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The Road to Medicare for Everyone

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For the first time since the passage of the Affordable Care Act in 2010, Democrats are debating the next big steps in federal health policy. What they're beginning to see is a path toward universal health care that looks very different from that embarked on seven years ago. This path depends on Medicare rather than the expansion of private insurance. And for those most eager to take this route, it depends on achieving something that has proven impossible in the past: replacing the patchwork quilt of American health insurance, including the employment-based health plans that cover more than 150 million people, with a single government insurance program.

In a way that wasn't true during the last fight—indeed, because of the last fight and its legacies—a growing share of those on the left are making the case that the United States is finally ready for Medicare for All. Is it? And if not, is there another way to achieve the goal it embodies—affordable health care as a basic right?

Lessons of the Past

These are questions I've struggled with for a long time. As a health policy expert, I'm one of the many social scientists and historians who've sought to understand why the American framework of health insurance looks so different from the systems found in other nations. Why do we spend roughly twice as much per person as any other nation while leaving tens of millions of people without insurance and many times more with inadequate protection—all with worse health outcomes?

The basic answer is simple: Americans are distrustful of government, and America's fragmented political institutions make transformative policies hard to enact, especially when they're opposed by powerful interest groups. Even at the height of the Great Depression, with overwhelming Democratic majorities in Congress, FDR decided not to include health insurance in the Social Security Act of 1935, because he feared the opposition of physicians would kill the whole bill.

FDR's decision turned out to be fateful. With America's entry into World War II, the nation's agenda shifted away from domestic affairs. Unions, corporations, and private insurers stepped into the breach—thanks in part to favorable tax laws and federal support for collective bargaining—and by the 1950s, the majority of working-age Americans got health benefits at work. By the time advocates of government insurance finally had another bite at the apple after LBJ's landslide election in 1964, they had strategically retreated to the goal of covering those left out of the employment-based system: the elderly and the poor. The result was Medicare and Medicaid—the biggest step toward universal health care until the passage of the Affordable Care Act.

The system was a mess, but it was also a minefield. You had a huge insurance industry, allied with a range of profitable

sectors that benefited from its open checkbook, from drug manufacturers to medical device makers to highly paid specialists. You had excessive costs that government could finance only with hefty taxes. Most important, for every unfortunate American who fell through the cracks, you had eight or nine more who had benefits at work or through Medicare or Medicaid. To make matters worse, most of these eight or nine had no idea how much their health benefits really cost, because the expense was hidden in their pay packages or spread across all taxpayers.

It would be hard to design a less welcoming context for single-payer. Enacting a universal program meant taking on a lobbying juggernaut to impose taxes on people generally suspicious of government, most of whom were insulated from the true costs of their care. Our unique health-financing system was a reflection of our unique political hurdles. But increasingly it was the system itself that posed the biggest hurdle of all.

There's a lesson in this history: The struggle over health care has always been about politics as much as policy. The evidence that the American model is inferior is overwhelming, and many policies would make it better. The challenge is figuring out how to overcome the political barriers to pursuing those policies—not only to get them passed, but to ensure that they foster the political conditions for continuing improvement.

In the 2000s, I began to write about this challenge, too, drafting a proposal for expanded coverage that contributed to the development of what would be called the "public option." The idea was to let Americans who didn't have coverage at work or through existing public programs buy into a Medicare-like national health plan. Thanks to the work of advocacy organizations, such as Health Care for America Now!, the public option eventually made its way into the reform plans of all the leading Democratic candidates for president in 2008—including Barack Obama.

The public option was the main addition by left-of-center thinkers to reform blueprints based on the bipartisan law passed in Massachusetts in 2006. That law, which became the template for the Affordable Care Act, sought to expand private insurance to those who lacked it while trying not to disrupt employment-based plans. It did so by creating a new regulated market for individually purchased private plans (called "marketplaces"). These regulated plans weren't allowed to discriminate against the less-healthy, and there was new government assistance to help poorer people pay for them. In turn, citizens would be required to show proof of coverage (a.k.a. the individual mandate).

The idea of the public option was to give people who bought insurance through the new marketplaces the choice of a public plan that used Medicare's payment rates to hold down prices. The aim was to guarantee good backup insurance, especially in the many parts of the nation where there are not many competing insurers, while simultaneously putting pressure on insurance companies to bring down their own costs.

