Medicare for All

by James A. Morone

Overview

Medicare for All proposes a sharp break with both the current health care system and with conventional wisdom. The proposal begins with the assumption that the problems of American health care—most notably the problem of the uninsured—will not be fixed by tinkering at the margins. Nor will they be fixed without popular agitation, without a movement.

This is not a proposal geared to the current Congress, but it does build on and improve one of the nation's most popular public policies. It is easy to understand. It is a proposal that citizens could rally around. And, given the trends in the American economy and the health care system, it might eventually prove to be more politically feasible—and effective—than programs lodged more securely in conventional wisdom.

The proposed program would improve the Medicare program and extend it to all legal residents. *Medicare for All* would cover a broad range of health care services: acute care, prescription drugs, mental health services, maternal and child health, and other services detailed below.

The proposed program addresses our health care delivery systems by placing strong emphasis on primary care. *Medicare for All* would fund primary health care in non-traditional settings. For example, it would foster community health centers and school-based health centers. More important, it would rethink and vastly expand the delivery of home health services, especially to the elderly and disabled. A generation ago, the medical profession resisted these kinds of innovations in care settings; today, the managed care revolution has prepared the way for such alternative practice settings.

Medicare for All would break with current financing arrangements. Medicare payroll taxes would be abolished. Medicare would not draw from general revenues. There would be no cost sharing. The current benefit limits (which force some elderly to spend down their life savings) would be eliminated. Providers could not bill their patients for covered services.

The system would be financed by a value-added tax (VAT) specifically earmarked for the new program. Today, the VAT is championed by a range of political bedfellows. In the United States, many fiscal conservatives seek to replace the income tax with a VAT; some tax specialists would combine the VAT with an income tax paid only by relatively wealthy people. And the VAT is the major tax used (in fact, required) by the European Union. In short, this is a familiar tax with a substantial track record. Turning to the VAT cuts through the Gordian knot of health care finance. The VAT's potentially regressive effects could be offset by graduated income tax reductions for low- and moderate-income taxpayers.

Employers could continue to offer health benefits by providing wraparound coverage that fills in the gaps in *Medicare for All* (such as dental insurance, expanded mental health benefits, or amenities such as private hospital rooms). These would be equivalent to contemporary Medigap policies. The tax advantages that accrue to employer-sponsored health benefits would remain in place.

Medicare for All would permit states to experiment—essentially mirroring Medicaid waivers. Any state could opt out of the Medicare program for residents under age 65. States that chose to opt out would design their own alternatives—under simple

federal guidelines. State plans would be required to guarantee universal coverage, they would have to offer health options with no cost sharing, and they would be required to organize their plans in a simple and transparent way. While Medicare would be fully funded from the VAT, state plans would get 75 percent of costs, matched by funds raised at the state or local level.

Medicare for All puts special emphasis on organizing an efficient bureaucracy. It would establish a new cabinet-level Department of Health, which would be charged with creating a simple, transparent, user-friendly health care system. By putting an end to multiple payment sources and extensive patient cost sharing, the proposed system would end some of the major sources of complexity in the American health care system. The new program would operate with electronic billing and payment. Major organizational initiatives would include a benefits board that would review, evaluate, and update the benefits package and a division for community health.

The existing Medicare program would be streamlined—for example, we would eliminate the arbitrary division between Part A (hospital) and Part B (physician services). Medicaid would become a smaller program focused largely on long-term care benefits.

Breaking with the Old Logic

Medicare for All introduces two sharp changes from current practice. It breaks the link between coverage and employment—a great American innovation rendered increasingly obsolete in the new global economy. And it limits the long, futile American effort to run a system with competing health care payers.

First, consider the link between employment and health insurance. The idea developed during World War II when health care benefits sidestepped wartime wage limits. It got a further boost from post-war policy, especially the seminal Taft-Hartley Act (1947). The approach was well geared to an industrial sector marked by stable (often lifetime) employment, relatively predictable domestic markets, and regular labor-management relations. By 1979, more than four out of five full-time employees got their health care from their employers. The numbers have declined ever since (with a brief uptick in the 1990s).[1] Rising health care premiums take a steady toll on the employment-based systems; and the apparent return of relentlessly rising costs (employer health insurance premiums increased three times faster than the rate of general inflation in 2001) have eroded a long-standing faith that corporate America would have the will and skill to rein in its health care costs.[2]

More important, the old industrial economy is sinking into history. People shift jobs frequently—lifetime employment with a single firm has become unusual. Global trade and fierce equity markets put enormous pressures on firms (and on their employee benefits). Contingent and part-time workers, consultants, and other flexible arrangements all undermine the kind of long-term commitment to employees that nourished the old system of health benefits. Of course, the pressures on companies vary by sector and firm—most large companies still offer health benefits; most small firms no longer do. However, the numbers are declining in every category. Efforts to reform the system by shoring up employer health care confront the new realities of an emerging global economy. As the quicksilver economy of the 21st century gathers velocity, the mid-20th century employment-based health system will be increasingly difficult to defend—or revive. It offers patchy coverage, it offers few footholds for expanding coverage to the uninsured (or the underinsured), and it places a heavy burden on many companies. Put bluntly, its days are numbered. As that becomes clear, *Medicare for All* may stand out as an appealing reform alternative.

