Research Article

Political Economy of Reform under US Federalism: Adopting Single-Payer Health Coverage in New York State

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Abstract—The US remains the only high-income country that lacks a universal health financing system and instead relies on a fragmented system with the largest segment of the population receiving health insurance through private, voluntary employer-sponsored health insurance plans. While not “universal” in the sense of being mandatory and tax-financed, through a series of reforms, the US has managed to provide some form of health insurance coverage to 90% of the population. Yet, the high cost of this system, the insufficient coverage afforded to many, and continued concerns about equity have led to calls for a national health insurance program that can reduce costs across the board while providing high-quality coverage for all. Given the policy gridlock at the national level, the states have often sought to achieve universal health financing on their own, but these bills have met with little success so far. Why has the ideal of states as “laboratories of democracy” failed to produce policy change towards national health insurance? This article examines the prospects for the New York Health Act, a single-payer bill that would create a universal health financing plan for all New York State residents. Applying the Political Economy of Health Financing Framework, we analyze the politics of health reform in New York State and identify strategies to overcome opposition to this policy proposal. We find that while a clear political opportunity is in place, the prospects for adoption remain low given the power of symbolic politics and institutional inertia on the reform process.

INTRODUCTION

Low- and middle-income countries around the world are embracing the drive for universal health coverage (UHC). Target 3.8 of SDG 3 is aimed at achieving UHC by 2030 through financial risk protection and improved access to quality essential health-care. Early estimates from the World Health Organization (WHO) suggest that average
coverage for UHC has increased roughly 20% from 2000 to 2015. Yet, even as many low- and middle-income countries are rapidly expanding risk pools, reducing fragmentation and realizing efficiency gains through single payment systems, the United States has the ignominious status of being the only industrialized country that has failed to provide universal financial protection and service coverage/access as a right of citizenship. While the uninsured rate in the US has shrunk from 17.8% to 10.2% since the adoption of the Affordable Care Act in 2010, the proportion of the public that is “underinsured” is estimated to be as high as 45% in 2018. Most Americans (56%) get their health insurance coverage from a private, employer-sponsored health insurance plan, with another 7% paying the full cost of health insurance on the “individual” market, which is notoriously expensive. Although the United States system most closely resembles a regulated multi-payer system, single-payer or national health insurance has frequently been the reform of choice advanced by certain advocates for universal health coverage, including the group Physicians for a National Health Program, an organization representing 15,000 American physicians.

Why has the United States continued to rely on private, employer-sponsored coverage and failed at attempts to unify its health coverage system into a universal financial protection for all? If this cannot be achieved at a federal level, can individual states do better? This paper examines the political factors that have both impinged upon and facilitated comprehensive health financing reform at a state level, by examining one case: the example of New York State. Applying the Political Economy of Health Financing Framework, we analyze how interest group politics, bureaucratic politics, budget politics, leadership politics and beneficiary politics interact to create both opportunities and obstacles to health reform. We then identify strategies that may be deployed by the health reform team to overcome these hurdles, and suggest some broader conclusions for the United States.

BACKGROUND

The present employer-sponsored health insurance coverage system in the US is largely the result of an historical accident that made employer-sponsored coverage tax exempt and a series of failed attempts at instituting universal health financing over the previous century. Whereas by 1940, no Western European country was without a government health insurance system at least for low-wage workers, in the United States, the failure to adopt national health insurance, abandoned in order to ensure the passage of Social Security as part of the New Deal in 1935, is widely viewed as a missed opportunity that has enabled the current employer-sponsored coverage to proliferate and dominate.

While the Affordable Care Act (ACA) of 2010 further filled in the gaps in coverage, the policy largely preserved the fragmented character of the health system built upon a foundation of employer-sponsored coverage provided by private health insurance companies. In spite of its rather limited scope and the fact that key foundations of the ACA have their roots in conservative reform bills and policy ideas (i.e., the HEART Act and individual mandate, and the Romney health reform in Massachusetts), almost as soon as it was passed, Republican efforts to repeal and replace the act began. However, in spite of a unified Republican government following the 2016 elections, and over eight years of posturing on the issue, Republican efforts to repeal and replace the act fell flat due to internal divisions within the party.

More recently, Bernie Sanders’ popular though ultimately unsuccessful presidential primary bid had the consequence of re-popularizing Medicare-for-All (i.e., single-payer national health insurance) as a viable health reform proposal. Following the failure of Republican repeal and replace efforts, Sanders strategically launched his Medicare-for-All bill (S.1804), which immediately received 16 Democratic co-sponsors in the 115th Congress (2017–2018). Commentators quickly noted that Democrats’ position on Medicare-for-All would become a litmus test for their democratic credentials in the midterm and presidential elections, a prediction that has largely played out in practice. Medicare-for-All, single-payer health care, a “fringe” idea that was quickly shoved off the table when the Affordable Care Act was proposed, has therefore come back as a policy idea that has made its way into the mainstream political discourse by 2019. An additional Medicare-for-All (H.R.1384) bill has also been proposed at the national level in the House of Representatives by Representative Pramila Jayapal in February 2019.