Needless to say, those companies were not fans, and they hammered the public option relentlessly. Critics on the right

described it as a backdoor route to single-payer, despite the fact that it would be available only to those who were buying coverage through the exchanges. In the end, the public option died a death of a thousand cuts. A pared-back version that lacked the ability to use Medicare's rates did make it through the House. But it was eventually stripped from the final bill at the insistence of Senator Joe Lieberman of insurance-rich Connecticut (my home state). Since the bill needed the support of all 60 of the Senate's Democrats to overcome a GOP filibuster, the public option was dead. It was a painful reminder of just how difficult the politics of government insurance could be.

Republican Destruction, Democratic Resistance

Many progressives rallied to the public option back in 2009. Yet they are now setting their sights much higher. The threat posed by unified Republican control has galvanized Democratic voters and activists, especially the party's progressive wing. Many have spent the past year in the political trenches fighting to preserve the Affordable Care Act in the face of the GOP's relentless assault. Now, energized and mobilized, they have turned that passion toward their own party, pressing candidates and public officials to adopt much bolder positions. In progressive circles, "I support single-payer" is fast becoming a required declaration of a politician's seriousness about health care.

The most visible sign of the shift is the single-payer plan introduced by Senator Bernie Sanders in September. In 2013, a similar bill introduced by the Vermont senator attracted not a single co-sponsor. His most recent has 16—a third of the Senate Democratic caucus. Moreover, they include all of the party's most-mentioned presidential contenders, including Cory Booker of New Jersey, Kirsten Gillibrand of New York, Kamala Harris of California, and Elizabeth Warren of Massachusetts. Sanders lost the Democratic Party's nomination in 2016, but he is defining its health-care vision for 2020.

The increasing boldness of the Democratic left reflects more than political calculations. It also reflects serious shortcomings of the Massachusetts-inspired approach. The individual marketplaces, in particular, have failed to live up to expectations. Their enrollment of around 12 million is approximately half what the nonpartisan Congressional Budget Office projected when the law passed. Those who've enrolled have also been less healthy than expected, sharply driving up premiums (though, thanks to government assistance, few pay the full tab, and premiums are roughly in line with initial CBO projections despite these increases). And many of the ACA marketplaces have had trouble getting private insurers to offer plans at all.

One consequence of all this is that most of the coverage gains under the law have come not from private plans offered in the marketplaces, but from Medicaid, the government program for low-income Americans that was expanded under the law. Indeed, Medicaid enrollment has so exceeded expectations that the CBO's overall projections for increased coverage have largely panned out despite the disappointing individual marketplace numbers. In an outcome that Medicare's designers never foresaw, Medicaid (the program for low-income Americans) is now larger than Medicare (the program for the permanently disabled and those over the age of 65), with almost 75 million enrollees, including those covered by the Children's Health Insurance Program (CHIP).

Of course, the ACA's travails reflect in part the ceaseless Republican attacks. In addition to the 19 Republican-controlled states that continue to refuse to expand Medicaid, many conservative states worked actively to undermine establishment of and enrollment in the individual marketplaces. Congressional Republicans couldn't repeal the law outright so long as President Obama held the veto pen. (Not for want of trying: They voted more than 50 times to kill it.) But they sued the president to stop subsidy payments for private plans, failed to appropriate funds to boost marketplace enrollment, and generally tried to turn their warnings about the ACA's imminent collapse into a self-fulfilling critique. Republicans have also dragged their feet on re-authorizing CHIP, which once enjoyed broad bipartisan support.

Even with a willing ally in President Trump, Republicans' repeal ambitions have continued to fall short. But the president who had promised on the campaign trail to provide "insurance for everyone" has done almost everything within his power to undermine the ACA, and congressional Republicans have shown no sign they're letting up. Witness their willingness to add repeal of the individual mandate to their big Senate tax bill, which was being reconciled with the House version at the time this article went to press.

In short, many of the problems with the Affordable Care Act are a product of Republican sabotage. But there's another reason Democrats are gravitating away from the approach enacted in 2014. Those once skeptical of the public option now seem willing to embrace it, and many on the party's left want to go much further. Those more progressive Democrats generally saw mandated private insurance as a second-best route to expanded coverage and political accommodation—one that had a chance of winning some Republican support, if not at the outset, at least down the road. But if the expansion is lackluster and the political accommodation nonexistent, why cling to the second best?

