# Medicare Expansion as a Path as well as a Destination: Achieving Universal Insurance through a New Politics of Medicare

*By*
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Growing interest in "Medicare for All" has revived hopes for universal health insurance. Yet serious disagreements remain over *how* to expand Medicare and *how far* to move toward a universal Medicare system. In this article, I consider these disagreements in light of what we know about "policy feedback"—the ways in which policies, once enacted, reshape public opinion, governing institutions, and political organizations. Rather than focusing on the "political feasibility" of proposals for Medicare expansion, I focus on their "policy sustainability": whether proposals, once enacted, can be *established* in place, *entrenched* over time, and *expanded* and improved as circumstances change. Achieving these "three E's," I argue, requires a flexible approach that builds on the current system (and hence falls short of Medicare for All) but also contains a universal coverage guarantee and other provisions designed to create strong feedback effects conducive to the expansion of Medicare over time.

*Keywords:* health care; health insurance; Medicare; policy feedback; American politics; Affordable Care Act

Growing interest in "Medicare for All" has revived hope for universal health insurance, after a decade of debate over the Affordable Care Act (ACA). Yet despite a near consensus among advocates of expanded coverage that Medicare should be the foundation for future coverage expansions, serious disagreements remain over *how* to expand Medicare and *how far* advocates can and should move toward a universal Medicare system in the relatively near term. Plans for expanding Medicare range from categorical expansions (for example, 55- to 65-year-olds) to various types of

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Medicare buy-in proposals to single-payer national health insurance—each with influential proponents within the health policy community.

In keeping with the goal of this special issue, this article considers these alternative policy ideas in light of what we know about "policy feedback"—the ways in which policies, once enacted, reshape public opinion, governing institutions, and political organizations over time. In particular, I focus on what I term *policy sustainability*, which should be distinguished from the more common phrase *political feasibility*. Feasibility usually concerns whether a policy can be enacted. Sustainability, by contrast, refers to whether policies, once enacted, can be *established* in place, *entrenched* over time, and *expanded* and improved as political and economic circumstances change. These "three E's"—establishment, entrenchment, and expansion—are fundamentally political outcomes. Moreover, they are political outcomes that we should expect to be heavily influenced by policy design, as the large and growing scholarship on policy feedback demonstrates.

Thus, my analysis of proposals for Medicare expansion really gets going where most policy analyses end, with the question of what happens *after* a policy gets passed. I start with (and hopefully justify) the premise that moving from our current system to Medicare for All in one "big bang" will be difficult to achieve and, even if achieved, vulnerable to backlash. But the core of this article concerns how to design reform proposals so that they (1) move as close as possible to the elusive aim of universal Medicare and (2) create feedback effects conducive to further movement toward that goal—that is, to establishment, entrenchment, and expansion.

## The Opportunity—and Challenge

Advocates for fundamental reform have embraced Medicare for three good reasons. First, while the ACA has produced tremendous achievements—cutting the share of Americans without health insurance roughly in half, extending new protections to almost everyone with private insurance (for example, requiring coverage for preexisting conditions), and helping to moderate medical inflation—it has not lived up to expectations in one critical area: providing affordable health insurance to those without workplace protections or access to Medicaid (a problem more glaring because of the judicially imposed incompleteness of the ACA's Medicaid expansion). Nor has the ACA created the kind of strong support coalition associated with other landmark social policies. Though political buy-in has increased and may well have been decisive in repelling legislative assaults in 2017, possibilities for *expansion* have seemed more modest. Enthusiasm for building on Medicare is partly a reflection of these lessons.

Second, Medicare has looked better and better relative to private insurance. It provides valuable and valued coverage through a simple enrollment and financing system. Coverage is not contingent on whether someone has the wherewithal or means to navigate a complex eligibility gauntlet; all eligible

Americans are enrolled more or less automatically. What is more, the prices that Medicare pays providers are lower and more consistent across services, regions, and providers (Cooper et al. 2018). And the gap has been growing, as doctors and hospitals increasingly consolidate into large medical systems demanding premium prices. In recent years, Medicare's overall tab has risen with the retirement of the baby boom generation. Yet its spending per enrollee, which is what really matters, has been essentially flat, rising less quickly than either economic growth or inflation (Bivens 2018).

Third, and perhaps most important, Medicare is not only effective; it is overwhelmingly popular (Norton, DiJulio, and Brodie 2015). Republican and Democratic voters alike embrace the program (though the former are much less keen on expanding it to new groups), and everyone knows what it is and roughly how it works. This helps to explain why a number of proposals that envision new systems that are fairly different from the current Medicare system use the label "Medicare for All" (U.S. Congress 2018, 2019).

In short, a much-expanded Medicare program is desirable. It is also arguably more feasible than other equally ambitious proposals. The popularity of Medicare—as well as some of its familiar features that account for its popularity, such as broad access to providers—buffers reform plans that are based on it against some of the harshest political counterwinds. Advocates of affordable, quality coverage for all have very good reasons to make Medicare a cornerstone of their efforts.