Federalism and state-based health reform in the US. Given the challenges of adopting comprehensive health reform at the national level, states have often attempted comprehensive health financing reform, especially in the shadow of failed federal efforts. In contrast with federal structures that seek to “hold together” diverse sub-national units, the federal structure in the US has been described as a “coming together” of previously independent units. Among the supposed benefits of federalism is the diversity that it permits to the different sub-national units, so that state policy may better reflect the preferences of the electorate in that state. Indeed, research on public opinion in the US has found a much closer fit between citizen opinion and state policy as compared with citizen opinion and federal policy.
States are also said to function as “laboratories of democracy,” a metaphor popularized by US Supreme Court Justice Louis Brandeis in New State Ice Co. v. Liebmann, to describe how states may experiment with novel social and economic policies “without risk to the rest of the country.”

Yet, states have been no more successful than the federal government at adopting universal health financing reforms, though not for lack of trying. Vermont, California, Colorado, and Hawaii have all tried to varying degrees at adopting a single-payer health system but so far no state has succeeded at moving towards a more comprehensive health financing reform that reduces the role of ESI. Single-payer proposals have failed to advance past committee, have stalled out in upper chambers, have been rejected in ballot initiatives, or, in the case of Vermont, were adopted but ultimately not implemented.

Research has found that failed national health reform efforts often breed state-level reform efforts in the US. After Clinton’s failed reform effort in 1992, a number of states moved to expand health insurance coverage at a state level, though none were successful at adopting a single-payer plan. This is in contrast with Canada, whose single-payer system started in Saskatchewan Province in 1947 and later expanded nationally by 1984. Other states have taken less dramatic approaches than single-payer. For instance, Massachusetts adopted a major health financing reform in 2006 that later served as a model for the ACA. Maryland adopted all-payer rate setting, a key cost control mechanism, in 1976 and has held onto it since. But these reforms still leave the US quite far from comparable OECD countries on key features of universal coverage.

However, the state as laboratory metaphor cuts both ways—while those on the left see the states as workshops where bold policy ideas can be tested and brought to the federal level, those on the right have looked at the states as means by which over-reaching federal policy can be constrained. Given the tradition of “states’ rights,” many Republican states are now using the state waiver process to enact reforms that advance a conservative take on health policy, with work requirements, premiums and copayments serving as the price for cooperation with the Medicaid expansion. Thus, while some states have used federalism to go beyond federal reform in moving towards universal financing, others have used it to try to claw back coverage, under the cloak of states’ rights, and reject federal pressure towards more redistributive and comprehensive health reform. Building on previous case studies of the politics of state health reform efforts, we examine the factors that contribute to state policy innovation in health reform. Below we describe New York State’s current bid to be the first state in the US to adopt universal health financing reform.

THE NEW YORK HEALTH ACT: A SINGLE-PAYER PLAN

The New York Health Act (A. 4738/S. 4840) would create “New York Health,” a single-payer system covering every New Yorker without deductibles, co-pays, or restricted provider networks. The most recent version of the bill passed the New York State Assembly in 2018, however, it was blocked in the Senate. The same bill has made it out of committee and passed the Assembly four other times, first in 1992, and subsequently in each of the last three Assembly sessions (2015, 2016, and 2017). The new version of the bill currently under consideration again in the Assembly as of March 2019 would go even further than previous versions by including long-term care as a benefit for all. Though the financing is not specified in the bill, an economic analysis of the bill by the Rand Corporation found that a payroll tax (to be shared 20% by employees and 80% by employers) combined with nonpayroll taxes could raise enough revenue to pay for the plan while reducing costs below the current cost of health insurance premiums.

While previously being unable to pass the Senate, the bill for a single-payer system now faces political dynamics that are different from previous sessions, because the composition of the Senate has changed. Whereas previously the bill could be reliably blocked in the Senate by a group of eight Democrats that caucus with Republicans known as the Independent Democratic Caucus (IDC), the tables have now decisively turned. Bolstered by the “Blue Wave” that brought voter turn-out to a record high in November of 2018, the IDC members were voted out of office and the Senate is decisively in the hands of Democrats, which now controls the Senate 39 to 22. The bill has support not only from the Health Committee members in the Assembly, but also from the bill’s co-sponsor and chair of the Senate Health Committee, Gustavo Rivera.

Yet, challenges to adoption still remain. Democrats are not universally supportive of the single-payer New York Health Act, with many preferring more incremental steps to achieving universal coverage including building on the ACA or introducing a public option (e.g., a Medicaid or Medicare buy-in). Governor Cuomo has argued that this issue is better left to the national stage and has not supported the bill. Opponents of the bill including the insurance industry and certain business interests have begun to mobilize creating a website named the “Realities of Single Payer,” which advances arguments that are common red herrings against single-payer. Below we elaborate on both the obstacles and opportunities for the New York Health Act applying the Political Economy of Health Reform Framework to...
identify strategies that the health reform team could undertake to address obstacles as well as likely opposition strategies.

METHODS/APPROACH

This study uses a process tracing approach to reconstruc and systemically describe key events drawing on evidence from policy documents, transcripts of public hearings, media reporting and interviews with stakeholders involved in the policy process. Open-ended interviews were conducted with a purposive sample of key stakeholders [N = 5] including policymakers, legislators, and representatives of advocacy groups that have been key leaders on the New York Health Act beginning in January 2019 to present. The interviews were conducted jointly by both authors. Detailed notes were taken at the time of interview and cleaned and compared following each interview. Information from the interviews were triangulated with other available materials with the goal of identifying the positions of key actors and stakeholders and identifying key barriers to support for policy change. In addition to interviews with stakeholders, the authors engaged in participant observation at a number of events including not only advocacy events, but also events organized by opposition groups and panels with different viewpoints represented. The authors are also engaged in a separate textual analysis of the transcripts from six public hearings held on the NY Health Act in 2014 comprised of 187 testimonies and were able to attend a recent public hearing held on the bill in Albany. These additional sources of information informed the analysis as well as news media reporting on events. The project received University of Albany IRB approval under protocol #5276.