To a degree that seemed impossible even a year ago, then, the discussion within the party has come to encompass a whole range of ideas for expanding Medicare, not just the public option. These range from voluntary buy-ins for workers and employers, to lowering the Medicare eligibility age from 65 to 55 or 50, or all the way to Medicare for All.

Indeed, to those pressing for single-payer, the public option is small bore. It would provide a backup in parts of the nation at risk of having no private plans, and bring some sanity to health-care prices for those it covered. But it would only be relevant to the limited slice of the population getting coverage through the exchanges. Something much bigger is needed, Medicare for All enthusiasts argue, to rally the sustained enthusiasm of grassroots activists and progressive leaders and truly achieve transformative change.

They might be surprised to know I agree. The case for single-payer is much stronger than it was during the strait-jacketed debate of 2009. The question is whether it's strong enough, and if not, what might be able to deliver on its promise.

Is It Time for Single-Payer?

What is the case for single-payer? The term itself dates back at least to the 1980s, when a small group of Massachusetts doctors founded Physicians for a National Health Program and began calling for a "single payer" to replace all private insurance and public programs. Unlike reformers in the 1940s and 1950s, they looked not to Social Security for inspiration, but to the universal health systems found abroad, especially that of Canada—which consolidated a system of universal government insurance (at the provincial level) in the 1970s.

Today, single-payer is generally a synonym for Medicare, not the Canadian system. But the emphasis on foreign experience remains. Introducing his plan, Senator Sanders declared it would "end the international disgrace of the United States, our great nation, being the only major country on earth not to guarantee health care to all of our people."

In fact, most major countries on earth don't have single-payer. They have multiple payers, but all the payers pay the same negotiated health-care prices and play by the same strict rules to ensure more or less equal treatment of all subscribers—rich and poor, well and sick, young and old. Even Medicare isn't really single-payer: A component of Medicare called "Medicare Advantage" allows beneficiaries to enroll in private plans that meet strict standards, and roughly a third of Medicare beneficiaries are in such plans.

The defining feature of the systems found in other rich democracies isn't the way payments are channeled. It's who's covered and how medical prices are set. First, these systems are universal. The government guarantees all citizens coverage and then figures out how to pay for it. Only in the United States is the responsibility to get and pay for coverage largely left up to individuals and their employers, leaving tens of millions to fall through the cracks. The ACA dramatically improved things, but roughly 30 million Americans still remain uninsured and the number appears to be rising again.

Second, these systems use government's bargaining power to restrain health-care costs. In recent years, as Paul Starr discusses elsewhere in this issue, a consensus has formed among health-care experts that the major reason why U.S. spending is so high is that we pay such high prices for medical goods and services and prescription drugs. When a nation's leaders commit themselves to providing insurance to everyone, they become much more aware of bill-padding and price-gouging. They also discover that government has a unique capacity to do something about it: It can require that providers charge uniform prices.

Medicare doesn't cover the entire population, but it's evolved in the same direction. At first, it paid whatever health-care providers demanded, and costs soared. Since the 1980s, however, it's increasingly improved its ways of paying for care, and costs have risen significantly more slowly than in the private sector.

My Yale colleague Zack Cooper, a health economist, has gained access to the claims records of some of the biggest commercial insurers. What he's found is that the prices they pay are much higher than Medicare's. They also vary enormously across providers. Moreover, the gap between Medicare and private insurance 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.

The experience of Medicare turns on its head the thinking behind the Republican repeal drive. According to many conservative critics of the ACA, patients should be left to pay for most care directly, so they have an incentive to shop wisely. But patients want and need insurance, especially for the big-ticket items that account for most health spending. And they need the expertise of providers to know what to shop for, especially when they're sick or injured. So insurance is going to pay for a lot of care, and providers are going to make most of the decisions that determine how that money is spent. This means, in turn, that someone has to put limits on what providers charge. The only institution that has the proven ability to do that is the government.

In short, Medicare for All isn't just a good slogan—and certainly a much better slogan than single-payer. It's a policy grounded in evidence about what works both here and abroad. It's also insanely popular, seen across the partisan divide as a vital part of the American social contract. Even voters who hate Obamacare love Medicare.