Second, this plan largely rejects one of the great

[1] See Marie Gottschalk. *The Shadow Welfare State.* Ithaca: Cornell University Press, 2000, for a fine description of Taft-Hartley and, more generally, the rise of the employment health care state. See also Michael Graetz and Jerry Mashaw. *True Security: Rethinking American Social Insurance.* New Haven: Yale University Press, 1999, chapter 7.

[2] *Employer Health Benefits: 2001.* The Henry J. Kaiser Family Foundation and HRET, pp. 3, 13, 14; Lawrence Brown. "Dogmatic Slumbers: Business and Health Care Policy." In James Morone and Gary Belkin (eds.). *The Politics of Health Care Reform.* Durham, NC: Duke University Press, 1994.

health care reform standards: consumer choice of health plans. (States that opt for their own health plans may keep the idea alive.) In theory, American health care offers two different kinds of consumer choice: the choice of provider is one of the great—and unassailable—values in American health care. That is not the same as choice of insurers. The idea of competing insurance packages has been a kind of holy grail for health reformers; the idea is intuitively appealing, because it more or less fits with traditional economic models. Consumers choose among competing plans, selecting the mix of price and services they most value.

However, the reality has rarely met expectations. In the real world, the choice of insurance packages is a source of confusion and frustration. People have no idea how to cut through the complexities. They do not understand what exactly they are buying or what trade-offs they are making. A full range of options is rarely available to them in any case (nine out of 10 small employers offered just one plan in 2001).[3]

Worse, the two kinds of choice often conflict: choice among competing health plans leads to limits on the choices that really matter to most people, a choice among health care providers. That, in turn, has led to the political backlash against managed care. *Medicare for All* challenges the conventional wisdom: competition among insurance plans is an idea that has never worked except in special circumstances. Medicare's current beneficiaries do not miss it, nor will the rest of the population when Medicare is extended to them.

Benefits and Coverage

Fixing Medicare

The first step for the proposed program involves fixing Medicare itself. The program's organization and benefits package (introduced in 1966) makes little sense today. Medicare is divided into two parts: Part A covers hospital costs and is financed by a payroll tax; this was the package that Medicare's proponents originally proposed. Part B (Supplementary Medical Insurance) was originally a voluntary program covering physician services and out-of-hospital expenses; it was proposed as a Republican answer to Medicare and dramatically added onto the package in the House Ways and Means Committee. Part B is funded 25 percent by beneficiary premiums and 75 percent from general revenues. Today, almost all Medicare beneficiaries participate in both parts of the program.

Medicare for All would abolish Parts A and B. A general benefits package would be available to all Americans. The financing mechanisms for both A and B would be abolished.

The benefits package would begin with current Medicare services: inpatient hospital services, physician services, short-term nursing care, home health services, hospice care, and post-hospital skilled nursing care and rehabilitation services.

Medicare operates with some gaping benefit holes that would be closed under the proposed plan. For example, outpatient prescription drugs and durable medical equipment would be covered. More generally, a careful review of the benefits package would be undertaken (and updated every two years, as described below). In part, Medicare services would have to be tailored to the entire population. Such benefits as maternal and child health care costs would be covered by the program.

Today, reformers often criticize Medicare for not protecting beneficiaries from catastrophic costs. People over 65 who do not have good supplemental insurance run a real risk of being impoverished by their medical expenses. That risk would be eliminated by abolishing patient cost sharing altogether.

Community Medicine

Medicare, like most of the American health care system, emphasizes highly technical sickness insurance. The closer a patient gets to the operating theater, the more sophisticated—dazzling is not too strong a word—American medicine generally gets. *Medicare for All* would make a strong commitment to the other end of the health care spectrum. The program would emphasize full access to primary care and early intervention.

Medicare for All would create a special Office for Community Medicine, which would oversee a new

[3] *Employer Health Benefits, 2001,* p. 7.

initiative in community-based programs. In some cases, this would mean returning to old efforts such as community health centers; in others, it would involve major new initiatives. Take four important examples: community health centers, school-based health centers, home health services, and drug treatment facilities.