The Political Economy of Health Financing Reform Framework draws on observations regarding the politics of health financing reform in LMICs (see Campos & Reich and Sparkes et al., this issue). The Framework identifies six categories of influences on health financing reform decision-making: Interest group politics; leadership politics; budget politics; bureaucratic politics; beneficiary politics; and external politics. The framework takes the vantage point of the health reform change team and examines common political factors faced by reform teams whose goal is to reform health financing towards universal coverage. Reform teams can be defined as the technical entities that design policies and build networks of support within government. While the Framework describes the common challenges faced in implementing health reforms, in this case the framework is applied to explain the adoption of health reform. Therefore, the perspective the analysis takes is from the point of view of a reform team largely comprised of legislators and a coalition of advocacy groups. Whereas implementation tasks are delegated to the bureaucracy, policy adoption is initiated in legislative health committees. We believe this is a reasonable extension of the framework because it is extremely unlikely that a thoroughgoing reform of health financing in the US would be initiated by the bureaucracy. Rather, change of this nature must come from the legislature. Moreover, we view our effort to apply the framework here as an initial validation of its applicability to the adoption phase of the reform cycle. Below we apply the framework to analyze the politics of health reform in New York State. In doing so, we identify both the sources of opposition and both actual and potential strategies of the reform team to overcome these sources of opposition.

RESULTS

Interest Group Politics

Interest group politics poses perhaps the most formidable challenge to the New York Health Act, particularly opposition from the private health insurance industry. The New York Health Act proposes not only to create a single-payer insurance system that would be likely to put health insurance companies out of business, but additionally the Act would bar the sale of private insurance in New York that duplicates any New York Health benefit. Providers would be barred from seeking or accepting additional payments for any New York Health service. This stipulation would further reduce the potential alternative role that insurance companies might play in the future in offering supplementary and complementary insurance plans.

The insurance industry and other opposition groups are already mobilizing and have created a website called the Realities of Single Payer that declares it provides neutral, factual information about the “realities” of the NY Health Act. However, the framing of the “facts” are far from value-neutral and instead aim at conveying single-payer as a threat that will raise costs and lead to rationing of care. One particularly damning and oft-repeated “fact” that the opposition has deployed is the statement that the total state budget will be doubled from the present $170 billion to nearly $400 billion through the need to raise nearly $200 in new tax revenue to finance the new government administered health plan (other estimates range from $139 billion projected in the RAND report to $250 billion cited by business groups). As stated on the Realities of Single Payer website: “Advocates claim it will not cost New Yorkers more to cover all individuals under the NY Health Act, but massive state tax increases would be
needed to pay for health care costs of a government-run, single payer system. The estimated new tax increases needed range from $139 billion to as much as $226 billion.\textsuperscript{32} The media also repeats this point in its reporting on the bill.

Of course, this statement is both true and misleading. The budget will increase because health care will become tax financed. But according to the projections of commissioned studies on the financing of reform, the overall costs to finance the single-payer plan will decrease as the tax revenue required to pay for health coverage for New Yorkers will be less than the current amount paid through insurance premiums, deductibles and co-pays.\textsuperscript{19,33} Whether intentionally or not, this tactic draws on the concept of loss aversion, which has been shown to be more powerful in swaying people’s attitudes and behaviors than highlighting equivalent gains.\textsuperscript{34} The idea that people may end up paying more in taxes is a frightening specter that is easy to exploit to boost opposition to the bill. Additionally, loss of choice and increased wait times are further caricatures of single-payer that are easily exploited to dampen support, even though cross-national comparisons do not bear this out.\textsuperscript{35} Thus, the strategy of the opposition is to paint the reform team as unrealistic and fiscally irresponsible.

The insurance industry has legitimate cause for concern. In 2019, there would be over 300,000 workers employed in health care administration in New York and over 26,000 employees of health insurers.\textsuperscript{27} The Friedman Report, one of the two commissioned economic reports on the New York Health Act, estimated that “as many as half of the health care administrative workers and most of the health insurance workers would be displaced by the New York Plan, resulting in as many as 150,000 newly unemployed workers.”\textsuperscript{27,29} This estimate is based on the assumption that six health-care provider employees handle insurance billing for every worker in the insurance industry. While the report goes on to note that the displacement would be balanced out by the creation of positions due to the increased demand for health care workers, the jobs created would not likely be for the same skill set as those displaced.

In addition to the insurance industry, which comprises a large portion of the website’s backers, other organizations oppose the bill, including a series of business groups, Chambers of Commerce, networks of health care providers as well as conservative think-tanks and advocacy groups such as the Empire Center and Unshackle New York.\textsuperscript{36} Although the RAND report suggests that 70% of businesses would benefit or be unaffected by the NY Health Act, the report acknowledges that small businesses that do not currently offer insurance would end up paying more since they would need to pay the payroll tax, which is not substitutable with current premiums. Small businesses are not presently exempted under the NY Health Act.