Medicare is also simple—or at least a lot more simple than the Affordable Care Act or the complex tweaks to it now being debated. Everyone pays in during their working lives, and everyone is covered at age 65 (or if they're permanently disabled). And unlike private plans, Medicare doesn't limit which doctors and hospitals patients can see: Virtually all accept its payments. It limits what prices those providers can charge.

The message that's being sent by Medicare for All enthusiasts is that the days of technocracy and triangulation are over. Stop offering Rube Goldberg contraptions that Americans will barely understand and activists won't rally behind. Stop trying to fill the gaps in a flawed system and smuggle in cost-control through the back door. Just say everyone is covered by Medicare, period. After all, Republicans are certain to call anything that Democrats try to do a "government takeover." So why not embrace the epithet and offer voters a takeover they seem to like: Medicare?

It's a powerful message, and it counsels a bold path. Unfortunately, that path is far more daunting than many embarking on it seem to understand.

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Political Reality Bites

Our nation's distinctive policy trajectory has left us with a fragmented and exorbitantly expensive system. At the same time, however, that system all but guarantees that every reasonably well-insured group—whether workers with employee health plans or beneficiaries of Medicare—will be distrustful of change and hyper-sensitive to new costs, even if those costs merely replace hidden charges they're now paying.

Remember: More than 150 million Americans are covered by employment-based health plans. These plans have become less common, more expensive, and more restrictive. Still, we're talking half the population, and people with workplace coverage are generally satisfied (though beneficiaries of Medicare are even happier). Replacing these plans with Medicare would be a huge lift. Even the extremely modest dislocations caused by the ACA precipitated a bipartisan scramble to ensure people could keep their current plans, however ill-designed or inadequate.

Financing this transition would also be a formidable challenge. We don't know exactly how much Medicare for All would cost, but independent analysts who looked at Sanders's 2016 campaign proposal estimated it would require new federal spending on the order of $2.5 trillion a year. Sanders's campaign said the total would be closer to $1.5 trillion a year. Yet whatever the exact number, we're talking about a historic tax increase: $1.4 trillion represents around 8 percent of our economy. By way of comparison, the 1942 tax hike to fund World War II amounted to 5 percent of GDP. The 1993 tax hike under President Bill Clinton that Republicans (falsely) claimed was the "largest in history" equaled just over half a percent of GDP.

Financing is always the hardest part of health reform. In recent years, Vermont and California have each flirted with statewide single-payer—only to founder when the scope of required taxes became clear. Vermont and California are not the federal government, with its much greater revenues and power. But the federal government isn't Vermont or California, either, with Democrats holding unchallenged control.

Now, it's important to note these taxes would replace private sources of financing. Alas, however, most well-insured Americans have no idea how much they're now paying. What they see is their portion of the premium and their out-of-pocket spending. What they're actually paying is much greater. It includes the lower wages they receive because they get health benefits instead of cash, as well as the higher taxes they pay on everything else because of the lower revenues that government receives because it doesn't tax their medical benefits as pay.

Our system is almost perfectly designed to hide the true costs of health care. Indeed, it would be hard for a system with such outrageous costs to survive if this were not so. Donald Trump lamented earlier this year: "Nobody knew health care could be so complicated." But complexity isn't randomness. Much of what makes health care so complicated reflects the preferences of those who benefit from a lack of transparency: drug companies, highly paid specialists, medical device manufacturers, commercial insurers, and so on. Yet the cure offered by Medicare for All—immediately bringing all these costs into the open—could very well kill the patient. Those with good coverage would suddenly face a steep tax bill for something they mistakenly believed they were getting on the cheap.

To be sure, Medicare for All would generate big savings, and not only because it pays doctors and hospitals less than private insurers do. Medicare's administrative costs are a tiny fraction of commercial plans'. Nor does it have to earn profits or pay high CEO salaries.

But extending Medicare to the whole population would involve new spending as well as new savings—not only to cover those currently uninsured, but also to raise payment levels for the 70 million-plus Americans covered by Medicaid, a notorious under-payer that makes Medicare look lavish. Moreover, single-payer advocates want to upgrade Medicare as

well as expand it. Sanders's new bill offers extremely broad protections, including dental and vision benefits, with no out-of-pocket costs. That's much more than what's now offered by Medicare—or Canada, for that matter—and would likely raise spending a lot.