Still, Medicare for All will be a heavy political lift. To say that is to state the obvious, and it should not be confused with claims about desirability. If we were building a system for broad coverage and cost control from scratch, the argument for universal Medicare would be extremely strong. But we are not starting from scratch (Hacker 2019a). The exorbitant costs and maddening fragmentation of our health care framework greatly bolster the case for reform. They also greatly increase the likelihood that highly resourced and powerful groups and those with good coverage will be effectively mobilized against it.

How, then, can Medicare be expanded? How can we overcome the formidable hurdles that have stood in the way of affordable universal insurance in the past, especially backlash from powerful vested interests and already-insured Americans? How can we increase the chance of initial *establishment* of a new law and encourage it to become increasingly *entrenched* over time? And how can we maximize the chance that these steps will lead to further ones—to *expansion* as well as establishment and entrenchment?

The key, I argue, is to think about reform as a path, not simply a destination: as a sequence of policy moves, flexible to changing circumstances, that are designed to enhance the power of those sympathetic to further moves, while weakening, sidelining, co-opting—and, yes, in some cases, buying off—opponents. Economists speak of a world of "second bests," in which ideal measures are off the table, either because they do not exist or because they are unattainable. What policy feedback research adds to this familiar refrain is a positive spin: second bests differ a lot with regard to their political effects, and the best of them—the first-best second-best, if

you will—have a greater chance of creating positive political forces that foster establishment, entrenchment, and enactment.

The proposal I have developed—and presented at extended length elsewhere (Hacker 2001, 2007, 2019b)—is meant as a constructive contribution to such a discussion. It draws from my own work on the topic beginning in the early 2000s, as well as many current plans for improving the ACA and expanding Medicare. Moreover, it is meant to be open to adaption and modification in several key areas.

In brief, this proposal would make Medicare the default source of coverage for everyone, but then allow people to obtain insurance through employment-based plans—and perhaps high-quality state Medicaid programs—if they met high (and rising) standards. Initially, at least, younger Americans would have their own part of Medicare, which I call "Part E." But the goal would be to spark a flexible step-by-step process that as quickly as possible united everyone without secure insurance within a single public pool. In short, this approach is designed to create a reform path that unites crucial stakeholders and constituencies, fragments or appeases critical organized interests, and yet still puts in place the conditions for effective cost control and continued expansion of Medicare.

## Go Big or Go Home?

The struggle over health care has always been about politics as much as policy. The evidence that the American model is inferior is overwhelming (Squires 2015; Papanicolas, Woskie, and Jha 2018). No other country spends as much as we do per capita, but the United States is the only rich democracy without universal insurance, and its health outcomes (including outcomes that are closely linked to the performance of the medical system) are middling to poor (Hacker and Pierson 2016). The problem is not coming up with ideas for reform that would be far better than this policy dumpster fire. The problem is figuring out how to overcome the political barriers to pursuing those ideas—not only to get them passed, but to ensure that they foster the political conditions for continuing improvement.

As already indicated, these challenges can be grouped into three broad categories, which I call the "three E's": the challenge of establishing a policy, especially in the face of likely backlash; the challenge of entrenching it over time, that is, getting beneficiaries and stakeholders to see it as valuable and invest in its continuance; and the challenge of expanding it, which requires not just forestalling a major counterpush against the law but also attracting new allies, gaining stronger allegiance from initial supporters, and creating new opportunities for constructive legislative or executive action.

One important point to emphasize up front is that policy approaches that minimize one set of risks may accentuate others. In particular, provisions designed to ensure quick establishment of a law may not create strong enough institutional foundations or vested interests to ensure entrenchment, much less

foster expansion. On the other hand, overcoming initial backlash is a precondition for doing anything else. The first consideration, therefore, must be how to tackle the major sources of initial backlash—both during and after legislative debate—in ways that do not compromise future success.

In health care, the most fundamental of these sources emerge out of the path-dependent development of American health insurance (Hacker 2002). Our nation's costly patchwork quilt of coverage both enriches powerful organized interests and makes middle- and upper-income Americans highly sensitive to perceived new costs or risks. Backlash from these groups (actual or expected) has repeatedly thwarted efforts to achieve universal insurance, and, indeed, it is why Medicare was limited to the elderly in the first place.

As noted, Medicare for All faces a tough climb here. First, it envisions displacing workplace insurance, through which half of Americans receive coverage. Past debates have repeatedly demonstrated that those with such protections can be frightened by the argument that their coverage will be taken away or undermined. Polling shows that support for Medicare for All drops precipitously when the elimination of employment-based insurance is mentioned and, in fact, that many who support a universal Medicare system think they could keep their employment-based coverage under it (Kirzinger, Muñana, and Brodie 2019).

Second, because it replaces employer coverage, Medicare for All involves enormous up-front spending and thus enormous new revenues. There is no need to debate the specifics, since everyone agrees on the basics: American tax levels would have to rise from their current low levels in cross-national perspective to something much closer to the international norm. (My back-of-the-envelope calculation is that annual federal health spending would have to go up by at least 8 percent of GDP: fully financed, this would roughly move the United States up to the German level of taxation.)