In the mid 1960s, the Office of Economic Opportunity launched a national network of community health centers (CHCs). The centers were meant to overcome the shortage of services in poor neighborhoods. They were originally conceived as a companion to Medicaid: Medicaid would overcome financial barriers to health care, and the CHCs would address other barriers by rethinking service delivery systems. Reformers expected the two programs to grow at roughly the same rate and predicted 1,000 centers serving some 25 million poor people by 1973. Of course, Medicaid grew, while the CHCs, which proved to be too sharp a departure from the existing models of medical care delivery, faded. The medical profession resisted the idea of working in health clinics that were not organized on a fee-for-service basis. Ironically, the managed care revolution has largely broken the professional resistance to what was once a radical service delivery innovation. Physicians routinely work in clinics and are often salaried. *Medicare for All* would return American medicine to the clinic model, funding a network of community health centers through state departments of health.

The program would also offer funds (on a per capita basis) for any school district that established a school-based health center. This is a popular intervention; over 1,000 school health centers have sprung up in the past decade. The idea is to get primary care to children and youths by going to where the kids are. The school-based clinics seem especially effective at getting care to teenagers—a population that is difficult to reach, especially in poor and immigrant neighborhoods. The centers offer annual physicals, mental health services, and reproductive health services, among others.[4]

Finally, one of the great, silent innovations in American medicine lies in the army of home health workers that has sprung up to care for the elderly, disabled, and very sick. Three-quarters of a million dedicated, low-wage workers are offering care and compassion in American communities. The Office of Community Medicine would place home health services in an entirely new framework. Currently, Medicare's home health services operate as an alternative to skilled nursing facilities. Eligibility is tied to hospital discharge and acute symptoms. However, a rapidly aging society is going to require far more extensive, but less intensive home health care. Old people need a vast range of help in the simple activities of daily living. Some of these activities are not medical: getting dressed or getting in and out of bed, for example. Other services involve very minor medical interventions: changing bandages, administering eyedrops, giving drugs, monitoring blood pressure, caring for skin wounds.

Today spouses and children provide much of this care. However, by all accounts, it is exhausting; aging spouses, in particular, often require help to care for their partners. Recent studies document the extraordinary contortions home health workers go through to qualify elderly clients for Medicare (looking for skin sores, for example). Under current rules, Medicare calls that fraud. Scholars like Deborah Stone counter that it looks to them a lot more like simple decency. In any case, an aging society is going to require enhanced home health care—and simple care that helps elders get through their daily activities while assisting with routine medical tasks fits the emphasis on community care that characterizes *Medicare for All.*[5]

Another important benefit is drug addiction treatment. The United States has, in the words of former Clinton drug czar Gen. Barry McCaffrey, "some five million people chronically addicted to drugs [who] are a total mess." Since the mid-1980s, the policy response has emphasized police action—incarcerating addicts at extraordinary rates. Drug policies have fueled an expensive (and extensive) penal regime; one in 33 Americans is now in jail or prison,

[4] See James Morone, Elizabeth Kilbreth, and Kathryn Langwell. "Back to School: A Health Care Strategy for Youth." *Health Affairs* (January/February 2001): 122–36.

[5] See Deborah Stone. *Reframing Home Health-Care Policy.* Cambridge, MA: Radcliffe Public Policy Center, 2000.

on parole, or under probation, about a third of them for drug offenses. *Medicare for All* would offer states treatment funds for first- and second-time drug users. The goal would be to shunt addicts from incarceration to treatment, a strategy now stirring in New York, California, and other states.[6]

The Benefits Commission

The benefits package would be overseen and updated by a commission. The Medicare experience offers a warning—echoed by the experience of national health insurance in some other nations. Political systems often freeze a benefits package into place; they rarely keep up with new health care technologies as efficiently as market systems do. The result of this program would be growing inequity: people with good wraparound policies would enjoy a more flexible and up-to-date benefits package. The problem tends to grow more acute in the generations after the program has been put in place—Medicare's failure to cover prescription drugs is a good example.

To begin to address the problem, *Medicare for All* would empower an independent national commission that would include representatives of provider groups, consumer groups, public officials, and local representatives. The commission would issue a biannual report on health care benefits proposing adjustments to keep up with medical technology.

The commission would report to the Secretary of Health, who, after review, would submit a proposal to Congress under fast-track authority. Congress would then vote the benefit changes up or down without amendment.

Cost Sharing

The proposed program would operate without any cost sharing, a perennial issue among health specialists. On the one side, analysts argue that cost sharing brings the discipline of economic calculation to bear on people's health care choices. On the other side, critics contend that cost sharing leads people to put off needed care; it discriminates against poor people, leads to worse health at lower income levels, and gets gamed by medical providers who often influence the use of services. There is good evidence for both sides of the argument—indeed, the two views are not incompatible.