But doesn't Medicare for All at least make sense as an aspiration? Shouldn't advocates start with their strongest proposal, rather than compromise even before the debate begins? It's one thing to aim for revolutionary change—any campaign for social transformation should have a vision that extends beyond the immediate fight. It's quite another to put forth a concrete plan to achieve that change, only to find you've divided your supporters, galvanized your opponents, and frightened everyone else.

Here it's worth noting another perverse feature of our system: It enriches a whole set of deep-pocketed stakeholders willing to spend whatever it takes to block changes that threaten them. Any political liabilities of a plan will be found and ruthlessly exploited. That has been the story of every health-care debate our nation has had, including the failure of the Clinton health plan back in 1994. When President Clinton described his plan before a joint session of Congress, it commanded majority support among voters. But after a few months of GOP and industry attacks, its poll numbers were in the basement. By the time Democrats gave up on trying to pass it, a majority in favor of congressional action had turned into a majority afraid of it.

Medicare for All is much simpler than the Clinton plan was, and it builds on a popular program. But it still has vulnerabilities that opponents will ruthlessly exploit. In polls, support for single-payer declines substantially when these vulnerabilities—higher taxes, a greater government role—are mentioned even innocuously. The longtime reform advocate Richard Kirsch, who headed Health Care for America Now! during the struggle to pass the ACA, puts it this way: "The solution is the problem." When public attention shifts from problems to solutions, every bit of rhetorical ammunition will be used to demonize the solution. And overcoming this initial impression can be close to impossible. In politics, opponents don't have to offer an alternative. They can just destroy yours.

Even candidates could put themselves at risk. Fast-forward to the 2020 campaign. The Democratic nominee has electrified the convention by promising to enact a Medicare for All bill. The campaign releases a detailed blueprint. The GOP and a vast assemblage of deep-pocketed organizations respond by hammering Democrats for wanting to raise taxes steeply while taking away Americans' health care. It's hard to see how the candidate—or the cause of Medicare for All—wouldn't be hurt.

Republicans just learned what happens when you make a health-care promise that turns out to be unpopular beyond your base. Democrats should not make the same mistake.

Medicare Part E

But Democrats should not make the opposite mistake either. A proposal must have a realistic path to enactment. But it also has to be ambitious enough to inspire supporters, and compelling and understandable enough to convince others to become supporters. It has to be grounded in policies that are popular and known to work—policies that can actually reach universal coverage and restrain health-care prices.

Perhaps most important, it has to be able to command support not just before it passes, but also afterward. If the troubled saga of the exchanges tells us anything, it's that even the most technically sound policy will fall short if it does not generate and sustain pressure for continuing expansion and improvement. Successful policies do not just reflect the politically possible; they reshape it.

I've already said I don't think the public option is robust enough to create such pressure, even though it would do much good. As a rallying cry, "Make Medicare available to the 12 million people buying insurance through the ACA marketplaces!" leaves much to be desired. Instead, the message should be at once simpler and bolder: "Make Medicare available to *everyone*." All Americans should be guaranteed good coverage under Medicare if they don't receive it from their employer or Medicaid.

To achieve this goal, a new part of Medicare would need to be created for those not already covered by the program. I've been calling this new component "Medicare Part E" (for "everyone")—a term that's been used before by Johns Hopkins's Gerard Anderson and others. Medicare Part E would cover the broad range of benefits covered by Medicare Parts A (hospital coverage), B (coverage of physicians' and other bills), and D (drug coverage).

The central feature of Medicare Part E is guaranteed insurance. All Americans would be presumed to be covered. They would not need to go through complicated eligibility processes or hunt down coverage that qualified for public support or even re-enroll on an annual basis. Once someone was in Part E, they would remain in Part E unless and until they were enrolled in a qualified alternative—whether an employment-based health plan with good benefits or a high-quality state Medicaid program.

Thus, the centerpiece of Medicare Part E is the same as that of single-payer: a guarantee that Medicare is there for everyone. Unlike single-payer, however, Medicare Part E seeks to improve employers' role rather than replace it. It does so by establishing new standards for employment-based plans and requiring that all employers contribute to Medicare if they do not provide insurance directly to their employees.

In this respect, Medicare Part E builds on the ACA's requirement that large employers provide coverage or pay a penalty.