To be sure, these new taxes are likely to be lower in the aggregate than existing private payments, leaving most households better off. But they will also be much more visible than today's hidden sources of financing, such as the reduced take-home pay of workers who receive employment-based benefits and the higher taxes that all Americans pay because of tax breaks for these benefits. As a result, many insured Americans will perceive that they are being made worse off—especially after the stakeholders whose interests will be threatened demonize the plan.

In short, political realities and policy requisites collide. Medicare for All would get us to universal coverage and effective cost control. But expecting the breakthrough necessary to pass it could be the political equivalent of waiting for Godot.

Hence the interest in partway proposals—not Medicare for All but "Medicare for More." A large number of such plans have been proposed in the past few years. Among health policy specialists, there has been extensive discussion of the policy differences among these plans and some of the political judgments that lay behind these differences, as well as of some of the economic incentives they might set up over time—such as whether a partial Medicare expansion would be a "glide path" to Medicare for All, as employers enrolled their workers in a lower-cost public plan (Neuman, Pollitz, and Tolbert 2018).

What has not received virtually any attention, however, is the *political* effects each proposal might create. For example, would a buy-in be seen as fallback coverage and shunned by middle-class Americans (especially healthy middle-class Americans) or encounter fierce opposition from current Medicare beneficiaries, worried about their coverage or resentful of new enrollees? Would a proposal that was not designed to achieve universality at first actually create political forces conducive to its achievement, or would movement toward this vital goal stall out (or even reverse), as it has so many times before? The policy differences do not look all that large, but lurking behind sometimes-technical distinctions—or left out altogether—are a number of crucial design choices that are likely to have big political effects.

The remainder of this article is about those choices and which provisions I think have the best chance of resolving them. The basic message is simple: different paths have different likelihoods of reaching an attractive destination because of the political effects they are likely to generate. If Medicare for All might mean "Waiting for Godot," some proposals for expanding Medicare remind me of the old refrain "You can't get there from here." They might be vast improvements, but they are not likely to unleash dynamics that lead to universal coverage or effective cost control. How such a path might be constructed—and where, roughly, we should want it to take us—is the next topic.

## Achieving the International Standard

Medicare is an attractive foundation for expanding coverage in part because it upholds the shared cross-national template for successful health policy (White 1995): it covers everyone who is eligible more or less automatically, and it restrains prices without impeding access (indeed, while offering the biggest provider "network" in the world). For almost everyone outside Medicare, either one or both of these elements of the international standard are absent, despite the great advances made by the ACA.

To be sure, there are many outcomes we should care about beyond coverage and costs. But universality and effective price control are both deeply dependent on each other and preconditions for almost every other health policy aim. A proposal for which it is clear that these goals will remain elusive even after enactment, establishment, and entrenchment—that you cannot get there from here—is not a good path to follow.

Of course, forecasting the feedback effects of new policies is difficult. Those who designed Medicare thought it would be a stepping stone to universal insurance. If political conditions had remained as favorable as they were in 1965, perhaps it would have been. But two negative feedback effects probably could have been foreseen (Hacker 2002).

First, Medicare's designers were so focused on finding a political inroad that they basically took the most sympathetic and hard-to-insure groups out of the employment-based system. (The congressional addition of physicians' insurance to Medicare and the last-minute decision to combine Medicaid with Medicare

only accentuated this.) Second, the desire to establish the program over provider resistance led to massive cost overruns, coloring perceptions of the program and eating up resources for potential expansions (Oberlander 2003). For both these reasons, Medicare never moved much beyond its original beneficiaries. Indeed, those beneficiaries have resisted new benefits they see as hurting theirs.

Medicare's story suggests not only that feedback effects may be hard to predict but also that there are tensions between establishment and entrenchment, on one hand, and expansion, on the other. Focusing on sympathetic constituencies and providing generous transition payments may facilitate the former but impede the latter. Nonetheless, a generation of work on policy feedback—updated for current hyperpolarized realities—suggests a few general conclusions about reform trajectories that are likely to arc toward universality and cost control.

- *Preventing backlash comes first.* In today's politics, backlash is a certainty—the question is how serious it will be. Unified opposition from partisan opponents, at least at the national level, is a given. Two more variable sources of backlash are medical industry actors and those who have relatively good coverage. The quicker they can be brought on board, or at least partly appeased, the better.
- *Move it or lose it.* Everyone knows windows of opportunity for passing laws are short. So too, however, are windows for establishing them. Quickly getting operations up and running and delivering benefits to key constituencies is vital—at the very least, to weather backlash. By the same token, messing up early can create lasting effects, both perceptual (this program does not work) and material (accommodating to this program is not worth my political or financial capital).
- *Start as big as possible.* A corollary proposition is that it rarely makes sense to have a slow ramp-up of policy operations that are designed in law to be big. Organized opponents just have more time to head things off. For proposals like Medicare expansion where size really matters—small program, small effects—you want to achieve the maximum feasible dimensions as quickly as possible.
- *Structure over specifics.* Though not always true, most policies rise or fall based on a few key structural questions—three, in particular: (1) Does a policy have the basic means to deliver promised benefits? (2) Does it have an adequate revenue stream? (3) And is it designed so that the answers to (1) and (2) will remain affirmative even if lawmaking is stalemated? Structure also shapes the most basic issue: What does this policy look like? If you want a policy to be recognized and its success to create self-reinforcing enthusiasm about what it does, it needs to be relatively visible and simple—at least to key political actors—and it has to create clear enough lines of accountability so that its architects and defenders are given credit for their work and its opponents can be held responsible for their attacks.

