Secret Weapon: The "New" Medicare as a Route to Health Security

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Abstract Over the past twenty years, Medicare has been transformed from a single-payer insurer into a hybrid of complementary public and private insurance arrangements. Despite creating ongoing controversy, these changes have resulted in an ironic and largely overlooked strategic potential: Medicare's evolving hybrid form makes it the most promising vehicle for overcoming the historical obstacles to universal health insurance in the United States. To make this surprising case, we first explore the distinctive political dynamics of programs that, like today's Medicare, are hybrids of public and private arrangements. We then consider how these political dynamics might circumvent past barriers to universal health insurance. Finally, we discuss the strengths and weaknesses of alternative pathways through which Medicare could be expanded to promote health security.

The notion of Medicare as a catalyst for universal health insurance is hardly new. Many of its original proponents saw coverage of the elderly and disabled as a stepping-stone to national health insurance (Oberlander 2003a; Marmor 1973). Proposals to open the program to all Americans were put forward and debated almost as soon as the ink was dry on President Johnson's signature in 1965.[1] Yet, these early expectations were never fulfilled, and today they appear increasingly anachronistic. Universal health insurance reforms at the national level are now widely viewed as politically infeasible.[2] Furthermore, a series of controversial changes over

1. The very week that Medicare began operation, a national news weekly was asking, "Medicare for All—How Near?" (*U.S. News and World Report* 1966: 1).

2. Theda Skocpol (1996: 198), for example, writes that "the turn against government" implies that "the hope that Social Security might expand to include universal health security

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the past twenty years have altered Medicare from its original single-payer model.

The premise of this article is that these changes to Medicare, as mixed in their effects and contentious in their enactment as they have been, have actually increased the potential for expanding the program beyond its current base of eligibility. Precisely because Medicare has become a public-private hybrid, it is uniquely situated to become the vehicle for serious efforts to universalize health coverage. While the combination of public and private insurance may irritate ideological purists, it bolsters Medicare's public legitimacy. While these dualistic features have been challenging to administer in an even-handed fashion, they give the program sufficient flexibility to effectively address the needs of a diverse population and perform under the heterogeneous circumstances in which health care is delivered in the United States. Ironically, then, changes in Medicare mostly pushed by conservatives may be bringing into reach one of the oldest and most elusive goals of liberals: assuring access to affordable health insurance. Indeed, as improbable as it may seem at first, Medicare may be the *only* practical avenue for achieving health security for all Americans.

This proposition may seem surprising to those who follow Medicare's politics most closely. The expanded role of private insurance in Medicare, particularly over the past decade, has proven deeply contentious. President Clinton vetoed the first large-scale expansion of private health plans in the Balanced Budget Act of 1995. Although similar reforms in the Balanced Budget Act of 1997 (establishing Medicare Part C) proved more politically resilient, they also signaled a fundamental breakdown in the "politics of consensus" that had characterized congressional supervision of the program for three decades (Oberlander 2003a: 157). The recent expansion of private insurance under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), which revised Medicare Part C and added Medicare Part D, was controversial in Congress and drew mixed initial reactions from the public. More Americans viewed the act negatively than positively, and elders (who followed the issue most closely) viewed the MMA with the least enthusiasm (47 percent found it unfavorable and only 24 percent found it favorable; Brodie et al. 2004).[3]

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has become little more than a chimera." Colin Gordon (2003: 301) concludes his evocatively-titled book, *Dead on Arrival*, with the assertion that "each lost opportunity (1918, 1935, 1949, 1965, 1971, 1994) fragmented provision, lowered the sights of reformers, underscored the clout of health interests and made subsequent reform both more difficult and less urgent." See also Quadagno (2005).

3. As the program was implemented, assessments by beneficiaries and the general public initially grew more positive, then swung back to be disproportionately negative, replicating

The track record of private health plans enrolling Medicare beneficiaries has been decidedly uneven. Many plans dropped out of Medicare Part C over time, leading to disrupted care for elders, furor among their advocates, and repeated congressional interventions to fine-tune the contracting arrangements (King and Schlesinger 2003). Furthermore, the implementation of Medicare Part D has not been smooth. The debate over the appropriate balance of public and private coverage for prescription drugs has continued (Davis et al. 2005), and millions of beneficiaries have forgone any coverage at all because of confusion about their options and choices (Hanoch and Rice 2006).

This might seem an inauspicious starting point for the road to universal insurance coverage, but initial appearances can be deceptive. Though far from perfect, Medicare's experience with private plans is a surprisingly underrecognized success story that shows the potential of a public-private partnership within protective guidelines. This more positive interpretation has been obscured because critics fail to recognize that both public and private components of Medicare hold distinctive advantages for particular groups of beneficiaries, specific services, and different parts of the country.

Although there has been considerable turnover among private plans contracting with Medicare, the biggest problems have been largely limited to beneficiaries who have chronic health conditions or who are relatively unfamiliar with managed care arrangements. Consequently, these problems can be partially addressed by channeling more vulnerable enrollees into public insurance or expanding program eligibility beyond the elderly and disabled to younger Americans who have more experience choosing among health plans. Beneficiaries enrolled in private plans have gained much from the broader benefits and greater financial protection that are offered by some forms of private insurance. Moreover, all beneficiaries profited when coverage of pharmaceuticals by Medicare health maintenance organizations (HMOs) increased political pressure to add this benefit to the program.

Although fee-for-service (FFS) Medicare has been criticized by conservatives as antiquated, that part of the program has actually been at the forefront of innovations in payment and quality-assurance methods. Plus, the fading allure of managed care for employer-based insurance has made what was "old" seem new again — "consumer-driven" health plans

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the largely pessimistic distribution of initial impressions among both elders and working-age Americans (Kaiser Family Foundation 2006a).

bear more than a passing resemblance to Medicare's FFS program with its growing emphasis on informed consumer choice, although consumer-driven plans typically have cost-sharing requirements that are more substantial than Medicare's.

To be sure, Medicare's existing arrangements for integrating public and private insurance are less than ideal, and the appropriate boundaries between public and private will always be contested. The inevitable tensions, however, represent an opportunity as well as a challenge. They present an opportunity, because many salient complaints about Medicare could actually be resolved by incorporating younger Americans into the program. Furthermore, improving Medicare's ability to provide secure access to public and private coverage for the aged means constructing a foundation that could be used to address the most daunting shortcomings of existing coverage arrangements for working-age Americans and their families.

To develop our case, we begin by suggesting that the political impediments to the adoption of national health care reforms have changed in fundamental ways over the course of the twentieth century. Although institutional factors, interest-group politics, and uneven political mobilization remain significant impediments, we contend that an increasingly important additional barrier is the public's ambivalence, rooted in the distinctive public-private structure of health financing that has arisen in the United States, about the appropriate form of government action in the health care arena. Persisting cleavages in public attitudes encourage strategic maneuvering by political elites, a response that has dissipated momentum for all reform initiatives that have been considered since 1970.

Our contention is that, under these circumstances, the most viable avenue to national health care reform involves programs that embody a particular hybrid of public and private insurance — one that allows Americans the choice between these two sources of insurance. We know relatively little about the political dynamics of such hybrid programs. Although this is not the place to fully develop such a conceptual framework, we draw on our own past work (King and Schlesinger 2003; Hacker 2002) to propose some ways in which the politics of hybrid programs is different from that of other government initiatives.

We then extrapolate from these general distinctions to the political benefits of using Medicare as a foundation for universal health insurance. More specifically, we explore how Medicare's current hybrid form might circumvent the policy gridlock that has blocked national health insurance in general and Medicare expansion in particular. We demonstrate how Medicare's recent history as a hybrid program suggests promise for universal health insurance. Finally, we conclude by showing how Medicare

might be expanded through incremental, flexible steps that would create a stronger Medicare program *and* a stronger system of health financing for all Americans.

Gridlock, Ambivalence, and How Hybrid Forms of Health Reform Might Overcome These Obstacles

Since the early 1910s, proposals for compulsory health insurance for working-age Americans have reached the policy agenda five times. Five failures later, proponents of reform are understandably disillusioned. They have accumulated an impressive list of culprits for reform's repeated demise — from the fragmentation of political institutions to the power of organized groups to uneven mobilization of political interests to the enduring scars of racial strife and class conflict (Quadagno 2005; Gordon 2003; Maioni 1998; Skocpol 1996).

These various barriers continue to bedevil proponents of universal insurance. Yet, in our view, these reasons are insufficient to explain the continued failure to expand collective insurance, particularly in the post-Medicare era. The crucial missing link is the peculiar divergent evolution of American health insurance, with its political balance of public coverage for vulnerable groups and private coverage for working Americans. The distinctive U.S. framework of public and private coverage profoundly influences contemporary reform debates, giving rise to enduring institutions and expectations that deeply condition people's attitudes about the proper roles of the public and private sectors and the appropriate place for collective action in health financing (Hacker 2002).

