Lessons From the Long and Winding Road to Medicare for All

Recently there has been a surge in political attention to Medicare for all, the latest chapter in a long history of conflict over national health insurance in the United States. This essay places the current Medicare for all debate in historical perspective.

My aim is to illuminate past struggles over single-payer reform, explore the genesis and evolution of Medicare, and analyze the implications for contemporary health politics of the public and private insurance arrangements developed by the United States over the past century.

The history of US health reform provides critical lessons for understanding the enduring appeal of single-payer models as well as the formidable political obstacles to transforming Medicare for all from an aspiration into a legislative reality. (*Am J Public Health.* 2019;109:1497–1500. doi:10.2105/AJPH.2019.305295)

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See also Donnelly et al., p. 1482.

Single-payer national health insurance is in the midst of a remarkable political resurgence in the United States. A decade ago, single payer could not get a hearing in Congress. When the Senate Finance Committee, chaired by Democrat Max Baucus, did not invite any single-payer advocates to testify about health reform in 2009, activists protested the proceedings, leading to their ejection and arrest.[1] That episode epitomized single payer's marginal position during the 2009–2010 health care debate.

The Obama administration and congressional Democratic leaders did not seriously consider single payer as a reform approach because they deemed it politically infeasible.[2] A more limited proposal to create a new public insurance option passed the House of Representatives but not the Senate and was jettisoned from the legislation that became the Affordable Care Act (ACA).[2,3] When Vermont senator Bernie Sanders ran for president in 2016, his single-payer platform appeared to be a quixotic departure from Democrats' support for the ACA.

Now, as the 2020 elections approach, single payer has moved from the margins to the mainstream of American politics and become a topic of national debate. Single-payer plans have drawn substantial public support; about 56% of all Americans currently favor Medicare for all (although public understandings of that label, including whether it means all Americans would obtain coverage from Medicare or instead would have the option to join Medicare, vary widely).[4]

Sanders is no longer alone: four Democratic senators running for president in 2020 are cosponsors of his Medicare for all legislation.[5] In addition, more than 100 Democrats are cosponsoring another Medicare for all bill introduced by Representative Pramila Jayapal in the House, which held hearings on single payer during spring 2019.[6] Other Democrats support proposals to establish a new, Medicare-like public option or extend Medicare eligibility to more Americans (such as people between 50 and 64 years of age).[7] Meanwhile, Republicans appear eager to run against single payer in 2020, further raising its political profile.[8]

NATIONAL HEALTH INSURANCE AND MEDICARE

Understanding the political history of Medicare helps to illuminate the current debate over Medicare for all. The origins of Medicare reside in failed efforts to enact national health insurance in the 20th century. In 1915, the American Association of Labor Legislation released a model health insurance bill for industrial workers that was eventually introduced in 15 states.[9] Reformers encountered opposition from the insurance industry, business and some labor groups, and the American Medical Association (AMA), as well as xenophobia (during World War I, opponents attacked compulsory health insurance as a "German plot").[10,11] By 1920, the first campaign for national health insurance in the United States had effectively ended.[9]

Franklin Delano Roosevelt considered pushing for national health insurance during his presidency (1933–1945) but never did, partly because of AMA resistance and the political controversy that surrounded the idea.[12] In 1943, however, three Democratic members of Congress, Robert Wagner (New York), James Murray (Montana), and John Dingell (Michigan), introduced a bill to create a national health insurance program for all Americans through the Social Security system, a forerunner of contemporary single-payer proposals.[13]

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Roosevelt's successor, Harry Truman, became the first president to formally endorse national health insurance in 1945.[13] It did not come close to passing Congress owing to divisions among Democrats and opposition from Republicans, fierce AMA resistance, and the stigma of "socialized medicine" that was amplified against the backdrop of Cold War tensions.[10–14] The AMA warned that the Truman plan would lead to compulsion, socialism, higher taxes, and poorer quality medical care, warnings that still echo in American politics today.[13]

The charged rhetoric used by opponents, hostility from stakeholders, and the specter of socialized medicine were not the only political obstacles that would confront the Truman administration and reappear in subsequent US reform debates. The rapid spread during the 1940s of employer-based private health insurance, touted by supporters as "the American way," gave critics a "voluntary" alternative to "compulsory" insurance.[10] Its rise, bolstered by worker demand, union bargaining, and favorable tax policies, thereby complicated the push for a single federal program. The more years that passed without national health insurance, the more the United States developed alternative coverage arrangements, creating additional barriers to organizing medical care under a single payer.[15,16]

Having failed to enact universal insurance, the Truman administration switched strategies and instead pursued demographic incrementalism. In 1951, administration officials announced a proposal for 60 days of federal hospital insurance for elderly Social Security beneficiaries, the genesis of Medicare, which finally passed in 1965 after President Lyndon Johnson's landslide victory in the 1964 elections that also gave Democrats large congressional majorities.[14] Reformers envisioned Medicare as a first step that, over time, would expand from insuring the elderly to cover children and eventually all Americans. Medicare for all was their ultimate goal.[17]

