THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Perspective

Navigating the Shifting Terrain of US Health Care Reform—Medicare for All, Single Payer, and the Public Option

JONATHAN OBERLANDER

University of North Carolina at Chapel Hill

Policy Points:

- "Medicare for All" is an increasingly common term in US health care reform debates, yet widespread confusion exists over its meaning.
- The various meanings of Medicare for All and other related terms reflect divergent political and philosophical assumptions about the preferred direction of health care reform, as well as the hybrid structure of the current Medicare program.

"Medicare for All" has emerged as a major flashpoint in American politics. Its unexpected rise is, in part, a reaction to a decade of the Affordable Care Act (ACA, also known as Obamacare)—an ironic development given that the ACA embodies a reform model that builds on private coverage and Medicaid. However, frustration with Obamacare's myriad political and policy limits as well as an unceasing struggle over its repeal have increased support among many reformers for alternatives that break with the status quo and substantially expand the federal government's role in health insurance.

Yet, just as Medicare for All is moving to center-stage in US health care debates, supporters of the idea are fighting over where to define its boundaries. If Medicare is to be expanded to all Americans, what does that actually mean and how would it change existing insurance arrangements? The answers may seem obvious. But Democratic presidential candidates Senators Bernie Sanders and Kamala

The Milbank Quarterly, Vol. 97, No. 4, 2019 (pp. 939-953)

Harris have issued Medicare for All plans that diverge substantially in their reform visions. That divergence speaks to the broader debate over, and to the complexity and confusion surrounding Medicare for All and related proposals for establishing "Medicare-like" programs. This essay traces the evolving language of health reform in the United States, clarifies the various meanings of Medicare for All, and explores what the debate over the label and other Medicare-related expansion plans, including the public option, reveals about health care politics.

The Shifting Language of Health Care Reform in the United States

Medicare for All is the latest in a long line of health reform terms and slogans. A century ago, the first proposals for government-organized sickness insurance in the United States spoke of "social insurance" or "compulsory insurance."[1-3] The latter term underscored reformers' view that voluntary insurance, such as mutual benefit societies organized by workers, was fundamentally flawed because "it failed to make insurance universal," "left without protection those who most need it," and imposed "the entire burden of the cost of sick-insurance . . . upon the shoulders of the . . . workers."[1] Health insurance programs only would be viable, advocates of compulsory insurance believed, if all eligible workers were required to participate and if employers, workers, and the public were required to share in financing such protection.

The idea of compulsory insurance persisted in US health policy for decades, though the enactment of Social Security in 1935 provided a programmatic platform that reshaped the language of health care politics. In 1945, when Harry Truman became the first American president to endorse universal coverage, he called for "expansion of our existing compulsory social insurance system."[4] When Truman's plan failed to pass Congress and the administration narrowed its focus to coverage for the elderly, reformers emphasized the goal of enacting health insurance "through" or "under" Social Security, an aspiration realized in 1965 with Medicare's passage.[5-7] Medicare's architects stressed the contributory nature of Social Security financing, supplanting earlier references to compulsory insurance.

After 1965, plans that called for enacting a single insurance program operated by the federal government, such as that proposed by Massachusetts Senator Ted Kennedy in 1971, were commonly referred to as national health insurance, though that term also was applied to universal coverage proposals that relied on private insurance.[8,9] Even though Kennedy embraced the aspiration of universalizing the type of federal health insurance embodied by Medicare, he did not call for Medicare for All, perhaps because of criticism at that time that Medicare was overly solicitous of the medical care industry and consequently had contributed to accelerating medical care spending.[10] By 1969, Senate Finance Committee Chair Russell Long was warning that Medicare, which initially had generous payment arrangements designed in part to assuage medical providers and ensure their participation in federal health insurance, had become a "runaway program."[6] For many reformers in the 1970s, Medicare was less a model than a part of the problem in American medical care. Indeed, rather than building on Medicare, Kennedy's bill proposed repealing and subsuming it into a new Health Security program (whose name echoed Social Security despite the bypassing of Medicare).[8]