Under the 2010 law, companies with more than 50 full-time workers are already required to pay a penalty if they don't offer insurance and their workers get subsidized ACA marketplace coverage. The penalty, however, is modest compared with the cost of health benefits, and there's no guarantee workers whose employers pay it actually get marketplace coverage.

Democrats knew this was a problem back in 2010. In fact, they tried to fix it: The House version of the Affordable Care Act required that employers that didn't insure their workers not only pay a fee, but also provide the federal government with the information to enroll those workers in health coverage though the marketplaces. Like the public option, however, this provision was dropped in the Senate.

It should be resurrected. Under the proposal I'm describing, employers would either provide insurance that was at least as generous as Medicare Part E's or they would contribute to the cost of Medicare Part E, which would automatically enroll their workers. Because the contribution requirement is central to signing people up, it should cover the entire workforce—including independent contractors and other self-employed workers (who would pay the contribution directly, as they do Medicare and Social Security taxes). But the level of contribution should vary with wages. That's how the House bill worked: The contribution would have risen from nothing for the lowest-wage firms up to 8 percent of payroll for the highest-wage firms.

Health policy wonks call this "play or pay." Employers would either play by offering qualified coverage to their workers (and their workers' families) or pay the federal government to cover their workers (and their workers' families) through Medicare Part E. Under this system, everyone who worked or lived in a family with a worker—including the self-employed—would be automatically covered. Those without any tie to the workforce could be signed up when they received other public benefits or filed their taxes or sought care without insurance. But just as important as signing people up is making sure they remain signed up. Once people were enrolled in Medicare Part E, they would remain enrolled for as long as they didn't have verified alternative insurance.

What about those eligible for Medicaid? I was once highly skeptical of retaining Medicaid as a separate federal-state program. But 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 proved more politically resilient than many experts, including me, expected. Nonetheless, it remains highly variable in quality and breadth across the states, is facing severe political and fiscal pressures, and pays doctors and hospitals so little that many providers refuse to accept it. The biggest problem is the continuing unwillingness of many Republican-controlled states to expand their programs. But there are also millions of Americans who are eligible for Medicaid, but who fall through its cracks, deterred by complex and burdensome eligibility rules and the stigma that still attaches to the program.

Medicare for All has a straightforward answer to these problems: fold Medicaid into Medicare. And, indeed, under my proposal Medicaid could be replaced with Medicare Part E, with wraparound benefits for those previously eligible for Medicaid to ensure they continue to receive as broad benefits as in the past. But total nationalization of Medicaid would be both costly and disruptive, and it may not be necessary to achieve the objective of ensuring that state programs are high-quality and that no one falls through their cracks.

Instead, the federal government could assume much of the responsibility of enrolling people into state Medicaid programs. When someone receives insurance through Medicare Part E—whether through the workplace or through other outreach and enrollment efforts—the federal government would check to see if they qualified for Medicaid and, if so, transfer their coverage to the states. States, in turn, would be required to tell Medicare Part E whenever someone's Medicaid coverage lapsed for whatever reason, so they could be covered by the federal government instead. Finally, the federal government could put up new funding to bring Medicaid's payment levels closer to Medicare's—as it did in the initial years of the Affordable Care Act.

These simple steps could all but eliminate the most serious problem with Medicaid today: that millions who are eligible never receive its protections. Indeed, they could complete Medicaid's historical transformation from a complex, stigmatizing program that many health-care providers shun into a system of easily accessible coverage with payment levels high enough to attract broad provider participation.

Equality *and* Efficiency

In short, opening up Medicare to everyone would deliver what's most inspiring about single-payer—health care as a basic right of citizenship. Yet it wouldn't require replacing employment-based health insurance in one fell swoop. That's because a large share of employers now providing health benefits would likely continue to do so.

After all, the penalty in the ACA is modest compared with the cost of benefits, but most larger employers still offer health insurance. Some might feel less compunction about paying the fee if it were a contribution rather than a penalty. Some might not want to upgrade their plans to match Medicare Part E. But previous estimates of play-or-pay plans suggest that at any contribution rate close to the House plan's, most employers providing coverage would continue providing coverage.

Medicare Part E would also begin to deliver on Medicare for All's second promise—lower prices. For one, more people would be covered by Medicare, which would mean more services financed at Medicare rates. For another, private plans would face competitive pressure to demand better prices so their customers wouldn't switch to Part E.