Prevailing American Values as Barriers to Universal Health Insurance

Five historically rooted patterns in public opinion have played a crucial part in shaping political discourse about proposals to universalize health insurance: (1) the desire to maintain some individual responsibility alongside shared financing, (2) the skeptical assessment of the institutional arrangements through which health insurance is financed and administered, (3) the commitment to choice among health plans, (4) the persistent disagreement over the optimal mix of public and private insurance, and (5) regional disparities in favored strategies for expanding health insurance enrollment.

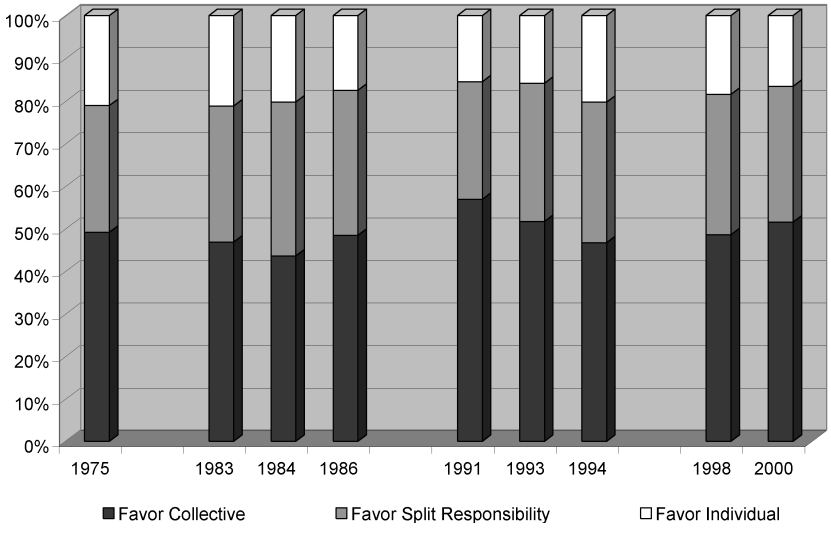

Figure 1 Americans' Preferences for Individual versus Collective Responsibility for Medical Care, 1975–2000. *Source*: General Social Survey, Selected Years

Support for Collective and Personal Responsibility

The vast majority of Americans have endorsed some government involvement in the financing of medical care since polls on this topic were first fielded in the mid-1930s (Schlesinger 2004). Yet just as consistently, about one-half of the public favors some role for individuals, and roughly 20–30 percent insists that health insurance ought to be a private matter entirely (Jacobs, Shapiro, and Schulman 1993; Shapiro and Young 1986). This means that while approximately 80 percent of the public endorses *some* collective responsibility for health care finance, support for a completely collective role rarely garners majority support and, if so, then for only brief periods of time (see figure 1). Although we have no comparable longitudinal data on elite attitudes, a survey of congressional staff in 1995 revealed an even divide between those who favored individual and collective responsibility, roughly matching the sentiments that prevailed in that year among the public (although elites were less supportive of shared responsibility than were their constituents; see the top half of table 1).

Table 1 Comparing Allocations of Responsibility and Assessments of Health Reform Options. Public versus Congressional Staff, 1995

	Ideal Allocation of Responsibility					
	Percent of general public			Percent of congressional staff		
	Mainly public	Shared	Mainly private	Mainly public	Shared	Mainly private
Allocating responsibility for paying for medical care	29.40	38.60	32.00	41.90	11.90	46.20

	Reasons for Support for Particular Types of Policies[a]			
	Percent of general public		Percent of congressional staff	
	Good for country	Favor reform	Good for country	Favor reform
Single payer	57.40	50.30	44.10	39.80
Vouchers for private insurance	51.60	38.70	31.70	51.50

Source: Schlesinger 1997

[a]Responses in some categories total to more than 100% because respondents were allowed to select multiple options

Skeptical Assessments of Key Institutional Arrangements

Even Americans who embrace public financing are often skeptical about government involvement in the content of care. Polls indicate that between one-third and one-half of the public expects the quality of care under private insurance to be better than that under government insurance (Schlesinger 2004). Concerns about the impact of government on quality were a prime factor in the public's turn against the Clinton administration's Health Security Act (HSA) in 1994 (Yankelovich 1995), in large part because opponents of the reform launched a concerted campaign to stoke the public's fears (Jacobs and Shapiro 2000).

This ambivalence toward government's role in American medicine is matched by equally conflicted assessments about employers' involvement in private insurance. Americans are generally supportive of requiring employers to offer insurance to their workers (Silow-Carroll et al. 1995), yet the public is split evenly between those who express confidence in businesses "to make our health care system better" and those who lack confidence.[4] Most Americans distrust the information that their employers provide about health insurance: 58 percent of the public report that "employers' main concern is saving the company money on health benefits" (Princeton Survey 1996).

A Desire for Choice among Plans

In health care, as in many other areas, Americans value choice. Although these preferences have been widely recognized in health policy literature, the literature often asserts incorrectly that the only important consumer choice in health care involves the choice of physicians and that the selection of an insurer has little perceived value to most consumers. The evidence suggests otherwise. During the debate over health reform in the early 1990s, 81 percent of the public reported that it was important or essential for a proposal to give "people a choice of different types of health insurance plans" (Louis Harris and Associates 1994). When asked whether "seniors should have the option of picking a private health plan approved by the Medicare program to provide their health benefits," 82

4. Forty-six percent report being very or fairly confident in business; 49 percent report being only somewhat or not at all confident (*Time Magazine*, Cable News Network, and Yankelovich Partners 1994).

Table 2 Preferences for Government versus Private Insurance for Universal Enrollment

Year of Survey	Percent Favoring Government Insurance	Percent Favoring Private Insurance
1945	54.00	36.00
1955	31.00	63.00
1970	45.00	40.00
1972	46.00	40.00
1976	43.00	44.00
1978	45.00	42.00
1984	38.00	42.00
1988	42.00	39.00
1992	52.00	28.00
1994	35.00	38.00
2000	42.00	37.00

Sources: For 1945–1955, Schiltz 1970; for 1970–2000, authors' data analyses based on the National Election Study, various years

percent of the public endorsed these choices (Zogby International 2003). Americans embrace choice of insurance not because they favor markets in health care per se but because they have so little trust in government, employers, or private insurers and want protection against problematic experiences (Blendon et al. 1998; Jacobs and Shapiro 1999).

Divided Policy Preferences

Caught between these competing concerns, Americans have long been deeply divided about their preferred approach to expanding health insurance. Although repeated surveys found that a majority endorsed "national health insurance" for most of the second half of the twentieth century (Blendon and Benson 2001), Americans, when asked explicitly, split evenly between those who favor administration of insurance benefits by the government and those who prefer subsidies for private insurers (table 2). Also evident from these survey findings is that the distribution of public support can be somewhat volatile whenever health reform is actively on the public agenda (compare attitudinal change between 1945 and 1955 or between 1992 and 1994).

A similar split is evident in data collected during the summer of 1995 from the public and congressional staff. The alternatives were presented as

a single-payer program of government insurance versus a program offering vouchers for the purchase of private insurance (see the bottom half of table 1). In this case, respondents were asked both whether they endorsed the policy and whether they thought that the policy would be "good for the United States" as a whole. The public was evenly divided — about one-half endorsed each strategy for expanding health insurance enrollment, with a small plurality favoring the single-payer approach. Congressional staffers, by contrast, were somewhat more likely to endorse the voucher model, reflecting the conservative shift in Congress following the 1994 election. In a refreshingly candid assessment, a number of the staff who endorsed vouchers admitted that this approach would not be very beneficial for the country as a whole, so a plurality of staff saw the single-payer approach as preferable in this regard. Neither approach, however, could gain even a minimal majority of support among the elite respondents.

Regional Variation in Policy Preferences

In addition to the variance in policy preferences evident over time and between the American public and political elites, there is also regional variation. Using the same measures of policy preferences reported in table 1, substantial differences in support can be seen for particular reform strategies across geographic regions. For example, the public's endorsement of a single-payer model is twice as high in the most supportive region of the country as it is in the least supportive region. This variation in policy preferences is striking because there does not appear to be a comparable variation in assessments of individual versus collective responsibility.

The Political Consequences of Value Cleavages: Interest-Group Fragmentation and Elite Maneuvering for Long-Term Strategic Advantage

Americans' persistent disagreements about the preferred allocations of responsibility, most trusted social institutions, and favored forms of health insurance pose some obvious challenges to advocates of universal coverage. But health policy, like most social policy, is not shaped in its details by public sentiment (Jacobs and Shapiro 2000; Page and Shapiro 1992). Public opinions establish broad parameters within which politicians and advocates seek viable strategies for social change. Some of the most consequential implications of the value cleavages affecting health care reform

are thus embodied in political elites' response to these divided attitudes. Two responses stand out.