Unions are another organized interest group that is somewhat divided over single payer in New York.\textsuperscript{37} Some have openly endorsed it while others are silent or on the fence. Still others, including some New York City public sector unions, have been openly antagonistic due to concerns about the possibility of either reduced benefits or higher costs from a payroll tax where the full premiums of members are currently covered by the state.\textsuperscript{37} Union opposition to single-payer largely stems from concerns about the loss of negotiation power that might come from decoupling health care from employment. They are also concerned that the incentive of joining unions could be curtailed if members no longer had the advantage of generous health plans.\textsuperscript{37}

Though certain health provider groups have openly joined the opposition to single-payer (see Realities of Single Payer website for full list of members), it is unclear where providers as a whole stand. Straddling the union and provider category, the New York State Nurses Association is a strong supporter of the New York Health Act as are nursing associations across the country.\textsuperscript{20} While recent polls of members of the American Medical Association show a majority support for single-payer,\textsuperscript{38,39} a key concern among some providers, particularly specialists, is likely to be how reduced reimbursement rates might impact their bottom lines and incomes. The Rand Report modeled two scenarios, one in which provider payments remained relatively high due to favorable negotiations between the state and providers and one in which they were more reduced. In a scenario in which provider payments stayed the same as well as administrative costs and pharmaceutical payments, the NY Health Act would lead to a 7.2% increase in health care spending, whereas under an alternative scenario with reduced costs in these areas, health care spending would fall by 11.5% by 2022.\textsuperscript{19} According to UMASS study, New York Health would cut $71 billion from the cost of care in New York, which could be used raise payment rates for Medicaid and Medicare providers to rates comparable to commercial insurance.\textsuperscript{32} Nevertheless, some legislators have raised concern that if providers face reduced pay, they could opt to leave the state, exacerbating the possibility of a provider shortage thereby increasing wait times.

On the side of single-payer proponents is a coalition of advocacy groups including the Campaign for New
York Health, and Physicians for a National Health Plan, among others. The Campaign for New York Health is a 501c4 organization that represents a state-wide coalition dedicated to passing and implementing legislation for universal health care in New York State. It represents over 150 community and labor organizations made up of nurses, teachers, patients, doctors, union members, business leaders, faith and immigrant rights community, progressive political organizations, health care advocates and providers. In total, it lists 656 endorsers on its website. While proponents appear to be mostly a cohesive group, as in previous single-payer efforts, if single-payer were to be watered down in some way, this could become a source of division among advocates. For instance, whereas supplementary and complementary plans exist in many countries with universal health coverage, single-payer purists stress the importance of prohibiting these types of plans in the US context. There may also be disagreements over whether complementary and alternative therapies should be covered as well as over whether a system that does not integrate Medicare would truly be considered a single-payer system and whether a system with some cost sharing (i.e., co-pays or coinsurance) would be acceptable. Thus, the reform team is also constrained by the need to maintain the progressiveness of the reform.

Leadership Politics

While leadership alone is not sufficient to pass legislation, without it, a bill is unlikely to succeed. If the New York Health Act passes, it will be largely thanks to the tireless effort of a single policy-entrepreneur—Assemblymember Dick Gottfried. He has sponsored the New York Health Act in the Assembly since 1992 and has been championing single-payer for the last 27 years. As described in an article in the Nation, “he can recite the pros and counter the cons in his sleep.” Representing District 24 (Hell’s Kitchen- and Chelsea-area) Gottfried is the second longest serving Assemblymember in New York State history, having been continuously re-elected for two year terms since 1971. Assemblymember Phil Steck, also on the Assembly Health Committee, and Senator Gustavo Rivera (head of the Senate Health Committee) have also championed the bill making the case in town halls and other venues.

In spite of this strong leadership in the legislature, in policy adoption, ultimate authority does not rest with key champions. In the context of New York State, much like the national level, there are at least three veto points that could curtail legislative adoption. A veto point is a political actor who has the ability to stop a change from the status quo. While the Assembly has shown quite consistent support for the bill, it is yet to pass the Senate. Even if it passes both chambers, it must be signed by the Governor. While it is unlikely that Governor Cuomo would veto a single-payer bill if it were passed in the Assembly and the Senate given the negative valence that this would imply (voting against one’s own party), the Governor has made clear that he believes that this is an issue that should be decided at a national level. He also plays into the fear tactics of the opposition by portraying the New York Health Act as budget busting. For instance, speaking at a primary debate against progressive challenger Cynthia Nixon in 2018, Cuomo stated that “the projected cost to transition to a single-payer system would be about $200 billion, more than the current $170 billion state budget.” He questioned how that could be done on a short-term basis without doubling the tax burden.

Within the two Chambers (Assembly and Senate), it is unclear how much support single-payer might have. The Realities of Single Payer website shows the vote counts and specific Assemblymembers that have voted for the NY Health Act in the past. In 2018, there were 91 yes and 46 no votes with similar margins in previous years. In the Senate, while there are 39 Democrats to 22 Republicans, it is unclear what the level of support is among the Democrats, though in the 2017 session, the Senate was one vote shy of passing the health bill. Even within the Assembly’s health committee, there are members with doubts about the bill given concerns about their constituent’s reactions to the large tax increases required to finance the reform and whether they could effectively convey the cost savings from reduced private expenditure.