At the same time, Medicare should be allowed to bargain for lower prescription drug prices as do other rich nations. Americans pay far higher prices for drugs than do citizens abroad, despite the fact that much of the investment in new drug development begins in U.S. federal R&D spending. The Medicare Part D benefit enacted in 2003 by President George W. Bush and a Republican congressional majority explicitly barred Medicare from providing drug coverage directly (it vested this responsibility in regulated private plans)—precisely because drug manufacturers knew they would be required to bring down their prices if it did. Drug coverage should be part of the basic Medicare package, for young and old alike.

Private insurance plans that participate in Medicare Advantage should also be required to offer coverage to both old and young. Medicare patients like these options, and younger Americans will want them, too. No less important, private insurers are deeply invested in Medicare Advantage. Ensuring they would still have a role—especially when it is lessened in other parts of the market—would reduce their inevitable opposition.

So too, of course, would ensuring that large employers still have the option and incentive to provide private coverage. (Most large employers pay medical claims directly—a practice known as "self-insurance"—but they often contract with large insurers to manage the benefits). Indeed, this system might even be more attractive than the ACA to the largest insurers, which have not shown much interest in the ACA marketplaces.

Many policy experts are critical of Medicare Advantage, because private plans have tended to skim off the healthiest Medicare patients. But the program was improved by the ACA, which reduced the payments to health plans to better reflect the actual cost of providing benefits to enrollees. Moreover, the playing field between Medicare and private plans would be even more level if Medicare could provide drug coverage directly. Today, only Medicare Advantage plans are allowed to cover prescription medicine alongside other services, which is one big reason beneficiaries enroll in them. Sweeten traditional Medicare, and private plans will lose this unfair advantage.

According to recent studies, the most efficient Medicare Advantage plans are already delivering Medicare's core benefits for less than Medicare can. This is, in large part, because these plans operate in a market in which their main competitor is Medicare, with its relatively low rates. Thus, they can pay rates close to Medicare's, 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.)

Medicare Part E could even give private plans additional leverage over providers. This idea is counterintuitive—wouldn't a bigger public program just shift costs onto the private sector?—but it's borne out in the experience of Medicare Advantage. And if Medicare covered more Americans younger than 65, this dynamic could play out in the rest of the market, too. After all, even the most consolidated and costly provider systems accept Medicare rates for older patients. Once Medicare Part E entered the mix, 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 a result, private plans would be able to lower what they paid for nonelderly patients and still attract providers.

Of course, even with these savings, Medicare Part E would require additional financing beyond the employer contributions. For starters, those enrolled in Medicare Part E should have to pay an additional premium beyond the payroll-based contributions made by employers (or by self-employed workers). As in Medicare Part B, these premiums should cover only a modest fraction of the total cost of Medicare Part E, and they should vary by income, with lower-income enrollees paying a minimal amount. (For workers, these premiums should be automatically deducted from pay.) The exact premium would depend on the precise benefits covered, as well as the employer contribution rate. But the full charge for higher-income enrollees would likely be in the range of $300 per month for family coverage. This estimate is based on a 2008 analysis conducted by the Lewin Group—an independent consulting firm with expertise in micro-simulation modeling of health-care plans.

To be sure, other sources of financing would also be needed. The improved benefits for current Medicare beneficiaries could be financed, in part, by increasing the Medicare tax paid by workers (which the ACA applied, for the first time, to capital as well as labor income). There is also a strong argument for bridging some of the remaining funding gap with relatively progressive tax sources, such as an income-tax surcharge on extremely high-income households. Still, because most Americans who receive employment-based insurance will continue to do so, the new costs are much more modest than those for single-payer. In its 2008 analysis, Lewin estimated that 99.6 percent of Americans would be covered and that the proposal would lower national health spending and require modest new federal spending. Over time, it was projected to produce enormous savings for employers, households, states, and the federal government.

Daring—and Doable

Medicare Part E is an ambitious proposal, and I'm under no illusion about how difficult it will be to enact. Obviously, any significant expansion of Medicare is a non-starter so long as Republicans control Washington, but Democrats are not unified, either. The Affordable Care Act was the product of a debate within the party that began well before President Obama's election. The next big steps toward universal insurance will require a similar conversation and convergence.