The first is evident in the fragmentation of once-cohesive interest-group stances on health care reform. As is evident from the policy preferences and assessments of responsibility reported by congressional staff (table 2), elites share Americans' divided assessment of the appropriate scope of public and private responsibility for addressing health-related financial risks. In contrast to reform debates during the first half of the twentieth century, policy deliberations during the early 1970s and early 1990s were characterized by a disintegration of interests (Gordon 2003; Hacker 2002; Skocpol 1996). Physician associations and business groups that were once allied in favor of subsidies for private insurance splintered into groups embracing very different reform proposals, some endorsing government-administered insurance programs. Unions that were once cohesively behind single-payer initiatives also split, some favoring employer mandates and some maintaining their traditional reform stance. Under these circumstances, advocates of reform were placed in the hopeless position of trying to craft proposals that would appeal to particular interest groups, only to have those groups come apart as a result of their own internal disagreements.

A second consequence of value cleavages was evident in the political maneuvering that accompanied health care reform debates. To both liberal and conservative strategists, health care appeared to be a fulcrum upon which they could leverage fundamental shifts in the public's view of the appropriate role for government in American society. Certainly health care initiatives had played a similarly decisive role in shaping the evolution of the welfare state in other countries (Maioni 1998; Touhy 1999). The current balance between competing conceptions of public and private responsibility made the scales seem ready to tip in either direction. This made the ideological stakes extremely high. So high, in fact, that liberals in 1974 (Hacker 2002) and conservatives in 1994 (Johnson and Broder 1997) deliberately forestalled promising compromises that might have yielded universal health insurance, albeit at the expense of a broader ideological agenda. By playing on the public's deep-rooted suspicions of either government or employers and private insurance, both sides could rally public opposition and disrupt momentum for reform (Jacobs and Shapiro 2000).

Under these circumstances, viable reforms must seem acceptable to key interest groups that are themselves fragmented between supporters of collective and private responsibility. Viable reforms must also diffuse the

pressures that induce ideologues on both the Left and the Right to draw firm lines in the metaphorical sand that they are unwilling to cross. In our assessment, the only plausible approach that can fulfill these criteria is to craft a system that combines public and private insurance into a single hybrid program.

The Potential for Hybrid Public-Private Initiatives to Overcome Obstacles to Reform

In assessing the implications of hybrid program design, it is important to be clear about the scope of our claims. No concrete proposal nor single strategy for reform will move universal health insurance onto the political agenda. Renewed political attention, when it next emerges, will be the product of the broader political context in conjunction with the dysfunctional state of health financing. Our proposition is a simple one: once health care reform returns to the forefront of political discourse, a reform strategy based on a programmatic hybrid of public and private insurance would be the most plausible approach to enacting universal coverage in a form that could remain politically viable over time.

Predictions about the politics of programs that combine public and private insurance ought to be grounded in more general theories about the political and operational dynamics of public-private hybrids. Unfortunately, no such general treatments exist.[5] The gap in the literature is puzzling given the prevalence of programs that combine aspects of public and private administration. Some of these programs were designed as hybrids—examples include public housing programs in the United States and a number of national health insurance schemes in other countries, most notably in Denmark, Australia, and Japan (Kain 1983; Silow-Carroll et al. 1995). Other hybrids emerged over time as one form of program was "layered" on top of an older version without eliminating the original version (Hacker 2004). Perhaps the best-known example in the United States involves the recent introduction of tax-financed vouchers for religious and secular educational programs that compete with older public

5. There is modest literature that examines the politics of the *transition* between social and private provision (i.e., "privatization") in both the United States and other countries (Biglaiser and Brown 2003; Roland 2002). There is also a small body of work that considers how the politics of private welfare benefits might differ from the provision of comparable benefits under government auspices (Hacker 2002; Roland 2002; Starr 1987; Butler 1987).

school systems (Ladd 2002; Henig 1994). Still other hybrid programs are the product of administrative consolidation of programs that were originally independent of one another. In the American context, this has been a frequent attribute of federal block grants (Knapp 1987; Rosenfeld 1979).

Whatever their origins, public-private hybrids are quite common. They are also diverse; some combine public financing with private administration, others reverse the roles, and others embody even more complex combinations of roles and responsibilities. To simplify our current discussion, we propose to focus our attention on one particular form of hybrid in which the public and private components of a program draw upon a common pool of resources and have an overlapping mission: in short, the type of hybrid program in which public and private components compete with one another. We will refer to this as a "competitive hybrid." This competition could take the form of individual beneficiaries choosing between public and private coverage (as is now the case for state Medicaid programs with voluntary enrollment in managed care plans) or of policy makers making this choice for an entire defined population (e.g., Medicaid programs with mandatory managed care enrollment or state children's health insurance programs [S-CHIPs] that are administered by either entirely public or entirely private insurance) in the context of a program that makes it possible to alter these choices over time.

Our central claim is that a competitive hybrid of public and private insurance significantly enhances the prospects of enacting universal health insurance coverage. As a corollary to this claim, we further predict that such a hybrid system will prove more resilient in its performance, although we also acknowledge that a health insurance system so designed will exhibit some persisting political and administrative tensions as well.

Enhanced Prospects for Program Enactment

A competitive hybrid of public and private insurance could draw upon broad public support that would transcend value cleavages and regional differences in Americans' conception of appropriate health security. Both liberals and conservatives could find aspects of the program attractive. When the public and private components compete for beneficiaries, those who fear either an impersonal government bureaucracy or unreliable, market-driven practices can be comforted that alternatives exist. To be sure, mustering public support is not simply a matter of agglomerating elements that appeal to the supporters of public and private insurance. The components must fit together in a manner that is coherent for the public;

this is where the Clinton administration's HSA fell short, since its combination of rights-based and market-driven elements never made sense to most American voters (Schlesinger and Lau 2000).

The prospects for competitive hybrids of public and private insurance are equally enhanced by their implications for political elites. Hybrid programs offer a means of addressing the heterogeneity of powerful interest groups. If, for example, some employers insist on retaining an active role in providing health benefits while others are equally ready to abandon this role, a hybrid program can be designed to make both options feasible (although this raises some challenges for administering the program). Hybrid programs reduce the ideological stakes associated with health care reform. Rather than setting the country on an irrevocable course that massively expands or contracts government's role in American society, a competitive hybrid allows strong partisans on both sides of the political fence to envision legacies compatible with their ideological predispositions. Equally important, hybrid programs are arguably less vulnerable to fear campaigns launched by opponents of reform. The specter of "big government" or "greedy insurance executives" loses much of its bite when Americans have the option to choose between public and private coverage.

A competitive hybrid design is most likely to enhance the prospects for program enactment in eras of divided government and balanced partisanship among the electorate. This was illustrated in the creation of S-CHIP in the mid-1990s. The program's design allowed states to establish coverage either by expanding their existing Medicaid programs (a government insurance option), by subsidizing the purchase of private health insurance, or by combining the two approaches. Arguably, this design was essential for the legislation to pass in the political circumstances of the time.

A public-private hybrid may be most appealing when policy makers are uncertain about how to appropriately design or implement a new initiative. Benefits administered under private auspices take markedly different forms from those provided through the public sector (Hacker 2002; Roland 2002; Starr 1987; Butler 1987).

On one hand, private benefits tend to be more adaptable over time and less constrained by political institutions that otherwise inhibit social policy change (Stevens 1988). Privately administered benefits evidence greater variability in how individuals are judged eligible and how benefits are allocated among the eligible population (Douglas 1983).[6] Private ben-

6. This distinctive quality of private benefits can be described positively as more "personal" treatment or negatively as less-equitable administration; either way, it becomes politically embedded as a difference in the oversight criteria for judging program performance.

efits also tend to be less redistributive in financial impact and may even be regressive in their incidence (Hacker 2004; Howard 1993).

On the other hand, publicly administered programs have been more innovative on the payment side, developing new prospective payment systems for hospitals, physicians, and long-term care facilities (Mayes and Berenson 2006). This appears to reflect a public-sector advantage in developing and diffusing innovations that involve substantial economies of scale (Kleinke 2005). Either component of the program may thus demonstrate the feasibility of innovative practices, thereby generating political pressures to extend successful innovations to other components and improving the overall performance of the program (Miranda and Lerner 1995).

As a result of these predictable differences in the dynamic properties of public and private benefits, there is potential for learning between the two components of the program. This holds considerable appeal when policy makers worry about affordability of benefits, equitable allocation of resources, or effectiveness in meeting the needs of individual beneficiaries. Arguably, all three of these concerns are evident in contemporary American health policy.

Increased Program Viability

The enhanced capacity for learning across program components can also improve the performance of a hybrid program over time and thus enhance its long-term political viability. Competitive hybrids arguably have several additional advantages over programs that rely exclusively on either public or private insurance.

First, hybrid programs can more readily accommodate regional variation in population density, health needs, or health care resources. To the extent that private insurance yields the best outcomes when there is effective competition among health plans, these performance advantages will typically be limited to metropolitan areas (Kronick et al. 1993). The public insurance option introduces choice in areas in which private insurance competition would be difficult or impossible to sustain.

