolina, New Hampshire, Michigan, and Oregon.[80]

However, even advocates of state-based single-payer healthcare systems recognize legal obstacles to their implementation–primary among them being federal preemption of state regulation of employer-based health insurance. Longstanding and durable federal case law has held the federal Employee Retirement Income Security Act of 1974 ("ERISA") prohibits states from regulating employer-based insurance and preempts state healthcare initiatives that, even broadly, "relate[] to" employer-sponsored health plans.[81] ERISA preemption is no small obstacle, and even proponents of state-based single-payer acknowledge the unlikelihood of any state-based program succeeding without substantial ERISA changes, whether they come legislatively or through the courts.[82] Slightly more than half of American adults and half of American children have some form of

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your-community/ (last visited Apr. 7, 2022). This is an example of how state and local legislatures could involve themselves in more solidaristic national single-payer advocacy. *See id.*

75. Fuse Brown & McCuskey, *supra* note 66, at 397–398 (defining a state single-payer proposal as any bill that "sought to establish universal health care coverage for all residents in a state by combining financing for all health care services into a single, state-administered payer").

76. *See, e.g.*, Dolores Huerta & Ro Khanna, *Lack of Health Care Was Fatal Against COVID-19. California Must Lead on 'Medicare For All,'* THE SACRAMENTO BEE (July 7, 2021), https://www.sacbee.com/opinion/op-ed/article252459283.html.

77. *See* Buonaspina, *supra* note 10; Morgan McKay, *New York Health Act Has the Votes; But Will It Pass?*, SPECTRUM NEWS NY1 (June 7, 2021), https://www.ny1.com/nyc/all-boroughs/politics/2021/06/07/new-york-health-act-has-the-votes-but-will-it-pass- ("Advocates and lawmakers led a march to the New York State Capitol in the steaming 90-degree heat on Monday, demanding the passage of the New York Health Act before the end of the legislative year in just a few days. The New York Health Act, which would provide universal health coverage for every New Yorker, has been on the cusp of passing for years, but has never quite crossed the finish line.").

78. Fuse Brown & McCuskey, *supra* note 66, at 400; *see also id.* at 400 n.49 (noting that "some states have held hearings or have benefitted from in-depth economic assessments of their single-payer plans, demonstrating both the specificity of proposals and a commitment of significant resources to understand their economic impact" and citing examples).

79. *See Schwarzenegger Vetoes Single Payer Bill*, CAL. HEALTHLINE (Sept. 25, 2006), https://californiahealthline.org/morning-breakout/schwarzenegger-vetoes-single-payer-bill/.

80. *See* Fuse Brown & McCuskey, *supra* note 66, at 400.

81. *E.g.*, FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990).

82. *See generally* Brown & McCuskey, *supra* note 66.

employer-sponsored private health coverage,[83] and a state single-payer program would have to bring *all* of its residents under its financing for single-payer to work.[84] In fact, Vermont, the state that got closest to implementing its own single-payer program, balked at the last minute partly due to what its governor characterized as "limitations of federal law."[85]

As much as state single-payer supporters would like to see states implement such programs, even they recognize implementation would require federal permission. But recent movement at the federal level suggests an appetite in Congress for granting individual states permission to experiment with single-payer programs through waivers of certain federal rules—primarily ERISA's preemption of state regulation of employer-based health insurance coverage—and allowing states to pool multiple federal healthcare funding sources into a single stream of state healthcare dollars.

B. The Legal Theories Undergirding State-Based Single-Payer

In 2019, California Representative Ro Khanna—who represents Silicon Valley—introduced House Resolution 5010, the State-Based Universal Health Care Act of 2019.[86] The bill would, according to proponents, lead the U.S. down the path of "our neighbors in Canada,"[87] where national single-payer was implemented a decade after Saskatchewan implemented a province-specific single-payer system in 1962.[88] H.R. 5010 would "amend title I of the Patient Protection and Affordable Care Act [ACA]" to provide a "flexible framework" for states to "establish[] . . . universal health care systems" by exempting states that pass single-payer legislation from federal rules that currently prohibit or impede state-

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83. *Employer-Sponsored Coverage Rates for the Nonelderly by Age (2019)*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/nonelderly-employer-coverage-rate-by-age/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Apr. 7, 2022).

84. It should be noted that even with ERISA changes, it is not clear whether state-based programs would "work" even after bringing all residents into the state's public program because of a major difference in the way state budgets operate. *See* Brown & McCuskey, *supra* note 66, at 446 n.296 ("Note, however, that many other forces complicate states' ability to achieve these goals, such as the federal tax preference given to employer-sponsored health insurance and many states' inability to deficit-spend in times of recession due to balanced-budget laws."). This is important to the question of whether states can "prove" the concept of single payer but is slightly outside the scope of this paper.

85. Jon Walker, *Road to Single-Payer: Overcoming Hurdles at the State Level*, SHADOWPROOF (May 2, 2017), https://shadowproof.com/2017/05/02/road-to-single-payer-healthcare-overcoming-hurdles-at-the-state-level/.

86. A substantially similar bill was introduced in the House for the first time by Representative Jim McDermott of Washington. *See* State-Based Universal Healthcare Act of 2015, H.R. 3241, 114th Cong. (2015).

87. Press Release, Congressman Ro Khanna, Release: Rep. Khanna Introduces State-Based Universal Health Care Act, Landmark Step Toward a Nat'l Medicare for All Plan (Nov. 8, 2019), https://khanna.house.gov/media/press-releases/release-rep-khanna-introduces-state-based-universal-health-care-act-landmark.

88. Sarah Kliff, *The Doctor's Strike That Nearly Killed Canada's Medicare-For-All Plan, Explained*, VOX (Mar. 29, 2019), https://www.vox.com/policy-and-politics/2019/3/29/18265530/medicare-canada-saskatchewan-doctor-strike.

level single-payer healthcare programs.[89] H.R. 5010 represents a major effort to provide a federal permission structure for single-payer healthcare in the states. The bill would allow states whose residents already participate in federal and federal-state health insurance programs to pool federal healthcare funds into a general fund that could then be used to implement universal single-payer healthcare in the state.[90] Combining a number of federal funding streams would "allow[] the creation of global health care budgets with negotiated reimbursement rates for all providers" within a state.[91]

H.R. 5010 requires that states "provide an assurance that the State has legal authority to implement such plan or has enacted the law described in subsection (b)(2)."[92] That is, in order to be eligible for a waiver the state legislature must pass a law, or the state governor must issue an executive order creating a single-payer plan.[93] Essentially, then, what H.R. 5010 would do is simply remove the major federal roadblocks to implementing single-payer legislation already enacted in a state. It could be especially encouraging to states that have come close to enacting single-payer but saw such a program as untenable due to existing federal restrictions.

Khanna and the bill's supporters laud a state-based federally backed effort as the true path to single-payer in the United States. Relying on the history of Canada's Medicare program, which began as a public hospital insurance program in Saskatchewan, supporters of state-based single-payer argue that its adoption throughout the United States is inevitable as early adopting states demonstrate its merits to others.[94] That is, "progressive states" would serve as laboratories of

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89. Medicaid "waiver programs" are programs that allow states to waive certain provisions of federal healthcare law in order to craft special or innovative Medicaid delivery programs. *See* Centers for Medicare and Medicaid Services (CMS), *State Waivers List*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html [hereinafter *State Waivers List*] ("Section 1115 demonstrations and waiver authorities in section 1915 of the Social Security Act are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP)."). *See also* State-Based Universal Health Care Act of 2019, H.R. 5010, 116th Cong. (2019).

90. State-Based Universal Health Care Act of 2019, *supra* note 89.

91. *HR 5010: The State Based Universal Health Care (SBUHC) Act of 2019*, ONE PAYER STATES, https://onepayerstates.org/legislation/hr-5010-the-state-based-universal-health-care-sbuhc-act-of-2019/.

92. State-Based Universal Health Care Act of 2019, H.R. 5010, 116th Cong. (2019).

93. Whether authority for waivers originates with regulatory agencies or requires legislation varies by state, so the process of adopting H.R. 5010's requirements will vary as well, but the bill makes clear that an enactment rather than simply regulatory action, is required.

94. Khanna, *supra* note 87 ("Our neighbors in Canada established their own successful national health program by allowing the province of Saskatchewan to lead with a universal hospital care program in 1947, a decade before the plan took hold nationwide. States are in a unique position to innovate and lead in the push for universal health care."); *see* Sarah Kliff, *What if the Road to Single-Payer Led Through the States?*, N.Y. TIMES (Nov. 8, 2019), https://www.nytimes.com/2019/11/08/upshot/what-if-the-road-to-single-payer-led-through-the-states.html#:~:text=A%20California%20congressman's%20plan%20would,experiment%20with%20health%20care%20policy.&text=The%20policy%20could%20create%20something%20akin%20to%20Medicaid%20for%20all ("What [Khanna] envisions is similar to Canada's progression toward universal coverage. It began with a single province,

democracy,[95] demonstrating the merits of single-payer to the rest of the country and leading other states to adopt similar programs.[96]

H.R. 5010 heats up the simmering action toward states going it alone on single-payer healthcare. But is state-level single-payer a step on the path toward national single-payer like it was in Canadian provinces? And how does one state's implementation of a single-payer system affect people in states that do not implement a single-payer system? How does it affect the broader struggle for a national single-payer program?

IV. The Myth of States as Laboratories of Democracy

This Section argues that, by allowing states to implement their own individual single-payer legislation and favoring a state-based laboratories approach, the federal government would deepen state-by-state and regional health inequalities that it has a responsibility to prevent and discourage. Drawing on existing examples of states as "laboratories" of healthcare reform—the ACA Medicaid expansion and state Medicaid waivers in general—this paper argues only a national single-payer program can protect and promote the health of all U.S. residents, particularly when it comes to systematically oppressed groups who bear the brunt of health inequities in the country. Furthermore, I argue one of the most important benefits of a single-payer program—the bargaining power of a large federal payer—is diluted and undermined by state single-payer programs in a way that further deepens regional and other health disparities, leaving individuals in non-single-payer states worse off. Finally, I employ a political theory analysis to argue that, even if only a few states implemented single-payer systems, popular momentum toward a national single-payer system would *regress*, and therefore, state-based single-payer healthcare is actually a stumbling block rather than a stepping stone toward health justice.[97]

A. The State of Laboratories of Democracy in Healthcare

The premise that state-level experimentation in the area of healthcare and healthcare financing will improve the healthcare system is flawed, and H.R. 5010

Saskatchewan, which started hospital insurance in 1947. Other provinces followed, and within two decades, the entire country had government-provided health coverage. Canadian provinces retain control of their coverage programs, which means the health benefits and payment rates in, say, British Columbia vary slightly from those in Ontario. Medicaid has a similar history. When the program began in 1966, only half the states opted to participate in the new health plan to cover low-income residents. It took more than a decade for all states to join, with Arizona signing up last in 1982.").

95. Wiley, *supra* note 72.

96. *HR 5010: The State Based Universal Health Care (SBUHC) Act of 2019*, *supra* note 91 ("The State-Based Universal Health Care Act responds to the calls for complete access and greater affordability of health care for all Americans coupled with a uniquely American tradition—namely, capitalizing on the role of states as incubators of policy from our founding. As such, states should have the opportunity to provide health care for all residents if the political will exists.").

97. *See infra* Section IV(B) (arguing that state-based single-payer healthcare actually makes national single-payer less likely while deepening nationwide health inequities).

and state single-payer advocates rely heavily on this premise. The press release announcing the introduction of the bill quoted a supporter as saying, "Supreme Court Justice Louis Brandeis urged each state to '. . . serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.' Let's bring healthcare reform back to the states."[98] Another supporter stated the "proposal allows us to use federal funding to *prove* the concept of Medicare for All."[99] But the federal government has long given states the freedom to experiment with healthcare—typically at the expense of the poor[100]—and those experiments have only deepened nationwide healthcare disparities and contributed to our fragmented, ineffective, and inefficient healthcare system.