Meanwhile, Canada had enacted national health insurance. In actuality, each provincial and territorial government had established its own public insurance program, also known as Medicare, which was jointly financed with the federal government. All provinces and territories had implemented such arrangements by 1972.[11] As Canada managed to insure all its citizens while spending much less on medical care than the United States, reformers in this country increasingly began to call for adopting Canadian-style national health insurance. By the 1990s, "single payer" had become the term of choice for American reformers, including Physicians for a National Health Program, who advocated replacing our mix of public and private coverage with one government insurance program (plans that alternatively sought to build on that mix were labelled as "universal health insurance" or "universal coverage").[12-16]

Single payer accurately described how medical services would be financed in a Canadian-like system—hospitals and doctors would be paid for covered services by one insurer. It also distinguished this approach to financing medical care from "all payer" models, such as those used in Germany and Japan, that relied on multiple regulated insurance

plans rather than one government program.[16] Still, single payer was ultimately a technical term that generated little public appeal, public understanding, or political momentum.[17] The label also spawned confusion over exactly what arrangements constituted a single-payer system. Did it encompass a British-style national health service or just Canadian-style national health insurance? Even academic experts could not agree.[18]

Reformers' recent invocation of Medicare for All reflects a significant change, and undoubtedly an improvement, in political strategy. Medicare for All immediately connects proposals for government insurance to a popular, familiar, and entrenched program that already exists in the United States rather than to a confusing financing label or a mostly unfamiliar and often vilified foreign insurance plan (supporters of the metric system can attest to the limits of citing international precedent as a means to securing changes in US policy). Campaigning against the supposed shortcomings of another nation's health insurance program or the imagined horrors of an abstract, future "socialized medicine" system is one thing; trying to convince Americans about the ostensible horrors of expanding Medicare, an immensely popular program that tens of millions of persons know and rely on, is a more difficult task. While public and policymakers' understandings of the philosophical principles and economic logic of social insurance may be limited, appealing explicitly to Medicare expansion offers an alternative, concrete way to talk about the virtues of social insurance.[19]

Polling data support the labelling change: Americans are much more likely to register support for Medicare for All (or universal health coverage) than single-payer health insurance.[20] The turn to Medicare for All also reflects the improved performance of Medicare, whose relative success (compared to private insurers) in moderating spending growth since the 1980s and maintaining low administrative costs has bolstered the program's reputation among reformers and policy analysts.[6,21-28] Medicare is often portrayed not merely as an equitable platform through which to provide all Americans with insurance, but as a symbol of administrative efficiency and cost control.[26-28] Medicare for All is thus seen as the key to making health care a universal right, eliminating the problems of the uninsured and underinsured, reining in spending and regulating prices in the world's most expensive health care system, and reducing the prolific waste and administrative costs generated by convoluted billing and insurance arrangements.[13,14,29-34]

The Pure and Hybrid Models of Medicare for All

The rise of Medicare for All has been accompanied by growing confusion over its meaning. As the debate between Senators Sanders and Harris over their respective health plans indicates, behind the label lie competing conceptions. The *pure model* of Medicare for All seeks to establish a national insurance program operated by the federal government, prohibiting private insurance for services covered by the publicly funded government plan. In contrast, the *hybrid model* would allow private insurance plans that abide by federal regulations, including those sponsored by employers, to operate alongside and within a government-run Medicare program. Neither version of Medicare for All, in fact, would extend Medicare in its current form to all Americans. Instead, both would *expand* Medicare's current benefit package to redress its many limitations.[35] Moreover, neither model would actually enroll all persons in the United States into a single insurance plan. Even in the pure model exemplified by legislation proposed by Senator Sanders, the Veterans Health Administration and Indian Health Service would remain intact, reflecting the political sensitivity of disrupting established arrangements for those populations. Simply put, Medicare for All plans would not cover all Americans.