Based on these considerations, there is reason to worry that some of the present plans will not get there from here. In particular, proposals that would simply

create a Medicare buy-in option or add Medicare to the individual marketplaces do not seem well poised to either become established and entrenched or create expansionary pressures.

The main problem is scale: the public plan envisioned in these proposals just would not cover a lot of people. Small scale is a policy liability, increasing the chance the plan would end up attracting people with disproportionately high health costs and decreasing its leverage to control costs. It is also a major political liability, since these policy problems and the lack of a strong support constituency or serious stakeholder investment would likely quell opportunities for expanding the public plan to a substantial share of the population.

Proposals for categorical expansion raise similar difficulties, though, depending on their design, they could cover a much larger group. The case for expanding Medicare to 55- to 65-year-olds—what Paul Starr calls "midlife Medicare" (Starr 2017)—is strong: this is a group that has faced increasing vulnerability in the labor market and has paid into Medicare for a good chunk of time. It is also a group that bears great similarity to those currently covered by Medicare: enrolling the "near elderly" in Medicare would pose much less threat to the identity of current beneficiaries than adding younger groups.

But these advantages of categorical expansions are counterbalanced by a major disadvantage: the serious risk that such proposals will stall out, leaving us with a bigger Medicare program but not a clear path to further expansions. We only have to look to Medicare's history to see how a policy can create a robust beneficiary group but not strong political dynamics for further expansion. Midlife Medicare would build on the current understanding of the program as an entitlement for retirees and near retirees based on years of work and contributions. Partly for this reason, it might make it even harder to achieve reforms built on different understandings.

A more technical issue that nonetheless really matters is how to integrate a new Medicare plan with employment-based insurance. Buy-ins and public option plans largely assume that such insurance will be minimally touched, at least at the outset, which is one reason why they are unlikely to deliver universal coverage. But a categorical expansion of Medicare forces the question: is everyone in the category in, and if not, how do we ensure that they get covered? On the one extreme, we could just lower the eligibility age for Medicare, full stop. This would require coming up with the revenues to replace displaced coverage and managing the inevitable backlash caused by that displacement—a mini version of the Medicare for All conundrum. On the other extreme, we could have a Medicare buy-in restricted to this group, which might be a "here" even farther from "there" than most buy-ins and public option plans, since it would make the new Medicare option available only to a particular, and potentially small, segment of the workforce.

## The Imperative of Enrollment

The foregoing discussion of how coverage expansions might stall out points to an important conclusion: if we want universality, we have to build it into the

structure of proposals. Even if we do not think it is achievable in round one, what we put in place in round one should give us the best chance of achieving it in round two (or three or four). If a categorical expansion is just about covering one group, that is not an issue. But if it is about getting to universality, as it should be, it is a big one.

The upshot, I have come to believe, is that all Medicare expansion plans should contain the foundations for universal, automatic enrollment. Without such provisions, proposals are basically designed to give up before the game begins, to accept a world of insecurity in which too many Americans are uninsured or at risk of becoming uninsured. Putting in place the foundations for guaranteed universal coverage does not mean achieving it immediately, or even in a single round. But policies should have a clear path to it.

In the case of categorical expansions, this would most likely entail including provisions that integrate Medicare with employer-sponsored insurance, so that eligible Americans still in the workforce would be assured of either workplace coverage or Medicare. (More in a moment on the general issue of how to allow employment-based insurance to continue without countenancing a world of health insecurity.) A categorical expansion might stall out, and indeed I fear it would, but at least it would ensure coverage of all who were newly eligible.

Guaranteed enrollment would respond to almost every one of the imperatives already discussed. It would create quick, visible effects, promoting political support and ramping up the size of the public plan quickly. It would also reduce the ability of opponents to undermine a Medicare expansion by stealth, deterring enrollment by stigmatizing beneficiaries or cutting funding for marketing and outreach.

Medicare is the gold standard for automaticity: you are 65 or permanently disabled, you are in.[1] Medicaid and marketplace coverage are both more hit or miss: roughly 30 million Americans remain uninsured and the number appears to be rising (Garfield, Orgera, and Damico 2019). The difficulty is twofold: (1) eligibility is complex and varies based on income and other factors; and (2) there is no single "touch point" where people are signed up (and reenrolled when necessary). If the destination is universality and the path is Medicare expansion, both problems must be tackled.

Given the role of employers in the current system, the natural place to begin is the workplace. So long as employers are still providing coverage to some workers, universality will be elusive if there is not a mechanism for (1) determining whether workers get coverage at their place of employment and (2) signing them up for Medicare if they do not. In addition, there is a strong political argument for (3) requiring some contribution toward the cost of that coverage, as I discuss here.