The primary manner in which the federal government allows states to experiment with healthcare financing and delivery models is by administering Medicaid "waiver" programs. Medicaid provides health insurance coverage to approximately seventy-seven million Americans[101] (making it by far the nation's largest health insurer),[102] including eligible low-income adults, children, pregnant women, older adults, and disabled people.[103] "Medicaid is administered by states, according to federal requirements[,]" and "[t]he program is funded jointly by states and the federal government."[104] Although federal law provides the general requirements and typically sets the floor for coverage requirements for state Medicaid programs, the federal government permits states to apply to waive certain requirements of federal Medicaid law and experiment with alternative ways of administering their programs. According to the Centers for Medicare and Medicaid Services ("CMS"), Medicaid waivers "are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid."[105]

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98. Khanna, *supra* note 87.

99. *Id.* (emphasis added).

100. Because federal law prohibits state regulation of private employer-based insurance, state experimentation has largely been under state-federal *public* programs such as Medicaid. The result is that states are given the freedom to "experiment" on poor and low-income people who receive means-tested public healthcare coverage, with results that make clear health promotion is not the chief objective of such policies. *See, e.g.*, *Edward F. Shay, Regulation of Employment-Based Health Benefits: The Intersection of State and Federal Law*, *in* Employment and Health Benefits: A Connection at Risk 293 (Marilyn J. Field & Harold T. Shapiro eds., 1993).

101. Ctrs. for Medicare and Medicaid Services (CMS), September 2021 Medicaid & CHIP Enrollment Data Highlights, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited Apr. 7, 2022).

102. *See* Kelsey Waddill, *Top 5 Largest Health Insurers in the US by National Market Share*, HealthPayerIntelligence.com (Sept. 29, 2021), https://healthpayerintelligence.com/news/top-5-largest-health-insurers-in-the-us-by-national-market-share (noting UnitedHealthCare, the largest private insurer, had "nearly 49.5 million consumers across all of its health insurance products, as of the first quarter of 2021").

103. U.S. Dep't of Health & Hum. Servs., *Who is Eligible for Medicaid?*, https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicaid/index.html (last visited Apr. 7, 2022).

104. Ctrs. for Medicare and Medicaid Servs. (CMS), *Medicaid*, https://www.medicaid.gov/medicaid/index.html (last visited Apr. 7, 2022).

105. *State Waivers List*, *supra* note 89.

In other words, Medicaid waivers allow states to serve as laboratories of democracy in healthcare.

States can use Medicaid waivers not just to experiment with *expanding* eligibility to new groups of new covered services, but also to *restrict* eligibility and covered services–with many states consistently using the waiver program to do the latter.[106] For example, as of February 2021, seventeen states had requested waivers to impose work requirements on Medicaid beneficiaries.[107] Sixteen states had requested waivers to restrict eligibility and enrollment, and thirteen had requested waivers to restrict benefits.[108] These restrictions include lifetime limits on enrollment, and even requirements that Medicaid beneficiaries pay premiums and copays.[109] Waivers that restrict coverage and complicate eligibility rules result in churn from Medicaid programs (meaning individuals and families often experience gaps in coverage) and worsened health outcomes.[110] Tennessee, South Carolina, and Mississippi, for example, impose or have applied for waivers to impose work requirements on parents receiving Medicaid.[111] These states also have some of the highest infant and maternal mortality rates in the country.[112] This represents a clear mismatch between the healthcare needs of a state's residents and how its politicians choose to innovate in healthcare finance and delivery.[113] The idea that state innovation in healthcare serves the unique needs of states' residents is misguided and prevents the enactment of a more effective single-payer system.[114]

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106. *See* KAISER FAM. FOUND., MEDICAID WAIVER TRACKER: APPROVED AND PENDING SECTION 1115 WAIVERS BY STATE | SECTION 1115 WAIVER TRACKER WORK REQUIREMENTS (2022), https://www.kff.org/report-section/section-1115-waiver-tracker-work-requirements/ (last visited Apr. 7, 2022).

107. *Id.*

108. KAISER FAM. FOUND., MEDICAID WAIVER TRACKER: APPROVED AND PENDING SECTION 1115 WAIVERS BY STATE (2022), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/ (last visited Apr. 7, 2022). *See supra* notes 32–33 (discussing churn).

109. *Id.* Medicaid already allows states to charge copays without requesting a waiver, but the copays must be nominal, and federal law limits them to around two to five dollars for most services. *See* U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Cost Sharing Out of Pocket Costs*, https://www.medicaid.gov/medicaid/cost-sharing/cost-sharing-out-pocket-costs/index.html (last visited Apr. 7, 2022).

110. *See* KAISER FAM. FOUND., *supra* note 108.

111. *Id.* Medicaid work requirements harken back to and are outgrowths of Clintonian "welfare reform" and their tragic results cannot be understated. Lillie Harden, who stood beside President Clinton as he signed into law the bill that would, partly though work requirements, "end welfare as we know it," died in 2014 after being denied Medicaid and unable to "afford a $450 prescription medication" following a stroke. *See* Nathan J. Robinson, *It Didn't Pay Off*, JACOBIN (Oct. 1, 2016), https://jacobinmag.com/2016/10/clinton-welfare-reform-prwora-tanf-lillie-harden.

112. CTRS. FOR DISEASE CONTROL AND PREVENTION, INFANT MORTALITY RATES BY STATE, https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited Apr. 7, 2022).

113. *See also* Mattie Quinn, *Report: Babies Are More Likely to Die in States That Didn't Expand Medicaid*, GOVERNING (May 21, 2019), https://www.governing.com/archive/gov-medicaid-expansion-maternal-infant-mortality.html.

114. *See* W. David Koeninger, *The Statute Whose Name We Dare Not Speak: EMTALA and the Affordable Care Act*, 16 J. GENDER RACE & JUST. 139, 173 (2013) ("From the viewpoint of the Court's

The federal government—often through the courts—can and has served as a backstop when states go too far in using waiver programs to restrict coverage. Such cases are examples of the persistent need for the federal government to take an active role in preventing state-by-state and regional disparities in healthcare. In *Gresham v. Azar*, the D.C. Circuit struck down a Department of Health and Human Services (HHS)-approved Arkansas Medicaid work requirement waiver because "[t]he primary purpose of Medicaid is to enable states to provide medical services to those whose 'income and resources are insufficient to meet the costs of necessary medical services.'"[115] The court held Arkansas could not subordinate the Medicaid statute's primary purpose—providing healthcare—to achieve the state's secondary goals, such as "the objective of transitioning beneficiaries away from government benefits through either financial independence or commercial coverage."[116] In other words, regardless of how little a state wishes to provide Medicaid coverage to eligible populations, it must do so anyway without imposing requirements completely attenuated from health because "the primary purpose of Medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it."[117]

Some of the most egregiously restrictive waivers are denied by HHS or struck down by courts prior to their actual implementation, so it is easier to determine their intent than their actual effect on enrollees or potential enrollees. But states' efforts to restrict coverage and impose extra requirements on Medicaid recipients tell us something about what state innovation really means in practice and how it is often detrimental to health. It demonstrates that rather than some laudable value-neutral "experimentation and learning" based on the unique needs of state residents, states often seek to undermine the very purpose of Medicaid through waiver authority.[118]

Unfortunately for its residents, the state of Arkansas' work requirement program was in fact implemented months before a court challenge resulted in its invalidation. As a result, its deleterious effects are well-known, and serve as an example of the duplicitousness of arguments that state experimentation in a program whose primary purpose is providing healthcare to the poor is good for its own sake. And worse, it highlights the duplicitousness of arguments that states—no matter how well-situated they are to understand the unique needs of their populations—will act in good faith in experimenting with the Medicaid program. In

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conservative wing, no state would possibly want to take advantage of the ACA Medicaid expansion to improve the health and productivity of its citizens, not to mention the solvency of its hospital infrastructure, at least not if there were federal rules attached to doing so.").

115. Gresham v. Azar, 950 F.3d 93, 100 (D.C. Cir. 2020), *cert. granted sub nom.* Arkansas v. Gresham, 141 S. Ct. 890 (2020) (quoting Pharm. Rsch. & Mfrs. of Am. v. Concannon, 249 F.3d 66, 75 (1st Cir. 2001)).

116. *Id.* at 101.

117. *Id.* at 100 (quoting W. Va. Univ. Hosps., Inc. v. Casey, 885 F.2d 11, 20 (3d Cir. 1989), *aff'd*, 499 U.S. 83 (1991)).

118. Koeninger, *supra* note 114, at 175.

the first six months between the Arkansas waiver's implementation and its invalidation, "approximately twelve percent of those with Arkansas Medicaid lost coverage yet without significant change in employment or community engagement [which was the stated purpose of the waiver]. Before the work requirement, roughly three percent of the Medicaid population was unemployed; after implementation, that number rose to just under four percent."[119] More importantly, though, "over eighteen thousand persons lost their health insurance for failing to meet the Arkansas work and reporting requirements, and that was before the full phase-in of the program to all age groups."[120] After those disastrous results had become clear, Arkansas still defended the work requirement all the way up to the Supreme Court, characterizing the Supreme Court's "narrow reading" of the Medicaid waiver statute to focus on health promotion as "threaten[ing] to severely curtail the kind of experimentation that has proven so valuable in setting national health care policy."[121] In other words, Arkansas hid its harmful policy of forcing Medicaid beneficiaries to obtain work behind the veneer of the laboratories of democracy theory.

Researchers have demonstrated, in the case of Arkansas and other states, that Medicaid work requirements also had "strong negative implications for state economies."[122] Essentially, state governments, while making claims that public welfare programs are too costly, have shown a willingness to go as far as to sacrifice revenue so long as they could make a statement to undermine health justice. For example, "[a]n analysis of the impact of disenrollment caused by work requirements in New Hampshire suggested the loss of between *seven and eleven percent of the state's entire budget*."[123] This further illustrates the irrationality, from a laboratories of democracy standpoint, of state healthcare reform legislation. It demonstrates that state governments can operationalize federalism to undermine health justice goals, entrench state-by-state inequality, and ignore the needs of their residents to which the laboratories of democracy theory holds state governments are uniquely attuned. Therefore, previous state experiments with healthcare management indicate that the underlying premise of federal legislation like H.R. 5010—the idea that states can "prove" state single-payer to other states, who will then adopt it—is false. The Affordable Care Act's Medicaid expansion is an exemplar of this problem.

B. The Test Case: The Affordable Care Act Medicaid Expansion

H.R. 5010's optimism that once some states begin to adopt single-payer, other states will see the light, as was the case with "[o]ur neighbors in Canada,"[124]

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119. Nicolas P. Terry, *Medicaid and Opioids: From Promising Present to Perilous Future*, 92 TEMP. L. REV. 865, 879 (2020).

120. *Id.* at 879–80.

121. Brief for Petitioners at 46, Azar v. Gresham, 141 S. Ct. 890 (2020) (No. 20-37), 2021 WL 260652.

122. Terry, *supra* note 119, at 880.

123. *Id.* (emphasis added).

124. Khanna, *supra* note 87.

belies the true nature and history of voluntary state-based healthcare reform in the United States. "Efforts to expand health coverage across the United States have always encountered the country's deep commitment to racism . . . . For instance, in the 1940s, southern Democrats conditioned their votes for the Hospital Survey and Construction Act on a rule that states be allowed to allocate resources locally, so that they could drive new hospital construction away from African American communities."[125] The deployment of states' rights arguments continues to undercut health justice today. "[I]n 2012, when the Supreme Court willfully gutted the [ACA's Medicaid expansion], some states took advantage of this to deny their citizens health coverage . . . . In these states, more than half of those who would have benefitted from the expansion were people of color."[126] In addition to the long history of states using Medicaid waivers to provide less coverage to fewer people with more restrictions, this recent example—the ACA's voluntary state Medicaid expansion—demonstrates that no number of positive results from other states can induce states hostile to the healthcare interests of their populations to adopt even the least costly means of expanding healthcare access and improving healthcare quality. This illustrates the perils of the federal government abdicating its healthcare financing role and handing over single-payer to the states.