Second, a competitive hybrid can more effectively satisfy the preferences of a heterogeneous population. Privatized arrangements typically offer greater flexibility of practice at the cost of reduced stability and consistency. Individuals differ markedly in their willingness and ability to deal with more flexible, but less stable, health insurance arrangements (Hibbard et al. 2000; Hibbard and Weeks 1987). When some beneficiaries

(e.g., those who are most vulnerable) demand substantially more stable, consistent, and secure arrangements, the public components of a hybrid program can better satisfy these preferences. Citizens who feel most at risk of discrimination or other abuses of private discretion will be more supportive of publicly administered benefits (Thompson and Elling 2000).

Third, programs that rely exclusively on public or private administration are often politically vulnerable in eras in which there are frequent changes in party control over Congress or the presidency or frequent shifts in the balance of power between the legislature and the executive branch during periods of divided government (Goldstein 1988). By contrast, hybrid programs can retain their political legitimacy by expanding the scope of either their public or private component to reflect the shifting balance of power or shifting ideological fashions among political elites.

Portents of Ongoing Tensions

Although competitive hybrids have attributes that can enhance their effectiveness and political stability, it is important to recognize that this program design also embodies some sources of tension. Precisely because competitive hybrids allow for public and private insurance to coexist, partisans of each will constantly contest the appropriate boundaries between the two and seek to amend the program in ways that favor their preferred form of insurance.

These ongoing political tensions can reinforce some of the administrative challenges inherent in a program that combines public and private insurance. Programs that offer beneficiaries a choice between the two forms of insurance have typically experienced favorable selection by private insurers, who adopt practices that encourage enrollment by relatively healthy beneficiaries and disenrollment among those who are chronically ill (Medicare Payment Advisory Commission [MedPAC] 2000). In the short run, these patterns of selection lead to slightly higher costs for a hybrid program than for pure public insurance.

The longer-term political implications, however, may be more consequential. Were hybrid programs to adopt policies of fixed contributions (so-called "premium support" arrangements), existing cost differentials could induce more beneficiaries to select private plans, even if their performance was no better than conventional FFS Medicare (Oberlander 2000). If politicians view the higher costs in the public component as an indication of inefficiency rather than selection, they could lose faith in the public component and try to move beneficiaries and resources to private insurers.

Hybrid insurance arrangements have also been characterized by instability on the private insurance side as commercial insurers enter and exit particular local markets (Long and Yemane 2005; Glavin et al. 2002–2003). Plan turnover has disrupted treatment arrangements and access to care for some beneficiaries, particularly those with chronic illness (Schoenman et al. 2005; Laschober et al. 1999). This instability in private insurance arrangements does not appear to be any higher than in employer-based insurance for working-age Americans (Claxton et al. 2004), but its greater impact on frail elders has induced policy makers to substantially increase their subsidies to private plans in an effort to stabilize their participation (King and Schlesinger 2003).

Competitive hybrids thus pose some administrative challenges, although they arguably enhance prospects for adopting and sustaining universal health insurance. In our assessment, their advantages outweigh their liabilities. Yet it is one thing to argue that hybrid programs, in general, are appropriate for universalizing health insurance and quite another to claim that Medicare in its hybridized form is a suitable template for expansion. To explore whether an expanded Medicare could provide a suitable foundation for universal coverage, we begin by reviewing the program's experience combining public and private insurance. We consider how this track record might help to overcome the political barriers that have foreclosed past reform efforts to enact "Medicare for all," and we examine a set of alternative strategies for how such a Medicare expansion might be implemented.

The Medicare Program as Public-Private Hybrid

The adoption of the Medicare Prescription Drug, Improvement, and Modernization Act in late 2003 was only the latest step in the extended transformation of Medicare into a competitive hybrid. To be clear, Medicare has always been a hybrid of sorts, with public financing and benefit design administered under the auspices of private insurers acting as fiscal intermediaries. Its transformation into a hybrid combining complementary public and private insurance began in the early 1980s. The role of private health plans was subsequently expanded in the Balanced Budget Act of 1997 (which christened these options as "Medicare+Choice" plans). Although the MMA is perhaps best known for establishing a distinctive role for private insurers providing wraparound drug benefits, our focus in this article is on provisions that further expanded the range of private

options as complements to FFS Medicare (renaming them "Medicare Advantage" plans).

It will take years to fully assess the consequences of MMA's varied provisions, but the structural implications of the act and its precursors are already apparent: Medicare is no longer a unitary, government-administered insurance program with uniform benefits. Instead, it has become a complex hybrid of public and private insurance, in which beneficiaries have access to a varied menu of options and experience the program in diverse ways.

Curiously, although the implementation of these private alternatives has attracted much policy commentary, the broader political implications of Medicare's restructuring have been largely ignored, even by knowledgeable observers. In 1994, when Congressman Pete Stark proposed to expand Medicare as an alternative to the HSA, the editorial writers of the *New York Times* said that he would "push health care back to the past" by preventing choice among health plans (*New York Times* 1994). Yet at the time, half of all Medicare beneficiaries could choose a private alternative to conventional Medicare, and more than 2 million had done so (King and Schlesinger 2003).

Pollsters were not helping to clarify matters. For example, a 2001 survey asked respondents to choose between "keeping Medicare as it is today" and "changing Medicare to give retirees a choice of either staying in the traditional Medical program or choosing from a list of private plans" (Kaiser Family Foundation 2001: 5). When that survey was in the field, 70 percent of Medicare's beneficiaries had the option of a private health plan and more than 6 million were enrolled in one.

It is difficult to explain why Medicare's inclusion of private plans has received so little attention from those interested in the politics of the program. Certainly enrollment in private plans has been substantial, peaking at roughly 17 percent of all elder beneficiaries in 1999 (Gold 2006). Under the expanded categories of private insurance permitted by the MMA, there are now more than six hundred contracts between private insurers and the Centers for Medicare and Medicaid Services (CMS) to provide a full range of medical services that fall into a half dozen categories of distinct insurance products.[7] With the inclusion of these private

7. In order of their prevalence, these include 276 "special-needs plans" (SNPs) that are exclusively for either low-income or chronically impaired beneficiaries, roughly 200 contracts with health maintenance organizations (HMOs), 106 contracts with preferred provider organizations (PPOs) operating in local areas, 21 private fee-for-service (PFFS) plans, 16 cost-based plans (an early arrangement in which HMOs contracted with Medicare without financial risk), and 11 regional PPOs (required to open enrollment to all beneficiaries in a multistate region).

insurance arrangements has come a larger role for employers, who must purchase supplementary coverage or steer former workers into selected private plans.[8] As of September 2006, almost 7.5 million beneficiaries were enrolled in private plans in lieu of Medicare's conventional coverage (Freudenheim 2006).

Whatever its cause, this persisting lack of attention to Medicare's transformation has obscured important lessons about hybrid arrangements for health insurance. Experience with Part C illustrates important limitations of the hybrid model when applied to health insurance. Despite this, the program has also been beneficial in many ways. Indeed, on balance, we would argue that Medicare's experience with private plans has been a largely unrecognized success story of public-private partnership.[9] However one assesses the bottom line, both the positive and negative aspects of Medicare's experience with private insurance highlight some of the benefits of expanding a hybrid Medicare to cover working-age Americans.

Concrete Lessons about Medicare's Hybrid Arrangements

Medicare's experience to date with private plans is consistent with a number of our general predictions about the performance and political implications of hybrid programs. Here, we highlight five lessons about the ways in which the program's public and private insurance interact.

Differential Dynamics: Private Flexibility, Public Stability

Private insurers enrolling Medicare beneficiaries have proven more dynamic than conventional Medicare in their coverage practices. Private plans were quicker to cover preventive services when evidence accumulated that these could benefit older patients. When outpatient prescription drugs became a substantial expense for older Americans, many private

8. Roughly one-third of all elder beneficiaries receive some or all of their health benefits under the auspices of their former employer (Kaiser Family Foundation 2006b; Rice 1999).

9. It should be recognized that this "success" did not extend to all of policy makers' initial expectations. Many in Congress anticipated that including private plans in Medicare would save the program money. In fact, the opposite has been true since the program was first hybridized and remains so to this day. Private plans tend to attract healthier enrollees and thus are, on average, overpaid by the Centers for Medicare and Medicaid Services (CMS) (Freudenheim 2006).

plans added pharmaceutical coverage, long before Congress added this benefit to the program as a whole. As rising medical costs made out-of-pocket liability for covered services a financial threat for beneficiaries in conventional Medicare, some private plans adopted caps on out-of-pocket liability.[10] Some of this flexibility is a consequence of reduced political constraints: private plans can, for example, selectively contract with providers and thus alter their mix of affiliated health care professionals, whereas CMS has been shackled by Congress in its efforts to selectively contract in the conventional program (Dowd, Coulam, and Feldman 2001).