The ACA does not do this: its coverage requirement only applies to larger employers (at least 50 full-time workers), the penalty for noncompliance is not a contribution to the cost of coverage, and the requirement only applies if the worker receives subsidies for private individual coverage through the regulated marketplaces. Most important, there is no process for automatically enrolling workers in coverage if their employer does not provide it. Add on top of this that many eligible for Medicaid do not get signed up—whether because they are unaware they could be covered; they are cycling between jobs or moving between

states; or they are deterred by complex, burdensome, and stigmatizing eligibility rules—and it is clear our current system is very far from having the foundations for guaranteed coverage.

The Medicare Part E proposal I have outlined would guarantee coverage in a few ways. Most important, it would change the ACA's "play-or-penalty" approach into a true "play-or-pay" system. Employers would still have to provide insurance ("play") or make a payment to the federal government. But these payments made in lieu of providing coverage would be considered *contributions* rather than penalties, with workers whose employers made the contribution automatically enrolled in Part E. (The design of these contributions is discussed later in this article, as it is closely related to Part E's over-time expansion.) And if employers did provide insurance, their coverage would have to meet high minimum standards, including automatic enrollment of workers. To ensure the federal government has an accurate record of all employment-based coverage, firms of all sizes would need to report if they covered their workers.[2] However, smaller firms would not necessarily have to pay a contribution, and contributions could be nominal to nonexistent for smaller, lower-wage firms. Similarly, the contribution requirement would have to extend to independent contractors and other self-employed workers (who would pay the contribution directly, as with Social Security taxes).

A play-or-pay requirement of this sort would essentially reach everyone who worked or lived in a family with a worker, including the self-employed. As a result, all but a tiny slice of Americans would have the opportunity to be automatically enrolled within a short period of time (Lewin Group 2008). To reach this small slice would require additional steps: signing people up when they receive other public benefits, or file their taxes, or seek care without insurance. But just as important as signing people up will be making sure they remain signed up. Today, most insurance requires that subscribers establish their eligibility up front and cuts them off if they fail to establish it or do not pay their premiums. Guaranteed coverage requires the opposite: sign people up and keep them signed up as long as they do not have a qualified alternative, and only in that context figure out what and how they can pay.

The debate over Medicare expansion is mostly focused on *what* will be expanded—Medicare, or something close to it. To really move to universal coverage, however, we need to know *how* people actually get covered by this expanded system. This is particularly true of plans that fall short of universal Medicare. After all, Medicare for All has an answer to the coverage question: you are born, you are in. Those who advocate a partial Medicare expansion have to answer the question as well, even if their path to universality may be longer and less direct.

## From Us versus Them to Them versus Us

The most effective attack on universal health care is relatively simple: you want to help "them" (lower-income Americans who lack coverage) at the expense of "us" (higher-income Americans who have it). This is a smear, of course, and it is

a smear that easily becomes racially laden, since the first group is much more likely to be nonwhite than the latter. But it is a smear that works because it contains some truth. In health care, progressive reforms *have* tended to provide the most visible direct benefits to Americans of modest means. The persistent fiscal constraints created by tax cutting push advocates to fixate on incremental federal costs and focus on those most likely to be uninsured. At the same time, the insurance arrangements of middle-class and affluent Americans, however flawed, have deep-pocketed defenders in the corporate and medical worlds.

The result is a vicious circle: the path of least resistance leads to cash-strapped reforms that leave millions uninsured while protecting the costliest segments of the system. This means that many Americans who are *not* low-income remain deeply insecure and that federal dollars spent on health care buy much less than they would in a system with reasonable costs. It also means that the minority of Americans younger than 65 who see government insurance as essential to their well-being lack the political heft or cohesion to defend what they have, much less advocate for more. It is hard to imagine a political dynamic more corrosive of solidarity than this.

Thus, a central imperative of Medicare expansion—perhaps *the* central imperative—is to foster communities of shared interest. Medicare has to be seen as a source of health security for many more nonelderly Americans. At the same time, both Medicare beneficiaries and those who remain in employment-based health plans have to see a direct link between a broader Medicare program and better benefits for themselves.

This imperative has at least three implications. First, Medicare has to be improved for older and disabled Americans if it is to be expanded to the rest of Americans. If the fight over the ACA carries any lesson, it is that Medicare beneficiaries need assurances that their benefits are secure and improving. It should not take two or three elections for them to find out that Medicare benefits are better and death panels are a conservative bogeyman.

Fortunately, smart politics is also good policy. For all its popularity and success, Medicare has significant gaps (Cubanski and Boccuti 2015). Addressing these shortcomings may not be sufficient to assuage beneficiaries' concerns, but if the upgrades are substantial and rapid, they should minimize the kind of backlash seen in the 2010 to 2014 interregnum.