However, the entire cost-sharing debate is not central to the current proposal. A single-payer, tax-based, health care system such as the one proposed here does not require cost sharing to control costs; it has a more formidable cost-control mechanism (tax resistance, discussed below). Almost all industrial democracies operate with few (if any) cost-sharing mechanisms.[7]

Without cost sharing, another trouble with contemporary Medicare could be addressed: its maddening complexity. Forms and statements could be kept brief and simple. Likewise, providers ought to be freed from the tyranny of billing that plagues every medical practice. An advisory committee of consumer and provider representatives, selected for three-year terms, would offer an annual report on program transparency.

Option Two: State Plans

The proposed system would offer states the option of forming a health care alternative for citizens under 65. States would apply for waivers and, following federal guidelines, organize and operate their own health care financing systems.

The guidelines could be kept relatively simple and would include the following:

• States would be required to guarantee universal coverage to all legal residents.

• States would be required to at least offer all residents a benefit package equivalent to *Medicare for All.*

• States would offer at least one plan without any cost sharing (again, equivalent to *Medicare for All*). Of course, states might choose to organize systems that also offered other choices—for example, front-end rebates with higher cost sharing for people who fell ill.

• All plans offered in a state must safeguard against catastrophic costs.

[6] James A. Morone. *Hellfire Nation.* New Haven: Yale University Press, 2003, chap. 15.

[7] My discussion of cost sharing follows Richard Kronick and Thomas Rice. "A State-Based Proposal for Achieving Universal Coverage" In Jack Meyer and Elliot Wicks (eds.). *Covering America: Real Remedies for the Uninsured.* Washington: Economic and Social Research Institute, pp. 123–4; see also the essays in *Journal of Health Politics, Policy and Law (*October 2000 and Fall 1995).

• The states would guarantee portability by reimbursing the federal Medicare program for care delivered to residents traveling in other states.

The state plans would be vetted for simplicity and transparency; they would be monitored and rated for costs, quality, and access to care. Plans that experienced significantly higher inflation rates or substantially lower access to care would not be renewed after five years.

Federal funds would provide 75 percent of the cost of the state program; states would find other sources for the remaining 25 percent. If state health care taxes were levied for the remaining 25 percent, individuals would receive limited exemptions on their income taxes, though the rebates would not cover the full tax burden.

For proponents of *Medicare for All,* this will seem an odd twist to the system. After all, to its partisans, the proposed plan's biggest difficulty will be overcoming the political hurdles to its realization. Once those victories are finally won, why raise all the complications of state alternatives? After all, there has been no popular outcry for waivers from the current Medicare program—despite all the problems the program has developed over the years.

The answer lies in the politics of innovation. State-level experiments would try out fresh ideas and innovations. Those that prove successful could be imported to the national programs. Many (perhaps most) successful social programs have their origins in innovative state efforts. A handful of state-level experiments, overseen and largely funded by the federal government, would foster innovation and creativity in the national program.

If the federal program began to falter over the years (by not keeping up with innovations in medicine, for example), ambitious politicians in innovative states might find it appealing to try and organize their own alternatives. The prospect would pressure federal policy makers to remain responsive, especially after the program has been running for some time.

Still, state programs would prove difficult to sustain over time. Successful programs would require skillful oversight and administration; the most successful state officials often move up to better positions in the federal government or the private sector. Moreover, states cannot engage in deficit spending, so economic downturns are likely to pressure states to participate in the national program. Finally, *Medicare for All* is likely to prove extremely popular with the public—like Medicare and Social Security. National administrators may very well need to tinker with the incentives to state policy makers if they are to keep a handful (say three to five) of states experimenting with health plans. Failing that, of course, the state option would simply fall into disuse.[8]

Skeptics of *Medicare for All* will have far more positive predictions about the prospects for state plans. It might be politically useful to let the states try to do better than *Medicare for All.*

Financing

Medicare for All introduces a sharp break with current health care financing. Today, Medicare (Part A) is financed by a payroll tax currently pegged at 2.9 percent and split between employers and employees. Part B is funded largely (75 percent) out of general revenues, with the rest coming from monthly premiums paid by enrollees.

For middle-class Americans, tax-subsidized employment plans are the most important source of insurance. More than 80 percent of households earning $50,000 or more are offered coverage by employers; in contrast, only a third of households earning between $15,000 and $20,000 are offered insurance coverage by employers.[9]

Medicare for All puts an end to this patchwork. Medicare payroll taxes are abolished. So are Medicare premiums. General revenue funds are freed for other uses. Employers can offer supplemental and wraparound policies, but workers are not reliant on them for basic medical care coverage.

Instead, the proposed program would be funded by a value-added tax (VAT), mentioned earlier. The value-added tax is a kind of national sales tax. However, rather than simply apply the tax to retail

[8] See Harvey Sapolsky, Jamie Aisenberg, and James A. Morone. "The Call to Rome: Obstacles to State Level Innovation." *Public Administration Review 47* (2) (April 1987).