For the same reasons that private insurers were more responsive to changing consumer preferences about coverage, they were also more sensitive to changing profitability regarding particular benefits or market areas. Many of the private plans that added benefits in the mid-1990s later cut back or eliminated them when they became more expensive. For example, of the Medicare beneficiaries who had prescription drug coverage through private plans at one time during the mid-1990s, roughly a quarter had lost that coverage at the end of two years, and another 10 percent had inconsistent drug coverage during the two-year period (Stuart, Shea, and Briesacher 2001). During this same time period, hundreds of plans dropped out of the program or reduced their service areas when their participation appeared unprofitable.[11] The consequences were far from trivial for enrollees in these plans: half of the beneficiaries who had been seeing a specialist were forced to discontinue care and almost a quarter delayed care that they needed because they were concerned about medical costs (Booske, Lynch, and Riley 2002; Laschober et al. 1999). Mortality rates for elders enrolled in these plans spiked after their withdrawal (Schoenman et al. 2005). Even when plans stayed put, their more flexible and selective provider networks experienced annual turnover of doctors as high as 30–40 percent in some states, further disrupting beneficiaries' continuity of care (Dallek and Dennington 2002).

Some politicians blamed this instability on a program that was poorly designed or ineptly administered. Medicare's contracting arrangements

10. Regional PPOs are required by provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) to incorporate these caps. Although this will certainly benefit the enrollees in these plans, this is not evidence of greater responsiveness among private plans, since they were simply responding to a legislative mandate. All coverage differences considered, Medicare HMOs reduce the average beneficiary's out-of-pocket spending by about 25 percent (Achman and Gold 2003).

11. Profits appeared to be the primary motivation for their unstable participation; similar nonprofit plans were about one-fifth as likely to withdraw from the program (Glavin et al. 2002–2003).

were repeatedly amended by Congress between 1997 and 2003 to reduce instability (Berenson 2004), but plan turnover persisted. Studies of the causes suggested that plan turnover had less to do with the generosity of Medicare payments or the details of its contracting arrangements and more to do with the characteristics and strategic aspirations of the private health plans (Glavin et al. 2002–2003; Lake and Brown 2002; Stuber, Dallek, and Biles 2001). Substantial instability appears inherent in all market-driven schemes that rely on private insurance. The Federal Employees Health Benefits Program, for example, has long been portrayed as a well-functioning market model, yet about 25 percent of its plans discontinue participation or change their service areas each year (Barry 2004).

Sorting between Public and Private Components of the Medicare Program

We suggested in the previous section that one of the central advantages of a hybrid program was that its public and private components would differentiate and attract beneficiaries with matching needs and preferences. To a certain extent, this sorting has been evident in the hybridized Medicare. Groups that typically report lower satisfaction with the conventional program (e.g., those with no supplementary policies, who have high cost-sharing obligations; the disabled, who report more problems with coordination of care) are more likely to consider a private plan. Twenty-five percent of those without a supplemental policy and 26 percent of disabled beneficiaries report considering private plan enrollment, compared with 15 percent among other beneficiaries (Gold et al. 2001).

Medicare's experience also reveals some of the limitations of self-selection. Many beneficiaries appeared insufficiently informed to make sound choices. Precisely because the coverage and administrative arrangements in private plans have been so volatile, many enrollees lacked even rudimentary understanding of administrative requirements; the problem was most severe among beneficiaries with unstable plans (Booske, Lynch, and Riley 2002; Hibbard et al. 1998). Gaps in knowledge were greatest among beneficiaries who were most frail and cognitively impaired (Gazmarian et al. 1999), but those least informed were often poor judges of how little they understood (Hibbard et al. 2000, 2001).[12] Early experi-

12. Nearly 13 percent of Medicare beneficiaries have both cognitive and physical impairments. These impairments rise with age, and more than 25 percent of beneficiaries older than age eighty have both cognitive and physical impairments (Moon and Storeyguard 2001). Sixty-six percent of aged beneficiaries and 62 percent of disabled beneficiaries had more than one chronic condition (Eichner and Blumenthal 2003).

ence with Medicare Part D reveals similar concerns. Of the beneficiaries who had selected a freestanding drug coverage plan, 25 percent reported that the choice had been very difficult; of those who failed to select any plan at all, 37 percent attributed this to the program being "too complicated," and 28 percent attributed this to difficulties deciding "which plan to choose" (Kaiser Family Foundation 2006b).

Personalization and Program Connection

Privatized programs hold the promise of greater connectedness (that is, the ability to identify beneficiaries, track their care, and provide timely feedback on their experiences) and adaptation to the personal circumstances of individual beneficiaries. In the health insurance context, this could take the form of outreach services and disease-management programs through which the insurer would connect enrollees to more appropriate medical services. For Medicare in particular, this differential connectedness evidently improved two long-standing areas of concern: inadequate utilization of preventive services by beneficiaries and racial disparities in the use of those services. Although Medicare FFS has made improvements in these areas, and enrollment in private plans has not eliminated either of these shortcomings, use of preventive screenings is higher than in the conventional Medicare program, and the magnitude of racial disparities for many forms of screening has diminished (Jencks, Huff, and Guerdon 2003; Schneider et al. 2001).

Variation and Heterogeneity

These comparative advantages from private insurance, however, have been unevenly available to Medicare beneficiaries. As we predicted earlier for all hybrid programs, CMS has found it far more difficult to attract private plans in rural areas than in urban areas. Even at the peak of enrollment in Medicare HMOs (1999), only about one-quarter of beneficiaries living in rural counties had access to a Medicare HMO, compared with about 80 percent of beneficiaries in urban counties (Grossman, Strunk, and Hurley 2002). Additional private insurance options were introduced to the program to overcome these geographic disparities—private fee-for-service (PFFS) plans first went into operation in 2001, and regional preferred provider organizations (PPOs) were established in 2006.

These new offerings made 2006 the first year in which virtually *every* beneficiary had access to at least one private insurance alternative to con-

ventional Medicare, but these changes may have done more to disguise than to resolve geographic disparities. It is not clear that the newly introduced forms of private insurance have the capacity to perform as well as the older Medicare HMOs (Geyman 2006). Private fee-for-service plans do not offer the same improved financial protections for beneficiaries (Achman and Gold 2003). Neither private FFS plans nor regional PPOs have the administrative capacities to improve outreach to enrollees and thus enhance preventive care. Although the track record of these newer private insurance alternatives is still sparse, their limitations appear to be recognized by beneficiaries: although PFFS plans have been operational since 2001, their enrollment has only recently begun to grow, reaching 820,000 enrollees by mid-2006 (less than 2 percent of all beneficiaries; Freudenheim 2006). Of the 10 million eligible for Medicare's PPO demonstration project, fewer than 100,000 enrolled (Berenson 2004).

The heterogeneity of private plans also has implications for the quality of medical care for beneficiaries with the greatest health needs. The introduction of private insurance to Medicare has allowed some plans to specialize in the care of beneficiaries with chronic illnesses: in 2006 there were twenty-five states in which special-needs plans (SNPs) exclusively enrolled beneficiaries who had been institutionalized or had serious chronic health conditions. Although the SNPs themselves are too new for a careful assessment of their performance (Peters 2005), earlier forms of specialized plans such as the Program of All-Inclusive Care for the Elderly (PACE) have a promising track record for innovative and high-quality care (Gross et al. 2004; Masters and Eng 2001). These specialized plans also have low rates of nursing-home use and disenrollment rates half those of other private plans (Temkin-Greener, Bajorska, and Mukamel 2006). However, they serve an almost exclusively urban population (Gold 2006). By contrast, when more beneficiaries with serious and chronic health conditions have enrolled in other private plans, their experiences have been less positive than in conventional Medicare, with high disenrollment rates, reduced patient satisfaction, and lower quality of care (Atherly, Hebert, and Maciejewski 2005; Miller and Luft 2002; Call et al. 2001; Gold et al. 2001). Inadequate treatment of chronically ill enrollees in nonspecialized health plans is partially a consequence of payment arrangements that fail to adequately compensate plans for enrolling beneficiaries with high medical expenses (Kronick and de Beyer 1999). Private insurers contracting with Medicare thus have a financial incentive to allow or encourage beneficiaries with expensive chronic conditions to become dissatisfied and disenroll. Since a variety of factors limit the

implementation of more sophisticated risk adjustment, these incentives are likely to be a lasting feature of any hybrid insurance program (Weissman, Wachterman, and Blumenthal 2005).[13] Consequently, within the heterogeneous mix of private insurers that treat Medicare beneficiaries, some (SNPs and PACE programs) hold the promise of better care for enrollees with the most serious and persistent health problems, whereas others have a consistently worse track record than Medicare FFS.

Learning between the Different Components of the Program

Medicare's hybridization of public and private insurance reveals numerous examples of lessons crossing the public-private divide. Expanded coverage of prescription drugs by Medicare HMOs demonstrated the feasibility of drug coverage for the elderly and helped increase political pressure to add this coverage for all beneficiaries through the MMA. The development of performance measures for Medicare health plans under the Health Employer Data Information Set (HEDIS) initiative provided a template for demonstration projects that are now testing comparable performance measures under Medicare FFS (King and Schlesinger 2003). Similarly, innovations in coordinating care for elders with chronic illness in specialized plans have provided a useful foundation for care-coordination demonstrations in the conventional program (Eichner and Blumenthal 2003). The quality improvement organizations (QIOs) that monitor treatment under FFS Medicare have drawn on the experience of Medicare HMOs to identify disparities in treatment that can be most readily mitigated.