One of the ACA's most successful provisions was its massive expansion of the Medicaid program, which brought nearly fifteen million people into Medicaid coverage, largely by expanding Medicaid to cover non-disabled childless adults, a population previously left out of the program.[127] The federal government also agreed to finance coverage of the expansion population at higher-than-typical levels in the federal-state program.[128] The ACA provided funding to cover one hundred percent of the costs of newly eligible enrollees until the end of 2016, and the federal share has since phased down to a still-high ninety percent, maintaining the appeal for states of covering the expansion population.[129] However, the Supreme Court, in *National Federation of Independent Businesses v. Sebelius* (*NFIB*),[130] laid the groundwork for a telling test of whether state governments could be counted on to expand healthcare services to their most vulnerable

125. Gregg Gonsalves & Amy Kapczyski, *The New Politics of Care*, *in* THE POLITICS OF CARE: FROM COVID-19 TO BLACK LIVES MATTER 11, 17 (Deborah Chasman & Joshua Cohen eds., 2020).

126. *Id.* at 17–18.

127. KAISER FAM. FOUND., MEDICAID EXPANSION ENROLLMENT (Dec. 2020), https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; *see generally MACPAC,* NON-DISABLED ADULTS, https://www.macpac.gov/subtopic/nondisabled-adults/ (last visited Apr. 7, 2022) (discussing ACA extended Medicaid eligibility for non-disabled childless adults).

128. *See* Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it Work and What are the Implications*, KAISER FAM. FOUND. (May 20, 2015), https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/.

129. *See generally* MACPAC, STATE AND FEDERAL SPENDING UNDER THE ACA, https://www.macpac.gov/subtopic/state-and-federal-spending-under-the-aca/ (last visited Apr. 7, 2022) (detailing increased federal spending towards Medicaid post-ACA).

130. *National Federation of Independent Businesses v. Sebelius* (*NFIB*), 567 U.S. 519 (2012).

residents when they had every possible incentive to do so. In *NFIB*, the Court held the federal government could not penalize states who refused to expand Medicaid under the ACA's terms by taking away their existing (non-expansion, pre-ACA) Medicaid funding,[131] essentially converting the ACA's mandatory expansion of Medicaid into an optional one. In other words, states that then decided to take the optional Medicaid expansion would be the laboratories in which the expansion was tested and proven.

States that expanded Medicaid demonstrated not only improved health outcomes, but also cost savings. Notably, the Medicaid expansion made a significant dent in regional health disparities typically seen in the South, as compared to other regions of the country, but only in Southern states that expanded Medicaid.[132] The results of a 2020 study of more than 15,000 non-elderly adults in the putative expansion population suggest that "for low-income adults in the South, Medicaid expansion yielded health benefits—even for those with established access to safety-net care [prior to the expansion]."[133] The study compared four expansion states in the South with nine non-expansion states and found that, in the expansion states, higher proportions of low-income adults "maintained their baseline health status" and "reported increases in Medicaid coverage" and reported lower proportions of "health status decline."[134] Although the study found eighty-six percent of its subjects were already enrolled at community health centers (i.e., they were already receiving some type of free or low-cost primary care even if not previously enrolled in Medicaid), it still found improvements.[135] This is likely because although "non-expansion states might have safety net providers —such as federally qualified health centers, which provide care regardless of income—such facilities generally do not offer the specialty care that Medicaid does."[136] Furthermore, a different 2019 study looked at adults aged 55 to 64 and estimated the Medicaid expansion saved "at least 19,000 lives" and—tragically —"state decisions not to expand have led to 15,000 premature deaths" between 2014 and 2017.[137]

It is perhaps belaboring the point to use studies to explain what seems like an obvious fact—that giving more people Medicaid, which provides by many

131. *Id.* at 585.

132. *See* John A. Graves et al., *Medicaid Expansion Slowed Rates of Health Decline for Low-Income Adults in Southern States*, 39 HEALTH AFFS. 67 (2020).

133. *Id.* at 67.

134. *Id.*

135. *Id.*

136. Michael Ollove, *Medicaid Expansion States See Better Health Outcomes, Study Find*s, PEW CHARITABLE TRS., (Jan. 7, 2020), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/01/07/medicaid-expansion-states-see-better-health-outcomes-study-finds.

137. MATT BROADDUS & AVIVA ARON-DINE, CTR. ON BUDGET AND POL'Y PRIORITIES, EXPANSION HAS SAVED AT LEAST 19,000 LIVES, NEW RESEARCH FINDS (2019), https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds. The small age sample group, coupled with the fact the study omits four states and Washington, D.C. that expanded under the ACA but did so before 2014 [when the Medicaid expansion became option following *NFIB*], indicates the startling numbers are a gross underestimation. *See id.*

metrics better health insurance coverage than private plans,[138] leads to better health outcomes—but recall the two-tiered welfare system and its notions of deservingness and personal responsibility. As illustrated in Section II, the current non-universal healthcare system shifts social blame for poor health outcomes and rising healthcare costs toward poor people, disabled people, Black and indigenous people, and other oppressed groups while reinforcing the idea that affluent people "earn" their better health outcomes; even a non-universal program like the Medicaid expansion has begun to upset that.[139] As empirical evaluations of the Medicaid expansion indicate,[140] poor people did not need simply to take more "personal responsibility" for their health or change their "lifestyle" to avoid early death; they needed healthcare. And this challenge to the American notion that poor health outcomes are not dictated by systems but rather by individual choices is a challenge state governments in non-expansion states seem to stifle at any cost. These state governments are not simply waiting for other states to prove the merits of expanding Medicaid before they do it themselves, and their actions are neither innocuous nor rational when viewed through a health justice lens. Rather, they are proof that, when it comes to free public healthcare the "laboratories of democracy" theory has been tested and it has failed. State governments will deliberately avoid proven ways to improve health outcomes if it means expanding notions of deservingness and shared humanity.

But what about the price tag? Is it not possible that the twelve state governments refusing to expand Medicaid are simply doing so because they cannot afford it? Or because their residents do not want the expansion? Are they well-intentioned but simply "fiscally conservative"? Evidence suggests the answer to these questions is a resounding no. Not only is the Medicaid expansion almost entirely funded without state money, but also most available data indicate the Medicaid expansion actually makes existing Medicaid programs cheaper for states overall.[141] Furthermore, several state governments in non-expansion states have fiercely resisted—through legislation and court challenges—popular efforts to expand Medicaid through ballot initiatives and other forms of direct democracy.[142]

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138. *See* Aaron E. Carroll & Austin Frakt, *Don't Assume That Private Insurance Is Better Than Medicaid*, N.Y. TIMES (July 12, 2017), https://www.nytimes.com/2017/07/12/upshot/dont-assume-that-private-insurance-is-better-than-medicaid.html; *see also* Press Release, The Commonwealth Fund, New Report: Medicaid Provides Equal- or Better-Quality Health Insurance Coverage That Private Plans as Well as More Financial Protection (Apr. 27, 2017), https://www.commonwealthfund.org/press-release/2017/new-report-medicaid-provides-equal-or-better-quality-health-insurance-coverage.

139. *See supra* Section II.

140. *See supra* notes 132-137.

141. *See generally* Trevor Brown, *The Long, Winding Road to Medicaid Expansion in Oklahoma*, J. REC. (June 28, 2021), https://journalrecord.com/2021/06/28/the-long-winding-road-to-medicaid-expansion-in-oklahoma/ (noting that Oklahoma, like many other states implementing Medicaid expansion, has not issued new taxes and have actually saved money).

142. *See infra* notes 157-166 and accompanying text.

As of 2020, any state offering Medicaid to the expansion population is now responsible for ten percent of its funding—approximately $100 million in the median expansion state, compared to the existing approximately two billion dollars in median state spending on existing Medicaid programs.[143] The federal government picks up ninety percent of the bill.[144] Despite the very low "sticker price" of the expansion, however, the net cost to states is lower and "[i]n some cases . . . the net cost is negative."[145] States can expand Medicaid and maintain a balanced budget without cutting other spending or raising revenue.[146] The Medicaid expansion comes at a low cost to states because of the high federal contribution to state programs, and research has found it saves states even more money because "expanding eligibility allows states to cut spending in other parts of their Medicaid programs" as well as "on state-funded health services for the uninsured."[147] In essence, funding Medicaid, which, like single-payer, provides care free at the point of service, is more effective than the patchwork of safety net programs, emergency room costs, and clinics that sporadically serve the healthcare needs of uninsured people. Researchers also theorize "expansion may increase state revenues due to taxes related to Medicaid expansion or taxes on the increased economic activity it triggers."[148]

So, twelve state governments have resisted the Medicaid expansion despite its health benefits and its fiscal advantages—the latter of which are of special concern to states, which, in contrast to the federal government, are not currency issuers and typically have balanced budget requirements. Expansion states have proven the Medicaid expansion works, and according to the laboratories of democracy theory and the proponents of state-based single-payer, this should lead the twelve state governments that have refused the Medicaid expansion to take it up, yet they have not done so, at the expense of at least 15,000 lives lost.[149] And they have refused the expansion despite democratic pressure from their residents. Below, I illustrate the ways in which state governments have been obstacles to popular healthcare reforms.[150] This illustration is important to a critique of states as laboratories of democracy in the public healthcare domain because it locates the criticism of state-level experimentation squarely within state *governments*, as opposed to their people, as an impediment to health justice.

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143. Bryce Ward, *The Impact of Medicaid Expansion on States' Budgets*, THE COMMONWEALTH FUND (May 5, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets ("While this is large in absolute terms, it is still small relative to state spending on traditional Medicaid. In 2018, total state spending on traditional Medicaid was more than $229 billion, and over $2 billion in the median state.").

144. *See* Snyder & Rudowitz, *supra* note 128.

145. *See* Ward, *supra* note 143.

146. *Id.*

147. *Id.*

148. *Id.*

149. Graves et al., *supra* note 132.

150. *See infra* notes 151-167 and accompanying text.

In 2020, Missouri residents—frustrated with the state government's refusal to expand Medicaid—took the issue directly to the people. Missouri voters approved a ballot initiative that would amend the state's constitution to expand Medicaid as set forth in the ACA.[151] Missouri's referendum came shortly after a similar successful ballot initiative in Oklahoma.[152] Oklahoma's ballot initiative passed despite objections from lawmakers and the state's governor, who tried to persuade voters "that approving Medicaid expansion would lead to dire budget cuts or tax increases."[153]

The Medicaid expansion in Oklahoma went into effect on July 1, 2021. But in Missouri, lawmakers refused to allow democracy to have the last word, and Medicaid eligible residents sued the state for failing to implement the expansion.[154] The state's challenge to the ballot initiative made it all the way to the Missouri Supreme Court. In July 2021, the Missouri Supreme Court ruled the ballot initiative did not violate state law and the Medicaid expansion would go into effect.[155]

Grassroots movements in four other states—Idaho,[156] Utah,[157] Maine,[158] and Nebraska[159]—took the ballot initiative route, bypassing state governments hostile to the expansion and experiencing official resistance along the way. In 2018, a coalition by the name of Reclaim Idaho launched a statewide door-to-door canvassing campaign that resulted in another successful ballot initiative to expand Medicaid.[160] Reclaim Idaho's inspirational grassroots efforts were documented extensively in local and national media and in an award-winning documentary film.[161] Idaho's ballot initiative served as an example of the power of popular resistance to state governments hostile to health justice and as an example of just how hard popular movements must work in order to put health justice on the

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151. *See* KAISER FAM. FOUND., STATUS OF STATE MEDICAID EXPANSION DECISIONS: INTERACTIVE MAP (Feb. 24, 2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

152. *See id.*

153. Trevor Brown, *The Long, Winding Road to Medicaid Expansion in Oklahoma*, J. REC. (June 28, 2021), https://journalrecord.com/2021/06/28/the-long-winding-road-to-medicaid-expansion-in-oklahoma/.