Budget Politics

Most of the opposition to single-payer centers on the budgetary aspects of the proposal. As one stakeholder pointed out at a recent single-payer event—the rights framing of single-payer has largely been successful—the public mostly now agrees that health care is a human right. Where the divisions lie is in convincing the public that a single-payer plan, which requires tax-financing and a large increase in the size of government, is the only path to achieving health care as a human right. Opponents point to the large tax increases required, i.e., “single-payer would at least triple New York State taxes,” as opposed to the evidence of cost-savings from the elimination of private health insurance premiums.
But a few other aspects of budgetary politics create both opportunities and constraints for the New York Health Act. First, there have been two independent economic analyses of the Act,\textsuperscript{19,33} which have both been used as evidence that the act can succeed at reducing costs while covering everyone, while at the same time illustrating the large tax increase that this will require. Moreover, the fact that costs might increase for certain high-income New Yorkers have been given disproportionately negative attention.\textsuperscript{48}

In fact, the Rand Report shows the financing strategy will shift what is currently a highly regressive private financing system to a steeply progressive tax financing system. For instance, the Rand Report finds that for individuals making over 1,000% of the Federal Poverty Line or FPL (approximately $150,000 a year) the proportion of compensation spent on health care payments would increase modestly from 23% to 25%. But for individuals earning more than 2,000% of FPL ($267,000 for a single individual), their contribution would increase from 24% of income to 36% of income. The share of compensation spent on health care would steeply decrease for all other income groups. In fact, the lowest income bracket (<139% FPL) would move from paying 35% of their compensation towards health care to 17%. As summarized in the Times Union: “The New York Health Act would reduce overall health care spending by 15%, or $45 billion per year, and over 98% of state house-holds would spend less on health care than they currently spend.”\textsuperscript{30}

However, the present legislation does not specify the exact financing of the plan, as, this is accomplished separately in New York State through a budget bill. While this has advantages in terms avoiding budgetary politics in the adoption of the bill, it also opens potential for the bill to be delayed and possibly stall out during implementation as occurred in Vermont.\textsuperscript{20} The current proposal requires the Governor to develop a plan that would be based on a payroll tax with an 80% employer contribution and 20% employee contribution and taxes other taxable income (e.g., interest, dividend, etc.).\textsuperscript{23} These are the assumptions that the RAND report used to derive its estimates, though specific brackets and rates would be set during an implementation period and would likely require Gubernatorial support.\textsuperscript{53}

Financing of the New York Health Act was not considered as part of the budget process that governs New York State, but presumably, if adopted, the ultimate budget would be set through this process. Given the power the Executive has over the budgeting process in New York,\textsuperscript{49} this could pose a challenge. The health budget in New York State is controlled by the health unit of the Division of the Budget (DOB). The DOB is part of the Executive Branch, acting as the fiscal advisor of the Governor, who has openly opposed single-payer at state level. New York State’s budget process is rather unique in terms of the amount of control that it gives to the Executive Branch.\textsuperscript{50}

An additional idiosyncrasy of New York’s budget also creates both opportunities and constraints for reform. New York is one of 18 states where the counties contribute to Medicaid through a funding formula that requires the state’s 62 counties to pick up 13% of the total cost of Medicaid, which is far more than counties in other states pay, if they pay anything at all.\textsuperscript{21} Referred to by former House Representative John Faso (R) as the “Medicaid mandate,” single-payer proponents, including Assemblymember Phil Steck, a member of the Assembly Health Committee, have pointed to the ways that state single-payer could lead to a reduction in local property taxes.\textsuperscript{52} This reduction in property taxes has not been factored into current projections of cost savings to tax payers, but as a state with one of the highest property taxes in the country, this is certainly a potential selling point for the NY Health Act. Given that Trump’s tax reform bill (the Tax Cuts and Jobs Act) also reduced the amount of state and local tax (SALT) deduction allowable for taxpayers of high-tax states like New York, this could be a selling point for New Yorkers living in high property-tax areas. The tax bill implemented a cap of $10,000 in deductions where previously, there was no limit.\textsuperscript{53} This hits high-income, high-property tax parts of New York (like Westchester County) particularly hard since those who stand to gain from deducting their property taxes tend to be those who have expensive homes in prosperous communities, giving further impetus to other means of reducing property taxes including single-payer.

**Beneficiary Politics**

Beneficiary communities include the general public—voters, citizens and even non-citizens. Symbolically, the purpose of universal health financing is to transform health care from a commodity purchased by consumers in a market framework to a guaranteed right of citizen-beneficiaries in a political framework. As representatives of citizens, legislators are ultimately accountable to the will of the public. Beneficiary support for single-payer is often judged through public opinion polls, which signal citizen preferences to representatives. Public opinion polls generally show majority support for single-payer (as high as 60%), especially when presented as Medicare-for-All.\textsuperscript{6} Majorities have supported for more government involvement in health care in public opinion polls for decades.\textsuperscript{54,55} However, citizen preferences are very mutable based on how information is presented and susceptible to scare tactics when presented
with cost of universal health coverage in terms of tax increases to pay for it. For instance, a single-payer referendum in Colorado ended in defeat after the ballot text began with the words (required by state law) “[s]hall state taxes be increased by $25 billion.”