[9] Graetz and Mashaw, p. 139.

sales, the VAT is paid every time a product is sold. For example, a VAT is added when a manufacturer sells a product to a wholesaler, when the wholesaler sells to a retailer, and when the retailer sells to the consumer. Put differently, the difference between a business's purchases and its sales is its value added. A portion of the tax is applied to every stage in the production process.[10]

The VAT is the official tax of the European Union. All but two nations in the Organization for Economic Cooperation and Development (OECD) rely on it. (The European single market has not gotten its member countries to agree on the VAT rate, however, which still varies from nation to nation.) In the United States, the VAT is championed by fiscal conservatives who would replace the entire income tax with a VAT. Former Rep. Sam Gibbons (D-FL) and Sen. Ernest Hollings (D-SC) have proposed the most recent shift to a national VAT.

Why a VAT? Because health care comprises the largest sector of the American economy. Nationalizing the funding has many advantages—as most other nations have discovered (and as I discuss in the last section, below). There is no question, however, that it would be extremely expensive. We are not likely to fund the American health care system by squeezing a bit more out of our businesses, juggling payroll taxes, or turning to general revenues. Instead of the usual pastiche, a VAT offers a clear, transparent, familiar way to cut through the conundrum of health care financing. This is not a theoretical idea but a practical source of revenue that can be studied in action across the industrial world before being put into place to fund American health care.

In short, consumer spending—the motor of the American economy—would provide the funds that finally solve the seemingly endless crisis in American health care.[11]

Two criticisms of the VAT are worth noting:

First, VATs are usually criticized for being sharply regressive. People earning $15,000 a year typically spend all their income on consumption items. Those earning $150,000 typically spend less on consumption, so they pay a smaller percentage of their income in taxes. There are many ways to relieve VATs of this regressive quality, however. *Medicare for All* would not tax food, medicine, or shelter. Moreover, the tax would be linked to an expansion of the earned income tax credit. That is, income tax relief could render the tax burden neutral for people earning less than $30,000 a year; the tax credit would gradually phase out for individuals earning between $30,000 and $45,000 a year.

Second, critics caution that a federal VAT might compete with state revenues. The states have traditionally relied on the sales tax, while the federal government has used the income tax (at least since the 1920s). But things have been changing in the states. By 1997, less than half of total state revenue (48 percent) came from sales taxes. In fact, the states themselves increasingly rely on incomes taxes (they now account for 39 percent of total state revenues). Moreover, *Medicare for All* solves the problem of health care finance—in many ways, the largest challenge facing state budget directors. On balance, the *Medicare for All* is a good deal for the states.[12]

Of course, any new tax system will take time to implement. The Internal Revenue Service (IRS) studied the implementation burden of converting the whole tax system to a VAT (in 1982) and estimated that the tax would apply to 20 million firms and would take some 18 months to put in place. Implementation of *Medicare for All* would require enough time (and attention) to get the tax changes right.[13]

Existing Programs

Employers

Medicare for All would end the longtime practice of relying on employers as the primary provider of

[10] See Michael Graetz. *The Decline (and Fall?) of the Income Tax.* New York: Norton, 1996.

[11] Though it is beyond the scope of this discussion, I would propose using the VAT to fund the two great American social problems: health care and education. A per capita grant to states for education funding (tied to per capita income) would also offer a way to solve the education funding dilemma and promote a basic and equitable floor for all students. Covering both health care and education would reflect American values by offering all Americans a real opportunity. I develop this plan elsewhere.

[12] Data computed from U.S Census Bureau. *Statistical Abstract of the United States* 1999 (119th ed.). Washington, DC, 1999, pp. 325–7.

[13] Graetz, p. 200.

health care insurance. As noted above, those practices developed in a very different social and economic context. If health premiums continue to rise faster than the general rate of inflation, employer-based health care will rapidly erode. But if the United States turned to *Medicare for All,* many companies would still want to offer some health benefits to employees. Some, for example, would find those benefits a good way to recruit and maintain valued workers.

The proposed program would encourage employers to continue offering health benefits. Employers could offer coverage that wraps around the *Medicare* benefits package. Such coverage might include dental benefits, enhanced mental health benefits, or hospital amenities such as private rooms. Even in the early years of Canadian Medicare (as they call their national health insurance), private insurers thrived by filling the gaps in what was back then a very generous package of benefits.

To encourage employer health benefit packages, the tax subsidies for employer health insurance would remain in place. This issue raises another difficult choice for supporters of a *Medicare for All* system: just how egalitarian a system should we be aiming for? Looking cross-nationally, even single-payer systems vary enormously on the level of equity designed into the system.

The argument against subsidizing employer benefits is simple: it fosters a multi-tier, unequal system from the start. As cost constraints begin to clamp down on the public system (discussed below), these differences will tend to grow. Over time, individuals with good wraparound coverage will have access to better facilities, new forms of treatment, and so forth. Encouraging supplemental policies will only hasten the development of inequalities. From this perspective, basic equality of opportunity—simple justice—requires treating people in equal circumstances in equal ways.