154. *See* Doyle v. Tidball, 625 S.W.3d 459 (Mo. 2021).

155. *Id.* at 465.

156. *See supra* notes 161-166 and accompanying text.

157. Erik Neumann, *Utah Voters Approved Medicaid Expansion, But State Lawmakers Are Balking*, NPR (Feb. 8, 2019), https://www.npr.org/sections/health-shots/2019/02/08/692567463/utah-voters-approved-medicaid-expansion-but-state-lawmakers-are-balking.

158. Abby Goodnough, *Maine Voted to Expand Medicaid. Judge Orders the State to Get Moving*, N.Y. TIMES (Jun. 4, 2018), https://www.nytimes.com/2018/06/04/health/maine-medicaid-expansion.html.

159. Bruce Japsen, *Nebraska Voters Approve Medicaid Expansion in Snub to Gov. Ricketts*, FORBES (Nov. 7, 2018), https://www.forbes.com/sites/brucejapsen/2018/11/07/nebraska-voters-approve-medicaid-expansion/?sh=6a12aae41565.

160. *Medicaid Expansion*, RECLAIM IDAHO, https://www.reclaimidahofilm.com/ (last visited Apr. 7, 2022); Anne Helen Peterson, *These Volunteers Are Battling Idaho's Government to Expand Medicaid*, BUZZFEED (Apr. 12, 2018, 10:55 AM), https://www.buzzfeednews.com/article/annehelenpetersen/idaho-medicaid-expansion-ballot-initiative.

161. RECLAIM IDAHO, *supra* note 160.

agenda when state governments have such a great degree of power over whether health justice is realized. Volunteers knocked on thousands of doors, sat in neighbors' living rooms, and heard stories of family tragedies and bankruptcies caused by lack of healthcare.[162] While canvassing to obtain signatures for the ballot initiative, one volunteer said: "Republicans, Democrats, everybody wanted insurance for somebody who needed it."[163] She said—of the more than one thousand doors she knocked, only a single person refused to sign the petition and "even if they were personally unsure about Medicaid expansion, at least thought it should be on the ballot for the public to decide."[164] Unlike in Missouri, the state government did not immediately lash out at the initiative through direct legal challenges. Medicaid expansion in Idaho would go into effect on January 1, 2020, making more than 90,000 Idahoans newly eligible for Medicaid.[165] Reclaim Idaho was democracy in action, but the state government had other plans for the future of its laboratory. "In response to the Medicaid expansion, Republicans in the House and Senate in 2019 tried to make the initiative process nearly impossible so they could head off future measures such as raising the minimum wage and legalizing marijuana."[166] In states like Idaho, Maine, and Missouri, state governments have demonstrated they are only amenable to being "laboratories of democracy" if they, rather than the people, are the ones doing the experiments.

That twelve state governments have refused the ACA's Medicaid expansion is as clear an indicator as any that the "laboratories of democracy" theory has been tested in the healthcare and health justice domain and failed with respect to programs that would provide a massive public benefit. State governments continue to reject the Medicaid expansion despite overwhelming evidence that it both saves money and improves health outcomes, further reproducing the systemic inequalities that arise out of and contribute to the fragmentation of the U.S. healthcare system. It is estimated that about four million currently uninsured people in the U.S. would be covered by Medicaid if the remaining quarter of states implemented the expansion, and these "state decisions about Medicaid expansion . . . exacerbate geographic disparities in health coverage" and "disproportionately affect people of color, particularly Black Americans."[167] The federal government

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162. DAVID DALEY, UNRIGGED: HOW AMERICANS ARE BATTLING BACK TO SAVE DEMOCRACY 31–35 (2020).

163. Nathan Brown, *'I Did It Because Everybody Else Needed It': Reclaim Volunteer Reflects on Medicaid Campaign*, POST REG. (Nov. 17, 2019), https://www.postregister.com/news/government/i-did-it-because-everybody-else-needed-it-reclaim-volunteer-reflects-on-medicaid-campaign/article_96e8bd1d-b74b-5d85-bd7a-fc401c460f54.html.

164. *Id.*

165. *Id.*

166. Rebecca Boone, *Idaho Supreme Court Weighs New Strict Ballot Initiatives Law*, ASSOCIATED PRESS (June 29, 2021), https://apnews.com/article/id-state-wire-idaho-supreme-court-idaho-voting-rights-courts-6bacd760b45af96a5318b0b93d99bc00.

167. Rachel Garfield, Kendal Orgera & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

cannot continue to leave patients at the mercy of states, and single-payer advocates cannot continue to accept the laboratories of democracy theory as truth. State governments' experiments in healthcare financing—particularly experiments directed at the poor—engender and deepen existing health injustices, including racial and regional health inequities, and states have demonstrated that they are not capable of or interested in promoting health justice. Although proponents of state-base single-payer healthcare see the "laboratories of democracy" model as the ticket to single-payer, the realities of state government action on healthcare demonstrate state single-payer advocates are misguided.

H.R. 5010 or similar enabling legislation, if passed, would lay the groundwork for states to implement their own single-payer systems, but it is virtually guaranteed that this will not lead to other states implementing single-payer the way "[o]ur neighbors in Canada" did,[168] leaving national single-payer the only remaining feasible option for a nationwide system in which healthcare is provided based on need rather than ability to pay. The federal government, then, would be abdicating an important health justice-promotion role if it placed the onus for single-payer implementation on the states by relaxing ERISA requirements. However, this is of course not fatal to the prospect of single-payer passing in *some* states, but other practical and political realities counsel against the implementation of state single-payer. I now turn to a deeper problem: that if the well-meaning efforts of state single-payer advocates result in some states implementing a single-payer system while others do not, state single-payer is a stumbling block rather than a stepping stone to health justice. Leaving single-payer up to the states in the short-term will not only worsen state-by-state and regional health disparities, but also make national single-payer *less* likely to pass than it is now. Under a health justice framework, such an outcome is unacceptable.

V. The Bargaining Power Problem with State Single-Payer

Having demonstrated that granting states permission to implement their own single-payer programs will not lead to other states doing the same, I now turn to the problems inherent in creating yet another patchwork health financing system in which some states have state-specific single-payer programs and others do not. State-level single payer is a stumbling block on the path toward the health justice goals of a national single-payer program because it would dilute both payer and patient bargaining power in a way that is harmful to the people already most disadvantaged by the fragmented and state-based healthcare system that currently exists in the United States. Furthermore, it would chill popular momentum toward a national single-payer program and make national single-payer less likely, at least in the short-term.

168. Khanna, *supra* note 87.

One of the primary advantages of a single-payer public healthcare program is that it greatly increases the overall bargaining power of both patients and the public payer.[169] The payer has bargaining power over providers, hospitals, and drug companies, and therefore can lower costs to itself, making universal healthcare delivery possible. And patients—the public at large—have bargaining power as to the public payer, both because of the due process protections that come with receiving public healthcare coverage and because the public is better able to assert bargaining power against a government payer than against a private payer, in which every patient is just one person bargaining with their insurance company. This Section discusses the nature of that bargaining power and argues first that state single-payer will unacceptably diminish the power of the federal payer to provide healthcare to the most vulnerable Americans in states hostile to health justice. Second, I conclude by employing a political theory analysis that the bargaining power of the U.S. public in favor of national single-payer will be diminished by the implementation of single-payer in even just a few states, chilling popular momentum toward national single-payer and making national single-payer less likely than it is now. Under a health justice framework, the deleterious effect on those left behind by their state governments is something that can and should be avoided.

A. The Importance of Bargaining Power in Healthcare

Since the early days of Medicare and Medicaid, the federal government has demonstrated the advantages of negotiating healthcare rates, prices, and conditions as a large public payer. Medicaid (in addition to the Veterans Administration) is lauded for wielding its bargaining power to keep costs—including drug prices—low and achieve good outcomes even as it provides healthcare to some of the country's most medically vulnerable patients.[170] And federal programs have a history of wielding their power as the nation's largest insurer to promote health justice. It was only after the enactment of Medicare—and Medicare's subsequent refusal to reimburse segregated hospitals—that U.S.

169. *See generally* APHA, *Adopting A Single-Payer Health System* (Oct. 26, 2021), https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Adopting-a-Single-Payer-Health-System. The basic definition of "payer" is ". . . the organization that negotiates or sets rates for provider services, collects revenue through premium payments or tax dollars, processes provider claims for service, and pays provider claims using collected premium or tax revenues." *The Role of Payers*, BROOKINGS HEALTH SYS., https://www.brookingshealth.org/why-brookings-health/health-care-value/understanding-medical-prices/role-payers#:~:text=The%20payer%20to%20a%20health,collected%20premium%20or%20tax%20revenues (last visited Apr. 7, 2022).

170. *See, e.g.*, Brett Venker, Kevin B. Stephenson & Walid F. Gellad, *Assessment of Spending in Medicare Part D If Medication Prices From the Department of Veterans Affairs Were Used*, 179 JAMA INTERNAL MED. 431, 433 (2019) (noting the potential savings that would come if Medicare were permitted to negotiate drug prices) ("Annual net Medicare Part D spending on the top 50 oral drugs ranged from $26.3 billion in 2011 to $32.5 billion in 2016 (Table). In 2016, if Medicare Part D obtained VA prices, the cost of these medications would have been $18.0 billion, representing savings of $14.4 billion, or an estimated 44%. The projected magnitude of estimated annual savings from 2011 to 2015 was similar, ranging from 38% to 50%.").

hospitals were desegregated "virtually overnight."[171] Medicare is among the most important achievements of the Civil Rights Era. On July 30, 1965, President Lyndon B. Johnson signed into law a bill that established Medicare Part A and Part B, which would take effect in 1966. In 1966, Southern hospitals were barred from participating in the Medicare program unless they discontinued their long-standing practice of racial segregation. The federal payer was simply too large and too powerful—it had too much bargaining power—for any hospital to refuse its funding in order to preserve *de facto* hospital segregation.[172]

Perhaps the most salient demonstration of the importance of the bargaining power of a single payer is an example of how *denying* the federal payer bargaining power *worsens* health outcomes and deepens health inequities while also increasing costs to both patients and the payer. "Over 40% of the revenue for 12 leading multi-national pharmaceutical companies comes from the United States . . .,"[173] in part because the country's largest healthcare payer, Medicare,[174] is prohibited by law from playing any direct role in negotiating and setting drug prices for beneficiaries of Part D, Medicare's prescription drug coverage program.

The final Medicare Part D bill was enacted as part of the Medicare Modernization Act ("MMA").[175] The bill also transferred "dual eligibles"—individuals eligible for coverage under both Medicare and Medicaid—to Medicare

171. Steve Sternberg, *Desegregation: The Hidden Legacy of Medicare*, U.S. NEWS & WORLD REP. (July 29, 2015), https://www.usnews.com/news/articles/2015/07/30/desegregation-the-hidden-legacy-of-medicare.

172. Beth Duff-Brown, *Desegregating Hospitals: How Medicare's Architect Forced Hospitals to Admit Black People*, STAN. MED. (2021), https://stanmed.stanford.edu/2021issue1/medicare-architect-forced-hospital-desegregation.html# ("In the early 1960s, [Assistant Secretary of Health] Philip Lee had lobbied in support of a precursor to Medicare—in opposition to the American Medical Association. He and LBJ took the political high road in making Medicare and Medicaid funding contingent on desegregation, said Peter Lee. 'Money talked—and most hospitals changed their policies almost overnight.'").

173. Gerald Friedman, *Economic Analysis of Single Payer Health Care in Washington State: Context, Savings, Costs, Financing*, WHOLE WASH. (2018), at 24, https://wholewashington.org/wp-content/uploads/2018/08/Economic_Analysis_of_Single_Payer_Health_Care_in__Washington_State__180220_1.pdf.