These two visions of Medicare for All take their inspiration from different sources. The pure model seeks to emulate Canada's insurance arrangements, albeit via a single national plan rather than a series of programs administered by states. It largely displaces private insurance with government coverage, just as Canada prohibits private insurance for services covered by publicly funded insurance.[36,37] But the pure model, which also has been endorsed by Massachusetts Senator Elizabeth Warren, albeit contingently, goes beyond Canadian Medicare in one crucial respect. In Canada, there is first-dollar coverage, with no patient cost-sharing, for services insured by the government. But there is a robust supplementary private insurance market for services, such as outpatient medications and dental services, that are not covered fully by the government plan.[36,37] Indeed, "private-sector spending . . . account[s] for 31% of total health expenditure" in Canada.[38]

However, current legislative versions of the pure Medicare for All model are capacious in design, with no patient cost-sharing and

extraordinarily comprehensive benefits, including coverage of long-term care and dental services.[39,40] The comprehensiveness of the proposed coverage is an antidote to trends in the United States of rising patient cost-sharing and a growing problem of underinsurance. The result, though, is that contemporary Medicare for All plans leave no room for a meaningful supplemental market. And while some versions of national health insurance legislation in the 1970s, including a bill cosponsored by Senator Kennedy and House Ways and Means Committee chair Wilbur Mills, relied on private insurers as administrative agents, current conceptions of the pure model of Medicare for All do not envision such a central role for them.[9]

The hybrid model of Medicare for All instead draws on existing arrangements in Medicare, where 34% of program beneficiaries enroll in private Medicare Advantage plans that contract with the federal government.[41] Medicare is a very different program today than when it was enacted in 1965, with a much larger role for private insurers (although from Medicare's inception, private entities have handled claims processing and beneficiaries have long carried private supplemental coverage that fills in some of Medicare's benefits gaps and cost-sharing requirements).[42] Enrollment in Medicare Advantage has more than tripled since 2000, reaching 22 million beneficiaries in 2019.[41] Another part of Medicare that provides outpatient prescription drug coverage, enacted in 2003, is composed entirely of private plans.[43]

In other words, while the appeal of Medicare for All rests largely on the presumed advantages of government-run insurance, the reality is that a significant portion of the current Medicare program is actually privatized.[44,45] The divide over Medicare for All, then, reflects the complexities in Medicare and the differences between its traditional component, where beneficiaries join a government program that reimburses private providers for medical services, and Medicare Advantage, where beneficiaries join private insurance plans that contract with and are paid by the federal government. Because Medicare currently embodies different approaches to health insurance, it lends itself to competing conceptions of Medicare for All.

The pure and hybrid models advance varying goals, embody different philosophies, and reflect different political calculations. The pure model, which is how the health reform community has until now generally understood Medicare for All, presumes that America's various

health care pathologies can only be remedied by eliminating private insurance as a major source of coverage. The goal is not simply to achieve universal health insurance but to do it through a government program and without relying to any meaningful degree on private insurers. Health security will never be achieved, from this perspective, unless private insurance is jettisoned because the corrosive effects of market forces are seen as the central problem in American health policy.[30,31] As a summary of the Sanders plan puts it, "the ongoing failure of our health care system is directly attributable to the fact that—unique among major nations—it is primarily designed to . . . maximize profits for health insurance companies, the pharmaceutical industry and medical equipment suppliers."[39] The pure model of Medicare for All holds that retaining private insurance as a primary source of coverage is incompatible with creating an equitable and efficient health care system.

In contrast, the hybrid model is willing to leverage both public and private insurance to cover all Americans. It makes a concession to perceived political realities and attempts to lessen disruption by preserving a significant role for private insurers and employers. It also embraces the altered nature of Medicare, building on the preexisting Medicare Advantage component. The growth of Medicare Advantage has reshaped the politics of Medicare as well as its programmatic character; more than 20 million beneficiaries are, after all, accustomed to its benefits, creating a broad constituency (which is led by private insurers) for maintaining Medicare Advantage.[46] The hybrid model would not compel Medicare beneficiaries in those plans to switch coverage, unlike the plan offered by Senator Sanders, which would eliminate Medicare Advantage after a transition period (though notably, his bill would eliminate the benefit gaps that such plans typically fill).[39,42] From this perspective, health care reform requires compromise; the Harris plan argues that "this isn't about pursuing an ideology."[47] Advocates of the hybrid model believe that the goal of enacting universal coverage justifies the retention of private insurance. However, by preserving Medicare Advantage, such models also inherit its problems, including a record of federal overpayments to such plans.