Nor have all the lessons involved conventional Medicare learning from private innovation. Private insurers have emulated Medicare's prospective payment systems for hospitals, physicians, and nursing homes. Many of the early techniques of utilization review were first developed by the professional standard review organizations (PSROs; two-generation precursors to the QIOs) in conventional Medicare and later diffused to private insurers. The learning across program components has clearly gone in both directions.

13. Although limited risk adjustment in Medicare is, in part, a consequence of political constraints, risk-adjustment methods have also been slow to find their way into employer-based insurance, suggesting that the primary barriers are technical rather than political (Blumenthal et al. 2005).

How Medicare Would Benefit as a Foundation for Universal Health Insurance

Medicare's track record is broadly consistent with our predictions about the political and administrative dynamics of hybrid programs. Both Medicare's public and private components evidence persisting distinctive capabilities, in terms of quality of care, beneficiary satisfaction, and programmatic innovation, and each component influences the performance of the other in largely positive ways.

By no means are Medicare's current arrangements ideal. The practices of its private plans could be improved by more directly rewarding them for improved outcomes and more carefully monitoring their ongoing performance.[14] The performance of conventional Medicare could be enhanced by more expediently adapting innovations from the private sector and more aggressively addressing long-standing disparities and quality shortfalls. The balance between the two parts of the hybrid program could be improved if beneficiaries were allowed to more freely choose and shift between the two components of the program (King and Schlesinger 2003). This would call for making prescription drug coverage part of conventional Medicare rather than forcing beneficiaries, even if ill prepared or inadequately informed, to choose among private plans (Davis et al. 2005).

We would, however, expect no realistically feasible set of changes to alter the fundamental distinctions inherent in a hybrid insurance program. Benefits provided through private insurance will always be more responsive and flexible — hence less stable and reliable — than the benefits provided under the conventional program. Quality of care will be more variable on Medicare's private side, reflecting the heterogeneity of private insurance plans. The geographic variability of performance will have larger consequences for beneficiaries who enroll in private plans, and it will always prove challenging for beneficiaries to decide whether they are better off covered by public or private insurance.

This said, we believe that some of the most problematic aspects of Medicare's current hybrid arrangements would be substantially ameliorated if the program were to open enrollment to working-age Americans.

14. To facilitate more private plan participation, the MMA actually weakened the quality oversight that CMS provides. Given the considerable variability of performance among different types of private plans and the financial incentives to stint on quality for beneficiaries with expensive chronic illnesses, these provisions were arguably ill conceived.

More specifically, we would expect that this expansion would improve the performance of private plans in two ways and the performance of conventional FFS Medicare in one.

Expanding Enrollment and Stability of Plan Participation

As noted in the previous section, one of the most problematic aspects of Medicare's private health insurers has been their tendency to withdraw from local markets that are temporarily unprofitable and thus to disrupt continuity of care for beneficiaries with chronic health problems. Congress has responded to these concerns by requiring that CMS increase payment rates to health plans. This turns out to be lucrative for private insurers but relatively expensive for Medicare. Glavin and colleagues (2002–2003: 350) estimated that CMS could reduce the yearly risk of plans withdrawing from a typical local market from 3.8 percent to 1.2 percent by increasing payments by about $800 per year. If a robust hybrid program enrolled 40 percent of Medicare beneficiaries in private plans, this additional payment would total almost $13 billion annually.

These same statistical analyses revealed that one could stabilize plan participation more effectively (and far more cheaply) by simply increasing the number of Medicare beneficiaries enrolled in each plan. More specifically, the models suggested that by increasing each plan's enrollment in a local market from thirty-four thousand (the average in the data used in the study) to eighty-nine thousand, one could decrease the probability of the plan withdrawing from the market to 0.3 percent (Glavin et al. 2002–2003). Consequently, by opening Medicare enrollment to Americans who currently lack reliable private insurance (and assuming that a reasonable number of these new enrollees would choose to go into a private insurance plan), one could *more* effectively stabilize private plan participation in Medicare. Put differently, the money that the MMA currently spends to bribe health plans into more stable participation could be used to make Medicare enrollment affordable for working-age Americans, thereby expanding insurance coverage *and* making the private component of Medicare more stable.

Of course, not all new enrollees would join private health plans. Although it is difficult to predict with any accuracy how many new enrollees might do so, surveys of the near elderly suggest that as many as one-third might prefer private insurance to conventional FFS Medicare (Schoen et al. 2000). Even if as few as two in ten new enrollees in an

expanded program chose a private plan, the expanded enrollment would be sufficient (extrapolating from the statistical results reported above) to reduce the odds of a health plan withdrawing from Medicare to less than 0.5 percent per year.

Expanding Enrollment and Improved Beneficiary Choice

Hybrid programs allow beneficiaries to match their own needs and preferences to the distinctive advantages of public and private insurance. Yet many Medicare beneficiaries now appear to make choices with too little understanding about their options. This problem would also be reduced if Medicare eligibility were expanded to workers and their dependents. Even when report cards and other standardized performance ratings are available, many Americans place the most trust in the information about health insurance that they obtain through their family and friends.[15] The broader the population enrolled in Medicare, the more individuals in any one social network would have experience in a given private health plan. Younger enrollees may also have more experience comparing health plans and more opportunities to learn from coworkers and other associates who are enrolled in the plans from which they are choosing. These changes would thereby enhance the reliability of beneficiaries' assessments of the plan's performance and characteristics.

Expanding Enrollment and Adverse Selection Involving Conventional Medicare

In a hybrid system, because private plans have a financial incentive to enroll relatively healthy beneficiaries and to encourage disenrollment among those with expensive chronic conditions, conventional Medicare tends to accumulate a relatively sicker, more frail population of enrollees. Under at least some forms of expanded eligibility, this sort of adverse selection would be buffered, particularly if employers were enrolling groups of workers in the Medicare program.

15. In assessing insurance plans offered under Medicare Part D, friends and family members were the second most trusted source of information, following health care professionals. And roughly twice as many respondents reported that they trusted information from their family and friends as trusted information from the insurance companies themselves or from insurance counselors (Kaiser Family Foundation 2006a: 6).

Medicare's experience suggests that a public-private hybrid for health insurance is both politically and administratively viable. As we have illustrated, the program's performance and political stability would almost certainly be improved if enrollment were expanded beyond the elderly and disabled.[16] Proposals to establish "Medicare for all," however, have been part of American political discourse for the past forty years and have consistently failed to gain political traction. How might Medicare's incorporation of private and public insurance alter these prospects?

Expanding Medicare in the Context of American Public Values

The persistent division in public sentiments that we documented early in this article helps to explain why proposals for expanding Medicare to the nonelderly have remained on the periphery of political discourse. Advocates have certainly *tried* to promote Medicare as an avenue for expanding health insurance. During the 1968 presidential campaign, all three candidates (Hubert Humphrey, Richard Nixon, and George Wallace) were asked about their support for "an extension of Medicare to cover all Americans" (*New York Times* 1968),[17] a proposal that had garnered sufficient attention that pollsters tested for public support in early 1967 (Louis Harris and Associates 1967). Over the subsequent thirty-five years, both Democrats and Republicans have introduced legislation to Congress that would expand Medicare enrollment — in some cases to all Americans, in others to particular subgroups — albeit with only marginal influence on the health reform debate.[18]

16. Political support for the program as a whole might also be reinforced were it to enroll a larger group of working-age beneficiaries and their dependents. In its current form, the program is largely seen as a benefit for the elderly. Over the past twenty years, the perception that Medicare is costly and burdensome has become a source of some intergenerational tension, both inside the Beltway (Oberlander 2003b) and among its own beneficiaries (Levy and Schlesinger 2005). More cross-generational enrollment could reduce these tensions and bolster the program's political legitimacy, although the magnitude of these potential changes remains a matter of speculation, given our currently limited understanding of the origins and determinants of intergenerational equity concerns.

17. Although an expansion of Medicare was rejected by George Wallace and Richard Nixon, Hubert Humphrey supported an incremental expansion to the disabled (not covered by Medicare until 1972) and young children in low-income families.

18. Jacob Javits introduced the first "Medicare for all" proposal to Congress in April 1970 (*New York Times* 1970). During the mid-1990s, proposals were introduced by both Pete Stark (as an alternative to the failing Health Security Act) and John Conyers (Pear 1994; Oberlander 2003b). In the middle of his second term, President Clinton proposed allowing the "near elderly" (early retirees older than sixty-two, and those older than fifty-five who had been laid off) to buy into the Medicare program (*New York Times* 1998).

As long as Medicare retained the image of a single-payer, government-run program, Americans' fears and divided preferences posed insurmountable obstacles to using Medicare as a foundation for universal health insurance, as they have to any other proposal that relied solely on government-administered insurance. Similar sentiments have colored the perceptions of political elites. As the Clinton administration's strategy for health care reform was being crafted, its architects explicitly rejected single-payer Medicare as a model, because they believed that it was inconsistent with public values and the evolving nature of the American health care system (Hacker 1997).