174. "The Centers for Medicare & Medicaid Services (CMS) is the single largest payer for health care in the United States. Nearly 90 million Americans rely on health care benefits through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)." *CMS Roadmaps Overview*, U.S. CTRS. FOR MEDICARE AND MEDICAID SERVS. 1 (2016), https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/downloads/roadmapoverview_oea_1-16.pdf. Sixty-one million of those individuals receive Medicare. *Total Number of Medicaid Beneficiaries*, KAISER FAM. FOUND., https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Apr. 7, 2022). By contrast, UnitedHealth Group, the country's largest private payer, has 49.5 million members. Morgan Haefner, *America's Largest Health Insurers in 2018*, BECKER'S PAYER ISSUES (July 10, 2019), https://www.beckershospitalreview.com/payer-issues/america-s-largest-health-insurers-in-2018.html.

175. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

from Medicaid for drug insurance coverage.[176] "In addition to transactional and administrative challenges, the transition of dual eligibles' prescription drug coverage from Medicaid to Medicare increased their costs for prescription drugs and simultaneously decreased the types of drugs available to them" in part because Medicare's hands were tied on drug-pricing negotiation.[177] As Jessica Neidhart Agostinho notes:

> The MMA adopted a "laissez-faire approach" to drug pricing. While under Medicaid the government negotiates the drug prices, under Part D the negotiating power is transferred to PDPs, private entities who then negotiate drug costs directly with pharmaceutical companies. The MMA expressly prohibits the Secretary of Health and Human Services ("HHS") from negotiating prescription drug prices on behalf of Medicare enrollees. CRS found that while "[i]n theory, the federal government may be able to leverage its market share to negotiate lower prices," the "noninterference" clause prevents the government from seeking lower prices. The House recognized this problem and, in January 2007, passed the Medicare Prescription Drug Price Negotiation Act. The Act would have required the Secretary to negotiate drug prices for this coverage, but the Senate failed to pass the bill.[178]

Because of Medicare Part D's noninterference clause, "Medicare Part D pays on average 73% more than Medicaid and 80% more than VA for brand name drugs. The federal government could save between $15.2 and $16 billion a year if Medicare Part D paid the same prices as Medicaid or VA."[179] These high drug prices paid by Medicare account for more than a third of all retail prescription expenditures in the United States and are projected to contribute to a doubling of Medicare spending from 2016 to 2025.[180] A 2008 study "found an approximately 8% increase in the costs of prescription drugs for dual eligibles [individuals eligible for both Medicare and Medicaid, with Medicare as the primary payer] under Medicare as compared to Medicaid.[181] The study also found that for drugs that

176. Jessica Neidhart Agostinho, *Improving Prescription Drug Access for Dual Eligibles After the Medicare Modernization Act*, 43 COLUM. J.L. & SOC. PROBS. 183, 183 (2009).

177. *Id.* at 194.

178. *Id.* at 195 (citations omitted).

179. STAFF OF H. COMM. ON OVERSIGHT & REFORM, 115TH CONG., THE MEDICARE DRUG PRICE NEGOTIATION ACT OF 2017–DISCUSSION DRAFT SUMMARY (2017), https://oversight.house.gov/sites/democrats.oversight.house.gov/files/documents/NegotiationBillTwo-PagerforReleas-Final_0.pdf; *see also* Meghan McConnell, *Medicare Part D: Buying Prescription Drugs Wholesale but Paying Retail*, 48 PUB. CONT. L.J. 123, 127 (2018) ("The VA and Medicaid have been able to effectively leverage their purchasing power through direct negotiations and statutory advantages, while Part D lacks similar tools to obtain savings.").

180. STAFF OF H. COMM. ON OVERSIGHT & REFORM, *supra* note 179.

181. Richard G. Frank & Joseph P. Newhouse, *Should Drug Prices Be Negotiated Under Part D of Medicare? And If So, How?*, 27 HEALTH AFFS. 33, 37 (2008).

dual eligibles use most heavily, drug companies reported an increase in their profits after the transition from Medicaid to Medicare.[182] The Medicare part D noninterference clause increases profits for drug companies and costs for both patients and the government.[183] It represents the worst effects of stripping a large payer of its potential bargaining power.

In addition to payer bargaining power, a healthcare system must also feature *patient* bargaining power if it seeks to maximize health outcomes. In the current U.S. healthcare system, those who receive public health insurance have a significant amount of bargaining power as to the payer, something often lacking among those with private insurance. Being the beneficiary of a government payer even increases the bargaining power of an *individual* patient, acting alone to pursue care, as to the payer. This is because patients seeking care and coverage under government health programs have due process protections.[184] For individuals with private insurance, coverage decisions are made in an administrative black box and provide far less deference to physician recommendations than government payers.

Individuals receiving health coverage under government programs, such as Medicaid, benefit from due process protections prior to changes to or terminations of coverage.[185] Because a national single-payer program would cover every U.S. resident, this type of bargaining power would become slightly less relevant as traditional means-testing fades. However, when it comes to actual decisions about covered services, a single-payer system provides a protection that no profit-motivated private health insurance coverage does: longstanding federal precedent mandates that government payers defer to provider recommendations when

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182. Jessica Neidhart Agostinho, *supra* note 176, at 195–96 (citing Marilyn Moon, *Letter: Improve Treatment of Dual Eligibles,* 27 HEALTH AFFS. 894 (2008); then citing Richard G. Frank & Joseph P. Newhouse, *Should Drug Prices Be Negotiated Under Part D of Medicare? And If So, How?*, 27 HEALTH AFFS. 33 (2008)).

183. A common retort to the argument that Congress should change the law to allow Medicare to negotiate drug prices is that it will stifle pharmaceutical innovation. *See* Juliette Cubanski, Tricia Neuman, Sarah True & Meredith Freed, *What's the Latest on Medicare Drug Price Negotiations?*, KAISER FAM. FOUND. (Jul. 2019), at 2–3, https://www.kff.org/wp-content/uploads/2019/07/Issue-Brief-Whats-the-Latest-on-Medicare-Drug-Price-Negotiations.pdf ("Opponents counter that the current system of private plan negotiation is working well, and that government involvement in price negotiations could dampen incentives for pharmaceutical companies to invest in research and development."). This myth is not grounded in reality. In fact, pharmaceutical research in the United States is heavily subsidized, and only about 1.3 percent of the post-tax deduction money that the industry spends actually goes into basic research, the type of research that leads to new medications. *See* Donald W. Light & Joel Lexchin, *Foreign Free Riders and the High Price of US Medicines*, 331 BMJ: BRITISH MED. J. 958, 958–960 (2005). Furthermore, there is "no convincing evidence to support the view that the lower prices in affluent countries outside the United States do not pay for research and development costs." *Id.* at 958.

184. *See* Goldberg v. Kelly, 397 U.S. 254, 260 (1970) (holding that procedural due process requires a full hearing before welfare benefits are terminated).

185. *Id.*; *see also Elements of the Medicaid Appeals Process under Fee for Service, by State*, MACPAC (Apr. 2018), https://www.macpac.gov/publication/elements-of-the-medicaid-appeals-process-under-fee-for-service-by-state/#:~:text=In%20Medicaid%2C%20due%20process%20protects,Kelly.

determining medical necessity, and therefore determining what specific health services, durable medical equipment, and drugs must be paid for by the payer.

In *Weaver v. Reagen*, Medicaid recipients with AIDS challenged a Missouri Medicaid rule that precluded coverage for the drug Azidothymidine (AZT) for AIDS patients except in certain circumstances.[186] The patients' treating providers had prescribed and recommended the drug, but Missouri still refused to cover it. The Eighth Circuit held that Missouri Medicaid could not deny AZT for patients whose physicians prescribed it, even though at the time, AZT was considered an off-label use of the drug by both Missouri and the FDA. The court stated:

> [T]he fact that [FDA] has not approved labeling of a drug for a particular use does not necessarily bear on those uses of the drug that are established within the medical and scientific community as medically appropriate. *It would be improper for the State of Missouri to interfere with a physician's judgment of medical necessity* by limiting coverage of AZT based on criteria that admittedly do not reflect current medical knowledge or practice.[187]

The Eighth Circuit expanded upon its holding in *Pinneke v. Preisser*, in which it held the denial of a gender-affirming surgery deemed medically necessary by the patient's physician violated the Medicaid Act.[188] The court laid out a general principle that illustrates the stark contrast between how government payers make coverage decisions and how private payers make coverage decisions. The court stated, "[t]he decision of whether or not certain treatment or a particular type of surgery is 'medically necessary' *rests with the individual recipient's physician and not with clerical personnel or government officials*."[189] Surely, patients seeking appropriate care still face obstacles even with public insurance, but even where courts have not found such a sweeping deference to provider recommendations is necessary under Medicaid statutes, they have still found patients have recourse when a government payer denies coverage for a particular service.[190] Courts have found Title XIX of the Social Security Act, which governs Medicaid, still requires a state Medicaid program's decision to limit services based on the degree of medical necessity to be reasonable.[191]

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186. *See* Weaver v. Reagen, 886 F.2d 194 (8th Cir. 1989).

187. *Id*. at 198 (emphasis added).

188. Pinneke v. Preisser, 623 F.2d 546, 550 (8th Cir. 1980).

189. *Id.* at 550 (emphasis added).

190. This is especially true given the increasing privatization of the Medicaid program, another issue which would be addressed by the implementation of a national single-payer program. *See* Jennifer L. Wright, *Unconstitutional or Impossible: The Irreconcilable Gap Between Managed Care and Due Process in Medicaid and Medicare*, 17 J. CONTEMP. HEALTH L. & POL'Y 135, 137–38 (2000).

191. *See, e.g.*, Hope Med. Grp. for Women v. Edwards, 63 F.3d 418, 425 (5th Cir. 1995) ("Other courts have declined to impose such a strict 'medical necessity' restriction on states' discretion. Instead, they read Title XIX as granting states some discretion to limit medical services based on their judgment as to whether a particular medical service is medically necessary. Under this approach, a state program's

One of the primary methods through which private insurers ration care is coverage denials. By denying care to their members, private insurers can increase profits.[192] Rationing care via the denial of coverage is rational from the perspective of a profit-motivated private insurer because it maintains incoming payments (premiums) without spending money on care. This method of rationing is less available to government payers because of the requirement that government payers defer to providers' recommendations for medically necessary treatment, and Medicaid's prohibition on states arbitrarily denying or reducing a service to a recipient because of their diagnosis, type of illness, or condition.[193] Rationing care based on profit concerns is the antithesis of a health justice-promoting system that provides care based on need rather than ability to pay.

By operating under legal standards of deference to healthcare providers' treatment determinations, a public healthcare program promotes health justice and reduces health disparities by doing a better job of ensuring individuals receive the care they need. In doing this, a public program places an individual patient on a far more level playing field with the healthcare payer than they are in the current system, in which health insurance companies expend money and human resources for the sole purpose of ensuring profits at the expense of care.

Of course, as discussed later, individual patients alone cannot effect massive structural changes.[194] The prevalence of legal services organizations focused on appealing coverage denials and decisions under public insurance programs is one demonstration of how, even with increased due process protections, healthcare is often out of reach of poor people, people of color, and other oppressed people because of the history of discrimination in healthcare and other social domains. These problems are exacerbated by the escalating privatization of Medicaid; in

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decision to limit a service based on the degree of medical necessity is subject only to Title XIX's requirement that the limitation must be reasonable.") (internal citations omitted).