The hybrid model reconfigures Medicare for All into a more flexible reform vehicle that, like today's Medicare program, accommodates both government and private insurance.[48] All Americans would not be covered by a single insurer and medical providers would not be reimbursed

by a single payer, but instead nearly all persons would either enroll in the public Medicare program or a private Medicare plan approved by the federal government. While the notion that Medicare's dual public-private structure offers a politically appealing model to expand insurance coverage is not new, previously these hybrid arrangements, as well as retaining a role for employer-sponsored coverage, had not commonly been packaged under the Medicare for All banner.[48] The hybrid model thus offers the rhetorical appeal of Medicare for All (presumably an advantage in the Democratic presidential primary) and the reality of preserving a major role for private insurance (presumably an advantage in a general election and in passing legislation through Congress).

A Medicare-like Public Option

Adding to the confusion is a third health reform plan that departs even further from the pure model by offering the promise of, as presidential candidate and South Bend, Indiana Mayor Pete Buttigieg has put it, "Medicare for all who want it."[49] In such models, also proposed by former Vice President Joe Biden, Americans could join a new "Medicare-like" or "Medicare-type" public option or otherwise remain in their current health plan. In contrast to the previously discussed iterations of Medicare for All, these plans would largely leave the ACA intact—the goal is to build on and supplement Obamacare rather than replace it with a new program.

Such plans are not Medicare for All, nor are they even Medicare for More since they generally seek to establish a new Medicare-like program rather than directly expand the current Medicare program (though some members of Congress have proposed doing exactly that by allowing persons aged 50 and older to buy into the program).[50] Within the public option category, there is substantial variation in who would be eligible to join such a program, which would shape its potential enrollment. Would a public plan be a residual option on the ACA insurance marketplace for the uninsured, a destination for most Americans, or something in between? Biden's plan envisions a broad program where both Americans without insurance and those with employer-sponsored or individually purchased coverage could enroll.[51] Other versions of the public option frame it as initiating a "glide path" toward Medicare

for All since enrollment in the new Medicare-like program could be substantial if private insurers can't compete successfully with it.[49] However, one person's stepping stone is another's slippery slope. Opponents of the public option have cast it as a "Trojan horse" for a single-payer system.[52]

One common feature that public option plans generally share is leaving the current Medicare program intact while establishing a new Medicare-like plan alongside it (though that doesn't preclude proposing improvements in the original Medicare benefits package).[50] That hands-off stance could help to reassure Medicare beneficiaries who are concerned that expanding Medicare to more or all Americans could jeopardize their own medical care, a fear fed by Republicans' warnings. Indeed, while Democrats are debating the meaning of Medicare for All, Republicans are trying to reframe such plans as "Medicare for None."[53,54] President Donald Trump has argued that "by eliminating Medicare as a program for seniors, and outlawing the ability of Americans to enroll in private and employer-based plans, the Democratic plan would inevitably lead to the massive rationing of health care . . . Seniors would lose access to their favorite doctors . . . today's Medicare would be forced to die."[54] While it may be harder to scare Americans about the prospects of Medicare for All than the perils of a foreign system of socialized insurance, Republicans are betting that Medicare beneficiaries themselves can be scared about the risks of opening up *their* program to others. A public option plan that does not envision Medicare for All or enrolling more persons directly into the current Medicare program might be more immune to such fearmongering aimed at older Americans. Yet the history of US health care reform debates demonstrates that fear of change can be successfully instilled by reform opponents regardless of the facts.[55,56]

Ultimately, public option plans aim to advance the rhetoric of choice while harnessing the benefits of association with Medicare without triggering the political liabilities of Medicare for All. Labelling a plan as Medicare-like capitalizes on Medicare's popularity. It signals as well that the new public option, which would amount to a sort of "safe harbor" from commercial insurers, will not be governed by the profit motive or engage in dubious insurance practices and will offer a broad choice of medical providers. By retaining private insurance, it also will offer a broad choice of health plans. In addition, public option plans aim to use Medicare's prices and purchasing power, which has proven to

be much stronger than that of private insurers, in order to hold down costs.[24,51,57-59] Private insurers would have to compete with a lower-cost public option, which could generate additional cost savings.[48,59]

Yet the political advantages of maintaining both government and private insurance plans, appealing to the virtues of choice, and retaining much of the status quo rather than establishing a single insurance pool also entail significant policy tradeoffs. These include concerns over whether costlier enrollees might disproportionately enroll in a public insurance option and questions over how to sync the benefits and financing of a new government-sponsored option with existing programs, including Medicare and the ACA.