Arguably, these political constraints on Medicare for all have been dramatically loosened by the transformation of the program into a hybrid of public and private insurance. The politics of universal health insurance seem fully consistent with the conditions, identified earlier, under which hybrid programs would be most appealing and resilient over time. Public and elite preferences are evenly and persistently divided in their support for public or private insurance. Support for each varies over time and across geographic regions, making it essential that any viable strategy for reform have the flexibility to vary as well. The heterogeneous needs and capabilities of individuals make the greater flexibility and responsiveness of private insurance more appropriate for some, but the greater stability and consistency of government-administered insurance are more suitable for others.

Hybridized Medicare has been all of those things. It has demonstrated its viability under diverse circumstances: Medicare functions reasonably well in rural parts of the country as well as in metropolitan areas and for people who purchase insurance individually as well as for those who obtain health coverage through the workplace or other organized groups. To be sure, the program is neither fully effective in providing financial protections against medical costs nor entirely capable of serving its diverse beneficiaries equally well. Medicare's combination of public and private insurance does not provide access or security as well to the disabled, to ethnic and racial minorities, or to the oldest old (who have the highest prevalence of multiple chronic health conditions). Its track record for these groups, however, remains comparable, and at times superior, to the performance of workplace health insurance (King and Schlesinger 2003; Davis et al. 2002).

Yet perhaps the most compelling rationale for Medicare as a vehicle for expanding insurance enrollment is simply that it is well known and well liked. The Clinton administration's HSA ran into difficulties, in part,

because it could be portrayed (with some accuracy) as an untested and unfamiliar new structure (Yankelovich 1995). These concerns were magnified by Americans' fears about government involvement harming the quality of American medicine, fears that were fostered by opponents of the proposal. And make no mistake about it: the same opposition will coalesce against any proposal for universal insurance. As they did in 1917, 1948, and 1974, opponents of reform will raise the specter of government bureaucrats standing between Americans and their doctors—a strategy that proved remarkably effective in 1994, despite efforts by the Clinton administration to design and market its proposal as not involving "big government" (Skocpol 1996).

The same fears do not hold for Medicare, however. No great leaps of faith are required to anticipate how it will operate, and tales of sinister bureaucracies are not quite so fearsome when the bureaucracy in question already takes care of grandparents, parents, neighbors, and friends.

As the program has evolved, it has retained its immense and deep-rooted popularity despite concerns about its cost burdens and complaints about the unstable practices of its private plans. This public legitimacy extends to proposals that would expand enrollment to younger Americans. Recent polls report that between two-thirds and three-quarters of the public favor the expansion of Medicare to the nonelderly.[19] This is substantially greater support than was evident when the public was first asked about Medicare for all in 1967, flush in the enthusiasm of a successful program launch and in the midst of an era embracing activist government.[20] Moreover, this is substantially greater support than is evident for either pure single-payer or voucher proposals, as documented previously.

Support for expansion should be equally strong among existing beneficiaries. Those currently enrolled in private plans would benefit because expanding the number of Medicare enrollees in these plans would stabilize their participation. Enrolling working-age beneficiaries in conventional Medicare under age-adjusted premiums could also help to buffer the program from adverse selection and reduce the potential for inter-

19. Support ranged from 68 percent in a survey fielded in February 1998 (Employee Benefit Research Institute 1998) to 76 percent in a survey fielded in November 2000 (Kaiser Family Foundation, Harvard School of Public Health, and Princeton Survey Research Associates 2000).

20. The Louis Harris (1967) survey that first assessed this support found that 51 percent favored Medicare expansion "to cover all members of your family," 39 percent were opposed, and 10 percent were uncertain. Support was about 25 percent higher in the east than in the west, and it was highest among respondents from low-income households.

generational disagreement about the top priority for health care reform: covering the uninsured or improving Medicare. Expanding Medicare eligibility to working-age Americans would do both.

Getting to Medicare for All, Step by Step

Despite its promise, the goal of universal coverage through Medicare is ambitious. It would not, however, have to be achieved in one fell swoop. At least four incremental pathways of Medicare expansion could eventually yield universal insurance: expansion by demographic groups, expansion by income strata, expansion through buy-ins, and expansion through default coverage. This choice of pathways suggests that there is considerable flexibility in how to go about expanding the program, although we argue that the last of the four has some important operational advantages.

Expansion by Demographic Group

Two groups have been most frequently nominated for Medicare eligibility: children and adults nearing retirement. Children, like the elderly and disabled, are not expected to earn their health benefits and are generally seen as a deserving group (Cook and Barrett 1992). With recent erosions in private coverage and expansions of Medicaid and S-CHIP, one-half of all children are already covered by government insurance. When Americans assess options for "providing health insurance to all children," a "Medicare-like program" garners the plurality of support.[21]

Yet, insuring children through conventional Medicare would have drawbacks. For starters, children would be eligible for a program for which their parents were not. This would not be as problematic if children were enrolled in private plans that contracted with Medicare, since children could enroll in plans that also offered private insurance in the community. Still, some cases of divided coverage would certainly occur, and some children would be covered when their parents were uninsured.[22] Equally problematic, incremental expansions to a politically attractive group, such as children, might weaken the political momentum for subsequent extensions of eligibility to other groups seen as less deserving.

21. Twenty-three percent more Americans preferred Medicare to a means-tested program for the children of the working poor (Coalition for America's Children, the Tarrance Group, and Lake Research 1995). Support was slightly higher for a Medicare-like system than for a subsidized expansion of private insurance.

22. It remains unclear whether this split coverage would impair access to care.

Expanding Medicare to the near elderly is higher on the policy agenda but is not without its own problems. As with current Medicare beneficiaries, those older than fifty-five are frequently retired and disconnected from employer-based insurance. They also have elevated health costs that make individual health policies unaffordable. Public support for expanding Medicare to the near elderly is stronger (two-thirds in favor) than is public support for expanding Medicare to children (Kaiser Family Foundation 2001). Among Americans between the ages of fifty and sixty-four, 63 percent would be interested in early enrollment in Medicare were that option available, even if they had to pay the "full cost" of coverage (Schoen et al. 2000: 5).

Here again, however, the public is divided. When given the choice of a Medicare buy-in versus employer-based insurance or directly purchased private insurance, Americans aged fifty to sixty are evenly split, with a slight plurality favoring the Medicare option (Schoen et al. 2000: 7). (Of course, if a Medicare buy-in were portrayed as a pathway to both public and private insurance, public support for that option would certainly increase.) The buy-in option also raises the distinct possibility that employers will drop coverage for near-elderly workers — a problem that would be much less worrisome in the case of coverage of children, given how many children are already covered by public insurance.

Expansion by Income Strata

Proposals to expand Medicare to Americans with limited income date back to Hubert Humphrey's 1968 campaign (*Washington Post* 1968). For this group, Medicare would substitute less for private insurance than for Medicaid and S-CHIP. The clearest potential advantage of replacing state low-income programs with Medicare would be increased participation among eligible families. Take-up rates for Medicaid and S-CHIP remain strikingly low (Kronebusch and Elbel 2004). Moving insurance coverage for lower-income Americans from the state to the federal level would also relieve states of a costly burden that expands whenever the state suffers an economic downturn.

Although this is attractive, there are also negative factors to consider. Replacing state programs with the federal Medicare program could reduce the potential for state-level innovation, although this concern might seem less pressing now that Medicare is a hybrid system, because private plans stimulate innovation and offer an alternative for beneficiaries who prefer more dynamic benefits. Another concern is that Medicare might come to

be seen as a program for the poor, although this must be weighed against the benefits accrued by eliminating the stigma attached to participation in Medicaid and S-CHIP.

Expansion by Optional Buy-in

A third option would allow any Americans to buy into the Medicare program if they preferred it to their existing insurance alternatives. The buy-in option has received the most congressional consideration of any proposal for Medicare expansion. Nonetheless, it has two potential drawbacks. The first is the risk of adverse selection caused by the disproportionate enrollment of less-healthy people, although even the least healthy of working-age Americans and their dependents are likely to have lower medical expenses than the disabled or the frail elderly already enrolled in Medicare (Fuchs 2004). The second risk is that some individuals might choose to go without health insurance altogether. Survey data on worker preferences suggest this outcome is unlikely, however, and it could be easily addressed by mandating that individuals have insurance coverage. Indeed, one could argue that a Medicare buy-in represents the ideal scenario for proponents of individual mandates by offering an affordable policy for purchase, one that allows a choice between public and private insurance options.

The hybrid version of Medicare should also lessen concerns about the "crowding out" of private coverage. With a readily available Medicare option, a significant number of employers may drop insurance as a fringe benefit. That would not necessarily portend a decline in private coverage, however, because their workers could purchase private insurance under Medicare's auspices.