Second, and by the same token, a Medicare expansion needs to provide something tangible to workers whose employers continue to provide insurance. To be sure, it will provide the security of knowing that if you lose or change jobs, you will have a simple, affordable option that is the same nationwide. Given the weaknesses of the marketplaces, the promise of fallback coverage provided by the ACA is much less reassuring.

Still, any proposal that envisions a good chunk of Americans remaining in employment-based coverage has to make workplace plans work better for the tens of millions of Americans who remain vulnerable to high medical bills and unexpected insurance gaps (Sawyer, Cox, and Claxton 2017; Claxton et al. 2017). The ACA's standards are simply not high enough, a reflection of the narrow political window it had to pass through and the determination not to displace

employment-based insurance. These standards need to be upgraded in a way that is visible, impactful, and directly linked to the expansion of Medicare.

In Medicare Part E, these linked imperatives would be achieved by upgrading Medicare for all beneficiaries, older and younger alike, and making this new benefit standard a floor for private coverage. To meet the play-or-pay requirement, in other words, employer plans would have to be as generous as Medicare. Thus, Medicare Part E would not only provide a guaranteed source of coverage; it would also set a floor for benefit generosity outside Medicare. Medicare would thus provide a high level of coverage for all its beneficiaries, and the quality of insurance would also improve for those whose employment-based coverage was below Medicare's new standard.

The third implication is that Medicaid has to be integrated more fully with Medicare and workplace plans. Medicaid has evolved tremendously in the past half century—from a marginal program of welfare medicine into the nation's largest insurer. And it has proven more resilient than many experts, myself included, expected. Nonetheless, it remains highly variable in generosity from state to state, is facing severe political and fiscal pressures, and pays doctors and hospitals so little that many providers refuse to accept it. The biggest problem, of course, is the continuing unwillingness of some states to expand their programs. But there are also millions of Americans who are eligible for Medicaid yet fall through its cracks, deterred by burdensome rules and the stigma the program still carries. What is more, a number of GOP-controlled states—with the imprimatur of the Trump administration—are increasing both the burdens and the stigma, which makes mainstreaming Medicaid all the more vital.

It will not be easy, as Jamila Michener's article in this special issue makes clear. Medicaid has its own political defenders, who understandably worry its beneficiaries will be harmed more than helped by folding the program into a national plan. Meanwhile, opponents will use this specter to frighten those currently on Medicare. And Medicaid is comparatively cheap—upgrading its payments and ensuring everyone eligible for it gets covered will raise the price of reform. But it is a price worth paying. No policy will reach universality if it keeps Medicaid as-is, and consigning the disadvantaged to a wholly separate system will only perpetuate the vicious cycle of us versus them.

At a minimum, Medicaid enrollment should be shifted to be automatic. In Medicare Part E, for example, when people were enrolled in Part E—whether through the workplace or through other efforts—federal authorities could check whether they qualified for Medicaid and, if so, transfer their coverage to state offices. In turn, states could be required to tell the federal government whom they covered through Medicaid and to inform the federal government whenever that coverage lapsed for whatever reason, so those affected could be covered by Part E. This alone would transform Medicaid from a program people scramble to get into—and frequently get knocked off of—into something much closer to the Medicare model, in which those who are eligible are automatically insured.

If there is going to be division, it has to be between a big us and a small them—everyone who has come to see Medicare and the standards it sets as

critical to their health security and the deep-pocketed defenders of our exorbitant system who stand in the way of this goal.

## Cost Control without (Too Much) Backlash

These deep-pocketed defenders are not particularly popular, which makes them an attractive target for reformers. They are, however, politically powerful. Organized interests that reap outsized rewards from lucrative pockets of American health care are perhaps the biggest wild cards in any reform fight. They will be against big changes, that much is sure, but how deep and prolonged their opposition is will matter greatly not just for enactment, but also establishment, entrenchment, and expansion.

The general advice from policy feedback research is that forestalling backlash and building communities of interest require spending generously and rapidly at the outset. But this advice raises the obvious rejoinder: how? New spending might not have to be paid for initially, but it will have to be eventually. Sustainable programs need sustainable revenues. And other progressive policies, such as infrastructure investment, have much greater claim to our deficit dollars.

Supporters of Medicare for All have proved reluctant to answer this question (wisely, I think—but they cannot remain silent forever). The basic approach, however, is clear: on one hand, replace premiums and a good chunk of out-of-pocket payments with taxes; on the other, generate major savings to ensure those taxes are not exorbitant. And, in theory, near-instant savings of considerable magnitude are possible: Medicare for All universalizes coverage within a single public insurance pool, lowering administrative costs, eliminating profits, and giving the federal government the leverage to cut prices.

The rub is that all this will provoke major opposition. Tax resistance has already been mentioned. But no less daunting is the prospect of quickly ratcheting down prices to Medicare levels, much less to international norms. The familiar adage that every dollar of health spending is someone's income is *literally* true when it comes to physicians, who make much more than doctors in other rich nations (especially specialists). But it is essentially true for every part of our medical-industrial complex: drug companies, hospitals, medical device manufacturers, and on and on. Only insurers, perhaps, do not have a lot at stake if prices come down. But by proposing to basically do away with them, Medicare for All would give them plenty of reason to fight, too.