While public option plans are not Medicare for All, they evidently do represent what much of the public thinks of when they hear the term. In a July 2019 Kaiser Family Foundation survey, 55% of Americans believed that persons could keep their current plans obtained through work or purchased individually under a Medicare for All plan.[20] Put another way, many Americans understand Medicare for All as making the program available to all persons or perhaps all who need coverage, not replacing all insurance with Medicare.

Conclusion

Medicare for All is now receiving more serious consideration from presidential candidates and lawmakers than at any time since the program's enactment over five decades ago. The debate over what Medicare for All means and which model of Medicare (or Medicare-like) expansion to pursue reflects persistent tensions in health policy between pragmatism and principle, incremental and systemic reform, and building on or tearing down the status quo. The current debate also reflects efforts by different political factions and interests to frame Medicare for All and related options in ways that, depending on their aspiration, will either help or hinder its legislative prospects. The question is whether Medicare will endure beyond 2020 as a prominent reform model that defines the health care debate or whether we are witnessing an ephemeral development that presages US health policy moving in yet another direction. The 2020 elections could clarify which direction reform will move in, but they are unlikely to resolve the longstanding American debate over the promise and perils of government-sponsored health insurance.

References

1. Rubinow IM. *Social Insurance, with Special Reference to American Conditions*. New York: Henry Holt and Company; 1913.
2. Numbers RL. *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912-1920*. Baltimore, MD: Johns Hopkins University Press; 1978.
3. Hoffman B. *The Wages of Sickness: The Politics of Health Insurance in Progressive America*. Chapel Hill, NC: University of North Carolina Press; 2001.
4. Truman HS. A national health program: message to Congress on a national health program from President Harry S. Truman. *JAMA*. 1945;129(13):888-891.
5. Marmor TR. *The Politics of Medicare*. Hawthorne, NY: Aldine de Gruyter; 1973.
6. Oberlander J. *The Political Life of Medicare*. Chicago, IL: University of Chicago Press; 1973.
7. Ball RM. What Medicare's architects had in mind. *Health Aff*. 1995;14(4):62-71.
8. Kennedy EM. Introduction of a bill to create a national system of Health Security. *Congressional Record—Senate*. January 25, 1971. https://www.healthcare-now.org/wp-content/uploads/2017/10/Health-Security-Act-1971-Intro-and-Full-Text.pdf. Accessed August 12, 2019.
9. Feder J, Holahan J, Marmor TR, eds. *National Health Insurance: Conflicting Goals and Policy Choices*. Washington, DC: The Urban Institute; 1980.
10. Oberlander J, Marmor TR. The road not taken: what happened to Medicare for all? In: Cohen AB, Colby DC, Wailoo KA, Zelizer JE, eds. *Medicare and Medicaid at 50: America's Entitlement Program in the Age of Affordable Care*. New York, NY: Oxford University Press; 2015: 55–74.
11. Government of Canada. Canada's Health Care System. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html. Published February 26, 2018. Accessed August 12, 2019.
12. Marmor TR. Health care reform in the United States: patterns of fact and fiction in the use of Canadian experience. *American Journal of Canadian Studies*. 1993;23(1):147-163.
13. Grumbach K, Bodenheimer T, Himmelstein DU. Liberal benefits, conservative spending: the Physicians for a National Health Program Proposal. *JAMA*. 1991;265(19):2549-2554.

