Opinion

Case Studies in Medicare for All

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GEORGE SANTAYANA'S FAMOUS QUOTE—"THOSE WHO CANNOT remember the past are condemned to repeat it"—comes to mind when considering prospects for a "Medicare for All" or single-payer health system revolution. There is history here demanding attention that goes beyond President Harry Truman's ill-fated effort in the late 1940s. Since 1994, four states have taken a cold, hard, and serious look at single payer and backed off, three via voter ballot initiatives and one by legislation. Collectively, they offer a compelling "starter's package" of case studies on Medicare for All. Let's take a closer look at each and then consider the patterns.

California Here We Don't Come, 1994. Voters rejected Proposition 186—the California Health Security Act—by 73% to 27%. The initiative appeared on the November 1994 ballot only two months after the final and ignominious death of Bill and Hillary Clinton's health reform plan. Throughout 1993-1994, single-payer advocates preached that Democrats were squandering a historic opportunity by advancing the Clinton's complicated and indecipherable proposal instead of moving single-payer legislation. The California initiative would have been financed by new taxes on employers, individuals, and tobacco products. A diverse group of "good guy" proponents had enough organizational heft to collect more than one million signatures statewide to qualify for the ballot.

A 1995 Kaiser Family Foundation postmortem concluded that the defeat was "largely the result of voters' attitudes against 'big government' and higher taxes—attitudes effectively tapped by the opponents" who "waged a well-financed, sophisticated media campaign that the proponents could not counter." Leading opponents included insurance companies, business organizations, and hospitals who outspent proponents by \$9 million to \$2.7 million. Polling in May 1994 showed California voters were divided evenly (42% apiece) on the question until the opposition campaign began at full strength and never stopped.¹

Oregon Trail Travails, 2002. Voters rejected Measure 23—the Health-care Finance Plan Amendment—by 78.5% to 21.5%. Like California’s proposition, Oregon’s single-payer initiative came at a seemingly auspicious time when public sentiment against aggressive management practices by insurance companies and health maintenance organizations (HMOs) was still red hot. The constitutional amendment would have been funded by progressive income taxes on individuals of up to 8% and by payroll taxes on employers from 3% to 11.5%. A public nonprofit called the “Oregon Health Care Finance Board” would have managed the new system.²

Opponents included insurers, businesses, the state AFL-CIO, hospitals, and nurses, who outspent proponents by an estimated \$1.2 million to \$95,000—most of the latter being spent on signature gathering. State Representative Mitch Greenlick of Portland, whose first legislative term coincided with the ballot measure, learned from the failure that “you need to do health reform incrementally, not all at once.”

Colorado Rockies, 2016. Voters rejected Amendment 26—Colorado Care—by 78.8% to 21.3%. Once again, an auspiciously timed initiative—after six years of civil war over the Affordable Care Act/Obamacare—failed to ignite the public. The system was to have been funded by a new 10% payroll tax split between employers and workers and by a new 10% tax on all nonpayroll income. Supporters were out-funded by opponents \$4.1 million to \$917,715. Most opposition funding came from the health care industry, including \$1 million from the insurance giant Anthem.

Many state Democratic officials, including then-Governor John Hickenlooper and US Senator Michael Bennet, opposed the initiative, as did the state’s leading prochoice organizations because the measure could have banned payments for elective abortions.³ “The proposal came too soon and too fast for where voters were,” Joel Dyar, who worked as state field director for the ColoradoCare Yes campaign, told *Vox*.⁴

Vermont’s Green Mountain Blues, 2014. No vote tally exists to assess Vermont state government’s pursuit of a path to single payer between 2010 and 2014, not from voters nor from the state legislature. Then-Democratic Governor Peter Shumlin, after winning election in 2010 on a platform to achieve single payer legislatively, threw in the towel on December 17, 2014 after concluding that the political risks were too high. The steepest risks included a new individual income tax of up to 9.5% for families and new payroll taxes of 11.5% on employers.

Three credible studies done in 2011, 2013, and 2014 provided increasingly more pessimistic outlooks for expected costs, savings, and revenues. Shumlin's reelection margin of 46% in November 2014 offered far less than the clarion call of confidence needed to advance such a dramatic proposition. In the process, the state offered a real-world cautionary story of rising risks and diminishing political prospects.⁵ The final result was less concrete than the three initiative failures, though no less dramatic.

Patterns. Though an "n" of four offers no statistical significance, it is more telling than an "n" of zero. What can we learn from these four case examples?

First, each effort stumbled fatally when the public conversation turned to financing. Though aggregate savings were legitimately estimated in each state, most voters understood single-payer proposals through their own personal and family contexts and saw risks deeply influenced by abundant opposition advertising.

Second, in each ballot battle, proponents were outspent overwhelmingly by opposition forces. The vested interests from insurance to business to pharma to hospitals to physicians always had abundantly more to invest than advocates.

Third, from start to finish in each case, favorability numbers started at a promising point and went in one direction: south. Seemingly secondary issues such as abortion coverage, actuarial value, and covered medical benefits threw proponents off balance.

Finally, as behavioral economics teaches us, ordinary voters valued hypothetical losses far more than hypothetical gains, and more reliably organized for defense rather than offense. They were more likely to believe the alarms of opponents than the promises of proponents.

The challenges in pursuit of single payer are acute, doubly so if ignored. What steps are being taken by the new generation of Medicare for All/single-payer proponents to avoid a repeat of this now familiar story?

During the 2008-2010 process of construction and passage of the Affordable Care Act, in which I participated as a Senate staffer, Democratic senators, representatives, and their staffs engaged in constant retrospective conversation regarding lessons from US health policy history as they applied to that era's challenge. The process began with a retreat in April 2008 in St. Paul, Minnesota, where Democratic and Republican staff,

current and former, together identified key lessons from past victories and failures, and never stopped reflecting.

If Medicare for All/single-payer advocates want to win, they must learn, absorb, and act on relevant history. These four cases are a good starting point.

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