Although these are powerful arguments, there are compelling reasons to encourage employer supplementary policies. The United States is a markedly unequal society. *Medicare for All* addresses health inequities in dramatic ways. However, wealthier people will always seek better care and more amenities, and private insurers will find and offer services that Medicare does not cover. In this context, encouraging companies to offer supplemental health benefits has numerous advantages: it increases the number of people with access to enhanced benefits, it accommodates the relentless American quest for "business class" upgrades, and it creates a market for innovation and luxury that is often missing in nationally funded health care systems.

The great trade-off lies in creating a first-rate health care system for all Americans on the one hand, and accommodating demands for different tiers of care and service on the other hand. To make the balance work, *Medicare for All* would not permit providers to extra-bill patients for covered services; the program itself would fully reimburse providers. On the other side, private insurance markets would pick up and develop benefits not covered by *Medicare for All.* Making this balance work will take careful oversight.

The Medicare Benefits Commission would be required to report to Congress on the state of the benefits package every two years. One of the commission's important tasks would be to scan the private insurance markets to ensure that important health care services were not migrating from public to private systems. This would be a significant danger as decades pass: medical progress introduces new therapies, program cost constraints grow, and private insurance markets stand ready to take up the slack. A well-run system would keep a close eye on private-sector innovations to keep Medicare up to date.

Medicaid

Medicare for All would replace a significant part of Medicaid. The new program would cover acute care benefits for every age group. Most of the services covered by the State Children's Health Insurance Program (S-CHIP), for example, would be turned over to the new program. Medicaid would also be relieved of paying Medicare premiums and copayments for low-income elders (since *Medicare for All* would operate without cost sharing). The new program's community health benefits and home health benefits would offer additional health coverage for

low-income and older people. Taken together, these changes would offer enormous budget relief in many states.

Some important features of the Medicaid program would remain. Most significant, Medicaid is currently the single largest expenditure source for nursing homes (covering just under 40 percent of total costs for the elderly). Though it is beyond the scope of this chapter, reduction of Medicaid's responsibilities (along with budget relief to most states) would offer an opportunity to finally rationalize funding for long-term care.

Administration

Health would be removed from the Department of Health and Human Services (HHS), carefully reorganized, and elevated to a cabinet-level department. Organizational details do not attract much media scrutiny, but, at the end of the day, a plan such as this one can thrive only with a sensibly organized, reasonably financed, and well-motivated bureaucracy.

Classic bureaucratic theory suggests that organizations with a bold new mission and adequate resources tend to attract more motivated workers. There is supposed to be a life cycle to bureaucratic agencies—the peak comes early on when the agency faces large challenges and forges new routines. Looking back on Medicare's implementation, for example, Lyndon Johnson described it as the greatest organizational mission the nation had undertaken since the invasion of Normandy. But effective organizations do not spring up spontaneously; they have to be assembled with care.[14]

In the high drama of winning health reform, the shape of the bureaucracy is overlooked—a detail, an afterthought. Ignoring the details early on will produce chaos during implementation.[15]

Planning for the new organization should begin very early in the political life of the proposed program. (That should be true for every proposal in this collection, incidentally.) Before *Medicare for All* is even introduced, a small bipartisan panel of former health officials (to include the last eight Health Care Financing Administration [HCFA] administrators) would develop an organizational plan for the new Department of Health, the administrative agency responsible for the proposed program. Those details may actually matter more for the health of this (or any) reform, than far more visible questions such as the details of the benefits package.

The committees already noted in this proposal signal some of the most important organizational elements of the proposed program. They include:

• an Office of Community Health;

• a Benefits Board to oversee the benefits package and keep it up to date over time; and

• a paperwork and simplification board, made up of both consumers and providers. As Medicare developed, it became extraordinarily complicated for both beneficiaries and providers. The new program should make a commitment to simplicity and transparency—and vest that commitment in a visible part of the agency.[16]

Simplicity is an especially important issue for the American health care system. A half-century of health care inflation, all the programs designed to deal with that inflation, a vibrant market for health insurance products, and a host of other factors have produced an extraordinarily complicated and inefficient system. Enormous resources are squandered in determining eligibility or negotiating reimbursements from multiple sources. A single-payer system with no out-of-pocket costs can bring a welcome simplicity—but only if policy makers are committed to achieving it.

A single-payer regime could be organized around a simple, national, centralized, electronic method of paying claims. A swift, efficient, and simple reimbursement regime would be the greatest spur to medical system productivity in recent history—it

[14] For a classic summary of the literature on bureaucracy, see Anthony Downs. *Inside Bureaucracy.* Boston: Little Brown, 1967; Lyndon Johnson. *The Vantage Point.* New York: Holt, Rinehart and Winston, 1971, p. 220. See also Judith Feder. *Medicare: The Politics of Federal Hospital Insurance.* Lexington, MA: Lexington Books, 1977.