14. Schiff GD. A better-quality alternative: single-payer national health system reform. *JAMA*. 1994;272(10):803-808.
15. Toner R. Backers of Canada-type health plan: idealistic, outmuscled but scrapping. *New York Times*. May 4, 1993. https://www.nytimes.com/1993/05/04/us/backers-of-canada-type-health-plan-idealistic-outmuscled-but-scrapping.html?searchResultPosition=4. Accessed August 12, 2019.
16. Peterson MA. Northern disclosure: getting Canada right. *J Health Polit Policy Law*. 2009;34(4):497-508.
17. Oberlander J. The virtues and vices of single-payer health care. *N Engl J Med*. 2016; 374:1401-1403.
18. White J. Gap and parallel insurance in health care systems with mandatory contributions to a single funding pool for core medical and hospital benefits for all citizens in any geographic area. *J Health Polit Policy Law*. 2009;34(4):543-583.
19. Marmor TR. Social insurance and American health care: principles and paradoxes. *J Health Polit Policy Law*. 2018;43(6):1013-1024.
20. Kaiser Family Foundation. Public opinion on single-payer, national health plans, and expanding access to Medicare coverage. https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/. Published July 30, 2019. Accessed August 12, 2019.
21. Boccuti C, Moon M. Comparing Medicare and private insurers: growth rates in spending over three decades. *Health Aff*. 2003;22(2):230-237.
22. Sullivan K. How to think clearly about Medicare administrative costs: data sources and measurement. *J Health Polit Policy Law*. 2013;38(3):479-504.
23. White C. Why did Medicare spending slow down? *Health Aff*. 2008;27(3):793-802.
24. White C, Whaley C. Prices paid to hospitals by private health plans are high relative to Medicare and vary widely. Rand Corporation. https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3033/RAND_RR3033.pdf. Published 2019. Accessed August 12, 2019.
25. Holahan J, McMorrow S, Urban Institute. Slow growth in Medicare and Medicaid spending per enrollee has implications for policy debates. https://www.urban.org/sites/default/files/publication/99748/rwjf451631_1.pdf Published February 2019. Accessed August 12, 2019.
26. Reinhardt UE. Medicare innovations in the war over the key to the US treasury. In: Cohen AB, Colby DC, Wailoo KA, Zelizer

JE, eds. *Medicare and Medicaid at 50: America's Entitlement Program in the Age of Affordable Care*. New York, NY: Oxford University Press; 2015:169–189.

27. Hacker JS. From servant to master to partner? Medicare, cost control, and the future of American health care. In: Cohen AB, Colby DC, Wailoo KA, Zelizer JE, eds. *Medicare and Medicaid at 50: America's Entitlement Program in the Age of Affordable Care*. New York, NY: Oxford University Press; 2015:273–293.
28. Stone D. Single payer-good metaphor, bad politics. *J Health Polit Policy Law*. 2009;34(4):531-542.
29. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med*. 2003;349(8):768-775.
30. Woolhandler S, Himmelstein DU. Single-payer reform: the only way to fulfill the president's pledge of more coverage, better benefits, and lower costs. *Ann Intern Med*. 2017;166(8):587-588.
31. Himmelstein DU, Woolhandler S. National health insurance or incremental reform: aim high, or at our feet? *Am J Public Health*. 2008;98(Suppl 1):S65-S68.
32. Seidman L. The Affordable Care Act versus Medicare for All. *J Health Polit Policy Law*. 2015;40(4) 911–921.
33. Frank RH. Why single-payer health care saves money. *New York Times*. July 7, 2017. https://www.nytimes.com/2017/07/07/upshot/why-single-payer-health-care-saves-money.html. Accessed August 12, 2019.
34. Morone JA. How to think about "Medicare-for-all." *N Engl J Med*. 2017;377(23):2209-2211.
35. Cubanski J, Boccuti C. Medicare coverage, affordability, and access. *Generations*. 2015;39(2):26-34.
36. Maioni A. *Health Care in Canada*. Don Mills, Ontario, Canada: Oxford University Press; 2015.
37. Tuohy CH. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. New York, NY: Oxford University Press; 1999.
38. Canadian Institute for Health Information. National health expenditure trends, 1975 to 2018. Ottawa, ON: Canadian Institute for Health Information; 2018. https://www.cihi.ca/sites/default/files/document/nhex-trends-narrative-report-2018-en-web.pdf. Accessed August 12, 2019.
39. Sanders B. The Medicare for All Act of 2019: Summary. https://www.sanders.senate.gov/download/medicare-for-all-2019-summary?id=FA52728F-B57E-4E0D-96C2-F0C5D346A6E1&download=1&inline=file. Accessed August 13, 2019.