Beneficiary politics is contentious because while some beneficiaries may see their benefits increase or improve, for others there is the possibility of a decrease in benefits or the possibility of exclusion (i.e., for non-citizens). This fear of loss (or loss aversion) is a central strategy that opponents of single-payer play upon. The Myths & Facts Sheet on the NY Health Act sponsored by the Realities of Single Payer website claims that “citizens in both Canada and the United Kingdom, the only two countries with true single payer systems, report long wait times for care, have higher rates of hospital mortality, and are increasingly dissatisfied with their country’s health care systems,” assertions that are not cited and are based on questionable facts, including conflating the British National Health Service with single-payer models. In fact, comparative studies drawing on research from the Commonwealth Fund’s National Health Systems Study have found no inherent tendency of single-payer systems to have longer wait times or higher dissatisfaction than the US. Though for the majority of beneficiaries, the amount they pay in payroll taxes is estimated to be less than the amount they currently pay in premiums, for some beneficiaries, they may end up paying more either because they were not paying anything before or if they fall in the highest income brackets due to the progressive tax financing proposed.

Yet there is also reason to believe that if single-payer were adopted, the public would come to support the bill and retrenchment would be unthinkable, as has been the case with Medicare and Social Security, which have been described as the “third rail” in American politics due to their untouchable status. A recent article has declared Medicaid the “new third rail” in American politics, a view evidenced by the failure of recent repeal and replacement efforts.

External Politics

While in the US context, external donors are not a major influence on policymaking, in the context of a federal system, state-led health reform runs up against the federal barriers and the politics of national health reform. There are divisions among single-payer proponents over whether state-based reform is the right avenue to pursue or if efforts are better placed on national political pressure. The case against state-led reform largely rests on the practicalities of advancing reform at a state-level. The three major barriers to state-led reform include:

1. The necessity of waivers from the federal government to change elements of Medicare and Medicaid provision.
2. The specter of ERISA (The Employee Retirement Income Security Act of 1974)\textsuperscript{a}

3. How to treat out-of-state insurance and non-residents that work in the state

If waivers are not adequately attained, the state risks losing federal dollars and must come up with more self-financing. If ERISA is enforced, companies that self-insure cannot be compelled to pay a payroll tax towards the state health plan. If private insurance claims from out-of-state plans continue to need to be processed, this undermines the administrative cost savings from the plan. In New York, the problem of non-residents that work in the state is especially acute since over 1.5 million people living in Connecticut and New Jersey are employed in New York City.\textsuperscript{59} Would non-residents be compelled to pay the payroll tax but not get the benefit of the insurance? Could they buy into the program? How will New York’s insurance be received outside the state?

Critics of state-led reform point out that these types of practical considerations constitute serious reasons to doubt the viability of state-led single-payer. Moreover, if single-payer might be passed at a national level, why bother with state-level reform? The New York Governor has said the bill is “a very exciting possibility [if it is] not incongruous to what the Federal government would do to us.”\textsuperscript{23} Given the current federal political climate, if there is no substantial change in government in the 2020 elections, the likelihood of getting waivers, and certainly of passing national Medicare-for-All, is highly improbable.

**DISCUSSION**

Applying the Political Economy of Health Financing Reform framework reveals numerous obstacles for reform, but also many opportunities and strategies that proponents might pursue in New York State. Interest group, leadership, budget, beneficiary, bureaucratic and external politics each raise pressures and challenges that must be addressed. Examining the main sources of opposition above, a recurrent theme is the contentiousness that tax financing raises for reform. For high-profile, redistributive reforms such as national health insurance, the powerful actors that stand to lose materially from financing reform (particularly private health insurance companies) have used various strategies, including “insider” and “outsider” tactics, to try to influence policy makers support for the NY Health act. “Insider” strategies include direct lobbying of legislators/bureaucrats to persuade them to do so through the provision of information, while “outsider” strategies include exerting pressure on legislators by working through civil society actors to influence the general public’s perception of the legislation.\textsuperscript{60} The development of the Realities of Single-Payer website is an example of an outsider strategy to try to discredit the policy through public persuasion.

For other groups, the existential threat posed by single-payer is not as great and support/opposition appears to stem less from material concerns and more from either misconceptions and misgivings about reform or perhaps a general fear of change and loss aversion. For instance, unions put more weight on not wanting to end up with worse health insurance for members than what they currently negotiate but fail to recognize the greater space they would gain to negotiate on salary or other demands by shifting to tax financed health coverage. Bureaucrats put greater emphasis on what this new program will mean for their workload and organization and fail to appreciate the opportunities that could come from enhanced responsibilities for the provision of health care. Providers worry about potential loss of income and autonomy even as their autonomy is already curtailed by the vicissitudes of health plan red tape and paperwork. Citizens have not been exposed to the full cost of health coverage and therefore do not see the gains to be realized through UHC.

Given the opposition from groups that do not stand to lose directly from financing reform, this discussion suggests that American political culture and a peculiar hostility towards taxation may be primarily to blame for the lack of progress towards universal health financing. America’s libertarian ethos and anti-socialist past appear to be easily exploited to denormalize single-payer options. These same symbolic strategies have been deployed throughout the history of US health reform to undermine comprehensive financing proposals, previously principally propelled by the American Medical Association in conjunction with a coalition of conservative Republicans and Southern Democrats.\textsuperscript{56}

The signature public, single-payer plans in the US—Medicare and Medicaid—are themselves a product of a compromise aimed at achieving universal health financing. The reform team responsible for enacting Medicare and Medicaid in 1965 viewed these programs as a stepping stone to national health insurance that could be expanded incrementally to additional groups (including children) and eventually the whole population.\textsuperscript{56} However, with defeat of Kiddycare in 1968 and subsequent development of concerns about the rising cost of public insurance programs, Medicare-for-All was relegated to the fringes of the Democratic Party and political left in the US.