So the two-part answer embodied in Medicare for All—raise taxes and cut prices—is at odds with what will almost certainly need to be done to get a new policy enacted and established. No country has gotten to universal insurance without making huge concessions to powerful private interests, and no country has had to deal with providers so consolidated and costly, drug manufacturers so insulated from competition and accountability, or insurers so free to make profits for doing what most countries consider a routine public function (Hacker 1998). The question is not whether concessions will be made; the question is what they will be.

A word of caution: 'tis the season of legislative sponsorship, when visions of precise legislative language dance through policy-makers' heads. Savvy bargaining may entail holding back some concessions that almost certainly will have to be granted. But it is a mistake to confuse current bills with future bargaining. Some sponsors of current legislation are incorporating the bargains they think will happen; others may be anticipating them but offering what is in effect their opening bid. Both approaches have merit, but neither is what will happen as an actual legislative package wends its way toward enactment. When we are pondering policy strategy rather than preparing legislative text, we should try to be clear about what we *expect* to happen as opposed to what we would like to happen.

What I expect to happen is relatively generous treatment of the medical industry in round one, but ideally a law that also puts in place the structural features that will ensure serious savings in the future. Expanding but not universalizing Medicare has many defects, but it does mean that major interests would not suddenly see their reimbursements for everything plunge to Medicare levels. At the same time, if the public plan is sufficiently big—refer back to the earlier discussion—a lot more people would still be covered by Medicare, which would mean more services financed at Medicare rates. Meanwhile, private insurers selling their services to employers that still offer coverage would face competitive pressure to demand lower prices so employers would not see it as a better deal to switch their workers into Medicare, too.

What about private plans that participate in Medicare Advantage and now enroll roughly a third of current beneficiaries? To minimize backlash, it seems wise to allow them to continue to operate within Medicare (with ongoing refinement of how these plans are paid to reduce overpayments). For one, Medicare patients like these options. Think how easy it will be to create resistance from current beneficiaries if reformers tell older and disabled Americans who are in private plans that they are no longer available. For another, it is hard to see how private options can be preserved for older and disabled Americans but blocked for new enrollees in Medicare. And given that a fair number of people will be moving from private employment-based coverage into Medicare, it seems wise to reassure workers that they will be available, too.

But the public is not the real problem; *insurers* are. The biggest companies are deeply invested in Medicare Advantage. Ensuring they still had a role in a postreform world—especially when it was lessened in other parts of the market—would reduce their inevitable opposition. Indeed, Medicare is much more attractive than the ACA marketplaces to the largest insurers, which have largely failed to jump into them.

Many progressive advocates are rightly critical of Medicare Advantage. But the program was improved by the ACA, which reduced plan payments to better reflect the true cost of providing benefits. Most plans actually pay rates close to Medicare's (Medicare Payment Advisory Commission 2017). This is, in large part, because they operate in a market in which their main competitor is Medicare. Thus, they can pay Medicare-like rates and still get providers to participate in their networks. (This, by the way, is one reason why privatizing Medicare would be a disaster; without the bargaining clout of the traditional

program, private plans would be paying the exorbitant prices they pay in the rest of the market.)

Expanding Medicare to a large number of younger Americans might even give private plans additional leverage over providers. After all, even the most consolidated and costly provider systems accept Medicare rates for older patients. Once Medicare was expanded, these lower rates would be paid on behalf of many younger Americans, too. For providers, the alternative to private payments would increasingly be Medicare rates for younger as well as older patients. As result, private plans might well be able to lower what they paid for nonelderly patients and still attract providers.

The general rule of thumb is that reformers should try to minimize up-front losses for powerful stakeholders. The exception is when such losses—read: revenues and savings—are integral to the design of the proposal and, in particular, to creating a sustainable revenue stream. In Medicare Part E, for example, the payroll-based contributions by employers fall into this category. They help to fund Part E and create a link between contributions and benefits, as in Social Security. Those newly enrolled in Medicare should also pay a modest premium. As in Part B, these premiums should cover only a small fraction of the total cost, and vary by income, with lower-income enrollees paying a minimal amount. Similarly, improved benefits for current Medicare beneficiaries could be financed in part by increasing the Medicare tax paid by workers.

None of this is to minimize the difficulty of raising the necessary revenue. (Ironically, the 2017 tax cuts could help with the problem, since ending them would be a popular way to raise revenues.[3]) Still, because most Americans who receive employment-based insurance would continue to do so and because employers would be required to contribute something, the additional new taxes needed would be much more modest than those for Medicare for All.

Two potential sources of *savings* are also critical enough to risk backlash: regulated provider payments and price bargaining for prescription drugs. In each case, the goal should be to begin with arrangements generous enough to blunt opposition yet that embody the capacity for future restraint. For example, providers could be required to treat newly enrolled Medicare patients if they accept traditional Medicare, but initial payments could contain a bonus of some sort, phased out over time. Even a partial move toward Medicare rates would produce major savings.