[15] This, incidentally, was one of the most serious flaws with the Clinton health proposal, though it never got much press. See James A. Morone. "Organizing Reform." *The American Prospect* (Spring 1994): 11–12.

[16] On Medicare's growing complexity, see T. R. Marmor. *The Politics of Medicare.* New York: Aldine, 2000, p. 107; and John Oberlander. *Medicare and the American State.* Ph.D. Dissertation, Yale University, 1995.

would release medical providers from their paperwork, and it would yield enormous cost savings; estimates range as high as 25 percent of health care costs.[17]

Practical Considerations

Political Feasibility

By the standards of contemporary politics, this is not a practical proposal. It would not be taken seriously, for example, in the current Congress.

However, American political history is full of far-reaching changes—both liberal and conservative—that seemed chimerical when first proposed.[18] The key to successful change lies in at least two factors: first, advocates have to develop a plan, publicize it, and push, push, push. Second, they have to find a following—a movement—that mobilizes and demands the change. Solving the American health care puzzle (with 40 million uninsured people *and* runaway costs) will take precisely that combination. Really fixing American health care will require one of the great reform efforts in American history. And that is not likely to happen without a popular outcry, a movement.

Medicare for All does not make much sense if measured simply by contemporary Beltway politics. But few other proposals are as well geared for generating a populist uprising. In that sense, it may ultimately prove more feasible than proposals that try to cover 40 million people with elaborate (and, to the layperson, incomprehensible) compromises, complications, and concessions.

Political History

The issue of feasibility can usefully be put in the larger context of policy change over time. Political historians often describe American political development as a process of punctuated equilibrium. Under normal conditions, the fragmented political system—with checks and balances everywhere—seems designed for stalemate. Only relatively small, incremental changes successfully negotiate the political process. Most of the time, American politics is the politics of tinkering on the margins. Most reform proposals sensibly reflect that reality. But over time, demands for larger change build up. Those underlying demands eventually are met in recurring moments of vast, tectonic change—like the New Deal or the Great Society. *Medicare for All* is based on the premise that fixing America's health care dilemma will take a comparable change.

Reformers who agree with that assessment ought to set their sights on the longer term. Leave others to work for incremental improvements and, instead, begin rallying support for a plan that is likely to address our health problems in a systematic and popular way. Medicare's supporters pushed for more than a decade (without much to show for it) before their opportunity came.

Cost Control

Though many Americans will find it hard to believe, the cross-national experience is unambiguous: single-payer systems (featuring monopsony buyers) offer the most effective methods of health care cost control. Indeed, over time they tend to create the opposite problem, they control costs too tightly. Why? Because public funding means that every rise in health care costs is very visible—it translates more or less directly into a rise in taxes. And there is no greater spur to cost control than tax resistance.

In 2002, many private corporations experienced double-digit health care premium increases. Some universities, for example, faced a 50 percent rise in premiums. Such increases pose serious problems for employers and workers, of course. But spread over thousands of institutions, the problems are local and dispersed. In contrast, a large premium increase in a single-payer system creates a crisis, because meeting the higher costs requires raising taxes. That dispersed problem becomes highly concentrated. Of course, employees are going to pay the premium increases, either directly or indirectly. In a nationalized system, however, those increases immediately become political. There's nothing like the prospect of

[17] See Elliot Wicks, Jack Meyer, and Sharon Silow-Carroll. "A Plan for Achieving Universal Coverage." In *Covering America,* p. 196.

[18] For examples—from the abolition of slavery to the prohibition of liquor, from racial desegregation to welfare reform, from social security to gender equality—see Morone. *Hellfire Nation;* Morone. *The Democratic Wish.*

a big rise in taxes to focus the public mind on effective cost-control measures. The chronic American health care problem—rising costs—would suddenly become politically unacceptable.

Is there anything comparable to a single-payer health system in American politics? Arguably, defense spending. Here is another highly technical industry performing services simultaneously vital and baffling to the layman. Health care providers are asked to square the circle among quality, access, and costs; likewise, defense contractors are asked for timeliness, high performance objectives, and low cost. There are many other similarities and one great difference. Defense is funded—as *Medicare for All* will be—by the government. And in contrast to health care, defense spending remained under tight control throughout the entire Cold War. Even with the American way of life at stake, defense spending never rose more than five years in a row as a percentage of gross domestic product (GDP). And, after the 1950s, it consumed a steadily diminishing portion of the American economy despite occasional rises (in 1965–67 and 1974–75). The Reagan administration's defense spending perfectly illustrates the syndrome of government-controlled expenditures: a popular politician articulates a new demand for spending; Congress allocates a large increase in funds; spending rises relative to other national priorities. However, the growth soon runs up against competing national goals, other programs, tax resistance, and alarm over the deficit. After the early and mid-1980s, defense spending flattened out and, once again, began to decline again as percentage of GDP.[19]

In short, for a nation that especially hates tax increases, the problem with a plan like this one is likely to be *too much* cost control.