Still, crowding out private coverage does have more worrisome implications. Workers whose employers drop health insurance as a fringe benefit should experience compensatory increases in their incomes. But this does not solve the problem that government will need to assume responsibility for payments that were previously channeled through employers, increasing public spending and evoking the specter of the "t-word": taxes. Moreover, if workers whose employers have dropped coverage must now purchase Medicare directly, these employees have lost the tax subsidies that currently exist for their fringe benefits when they are paid as compensation. This problem could be addressed by allowing Medicare to be a part of an array of tax-exempt benefits or—if policy makers were more

ambitious — by requiring that employers contribute a share of the premiums for either private or Medicare coverage. Indeed, these challenging issues of public finance are a strong reason to favor an approach that requires employers to contribute to the cost of workers' medical coverage, which could easily be done if Medicare were made the default option for employers who do not now offer (or do not wish to continue to offer) insurance to their workers.

Expansion by Default Coverage

This brings us to the final and most comprehensive route to an expanded Medicare program: making Medicare the default coverage for Americans without workplace insurance. Workers whose employers did not provide basic health coverage would be automatically enrolled in Medicare (with employers making some type of payroll-based contribution to cover part of their costs). Affected workers would then be free to enroll in private plans through Medicare.

Hacker (2001) has outlined a plan along these lines for the Robert Wood Johnson Foundation–funded Covering America project. The plan, Medicare Plus, has been carefully modeled by the Lewin Group, which found that it would cover 37 million of the uninsured (in 2002) at a cost of $115 per person in new national health spending (Sheils and Haught 2003). In July 2006, Rep. Pete Stark (D-CA) introduced the AmeriCare Health Insurance Act of 2006, which was based on this proposal.

Under the Medicare Plan proposal, roughly half of working-age Americans would be covered through their employers, while 46 percent would be covered either by conventional Medicare or by private health plans with which Medicare contracted. The size of the private insurance sector would depend on how many workers chose private plans under Medicare. Only a fairly small share of the nonelderly who were previously uninsured would have to choose private plans over conventional Medicare for group-based insurance to actually increase in scope compared with existing insurance arrangements.

The Bottom Line on Incremental Expansion

Of these alternatives, we favor an approach that relies on Medicare as a default coverage, since this strategy uses employer-based insurance selection, thereby reducing adverse selection among those entering conven-

tional Medicare or the program as a whole.[23] Nonetheless, it is important to recognize that a multiplicity of pathways toward incremental expansion allows advocates of universal coverage to take advantage of situational opportunities for reform. For example, the program recently adopted by Massachusetts promises to bring universal coverage to its residents through a combination of individual and employer mandates (Johnston and Turnbull 2006). Medicare expansion could be based on a similar combination of mandates.

Indeed, one could argue that a hybrid Medicare is an essential building block for broadening the Massachusetts approach to other states. One of the most difficult and controversial challenges in implementing the reforms within Massachusetts involves how to specify the coverage requirements for default plans (Krasner 2006). Hybrid Medicare offers an ideal template, since it has benefits that are widely understood. Another challenge in expanding this model of reform to other states has been identifying revenues to subsidize insurance and make it affordable for individual enrollees and small businesses.[24] Here again, Medicare serves the bill. If enrollment in Medicare's private plans were expanded, the program would no longer need to squander resources bribing private insurers to have more stable participation. These current overpayments run about $7–8 billion a year (Berenson 2004)—this is not sufficient to fully subsidize universal insurance, but it is a step in the right direction.[25]

Whatever the prospects or merits of expanding health insurance through state-based initiatives, it seems clear that this approach would be more feasible and equitable were hybrid Medicare to be available as a default coverage option. At a minimum, reform-minded states should be allowed to apply for a waiver with CMS to use the program in this manner.

23. There is obviously a tension among allowing individual choice, better matching personal preferences to the comparative advantages of public or private insurance and group enrollment, reducing the administrative costs of enrollment, and buffering the program against adverse selection.

24. Massachusetts diverted funds from its uncompensated care pool for hospitals and federal demonstration funds; neither are likely to be available in most states.

25. Another $2–3 billion per year could be recaptured from the subsidies provided to regional PPOs to induce them to operate in geographic areas with limited penetration from private Medicare health plans (Geyman 2006).

Discussion and Conclusion

In this article, we have suggested that Medicare's transformation into a hybrid of public and private insurance represents a potential turning point—not just for the Medicare program itself but also for the prospects for universal health insurance. A hybrid Medicare program provides an attractive template for a new reform agenda that satisfies both the demands of technical feasibility and the divided expectations of Americans.

Medicare's experience combining public and private insurance has been frequently uncomfortable and, at times, tumultuous. Nonetheless, Medicare stands out as a surprisingly successful marriage of public and private insurance that compares quite favorably with the health insurance available to working-age Americans (King and Schlesinger 2003; Davis et al. 2002). Expanding its umbrella of protection to the nonelderly—whether through categorical extensions, an optional buy-in, or making Medicare the default source of coverage—would not only provide security to the uninsured and underinsured but would also make Medicare a more secure and dynamic program for its current beneficiaries.

It may seem odd to suggest that the holy grail of liberal health care reforms is attainable only by taking advantage of a program that is itself in the throes of partisan and ideological contestation. As Americans look longingly to other countries that guarantee health insurance to their citizens, it is easy to assume that these initiatives were a natural outgrowth of a more homogeneous and harmonious conception of collective responsibility for medical care. Yet the history of health politics in these other countries suggests otherwise. National health insurance and health service programs were often enacted under circumstances that were deeply controversial and emerged from distinctive "windows of opportunity" that aligned political forces that were otherwise discordant (Touhy 1999).

This should be no surprise to those familiar with the history of American health policy. When Medicare was first adopted, the scope and form of government involvement were deeply contested in a manner that is remarkably similar to contemporary debates over the future of the program. As Jonathan Oberlander (2003a: 196) recently observed, "Medicare politics is now transparently a battle of ideas about the role of markets and government in public policy. That is, in many respects, the same debate held in the 1950s and 1960s. . . . Medicare politics is back where it started." Political discord was not an insurmountable barrier to Medicare's enactment, nor is it likely to be to Medicare's expansion.

For some observers, the intensity of this political debate makes Medi-

care a less-promising platform for expanding insurance than its companion program from the mid-1960s (Grogan and Patashnik 2003). Medicaid, it is argued, has also incorporated private insurance, thereby gaining the benefits of becoming a competitive hybrid, and it has done so with less conflict than has Medicare. Brown and Sparer (2003: 40) have suggested that "Medicaid has, for better or worse, modernized itself into managed care more adroitly than has Medicare," but we would argue that this comparison is somewhat misleading. Medicaid remains a program that many Americans consider less desirable than private insurance (Stuber and Schlesinger 2006). As noted previously, this stigma discourages enrollment by eligible populations and would inhibit take-up by middle-income households (Kronebusch and Elbel 2004).

It is also not clear that Medicaid's incorporation of managed care plans has actually been more successful than that of Medicare. Medicaid's hybrid program has generated less controversy, but participation by commercial insurers has been just as unstable in Medicaid as in Medicare (Long and Yemane 2005). States have arguably demonstrated less capacity than the federal government for monitoring the experience of their beneficiaries enrolled in these plans (Fossett et al. 2000). Less-intense controversy may reflect lower expectations rather than superior implementation.

It is precisely the more intense scrutiny that has accompanied Medicare's transformation into a competitive hybrid that makes it the more suitable foundation for extending such arrangements to the American population as a whole. To be frank, it is too easy for policy makers to consign poor people to managed care plans. Policy makers in many states have abandoned Medicaid's original goal of connecting low-income families with mainstream medical care. With these shrunken aspirations, Medicaid avoids conflict, but it also fails to tackle the challenges of ensuring that those enrolled in private plans are receiving medical care that is comparable to that available for the rest of the population. Yet these are precisely the challenges that policy makers must address for a program of universal health insurance to prove acceptable to the American public.

Other skeptics might wonder if policy makers' fears about Medicare's future solvency could vitiate its other attractive attributes as a vehicle for universal coverage. For several reasons, we think not. Political rhetoric about Medicare's impending "bankruptcy" can be seriously misleading and ignores past successful efforts to control program costs (Oberlander 2003b). Were these fiscal concerns emerging from a weakness in program performance, they would pose more of a challenge to the case for Medicare expansion. In fact, over the past thirty years, Medicare's track record

for cost containment is stronger than that established by employer-based insurance in the United States (Boccuti and Moon 2003). Although this is admittedly not a sterling benchmark, there is little reason to think that an expanded Medicare program would heighten concerns about cost containment. Quite the contrary—by adding to the program's market power, an expanded Medicare would allow CMS to better contain overall medical spending. Moreover, expanding enrollment to a broader portion of the American population could defuse intergenerational tensions that result from the currently inconsistent age profile for the program's benefits and fiscal burdens (Cook et al. 1994).

Admittedly, expanding a hybrid form of Medicare is not as conceptually elegant or ideologically pure as the grand visions of policy partisans on either side of the ideological spectrum. That is exactly why we believe that expanding Medicare is the most promising approach to breaking the current stalemate. The familiarity of the program to the public and the track record of administrative experience at CMS both offer a foundation upon which one can construct an initiative with broader aspirations. Ultimately, the stakes are too high to continue to debate Medicare reform without also discussing the millions of Americans who lack even basic health security.

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