192. Audiotape: Oval Office Conversation: Nixon Tapes (Feb. 17, 1971) (UVA Miller Center Archives). Few politicians have described the disincentive to provide care with such candor as Richard Nixon in a taped conversation with White House advisor John Ehrlichman prior to the legalization of HMOs in the early 1970s:

> President Nixon: "Say that I . . . I . . . I'd tell him I have doubts about it, but I think that it's, uh, now let me ask you, now you give me your judgment. You know I'm not too keen on any of these damn medical programs."
>
> Ehrlichman: "This . . . this is a . . . private enterprise one."
>
> President Nixon: "Well, that appeals to me."
>
> Ehrlichman: "Edgar Kaiser is running his Permanente deal for profit. And the reason that he can . . . the reason he can do it . . . I had Edgar Kaiser come in . . . talk to me about this and I went into it in some depth. All the incentives are toward less medical care, because . . . the less care they give them, the more money they make."
>
> President Nixon: "Fine." [Unclear].
>
> Ehrlichman: [Unclear] ". . . and the incentives run the right way."
>
> President Nixon: "Not bad."

193. 42 C.F.R. § 440.230(c).

194. *See infra* Section V(C)(2).

most states, Medicaid is outsourced to HMOs, MCOs, and other private insurance companies.[195] Public programs can and should get better, and popular rather than individual bargaining power must be exerted to bring this about. Nonetheless, patients have far more bargaining power against public than private payers.

B. State Single-Payer and Federal Bargaining Power

In addition to the unlikelihood of successful state single-payer programs being adopted by states that have traditionally refused to expand healthcare access, the very adoption of single-payer in some states would deepen persistent regional health inequities in the United States by leaving individuals in states that do not adopt single-payer worse off than they are now. Because health justice "requires a regulatory and jurisprudential approach that consistently and reliably considers the health ramifications of judicial and legislative decision making,"[196] H.R. 5010 or other legislation enabling state-based single-payer are not acceptable actions for the federal government to take under a health justice lens if they will worsen health disparities.

The move to state-based single-payer plans in some states would deepen state-by-state health disparities in one primary way. The movement of individual states' populations out of the existing public federal system will decrease the overall bargaining power of existing federal healthcare payers like Medicaid and Medicare. It would do so by reducing the number of people insured by federal programs once people in individual states move to the state plan.[197] This would weaken the bargaining power of federal programs which pay for care for the country's most vulnerable patients. For example, if California and New York—sites of some of the most promising efforts toward state single-payer—adopt state-based plans, their twelve million and six million Medicaid recipients, respectively, would be moved out of the federal Medicaid population.[198] Nationwide, Medicaid covers more than seventy-eight million people, and removing just those two states would bring that number to around fifty-three million people, less than the number of people covered by UnitedHealthcare, the nation's largest private insurer.[199]

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195. *See* Elizabeth Hinton & Lina Stolyar, *10 Things to Know About Medicaid Managed Care*, KAISER FAM. FOUND. (Feb. 23, 2022), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

196. Benfer, *supra* note 24, at 337.

197. *See State Based Universal Health Care (SBUHC) Act of 2021*, ONEPAYERSTATES, 2–3, https://onepayerstates.org/legislation/hr-5010-the-state-based-universal-health-care-sbuhc-act-of-2019/ ("[H.R. 5010 would] allow[] the creation of global health care budgets with negotiated reimbursement rates for all providers . . . ."). By moving its residents out of the federal government's coverage population and into the state's, states would reduce the bargaining power of the federal payers, therefore making it more difficult for the federal government to negotiate favorable prices, reimbursement rates, and other healthcare conditions for the population that remains covered by the federal payers.

198. *See November 2021 Medicaid & CHIP Enrollment Data Highlights*, MEDICAID.GOV (Nov. 2021), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (noting that California and New York had 11,875,831 and 6,438,378 Medicaid enrollees as of November 2021, respectively).

199. *See id.* (noting that 78,910,300 individuals were enrolled in Medicaid as of November 2021); *see also supra* note 102.

This massive reduction in bargaining power of the federal payer could have serious implications for how Medicaid manages costs among its remaining beneficiaries.

Removing millions of people from the Medicaid and Medicare populations will result in a reduction of the existing federal payers' ability to negotiate low drug prices (in the case of Medicaid) and provider reimbursement rates where states fail to do so. An increase in Medicaid costs will squeeze state budgets and further incentivize non-single-payer states to cut Medicaid costs in any way they can. That is, the use of waivers to restrict coverage and benefits and increase patient cost-sharing, as well as some states' refusal to cover optional groups such as the ACA Medicaid expansion group, would only increase as state Medicaid costs increase due to the dilution of federal bargaining power.

State-level reforms do not exist in a vacuum, and national policymakers—and health justice advocates—must consider the broader implications of state-level policies. In particular, state-based single-payer programs, by reducing the bargaining power of the federal payer without making a national single-program more likely, deepen some of the very inequities a single-payer program is designed to address. Other areas of law and policy acknowledge the fundamental differences in motivation between states and the federal government. For example, part of the justification for national-level environmental regulations is the fear that states acting alone could improve their own air and water by offloading damaging externalities to other states.[200] If states, acting alone, can deepen nationwide regional inequality in healthcare, a national scope for health is just as necessary as a national (or global) scope of analysis in the context of environmental protection.

C. Popular Bargaining Power and Mass Movements

I now draw on the introductory discussion of how universal programs create large cross-demographic constituencies and discuss the converse: the fracturing of constituencies inherent in incremental, non-universal reforms. I will also discuss how moving large swaths of people into state-based single-payer programs would chill momentum toward a national single-payer program by splitting up a growing national constituency in favor of single-payer healthcare. Because of this, I conclude, state-based single-payer is, in fact, a stumbling block rather than a stepping stone to national single-payer and to achieving health justice in the United States.

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200. *See generally* Mary Graham, *Environmental Protection & the States: "Race to the Bottom" or "Race to the Bottom Line"* (Dec. 1, 1998), https://www.brookings.edu/articles/environmental-protection-the-states-race-to-the-bottom-or-race-to-the-bottom-line/ (noting that "[m]aintstream Democrats and Republicans agree that air pollution, water pollution, and other environmental problems that cross state lines should continue to be controlled by federal rules").

1. Stepping Stones and Stumbling Blocks—Evaluating Reform Proposals

Not all healthcare reform promotes health justice. This is not only true of reforms that explicitly seek to restrict healthcare, but also sometimes true of reforms that, at least putatively, expand coverage and access to care. In order to navigate the difficulty of organizing and advocating for systems reform, social philosopher André Gorz proposed a taxonomy that would characterize putatively "positive" reforms as reformist, non-reformist, or revolutionary.[201] The "reformist" versus "non-reformist" reform framework is employed in current-day discussions of political economy and theory. "Articulated in protests, strikes, campaigns, and policy platforms by organizations like Mijente, Black Visions Collective, Sunrise Movement, the Right To The City Alliance, and the International Longshore and Warehouse Union, non-reformist reforms provide a framework for thinking about reforms that aim to build grassroots power as they redress the crises of our times."[202] The framework allows political analysis to move beyond characterizing reforms as merely incremental or sweeping/sudden and into a mode of analysis that looks at the *quality* of the reform itself and whether it contributes to an end goal of systems change (non-reformist) or further entrenches oppressive structures (reformist).

A reformist reform is one that "subordinates its objectives to the criteria of rationality and practicability of a given system and policy. Reformism rejects those objectives and demands—however deep the need for them—which are incompatible with the preservation of the system."[203] A non-reformist reform is one that "does not base its validity and its right to exist on capitalist needs, criteria, and rationales. A non-reformist reform is determined *not in terms of what can be, but what should be*."[204] A revolutionary reform is one that makes an "advance toward a radical transformation of society."[205] Organizers and scholars have adopted the reformist versus non-reformist framework as a way to set organizing and political priorities. In the area of criminal legal system reform, for example, a reformist might seek to apply technocratic "tweaks" such as law enforcement data transparency and police-worn body cameras. A non-reformist, however, would counter this reformist position by asserting that tweaks simply make an "irreparabl[e]"[206] system better able to continue functioning and would assert the only solution to police violence is through abolishing the irreparable system. Thus, a non-reformist would seek a reform that *furthers* the end goal of abolition and justice—such as defunding law enforcement—as opposed to a "solution"

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201. *See generally* André Gorz, Strategy for Labor: A Radical Proposal (Martin A. Nicolaus & Victoria Ortiz trans., Beacon Press 1967).

202. Amna A. Akbar, *Demands for A Democratic Political Economy*, 134 Harv. L. Rev. F. 90, 97–98 (2020).

203. *See* Gorz, *supra* note 201, at 7.

204. *Id.* at 7–8 (emphasis added).

205. *Id.* at 6.

206. Marina Bell, *Abolition: A New Paradigm for Reform*, 46 L. & Soc. Inquiry 32, 33 (2021).

such as body-worn cameras or training, all of which require further funding of the system and validate the system's existence.[207]

Rachel Brewster helpfully provides another framework that maps onto the reformist versus non-reformist concept. She characterizes reforms as either "stepping stones" (non-reformist) or "stumbling blocks" (reformist) toward an end goal because "measures that are positive in a static sense can be self-defeating in a dynamic sense."[208] In applying the characterization to climate policy, Brewster posits, "[i]ncremental actions can prove to be a stepping stone, easing the way to climbing higher, or a stumbling block, a barrier that makes advancement more difficult."[209] From a political theory standpoint, "[p]olicymakers are constantly faced with the dilemma of whether to spend political capital on an ambitious proposal or to settle for a partial measure with the hope that it eventually will create greater support for the more ambitious plan."[210] However–as I have argued when discussing state governments' hostility to health justice,[211] and will argue in this Section–there are certainly indications that policymakers do *not* in fact hope incremental reforms eventually will create greater support for the more ambitious plan. Regardless of that quibble over motivation, applying Brewster's stepping stones versus stumbling blocks analysis is a necessary step in evaluating reforms under a health justice framework because U.S. healthcare policy has been, for the past several decades, defined by stumbling blocks. In the debate over whether the federal government's role in single-payer is to take up the mantle itself or to outsource single-payer to states, the federal government must consider that spending political capital enabling state single-payer may serve as a massive stumbling block to the implementation of a national program.

An infamous feature of the political economy in U.S. healthcare is what Paul Starr calls the "policy trap"—the phenomenon that healthcare reforms create an "increasingly costly and complicated system that has satisfied enough of the public and so enriched the health care industry as to make change extraordinarily difficult."[212] In other words, rather than transforming healthcare, public policy further entrenches the perceived necessity of the existing ineffective U.S. healthcare financing system; the reforms are stumbling blocks because "[o]ur health

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207. *See, e.g.*, Jacob Silverman, *Police Are Quietly Collecting Dystopian Gadgets That Put More Lives in Danger*, NEW REPUBLIC (July 27, 2021), https://newrepublic.com/article/163064/tasers-body-cams-ai-police ("But rather than increasing personal liberty or reducing police violence, police tech is—perhaps predictably—granting more power and authority to law enforcement agencies. Instead of enabling police to protect people and solve crime, police tech is encouraging the profession's authoritarian tendencies and opening new opportunities for manipulation and abuse. Whatever hopes some law enforcement reformers might put in the democratizing powers of new technologies, recent reporting suggests that they have a long way to go.").

208. Rachel Brewster, *Stepping Stone or Stumbling Block: Incrementalism and National Climate Change Legislation*, 28 YALE L. & POL'Y REV. 245, 246, 282 (2010).

209. *Id.* at 246.

210. *Id.*

211. *See supra* Section IV.

212. PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 2 (2011).

care system is engineered, deliberately or not, to resist change."[213] The portrayal of healthcare—a topic that certainly affects every American's life in deeply personal ways—as a complicated issue to be analyzed and defined by economists and other experts, rather than the public at large, is an example of this. Certainly, balking at systemic reforms because they are "complicated"[214]—as though the current system is not—reinforces the tendency toward stumbling blocks and reformist reforms. Both supporters and opponents of certain healthcare reforms always caution that policymakers must tread lightly on healthcare reform primarily because it would make fundamental changes to about one-sixth of the economy.[215] This purely fiscal argument, Gorz would say, "base[s] its validity and its right to exist on capitalist needs, criteria, and rationales" rather than on the urgent need to provide relief for the millions of Americans who are sickened, forgotten, and bankrupted by U.S. healthcare.[216]

When Congress reforms the healthcare system, it often does just enough to placate[217] large and influential voting or lobbying blocs,[218] to make beneficiaries of some public programs suspicious of more reform, and to make the healthcare system seem so monumentally complicated as to be incapable of large structural shifts.[219] It creates not only buy-in for the status quo, but also—more perniciously

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213. David Leonhardt, *Challenge to Health Bill: Selling Reform*, N.Y. TIMES (July 21, 2009), nytimes.com/2009/07/22/business/economy/22leonhardt.html.