Although Congress extended Medicare eligibility in 1972 to individuals with end-stage renal disease and permanent disabilities, the program never fulfilled the expansionary trajectory that its architects expected.[17] Liberal reformers, including Massachusetts senator Ted Kennedy, unsuccessfully pushed single-payer national health insurance legislation during the 1970s. Meanwhile, over time Medicaid, which had been enacted as part of the same 1965 law that created Medicare to finance medical care for certain categories of low-income individuals, grew substantially in its coverage of children and pregnant women. Medicaid emerged in the 1980s and 1990s as the primary public platform to address the growing uninsured population.[18] American politics also moved rightward after the mid-1970s, with an erosion of faith in government amid the Vietnam War, Watergate, and the economic shocks of stagflation and a rise in antitax sentiment.[17]

The idea of Medicare for all faded. Although some reformers, inspired by Canada's experience with government-provided health insurance, pushed for single-payer health care, after the mid-1970s Democratic party leaders increasingly embraced reform models that relied on expanded private coverage, regulated competition between insurers, and subsidies for the uninsured.[17] The aim, exemplified by the Clinton administration's proposed 1993 Health Security Act, was to move toward universal coverage through regulated private insurance rather than replace private plans with a government program.

Proponents viewed this as the only politically viable reform path because it did not threaten to displace private insurance and employer-sponsored coverage.[16,17] They touted its ostensible compatibility with Americans' skepticism of government and embrace of markets, choice, pluralism, and competition.[19] Such an approach was believed to be more acceptable to the health care industry, which feared the concentration of purchasing power in the federal government that a single-payer plan would create. In the aftermath of the Clinton plan's spectacular defeat in 1994, attributed partly to the ambition of its proposed changes in employer-sponsored insurance, Democrats did not abandon but instead doubled down on the strategy of leveraging private insurance to expand coverage, thereafter embracing proposals that committed even more to minimizing disruption.

The ACA, which itself largely emulated Massachusetts' influential 2006 health law, embodied the political presumption that (near) universal coverage could be achieved only by retaining private insurance.[2] The ACA did not build on Medicare. It did, however, extend insurance coverage through Medicaid, whose reliance on state administration and private managed care plans makes its expansion a less threatening prospect to health system stakeholders and political moderates than Medicare expansion.

POLITICS OF SINGLE-PAYER REFORM

Four major lessons emerge from this history. First, single-payer models have been part of our health reform debates for more than 75 years. Their recurrent appeal reflects the deep, enduring problems of American health care. The United States has not, as all other rich democracies have done, established a system of universal coverage that provides health security to all of its citizens. Single payer offers a solution to America's persistent problems with health care costs, access, affordability, and fragmentation and complexity of insurance.[20,21] As long as those problems persist, so too will support for single payer.

Second, proposals to establish a federally run national health insurance program, with the important exception of Medicare, have consistently failed to come anywhere close to passing Congress. Their repeated defeat underscores the daunting barriers that have long stood in the way of single-payer plans, including intense opposition from health system stakeholders, Americans' ideological ambivalence about government, fear of socialized medicine, and fragmented political institutions that make enactment of ambitious reform legislation difficult and give opponents multiple opportunities to block reform.[20]

Third, in the absence of national health insurance, the United States developed, through a series of incremental reforms, a patchwork nonsystem of public and private insurance arrangements encompassing employer-sponsored coverage, Medicare, Medicaid, the Children's Health Insurance Program, and, more recently, the

ACA. That patchwork has itself become a major barrier to single-payer reform as those insurance foundations have developed their own constituencies and stakeholders and constituted a status quo to which Americans have grown accustomed.[15,16]

Cohering the byzantine, fragmented collection of governmental and private insurance programs into a single national plan is an extraordinarily formidable task.[20] Each piece of our health care patchwork has influential political interests that are fiercely protective of the status quo and resistant to the major disruption in current arrangements that Medicare for all would require. Moreover, the proliferation of alternative coverage sources means that moving to a single federal plan would require more than 200 million people, many of whom are satisfied with their present arrangements, to change insurance.[22] Even Medicare beneficiaries are subject to political attacks against Medicare for all that claim it would threaten their existing access to medical services.