40. Medicare for All Act of 2019, HR 1384, 116th Cong, 1st Sess (2019). https://www.congress.gov/bill/116th-congress/house-bill/1384/text. Accessed August 13, 2019.
41. Jacobson G, Freed M, Damico A, Neuman T; Kaiser Family Foundation. A dozen facts about Medicare Advantage in 2019. https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/. Published June 6, 2019. Accessed August 13, 2019.
42. Gaba C. Despite what Sanders says, Harris may have the best claim to Medicare-for-All. *Washington Post*. July 30, 2019. https://www.washingtonpost.com/opinions/2019/07/30/despite-what-sanders-says-harris-may-have-best-claim-medicare-for-all/. Accessed August 13, 2019.
43. Oberlander J. Through the looking-glass: the politics of Medicare Prescription Drug, Improvement, and Modernization Act. *J Health Polit Policy Law*. 2007;32(2):187-219.
44. Oberlander J. Voucherizing Medicare. *J Health Polit Policy Law*. 2014;39(2) 467-482.
45. Glied SA, Lambrew JM. How Democratic candidates for the presidency in 2020 could choose among public health insurance plans. *Health Aff*. 2018;37(12):2084-2091.
46. Kelly AS. Boutique to booming: Medicare managed care and the private path to policy change. *J Health Polit Policy Law*. 2016;41(3):315-354.
47. Harris K. My plan for Medicare for All. Kamala Harris for the People website. https://kamalaharris.org/healthcare/. Accessed August 13, 2019.
48. Schlesinger MS, Hacker JS. Secret weapon: the "new" Medicare as a route to health security. *J Health Polit Policy Law*. 2007;32(2):247-291.
49. Buttigieg P. Health care. Pete for America website. https://peteforamerica.com/issues/. Accessed August 13, 2019.
50. Kaiser Family Foundation. Compare Medicare-for-All and public plan proposals. https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/. Published May 15, 2019. Accessed August 13, 2019.
51. Biden J. Health care. Biden for President website. https://joebiden.com/healthcare/. Accessed August 13, 2019.
52. Verma S. I'm the administrator of Medicaid and Medicare. A public option is a bad idea. *Washington Post*. July 24, 2019. https://www.washingtonpost.com/opinions/a-public-option-for-health-insurance-is-a-terrible-idea/2019/07/24/fb651c1a-ae2e-11e9-8e77-03b30bc29f64_story.html. Accessed August 13, 2019.

53. Sullivan P. McConnell fiercely attacks 'Medicare for all' in visit to hospital group. *The Hill*. April 9, 2019. https://thehill.com/policy/healthcare/437993-mcconnell-fiercely-attacks-medicare-for-all-to-hospital-group. Accessed August 13, 2019.
54. Trump D. Democrats' 'Medicare for All' plan will demolish promises to seniors. *USA Today*. October 10, 2018. https://www.usatoday.com/story/opinion/2018/10/10/donald-trump-democrats-open-borders-medicare-all-single-payer-column/1560533002/. Accessed August 13, 2019.
55. Starr P. *The Social Transformation of American Medicine*. New York, NY: Basic Books; 1982.
56. Blumenthal D, Morone JA. *The Heart of Power: Health and Politics in the Oval Office*. Berkeley, CA: University of California Press; 2009.
57. Holahan J, Blumberg LJ; Urban Institute. Is the public plan option a necessary part of health reform? https://www.urban.org/sites/default/files/publication/30456/411915-Is-the-Public-Plan-Option-a-Necessary-Part-of-Health-Reform-.PDF. Published in 2009. Accessed August 13, 2019.
58. Berenson R, Holahan J, Zuckerman S; Urban Institute. Getting to a public option that contains costs: negotiations, opt-outs, and triggers. https://www.urban.org/sites/default/files/publication/30756/411984-Getting-to-a-Public-Option-that-Contains-Costs-Negotiations-Opt-Outs-and-Triggers.PDF. Published November 2009. Accessed August 13, 2019.
59. Hacker JS. The case for public plan choice in national health reform: key to cost control and quality coverage. Berkeley, CA: Berkeley Law, University of California, and Institute for America's Future; December 17, 2008. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.525.223&rep=rep1&type=pdf. Accessed August 13, 2019.

Address correspondence to: Jonathan Oberlander, PhD, University of North Carolina at Chapel Hill, Department of Social Medicine, CB# 7240, Chapel Hill, NC 27599-7240 (email: oberland@med.unc.edu).