214. *See, e.g.*, Maureen Groppe, *'Medicare for All' System Could Be Complicated, Potentially Disruptive, Say Budget Analysts*, USA TODAY (May 1, 2019), usatoday.com/story/news/politics/2019/05/01/medicare-all-cbo-single-payer-disruptive/3643297002. This news article presents just one example of the presentation of single-payer as "complicated" without reference to the objectively higher complicatedness of the current patchwork U.S. health care system. *Id.*

215. *See, e.g.*, *Editorial: GOP's Secret Trumpcare Bill Will Impact a Sixth of the U.S. Economy. What Could Possibly Go Wrong?*, L.A. TIMES (June 21, 2017), latimes.com/opinion/editorials/la-ed-senate-secret-healthcare-bill-20170621-story.html. Notably, this particular editorial, in which the *L.A. Times* ostensibly opposed a plan that would roll back the ACA's coverage gains, also criticized the Republican plan at issue because "dozens of groups representing doctors, hospitals and other healthcare professionals say their input has been ignored." *Id.* In this conversation, the actual healthcare needs of patients are left out of the conversation about who should influence health policy. Even those who ostensibly support increasing coverage or access to healthcare often portray healthcare as a complicated, technocratic puzzle exclusively in the domain of experts.

216. GORZ, *supra* note 201, at 7.

217. I use "placate" in the general sense of the word to mean "pacify," "mollify," etc. But "placation"—a way of diluting citizen participation—is also a term of art in political theory. Most notably, Sherry Arnstein's "ladder of citizen participation" placed placation in the category of "tokenism" rather than actual "citizen power." Sherry R. Arnstein, *A Ladder of Citizen Participation*, 35 J. AM. PLAN. ASS'N 216, 217 (1969). "Placation, is simply a higher level tokenism because the ground rules allow have-nots to advise, but retain for the powerholders the continued right to decide." *Id.*

218. Evan D. Anderson et al., *Intensive Care for Pain as an Overdose Prevention Tool: Legal Considerations and Policy Imperatives*, 5 U. PA. J. L. & PUB. AFFS. 63, 133 n.301 (2019) ("[M]any older Americans like Medicare enough and many affluent Americans like their employer-based insurance plans enough to not want to support healthcare reform that would probably, but not definitely, improve the status quo.") (citing PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 122–23 (2011)).

219. *See generally* PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM (2011).

—uses the veil of complicatedness to suggest that reforms and demands can be made only piecemeal and conceived only from above, by technocrats and experts. And the deeper the U.S. falls into the "policy trap," the easier it is to present large-scale reforms like national single-payer as untenable. Essentially, the policy trap is paved with stumbling blocks. Every reform, rather than being transformative, further entrenches a status quo that actually makes it more difficult to achieve the transformative change required to smooth the road toward health justice. Therefore, in order to understand the health justice implications of moving forward with a state-based single-payer program, one must look past its nominal value and determine whether, politically, the federal government enabling state-based single-payer will in fact make national single-payer—and ultimately health justice—more or less possible. I argue a federal policy favoring state-based single-payer is a stumbling block, rather than a stepping stone, to national single-payer and health justice in the United States.

2. Fracturing Constituencies and Stigmatizing Poor People's Programs

In Section II, I briefly discussed the way public programs create—and destroy—political constituencies and the way universal programs create large cross-demographic constituencies.[220] I now turn to a political theory analysis to discuss the implications of state-based single-payer programs for the movement toward national single-payer and, ultimately, health justice. That is, is state single-payer a stumbling block or a stepping stone to health justice? Specifically, I argue state-based single-payer programs would fracture a growing constituency in favor of a national single-payer program and chill popular momentum toward a transformative non-reformist reform.

A fundamental feature of a universal national single-payer system is a high level of patient/people bargaining power as compared to the current fragmented system. This allows the public to exert greater pressure on the payer to promote health justice and be sensitive to the health needs and concerns of the population. In addition to the due-process-related bargaining power described above that is inherent in a public healthcare system, national single-payer increases popular bargaining power in another domain. Simply put, larger numbers of patients can exert more power as to the public payer, including bargaining for increased coverage of certain services and better standards of care. This bargaining power is increased when all individuals benefit from the same program and benefit from its maintenance and improvement. Additionally, a single public payer is more directly accountable to the people than are the dozens of private insurance companies across which U.S. patients are currently distributed.

The current system has compounding bargaining power disadvantages that will only be worsened if state-based single-payer is implemented as federal policy. First, the splitting of constituencies among those who receive visible welfare

220. *See supra* Section II.

(including health programs like Medicaid) makes popular organizing around health justice demands difficult, and this is worsened by the stigma attached to those who receive means-tested public benefits.[221] Second, the current system gives rise to such entrenched and influential private and professional networks that mass organizing among exclusively those who receive means-tested benefits (that is, the poor) is unlikely to result in the massive political pressure necessary to achieve single-payer.[222] Because of this, advocates of a national single-payer system must seriously contend with the ways in which state single-payer programs, although nominally positive, can hinder progress toward transformational national reforms and undermine health justice.

Throttling popular momentum toward expansive social programs such as universal single-payer healthcare is a strategy often employed by politicians hostile to expanding social welfare, and especially those reticent to expand public programs in a way that would cause the public to begin to perceive those programs or their benefits as rights.[223] Medicaid, which covers one in five Americans, is often stigmatized as a drain on the public budget because it covers the poor and is associated with traditional "welfare."[224] And even among those one in five Americans who receive Medicaid, there is no single Medicaid constituency because Medicaid comprises at least a dozen separate programs with different constituencies interested in their maintenance.[225]

Splitting up constituencies is a long-standing practice in politics, and it chills popular momentum toward expansive social programs. At its most basic electoral level, splitting constituencies is popular among politicians during the political

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221. *See* Sanford F. Schram, *The Battle for Welfare Rights: Politics and Poverty in Modern America*, 82 SOC. SERVS. REV. 345, 347 (2008) (book review) (noting, regarding the 1960s welfare rights efforts of the National Welfare Rights Organization (NWRO), that the "potential for success was limited by (and that the current fight for welfare rights must struggle within) the constraining parameters set by profound class, race, and gender biased").

222. *See* STARR, *supra* note 1, at 4.

223. *See* Karen M. Tani, *Welfare and Rights Before the Movement: Rights as a Language of the State*, 122 YALE L.J. 314, 381 (2012) ("The second question is about the political motivations of those who are most alarmed by assertions of rights to public benefits. Critics have long alleged that when benefits come with rights, or are packaged as rights, policymakers lose flexibility, taxpayers suffer, and the poor lose incentive to work. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act 'ended welfare as we know it' in large part by eliminating rights claims. It did this first by placing time limits on benefits, and second, by authorizing states to condition benefits on any number of behavioral requirements. Under the terms of the new law, welfare payments were an incentive, not a right; their termination was an unobjectionable form of discipline, not a rights violation. These changes generated broad support, and the law continues to receive praise, despite mounting evidence that it has failed to achieve many of its stated goals.").

224. Arik Levinson & Sjamsu Rahardja, *Medicaid Stigma* (Geo. Univ. Dep't Econ., Working Paper), at 2, https://faculty.georgetown.edu/aml6/pdfs&zips/stigma.pdf; *see generally* AM. HOSP. ASS'N, *Medicaid*, https://www.aha.org/medicaid#:~:text=The%20Medicaid%20program%20currently%20provides,adults%2C%20seniors%20and%20disabled%20individuals (last visited Apr. 7, 2022) (noting that Medicaid covers one in five Americans).

225. *See generally How to Qualify for DC Medicaid*, DEP'T OF HEALTHCARE FIN., https://dhcf.dc.gov/service/how-qualify-dc-medicaid (last visited Apr. 7, 2022) (outlining the different rules applicable to the more than a dozen distinct groups afforded Medicaid).

apportionment process and is "used to disenfranchise voters."[226] In voting rights law, scholars and courts have described the common tactics of "packing," "stacking," and "cracking" among those hostile to minority representation in government.[227] When trying to lessen the impact of the minority vote or of a particular political party, state legislatures have "packed" minority voters into districts "where their majority would be overwhelming" but limited to that district.[228] They have also "split"[229] or "cracked" voters by "fragmenting populations of . . . voters among other districts where their voting strength would be reduced"[230] in order to avoid the voting bloc from achieving a majority in any district. But slicing up constituencies to reduce their power is accomplished in other sophisticated ways beyond purely electoral gerrymandering.

Politicians who oppose the expansion of public programs have long relied on demonizing those programs, reducing their numbers of vocal advocates to few outside the constituency that benefits from them directly.[231] Splitting constituencies in the welfare policy arena is accomplished by individualizing social ills and "otherizing" those who benefit from public welfare programs for the poor, including healthcare programs. In public programs for the poor, this stigma is a fundamental and enduring feature,[232] and it staves off popular momentum toward perceiving certain forms of welfare as rights, and therefore avoids the building of popular momentum to support universal programs like single-payer healthcare. Christopher Howard describes the American welfare state as "two-tiered," with the "lower tier" consisting of "means-tested programs like AFDC [now TANF] and Food Stamps" and the higher tier consisting largely of tax-related benefits.[233] Otherizing those in the lower tier is accomplished by multiple means. The way in which public welfare programs for the poor are administered is a stark contrast

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226. *Id.*

227. *See* Laughlin McDonald, *Stacking, Cracking and Packing*, ACLU, https://www.aclu.org/video/stacking-cracking-and-packing (last visited Apr. 7, 2022).

228. Davis v. Bandemer, 478 U.S. 109, 180 (1986) *abrogated by* Rucho v. Common Cause, 139 S. Ct. 2484 (2019).

229. Gill v. Whitford, 138 S. Ct. 1916, 1927 (2018).

230. Davis, 478 U.S. at 180.

231. I do not seek to overstate this point. Medicaid is largely a popular program even among those who do not themselves receive Medicaid benefits, however, there is a difference between ideologically or hypothetically supporting a program designed for the poor and having a vested material interest in its maintenance. *See Data Note: 5 Charts About Public Opinion on Medicaid*, KAISER FAM. FOUND. (Feb. 28, 2020), https://www.kff.org/medicaid/poll-finding/data-note-5-charts-about-public-opinion-on-medicaid/.

232. *See, e.g.*, Griffin Schoenbaum, *Predetermined? The Prospect of Social Determinant-Based Section 1115 Waivers After* Stewart v. Azar, 124 DICK. L. REV. 533, 539 (2020) ("The Elizabethan Poor Laws emerged in England between 1597 and 1601. Making a moral distinction "between the 'deserving' and the 'undeserving' poor," they obligated local churches to assist the vulnerable and punished the "paupers who were capable of working." The Elizabethan Poor Laws greatly influenced the American colonies. Each colony enacted laws that were nearly identical—both in their welfare aims and moral overtones. And even as welfare assistance evolved throughout early American history, it retained the stigma it inherited.").

233. Christopher Howard, *The Hidden Side of the American Welfare State*, 108 POL. SCI. Q. 403, 418 (1993).

from the "hidden welfare state" that benefits largely middle-class and rich people.[234]

By framing the welfare state for the poor as the true "welfare" and burying the welfare state for the rich in the tax code, politicians ensure programs for the poor are always subject to stigma and are threatened by austerity while welfare for the rich sits quietly in the background. "Like means-tested programs, tax expenditures are financed out of general revenues rather than contributory payroll taxes. Yet most tax expenditures are structured as open-ended entitlements; their receipt does not depend on the judgment of caseworkers and does not entail social stigma."[235] Perhaps the starkest example of the hidden welfare state is the mortgage interest tax deduction, a welfare program administered through the tax code, which cost the federal government $71 billion in 2015.[236] The same year, federal expenditures on the Housing Choice Voucher Program ("Section 8"), a form of direct assistance, were less than half that: approximately $30 billion.[237] But when "welfare reform" is on the national agenda, it is not the mortgage interest tax deduction that sits on the chopping block.