Will this current effort (in a long number of efforts over many years) succeed in New York State? Will Medicare-for-All come to pass in the US? What are the chances? While single-payer health financing reform has largely been off the
table at the federal level since the 1970s, there are promising signs that this may be changing. First, Bernie Sanders’ unsuccessful bid for the Democratic nomination in 2016 re-popularized single-payer and made it a litmus test of subsequent Democratic candidates. As an indication of this shift, Representative John Conyers has introduced single-payer in each Congress since 2003, but it was not until 2017 that the plan gained the backing of 60% (117) of House Democrats. Under the sponsorship of Representative Pramila Jayapal, the bill has expanded and remained popular. Sanders’ Medicare-for-All bill in the Senate is backed by several 2020 Democratic presidential contenders, including Senators Kamala Harris, Elizabeth Warren, Cory Booker and Kirsten Gillibrand. The ultimate prospects for single-payer at the national level will hinge almost entirely on the outcomes of the Democratic primaries and the 2020 elections. If the wave of progressivism that has brought record numbers to the House Progressive Caucus continues to gain momentum, then single-payer may indeed be a legitimate possibility. If not, its fate remains improbable.

The prospects for New York State will likely also largely hinge on trends at the national level. If there is a clear signal towards support for progressivism, this will likely push the Democratic majority in the state Senate to support the New York Health Act or face penalty at the voting booth. On the other hand, if it looks like health reform will be passed federally, this could dampen enthusiasm for a state-based solution. Presently, single-payer is not the main focus of the state legislative agenda as the Senate moves to approve a variety of bills that had been previously stymied by the Independent Democratic Caucus. At the time of reintroduction of the NY Health Act, 81 Assembly Members (54% of Assemblymembers) and 22 Senators (35% of Senators) were listed as original cosponsors on the bill. Thus, support in the Senate even with a Democratic majority is not guaranteed. Further, the fact that single-payer is advancing at the national level could provide cover to Democrats that are less supportive of universal financing reform in New York State, reducing its likelihood of adoption.

This is one of the unique qualities of efforts to reform health financing at a sub-national level. While the “states as laboratories of democracy” metaphor is often held up as a normative ideal of federalism, states may be reluctant to try such a bold reform if it appears that the same reform is on the federal horizon. This is especially true given the challenges of implementing single-payer at a state level. This is evident in the strategy of the Governor who cites the complexities of implementing single-payer at a state-level as a reason to leave this to the federal level. None the less, it would be hard to imagine that the Governor would veto the bill if it were passed by the state Legislature, especially if by wide margins. Given the current attention to Medicare-for-All on the national stage, being the head of government for the first state in the Union to adopt and successfully finance a single-payer system could be a point to claim credit over. Governor Cuomo’s wide win margin in the recent primary against Cynthia Nixon, a single-payer proponent, could be interpreted as support for his more moderate political agenda. Thus, in spite of having a solid Democratic majority in the Assembly and the Senate, the prospects of the New York Health Act passing even in future session remain low in the present session.

Furthermore, experience dictates that the closer a bill gets to being viable, the more that the opposition ramps up its counter-messaging, which could dampen support even as it builds. Though it is difficult to estimate the exact impact or amount of effort towards lobbying at a state level, at a federal level, according to the Center for Responsive Politics, the pharmaceutical and insurance industries spent more than any other industry (including oil and gas) on lobbying. The pharmaceutical industry spent over $282 million in 2018 and the insurance industry spent more than $158 million in that year. Public support also tends to wane as the details about large changes required and the uncertainty this presents gain attention.

**Strategies to Increase Support**

The central role that Medicare-for-All is playing as a litmus test for progressivism within the field of Democratic hopefuls who will be running for the presidential primaries bodes well for compelling State Senators to be bold and forward looking in the next legislative session. To build additional support, the reform team might undertake various strategies to apply pressure to reluctant Democrats to support this bill.

One strategy used in 2014 was to hold public hearings across the state to build enthusiasm and support for the NY Health Act. A series of six public hearings were held across the state from December 2014 to January 2015 that brought out 189 speakers, most enthusiastically endorsing the plan (176 out of the 189 witnesses). The hearings served as a way to demonstrate the wide support from the public and gather public opinion on the NY Health Act before the bill (A.5062) was put on the floor vote for the first time in the 2015–2016 session. One hearing was held in Albany on May 28, 2019, and the Senate Health Committee Chairman announced that there would be a series of hearings across the state. The present strategy of the Campaign for New York Health in conjunction with local chapters of Physicians
| Dimension | Political economy factor | Potential or Actual Strategies used by reform team | Strategy Used by Opposition |
|-----------|--------------------------|-----------------------------------------------|-----------------------------|
| **Interest group politics** | “Manage outside” by managing interest groups that may resist or promote policy implementation to protect their interest. | | |
| | Insurance company opposition | Point out continued role in providing supplementary insurance plans; Point to losses from current system and the self-interest of opposition groups | Emphasize reductions in choice; government inefficiency/corruption |
| | Union opposition (due to perceived reduction in benefits) | Make benefit package as generous or more generous than the most generous union benefit package; Continue to pay full amount for unions where state pays full benefit; include new benefits like LTC | |
| | Provider opposition due to concern over reimbursement rates | Increase pay to at least Medicare rates to ensure participation; Tort reform; Provide loan forgiveness or scholarship programs for medical training; point to survey that shows a majority of AMA members support single-payer | None of these proposals are in the current bill |
| | Hospital opposition due to concern over reimbursement rates | Emphasize administrative savings from single-payer and consistency; appoint representatives to an independent board | Emphasize incremental strategies that maintain status-quo |
| | Business group opposition due to increased tax burden | Exempt small employers from payroll taxes; Use cost study (Rand) to show savings to businesses; try to gain public support of large and small businesses to assuage concerns of others | Play on fears of increased taxes, decreased bottom line |
| **Bureaucratic politics** | “Manage within and around” by managing bureaucrats working in the multiple layers of administrative organizations. | | |
| | Concern about increased responsibility for program administration without increased resources/pay | Stress the increase in resources and agency growth; contract out administrative functions | Play on fears of public administrators |
| | Little clarity on who would be responsible for what (i.e., financing/budget) | Unclear whether a financing strategy can be set by the legislation or needs to be determined by the DOH | Exploit lack of financing plan to undermine legislation down the road (as happened in VT) |
| | Concern about technical difficulties of state-level reform | Is it possible? Waivers required. Would state lose money? | Play on practical fears to steer support towards more modest reforms |