Access to Care

The proposed plan would solve the problems of access to care. All legal residents would have health insurance, and they would pay no costs at the point of service. Providers would not be permitted to extra-bill their patients; Medicare would pay the costs in full. Moreover, the plan also addresses other barriers to access: community health centers, school clinics, home health benefits. Each feature of the plan would help ensure broad—and unprecedented—access to health care.

Innovation

Broad access and lower costs come at a price. *Medicare for All* would very likely dampen the fast pace of innovation in American health care. National systems are slower to adopt new organizational forms and new technologies. Today, the American system is marked by nothing so much as the proliferation of new insurance products, new medical technologies, and new organizational models (that fly rapidly in and out of favor—remember managed care?). This feature of the American system would diminish even as we solved cost and access problems.

One reason to continue encouraging employer-sponsored health insurance is to maintain a market (albeit a smaller one) for innovative services and technologies not covered by the new national program. On balance, I have argued, the risk of injecting inequality back into the health system is worth taking in exchange for the innovations the private market is apt to stimulate. The key, again, is to organize *Medicare for All* to monitor and adopt the best innovations of the private insurance sector.

Quality of Care

Nothing will improve the quality of care for more Americans than extending health insurance to the 40 million people who do not have it (or the 30 million more who do not have enough). That said, the proposed plan marks a shift in American health care priorities. This plan emphasizes primary care and low-technology interventions—home health workers are a good example.

On the other side, the grip of cost control will loosen the irresistible march of high technology. This plan is likely to force hard choices about heroic measures undertaken on the very sick and the very old. Americans will be much slower to perform heroic measures that prolong life for a matter of weeks. Does that diminish quality of care? In some

[19] For the defense spending analogy, see James A. Morone. "Beyond the N Words: The Politics of Health Care Reform." *Bulletin of the New York Academy of Medicine* 66 (4) (July–August 1990): 344–65.

ways it does. And yet, anyone who has recently watched a dying loved one run the gauntlet of high technology may very well think not.

Acknowledgements
I am grateful to Michael Graetz (Yale Law School), Deborah Stone (Dartmouth College), James Morone, Sr. (my father), Mark Schlesinger (Yale School of Public Health), David Frankford (Rutgers Law School), Tom Rice (UCLA), and the staff at ESRI for very helpful comments and ideas. ■

Morone Proposal

Key Elements

James A. Morone has proposed a single-payer approach to provide universal coverage with the following elements:

THE MEDICARE PROGRAM with expanded benefits, including no cost sharing, would provide automatic coverage for all legal residents of every age.

FUNDING WOULD COME SOLELY from revenues raised by a new federal value-added tax.

STATES COULD OPT OUT (for residents under age 65) by proposing a program that meets federal guidelines and by paying 25 percent of the cost.

EMPLOYERS COULD OFFER COVERAGE for additional benefits, with the employer-paid premium not subject to income tax.

About the Author

JAMES MORONE is Professor of Political Science at Brown University. His *Democratic Wish: Popular Participation and the Limits of American Government* (Basic, 1990; Yale, 1998) won the American Political Science Association's 1991 Gladys Kammerer Award for the best book on the United States and was named a "notable book of 1991" by the *New York Times.* His *Hellfire Nation: The Politics of Sin in American History* is forthcoming in February 2003. Morone co-edited *The Politics of Health Care Reform* (Duke University Press, 1994) and *Health, Wealthy and Fair* (Westview, forthcoming). He has written more than 100 articles on American politics, history, and health care policy. Professor Morone received his B.A. from Middlebury College and his Ph.D. at the University of Chicago. He has been on the faculty of The University of Chicago, Yale University, and the University of Bremen (Germany). The Brown University classes of 1993, 1999, and 2001 voted Professor Morone the Barret Hazeltine Citation as teacher of the year. Professor Morone has testified before Congress numerous times. He was a secretary and member of Governor Cuomo's task force on Universal Health Care for all New Yorkers (UNY*CARE) and a member of the National Academy of Sciences Committee on the Social and Ethical Impacts of Developments in Biomedicine. He is on the editorial board of six scholarly journals and chairman of the board of *PS: Politics and Political Science* and *The Journal of Health Politics, Policy and Law.* He is a founding member of the Health section of the National Academy of Social Insurance. He is currently president of the New England Political Science Association and immediate past president of the Politics and History section of American Political Science Association. Professor Morone has won multiple grants, including an Investigators Award from The Robert Wood Johnson Foundation.