The splitting apart of programs intended to enrich people's livelihoods into the two-tiered welfare state helps to ensure the constituency that supports maintenance and expansion of the "lower tier" benefits is small, politically disenfranchised, and divided from the rest of the population. It ensures further stigmatization and separation of the poor from the civic concept of the population as a whole. Right now, the splitting of constituencies is accomplished by the very nature of the fragmented and highly individualized U.S. healthcare system.

Activists and organizers are well-aware of this strategy to split constituencies, and it complicates their fight for health justice. Insulin-pricing activists are one of the largest and most visible health justice advocacy groups in the United States. In early 2021, as a drug-pricing bill was batted around in Congress, those organizing for free or low-cost insulin worried that their visibility and the impact or their organizing would result not in broad-based drug-pricing reform, but rather in chilling momentum toward broader drug-pricing reform by placating insulin advocates as a specific group.[238] Their fears are well-placed. After the insulin-pricing movement received significant media coverage in the late 2010s,

234. Milan Markovic, *Lawyers and the Secret Welfare State*, 84 FORDHAM L. REV. 1845, 1846 (2016).

235. Howard, *supra* note 233, at 418.

236. Derek Thompson, *The Shame of the Mortgage-Interest Deduction*, ATLANTIC (May 14, 2017), https://www.theatlantic.com/business/archive/2017/05/shame-mortgage-interest-deduction/526635/; Kathy Orton, *Federal Government Spends More Subsidizing Homeowners than it does Helping People Avoid Homelessness*, WASH. POST (Oct. 11, 2017), https://www.washingtonpost.com/news/where-we-live/wp/2017/10/11/the-federal-government-spends-more-than-twice-as-much-subsidizing-homeowners-as-it-does-helping-people-avoid-homelessness/.

237. *See* Orton, *supra* note 236.

238. Death Panel, *Surrogate Endnotes (06/10/21)*, (June 10, 2021) (downloaded using Apple Podcasts).

particularly in the time leading up to the 2020 U.S. Presidential election,[239] a number of insulin-specific price reduction bills were introduced in Congress.[240] The bargaining power problem with these gradual actions is that placating specific groups, often the largest and most well-organized groups, creates further splitting of the constituency that might otherwise organize *together* for broader drug-pricing reform. Placating a constituency allows politicians to "return the genie of citizen power to the bottle from which it . . . escaped."[241]

But, although splitting up constituencies is largely seen as an *intentional* strategy among politicians reticent to expand social programs, state-based single-payer gives rise to the same issues, however good its intentions are. Again, this is key to applying the stepping stones and stumbling blocks framework, in which nominally positive reforms must be subject to further analysis of whether they will actually contribute to achieving the end goal, which, here, is health justice. State-based single-payer not only dilutes the bargaining power of the federal payers, which cover the vast majority of poor, low-income, and older adult patients, it also chills popular momentum toward a national single-payer system by placating single-payer advocates in the states, chilling the possibilities of mass organizing for a national program.

3. The Task Ahead of National Single-Payer's Proponents

Healthcare in the United States has become something far more than medicine. If politics is the process of power struggles over public resource allocation, there is nothing more emblematic of U.S. politics than its health financing system. Those who seek universal healthcare in the United States face powerful entities in opposition: state governments, physicians, and care profiteers, like medical device manufacturers and pharmaceutical companies. To counteract these entrenched influences, popular organizing for national single-payer is paramount, especially given the unlikelihood that the mere adoption of single-payer in some states will cause the reform to catch on in other states.[242] It is clear that a strong popular movement is necessary to push single-payer over the finish line in the United States. Power in the United States has coalesced around the highly financialized, profit-motivated health system and subordinated the care needs of the public to private interests for decades. Beyond state governments that restrict healthcare, especially for the poor, a host of interest groups that influence states and the federal government are hostile to universal healthcare, and advocates of single-payer healthcare must organize against them. Chief among those interest

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239. *See* Bram Sable-Smith, *'We're Fighting For Our Lives': Patients Protest Sky-High Insulin Prices*, NPR (Dec. 10, 2018), https://www.npr.org/sections/health-shots/2018/11/28/671659349/we-re-fighting-for-our-lives-patients-protest-sky-high-insulin-prices.

240. *See* Affordable Insulin for the COVID–19 Emergency Act, H.R. 2179, 117th Cong. (2021); Insulin Price Reduction Act, H.R. 4906, 116th Cong. (2019); Insulin Price Reduction Act, S. 2199, 116th Cong. (2019); Affordable Insulin for All Act, H.R. 5749, 116th Cong. (2020).

241. Sherry Arnstein, *A Ladder of Citizen Participation*, 35 J. AM. PLAN. ASS'N 216, 220 (1969).

242. *See supra* Section IV.

groups are physician lobbyists and health insurance industry actors, who have outsized influence in government that can curtail the influence of mass popular movements. For example, "[p]rivate physicians have sought to keep government from competing with them, regulating their practice, or, worst of all, incorporating medical care into the state as a public service like education" and "[t]heir struggle to limit the boundaries of public health, to confine public medical services to the poor, and to prevent the passage of compulsory health insurance all exemplify these concerns."[243]

One of the country's largest lobbying groups, the American Medical Association (AMA), a lobbying group for physicians, is emblematic of the monied influence brought to bear against public healthcare programs in the United States. "Hardly anywhere have doctors been as successful as American physicians in resisting national insurance and maintaining a predominantly private and voluntary financing system."[244] The AMA, with its veneer of expertise in matters of life and death, has been tremendously influential in U.S. healthcare politics. Researchers have found the influence of the AMA in Congress is greater even than that of the labor giant AFL-CIO[245] and "[t]he lavish generosity of the American Medical Association (AMA) toward candidates for Congress has given it a reputation as a purchaser of political influence."[246] This has become increasingly true as the AMA's political influence and lobbying budget continues to grow while it represents a smaller and smaller portion of physicians than ever.[247] The AMA spent $20,417,000 on lobbying in 2018.[248] It is one of the most influential lobbying organizations in the United States and has influenced the development of "professional sovereignty" over the politics of care in addition to medicine itself.[249] "The dominance of the medical profession . . . goes considerably beyond [its] rational foundation. Its authority spills over its clinical boundaries into arenas of moral and political action for which medical judgment is only partially relevant and often incompletely equipped. Moreover, the profession has been able to turn its authority into social privilege, economic power, and political influence."[250] The medical profession, rather than the population as a whole, "receives a radically disproportionate share" of "rewards from medicine."[251] The

243. STARR, *supra* note 1, at 28.

244. *Id.* at 6.

245. *See* K. Robert Keiser & Woodrow Jones, Jr., *Do the American Medical Association's Campaign Contributions Influence Health Care Legislation?*, 24 MED. CARE 761, 764 (1986).

246. *Id.* at 761.

247. *See, e.g.*, Roger Collier, *American Medical Association Membership Woes Continue*, 183 CANADIAN MED. ASS'N J., E713, E713 (2011) ("[S]omewhere in the neighbourhood of 15% of practising US doctors now belong to the AMA.").

248. Joe Perticone, *The 20 Companies and Groups that Spend the Most Money to Influence Lawmakers*, INSIDER (Mar. 11, 2019), https://www.businessinsider.com/lobbying-groups-spent-most-money-washington-dc-2018-2019-3.

249. STARR, *supra* note 1, at 7.

250. *Id.* at 5.

251. *Id.*

AMA exerts an incredible amount of influence on healthcare policy, particularly at the federal level, and it has long opposed single-payer healthcare in particular.

In the early 1930s, the AMA strongly opposed the inclusion of publicly funded healthcare programs in Franklin Roosevelt's proposals for early Social Security reforms. Former labor activist and Secretary of Labor Frances Perkins noted that the inclusion of public healthcare programs was so strongly opposed by the AMA that they "would have killed the whole Social Security Act if it had been pressed at that time."[252] Even before proposals for robust public healthcare programs gained steam, the AMA "[denounced] modest proposals for group medicine and voluntary insurance . . . as 'socialized medicine.'"[253] As an indication of how the AMA exerts its professional sovereignty beyond the millions of dollars it spends to the detriment of healthcare reform is the AMA's Truman-era tactic of "lobbying of legislators by their own personal physicians."[254]

The ability of the AMA to exert such a profession-tinged influence over healthcare policy is one of many examples of the task ahead of national single-payer advocates seeking to out-leverage moneyed interests. Because single-payer advocates are unlikely to outspend groups like the AMA, the path to single-payer can only be created by a mass politics that out-organizes such groups and makes forceful demands.

In addition to the AMA, power in the healthcare arena has inhered "toward complexes of medical schools and hospitals, financing and regulatory agencies, health insurance companies, prepaid health plans, and health care chains, conglomerates, holding companies, and other corporations."[255] Because of the power of these entrenched interests, patients and the larger public are at a significant bargaining disadvantage when it comes to healthcare policy. Splitting the growing constituency for national single-payer healthcare could have disastrous consequences for the movement.

I began by characterizing national single-payer healthcare as a stepping stone to health justice in the United States. However, *state* single-payer programs—enabled by the federal government—would be a stumbling block to health justice not only because of the payer bargaining power and economic issues attendant to state single-payer but also because of the *public* bargaining power problem described in this Section. Mass public bargaining power is not necessary just to pass single-payer in the first place; single-payer's very maintenance and ability to drive health justice depends on the continued capacity of the public to pressure the healthcare payer to promote health justice goals. Severing single-payer constituencies from one another—which will no doubt occur if single-payer

252. Jaap Kooijman, *Soon or Later On: Franklin D. Roosevelt and National Health Insurance*, *1933-1945*, 29 PRESIDENTIAL STUD. Q. 336, 336 (1999).

253. Beatrix Hoffman, *Health Care Reform and Social Movements in the United States,* 93 AM. J. OF PUB. HEALTH 75, 76 (2003), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447696/pdf/0930075.pdf.

254. *Id*. at 77.

255. STARR, *supra* note 1, at 8.

movements shift their efforts to individual states—has a chilling effect on mass organizing toward both goals.

If the federal government grants states permission to implement their own single-payer programs, it will fracture a growing constituency in favor of national single-payer and abdicate an important federal role in curbing health disparities fed by state government policies. In states with the most organized single-payer advocates, applying that organization to pass a state single-payer bill would placate some of single-payer's most vocal constituencies. This fracturing could make it difficult to revive national popular momentum toward a national program in the face of adoption of state single-payer. In effect, single payer advocates would be splitting their own constituency. As discussed above, popular momentum, rather than the momentum of successful state-based "innovation" in single-payer healthcare, is far more likely to bring about a national single-payer program. Because of this, fracturing the constituency for a national single-payer program would make national single-payer less likely than it is now.

VI. Conclusion

However well-meaning proponents of state-specific single-payer may be, the historical and legal realities of the laboratories of democracy theory in healthcare illustrate the falsity of their underlying assumption: that state governments will act in the best interests of their residents to implement single-payer once its merits are proven by other trailblazing states. Rather than being a neutral or positive stepping stone toward national single-payer and health justice, implementing state-specific single-payer is a stumbling block that will weaken the power of existing federal payers, proving harmful to patients in states that do not adopt their own single-payer programs. Furthermore, state-specific single-payer will chill popular momentum toward a national single-payer program, undermining the health justice goals of a national program and contributing to the further fragmentation of the U.S. healthcare system. Because of these concerns, the federal government would be abdicating an important national policy role by expending political capital to enable state single-payer rather than to implement a national single-payer program.