(Continued on next page)
for a National Program has been to collect personal testimonies of ordinary citizen’s experiences with the health care system for possible public use. These are largely an “outside” lobbying strategy.

Potential “inside” lobbying strategies (which to our knowledge are not presently being implemented by the reform team) might include building quiet support among key bureaucrats whose affirmation of the bill would speak to the feasibility of reform. Individual pressure could be applied to Democratic Senators who do not presently endorse the bill with efforts to run more progressive candidates in state primaries and draw attention

| Dimension          | Political economy factor                                                                 | Potential or Actual Strategies used by reform team                                                                 | Strategy Used by Opposition                                                                 |
|--------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Budget politics    | Opposition from finance authorities based on fiscal sustainability                       | Link health reform to other cost-saving policies and conduct actuarial analysis to convince of long-term fiscal impact (Commissioning of RAND study by the NY State Health Foundation). | Stress the massive tax hike required/the doubling of the state budget to scare people and that cost savings compared with status-quo are minor at best. |
| Leadership politics| Low support of Executive (Governor)—punt to federal level                                | Pass legislation and force Governor to veto; Point to strong public support as signaled in opinion polls         | Point to technical difficulties of reform at a state level; Appoint a study commission on the issue to stall a vote. |
|                    | Low support among establishment Democrats/Assembly Speaker                               | Organize public hearings across the state to drum up grassroots support and pressure reluctant legislators         | Assemble meetings/hearings among opposition                                                |
| Beneficiary politics| Uncertain support and trust in expansion of services and demand for enrolment into scheme, (ii) Concern from current beneficiaries of scheme about reduction in benefits and subsidization of poor | (i) Provide generous benefits, improve supply conditions and (ii) gradually increase benefits to align with highest level and ensure no reduction for current enrollees, (iii) Show cost savings to all but the richest top 1% of income earners (Rand study); Stress reductions in property taxes due local Medicaid financing in NY State | Show that public support wanes when details are fleshed out-like increase in taxes and doubling of state budget |
|                    | Concern about supply of health services being reduced due to increased demand leading to longer wait times | Use evidence to assuage concerns                                                                                | Play on fears of long wait times in Canada                                                 |
| External politics  | Federal health reform specter                                                             | Point to benefits at the federal level of having a state-based example for reform (states as “laboratories of democracy”) | Use the possibility of federal health reform to punt and stall                            |

TABLE 1. Political Economy Factors and Strategies
to their lack of support for the bill, a strategy that contributed to the “Blue Wave” at the national level.

The reform team may also need to compromise on key components of the bill to make it appear less radical or to gain support from certain key constituencies. Already, in discussions with certain unions, the reform team has agreed to cover the full cost of payroll taxes for unions that currently have their health care fully covered. The reform team might also employ strategies that have been proposed in other states attempting single-payer, like Vermont, where the reform team recommended tort reform for physicians, reduced payroll taxes on small employers, or related strategies like allowing supplementary coverage to placate insurance companies or modelling scenarios that might include modest co-pays and a more limited benefit package. Table 1 summarizes actual and potential strategies that either have been or may be undertaken by the reform team as well as strategies of the opposition.

CONCLUSION

New York State is at a critical juncture in terms of its ability to be the first state in the nation to adopt a single-payer universal health coverage system. Due to changes in the composition of the Senate occasioned by broader political headwinds at the federal level, New York might plausibly have enough votes to adopt the NY Health Act. However, the path to victory is far from straightforward. The reform team faces many obstacles, particularly how to counteract symbolic framings of single-payer that evokes paternalistic constraints on freedom and liberty. In this regard, the merits of single-payer may be its own worst enemy—the fact that it is a tax-financed government program can either be framed as its greatest merit, providing equitable and affordable coverage to all as a right, or as a coercive Leviathan extracting tithes while rationing care.

Notes

[a] ERISA is a federal law that sets minimum standards for voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans and is not allowed to be regulated by state law. Thus, there are questions about whether employers that self-insure could use ERISA to block the levy of payroll taxes to finance a state health insurance plan.

[b] For information on this, see: https://www.opensecrets.org/lobby/top.php?showYear=2018&indexType=i.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflict of interest was reported by the authors.

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