It will also require tough thinking about how to build support for these steps over time, something Democrats haven't exactly excelled at. So far, the ACA has failed to generate the kind of middle-class buy-in that has made Medicare so popular and resilient. To the contrary, many Americans—including those covered by Medicare—ended up seeing the law as a threat to their benefits, despite the many ways in which it improved Medicare and private plans. Indeed, over three election cycles from 2010 to 2014, Republicans peeled off the votes of older Americans by frightening them into believing that the ACA would cut their benefits—or worse (remember "death panels"?).

Thus, advocates will need to prominently improve Medicare for the elderly and disabled even as they open up the program to the rest of Americans. The two most important upgrades are long overdue: a cap on out-of-pocket costs, which Medicare inexplicably lacks, and a direct prescription drug benefit. No less important, these upgrades need to be coupled with ongoing strengthening of the ACA standards for employment-based health plans as well, so workers covered by their employers rather than Medicare don't feel they're getting a raw deal.

Even with these boxes checked, the battle will be intense. Providers, drug manufacturers, and insurers will vigorously fight any plan that threatens their profits and privileges. Every interest group will have a pet demand: Big commercial insurers will want new Medicare enrollees to get access to private health plans through Medicare Advantage; drug manufacturers will inevitably try to limit the scope of federal bargaining for better prices; providers will want a premium over Medicare rates. No country has gotten to universal health insurance without making concessions to industry stakeholders. (Asked how he overcame doctors' resistance, the architect of the British National Health Service replied that he "stuffed their mouths with gold.") But every step toward a bigger Medicare program increases government's capacity to resist such special pleading in the future.

How big a step will be possible if Democrats regain unified control of Washington? It's hard to know and will depend on whether they can come together around a common vision, as they did in the late 2000s. But one of the virtues of Medicare Part E is that its core components could be pursued sequentially if they couldn't be enacted all at once. Medicare could be upgraded, and Part E could be added to the exchanges. Employers could be given the option of buying into Medicare Part E to cover their workers; at the same time, the standards for private 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.

Even Medicare for All purists understand a staged approach might be necessary. Buried in the back of Sanders's new bill, for example, are provisions that are supposed to go into effect during the law's first four years, before the complete replacement of private insurance. These include an expansion of Medicare's benefits, coverage under Medicare for

everyone up to age 18, and measures to allow people older than 35 to buy into Medicare. These provisions reflect the idea that an expanded Medicare program may have to be achieved in steps. The problem, however, is that last great leap: the replacement of all employment-based coverage with Medicare overnight. The big steps implied by Medicare Part E will get us to guaranteed universal coverage. Unless we can jump across that last political divide, Sanders's big steps will not.

Other proposals on the table—such as lowering the Medicare eligibility age to 55 or 50—might also stall out. The question to ask is whether an expansion will increase or decrease the pressure for more. Those who designed Medicare thought it would be a stepping stone to universal insurance. But because it basically took the most sympathetic group out of the employment-based system, it never moved much beyond its original beneficiaries. (Indeed, those beneficiaries have resisted coverage expansions they see as hurting their coverage.) The same thing might happen if Medicare were expanded to 55- to 65-year-olds: a bigger Medicare program but not affordable health care as a right.

Fortunately, Democrats will be able to move forward even if they don't have the 60 Senate votes they momentarily had in 2009. That's because many of the changes I've discussed—improved Medicare benefits, stricter rules for employment-based plans, even the establishment of Medicare Part E—could be achieved through the so-called reconciliation process. As Republicans have learned, it's difficult (though hardly impossible) to use this process to roll back the ACA's regulations. But advocates of expanded coverage want to build on these rules, not gut them. Nothing is simple when it comes to budget procedures, but many of the big steps toward Medicare Part E should be possible through the budget process, meaning they need just 50 votes in the Senate.

The big unanswered question is whether those now demanding single-payer will fight for these changes, even if they fall short of Medicare for All. Every social movement in our nation's past has featured tensions between pragmatists and purists. These fissures can be painful, but they can also be productive. The Social Security Act passed only because powerful grassroots forces were pressing for more.

The passion of those who resist half-measures is essential. But passion should not blind us to political risks. The test of seriousness should not be whether politicians say, "I support single-payer," but whether they are willing to support policies that will truly achieve its goals: health care as a right, at a cost our nation can afford.

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