With drug manufacturers, price bargaining could begin with frequently used and high-cost drugs that have few substitutes and gradually move to a formulary of the sort most nations use. Initially, prices could be negotiated on behalf of private Part D plans, before moving to allow direct coverage of prescription drugs through Medicare itself. These changes will encounter serious opposition, but the cost savings from allowing Medicare to bargain for lower drug prices and provide a drug benefit directly are so substantial that significant pushback is worth courting.[4]

These examples illustrate the balance that will have to be struck between establishment and entrenchment. If a plan is really to be a "glide path" to universal affordable health care, it is going to need a fair amount of altitude at the outset

and a relatively low-angle descent. It will also need some power—self-reinforcing dynamics that foster expansion.

## Fostering Expansion

If backers of Medicare for All have to explain how it passes, advocates of Medicare for More have to explain how it grows: how does their plan expand into affordable health care for all?

In our joint article in this special issue, Paul Pierson and I call this "sequencing." If complete transit is unlikely, how much pressure will each step in a sequence of reforms create for the next? Sequencing should be distinguished from "staging": the steps laid out in a bill for implementing specific provisions over time. Medicare for All bills, for example, often include some initial moves toward that goal. But these early provisions are staged, not sequenced, and opponents will inevitably focus on the final stage: universal Medicare. In the best case, staging gives advocates time to get things right and create buy-in. In the worst, it gives opponents time to undermine or reverse the policy.

Sequencing, by contrast, involves multiple rounds of policymaking in which each policy ideally creates momentum for the next. And it has to be at the heart of any evaluation of plans to expand but not universalize Medicare. Such plans need to provide a focal point for expansion, easily understood and defended. They need to offer cost-saving opportunities for employers, states, and individuals so they buy in. In short, they need to embody a step-by-step process (flexible to changing circumstances) that unites crucial stakeholders and constituencies, fragments or appeases opposition forces, and yet still puts in place the conditions for effective cost control and continued expansion of Medicare.

Although the ACA finally appears well established, its ability to create such expansionary forces has proven mixed. More and more states are expanding Medicaid, but the ACA has not generated the kind of middle-class buy-in that has made Medicare so popular and resilient. To the contrary, many Americans still see the law as a threat to their benefits, despite the many ways in which it improved Medicare and private plans.

Such scare tactics will be harder when benefits are provided directly by Medicare. Medicare is familiar, and people know they have it because of government. In addition, if Medicare becomes the benefit floor for private plans, Medicare expansion would encourage privately insured workers to believe they had a stake in the program, too.

Employers' role is pivotal in this regard. If they see Medicare as an attractive means of insuring their workers, they are much more likely to climb on board. In the past, business opposition to social programs withered once employers realized they were a good deal. Although such dynamics are likely to be more muted today, a Medicare expansion could appease or fragment key parts of the business community if designed correctly.

In my proposal for Medicare Part E, for example, the employer contributions are meant to be significantly lower than the full cost of coverage, in part to minimize corporate resistance, in part to encourage enrollment in Medicare. They should be in there to encourage large employers to continue to provide insurance on their own (which would also decrease initial backlash by reducing revenue needs and coverage dislocations). But they should be modest and raise only a small share of the total cost of expanded Medicare coverage.

A similar set of considerations arise with regard to Medicaid. For example, a reform plan could give states strong incentives to cover low-income families through Medicare. States would not be allowed to simply "dump" Medicaid beneficiaries into Medicare, but they could be given a fairly generous deal, so those ambivalent about managing coverage see gains in transferring it to the federal government. Of course, this would also make it more likely that low-income Americans would enjoy seamless coverage through Medicare.[5]

One of the virtues of Medicare Part E is that its core components could be pursued sequentially. Indeed, many of them have already been established by the ACA—preexisting coverage protections, limits on lifetime benefit caps, coverage of young adults under their parents' employer plans—while others build on the ACA's provisions, such as the shift from a play-or-penalty to a play-or-pay requirement.

Consider the following sequence. First, Medicare could be upgraded and employers given the option of buying in to cover their workers. At the same time, the standards for employment-based plans could be raised. Then, the penalty under the ACA could be transformed into a contribution requirement—first for larger employers, then for all employers. Each of these steps would be popular, do much good, and create momentum for further action.

The test with any sequenced approach is whether each step will increase the pressure for more. As I have argued, simply adding Medicare to the marketplaces or even expanding Medicare to new categorical groups might not meet that test. I think Medicare Part E does meet it—that is, it is likely to get us to guaranteed universal coverage through a self-reinforcing process.

## Conclusion

Advocates of fundamental health reform will continue to debate the best way forward. Such disagreements, however, should not obscure shared principles: that affordable health care coverage should be guaranteed for everyone and that the bargaining power of a democratically accountable government can and should be used to restrain costs.

The disagreements that remain are real, but many reflect issues of political feasibility—and, in particular, differing assessments of whether we can almost immediately replace the current employment-based patchwork framework (and especially all employment-based plans, which cover approximately 150 million Americans) with a single system that replaces the bulk of current private financing with new federal taxes. The hopes of advocates of universal insurance are mostly shared. Their assessments of what is politically possible are not.

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