Single-payer reform would also require, if employer-sponsored insurance is to be substantially displaced by a government plan, supplanting private with public financing. Although single payer has efficiencies that could produce considerable savings, those savings do not obviate the enormous political challenge of substituting highly visible (and high) taxes for often obscured employer premium contributions.[23,24]

Fourth, from about 1975 to 2015 the political fortunes of single-payer health reform faded.[17] Whereas national health insurance organized by the federal government had previously been the dominant model of liberal reformers and Medicare's enactment was originally seen as a first step to realizing that goal, during that period the prevailing reform models shifted rightward and largely sought to build on private insurance, reflecting changing ideological currents and electoral alignments as well as concessions to perceived political realities. The turn away from single-payer models and Medicare expansion was embodied in the ACA, which increased coverage through private insurance and Medicaid rather than Medicare. Medicare itself bears the mark of these changes; a growing portion of program beneficiaries, now about one out of three, enroll in private plans that operate as an alternative to traditional Medicare (their role suggests the complex issues that reside beyond the Medicare for all slogan).

CONTEMPORARY PROSPECTS OF MEDICARE FOR ALL

As this history shows, Medicare for all is an old aspiration that has resurfaced in contemporary US politics. Its resurgence reflects the impact of Senator Bernie Sanders' 2016 campaign for the Democratic presidential nomination and the leftward shift of the Democratic party, which includes a renewed willingness to consider tax increases and big federal initiatives. It is also a reaction to efforts by the Trump administration and congressional Republicans to repeal Obamacare during 2017–2018, which raised questions about the law's sustainability, as well as a response to the ACA's limitations and state obstructionism that has restricted the reach of Medicaid expansion.[25]

The ACA has substantially reduced the uninsured population. However, about 30 million individuals are uninsured; coverage remains unaffordable for many Americans; private plan enrollees often face large (and growing) deductibles and copayments, leaving many of them underinsured; and patients' struggles with insurance companies over billing and coverage decisions persist, as do high administrative costs and exorbitant medical care prices. No wonder, then, that Medicare for all has widespread appeal.[20]

Can Medicare for all move from aspiration and slogan to legislative reality? Single-payer reform would entail an extraordinary degree of change in US health policy and centralization of insurance coverage, financing, and provider payment under the federal government. Such disruption may be justified given the myriad pathologies of American health care. But that does not make any easier the political task in a nation whose political institutions and health care system both have powerful biases toward incrementalism. The political hurdles that tripped up national health insurance in the 20th century endure. Moreover, the ACA has become another obstacle to single-payer reform because it too is now part of the status quo.

Both the politics, replete with formidable barriers and fierce opposition, and history of health reform, dominated by failure and incrementalism, are stacked heavily against Medicare for all. The ACA won enactment partly because it embraced incrementalism, built on the status quo to reduce stakeholder resistance, and minimized disruption for the already insured.

Medicare for all is the anti-ACA; it eschews incrementalism and compromise, overturns the status quo, and disrupts most prevailing insurance arrangements. But in devising a plan that, relative to the ACA, is certain to draw much fiercer resistance from stakeholders, create greater public anxieties about rationing access to medical services and other consequences of a government "takeover" of insurance, require a much larger scope of disruption in the health system and increase in taxes, and have a much bigger impact on the federal budget and national economy, it is not clear what political strategies single-payer advocates have to overcome such immense obstacles. Seizing the moral and policy high ground is not a legislative strategy.

Given the enormous barriers to Medicare for all, how could it come to pass? A mass movement, such as the movement that propelled civil rights legislation in the 1960s, could help break down those barriers, as could a decision by employers buffeted by health costs to back single payer. Yet, such developments have long been awaited but not materialized. Ironically, conservative judges may be Medicare for all's best hope. A federal judge in Texas has declared the entire ACA unconstitutional, and the case could wind up in the Supreme Court. If the court ultimately strikes down the ACA, it would destabilize the health insurance system, and tens of millions of Americans would lose coverage and consumer protections. That catastrophic outcome and ensuing turbulence could delegitimize the incremental reform approach that Obamacare represents and dramatically increase the political viability of Medicare for all.

Short of the ACA being eviscerated by the courts (or a

future Republican Congress and president), Medicare for all's fate could be altered by coming elections. A transformation of the political landscape in 2020 and beyond—with a president committed to Medicare for all and large liberal majorities in Congress—could substantially improve the chances of single-payer reform.

However, in the foreseeable future incrementally expanding Medicare or establishing a Medicare-like plan to cover more Americans (e.g., the uninsured, near retirees, or workers) will likely remain a more politically feasible (although still extraordinarily challenging) project than achieving Medicare for all in one great leap away from private insurance. Such reforms would be less disruptive to existing insurance arrangements and tap into a large strain of public opinion that favors Medicare as an option for all (or more) Americans rather than as the sole source of coverage. The struggle over Medicare for all and universal health insurance continues. AJPH

CONFLICTS OF INTEREST

During the past three years, the author received honoraria for giving talks on health policy at the LTC & Senior Living CXO Summit, the Riverside Health System Leadership Conference, the annual meeting of the Hospital Association of New York State, the Cedars-Sinai Medical Center, the Mid-sized Retirement & Healthcare Plan Management conference, and the St. Louis Area Business Health Coalition annual meeting.

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