You know, there’s an interesting dynamic right now because I think the best allies that single-payer Medicare for all has are actually conservatives, particularly conservative justices.

You know, one set of, of possible strategies is to take those elements of the Affordable Care Act and diffuse them more broadly among states to really make everyone [Massachusetts].

[musical interlude]

Hello, welcome! This is the November 2019 podcast of the American Journal of Public Health. This month, editors Paul Erwin, Dan Fox, and Colleen Grogan and guest editor Peter Donnelly have commissioned a set of articles to review the different ways of financing health care with a discussion about single-payer, multi-payer, and state-based financing systems and their relevance for the United States.

The US system of insurance is a complex machine, and it was built progressively and it underwent many social and political battles. The population coverage has improved in quantity and in quality over time, but it remains a combination of sometimes contradictory systems and importantly, it leaves about 30 million people without health insurance. The system is today at a crossroads: Will it continue to grow incrementally or are we on the brink of a profound transformation in which all of the existing financing institutions are going to be cancelled and replaced by a single system? I have explored these questions with two guests. The first is Jonathan Oberlander. He’s a professor at the Department of Social Medicine and at the Department of Health Policy and Management
at the University of North Carolina at Chapel Hill. With him, we will review the history. The major steps in the incremental construction of the current health care financing system and the current paradox that the ACA, the Affordable Care Act, appears as a potential obstacle to a single-payer system. My second guest is Sherry Glied. She’s a professor of health policy and management who’s now Dean of New York University’s Robert F Wagner Graduate School of Public Service. With her, we will explore what are the options to substantially increase coverage, building up and expanding from what already exists which is essentially Medicaid, Medicare, and the Affordable Care Act, or Obamacare. I am Alfredo Morabia, Editor-in-Chief of the AJPH and we are October 1, 2019.

I’m reaching out now to Jon Oberlander. Good day, Jonathan, how are you?

JO Great to hear from you, I’m doing well.

AM Can we say that the first serious qualitative steps towards a national health insurance date from when Lyndon Johnson created Medicare and Medicaid in 1965?

JO I think we can say those were the first successful steps. The dominant theme of the history of health care reform in the United States is failure and also disappointment, and for most of the 20th century, health care reformers failed and the efforts to enact some form of government health insurance go back actually a century to the early part of the 20th century and during the time of Franklin Roosevelt and Harry Truman in the 1930s and 40s, there were efforts to enact what today we would call national health insurance. But those were unsuccessful, and really enactment of Medicare and Medicaid in 1965 was the first successful effort to pass government-sponsored health insurance in the United States, and it really transformed our health care policy.
But what was the idea underlying Medicare and Medicaid? What was the idea to add some federal regulation to a system that would essentially be based on private insurance or was there a different intention?

What had happened in the United States is that in the 1930s and especially in the 1940s, we had huge growth in employer-sponsored private insurance. And that became a cornerstone of our system, and so it stands today. When the idea for Medicare came along, the architects of Medicare were believers in national health insurance. They wanted what would later be called a single-payer system—government health insurance, federal health insurance for all Americans. But under the Truman administration, they failed to pass it, so Medicare was an incremental step, a strategic step back to really begin with the elderly. And they thought that if started with the elderly and you showed that federal health insurance could work, next you would cover children and eventually you would cover everybody. Medicaid really was thrown in towards the end of the Medicare debate, and they had not planned on that and of course that created another fork in the road that US health care policy would go down. But the original idea of Medicare was actually Medicare for all.

But let me understand, were those two groups, the poor and the elderly, the easiest group to cover with a single-payer system because they didn’t have an employer-based insurance system?

Yes, and in some ways the rationale was the most compelling because they had been left out of the growth of employer-sponsored insurance in the 1940s or 1950s. So seen from that American perspective, it made sense. Seen from the perspective of any other industrialized democracy in the world, it doesn’t make sense at all. Why would you take
the most expensive population with the highest health care needs, in this case the elderly, and isolate them on their own financing base and a separate insurance program? The Canadians don’t do it that way; the British don’t do it that way; the French and the Germans, and so on. They don’t do it that way, so this is really a, a sort of unique American invention, and really the enactment of Medicare and Medicaid defined the next half-century of American health policy with what I would call demographic incrementalism where we would identify sympathetic groups and we would cover them one by one.

AM But do you think that the poor and the elderly were simply a market that was not interesting for the insurance industry?

JO Certainly when you talk about older Americans, there was a very high uninsured rate before Medicare. They were a bad risk. They were expensive to cover, but there was some private insurance coverage, much of it inadequate, and in a sense the government took the worst risks off the market which was good for insurers. Now, of course later on in the history of Medicare, private insurers wanted back in that market and thought they had a way to make it profitable.

AM I see, and so if there were those good intentions to create a single-payer system incrementally, what happened over the last 50 years?

JO Well, remember that when Medicare and Medicaid were enacted, it was during the Great Society, during a period of liberal Democratic ascendance in American politics, and to the architects of Medicare it was natural that you would pass this Medicare program and next you would cover children and then it would grow to cover all Americans. They did not anticipate the turn in American politics to the right that would happen in the early and
mid-1970s. So, American politics shifted and it shifted rightward in a way that really marginalized the idea of expanding Medicare. It’s also the case that Medicare itself had problems. It was a very expensive program with no cost control at all when it was enacted, and because it had no cost control, its reputation in Washington was as a problem, an expensive program that they couldn’t control, and it’s hard to build off something like that. In the 1980s and 90s when we have that large uninsured population in the United States, policy makers looked to Medicaid which was closer in some ways demographically in terms of income than Medicare was to the uninsured. And Medicaid becomes the platform, the public platform, to cover uninsured Americans.

AM Just a point here, Jon, I mean wasn’t Medicare Part D a Republican—

JO Medicaid?

AM Medicare Part D, you know the—

JO Oh, Medicare Part D, yes, so Medicare Part D, so when we get all the way now to the 2000s and um under President George W. Bush and there was a lot of pressure at that time because of rising prescription drug costs, which is a theme that of course echoes again today, and the Bush administration wanted to do that largely for political and electoral reasons. It was controversial among conservatives, but they end up expanding the Medicare program although they do it in a conservative way. The Medicare prescription drug program is comprised entirely of private plans. There is not a governmental plan or a public option.

AM And so, what’s the situation now? Are we closer to a single-payer system or further away from it with the Obamacare?
JO Well, in some ways the Affordable Care Act moves us closer in the sense that it has entrenched principles in the United States, for example, that we will not tolerate insurers discriminating against people with pre-existing conditions which, before the Affordable Care Act, was common across the country. So, in terms of its aspirations, in terms of some of its core principles, in terms of expanding coverage, Obamacare has moved us closer. On the other hand, Obamacare itself is an obstacle because one of the problems, central problems, of single-payer is you’re trying to take this complicated, Byzantine patchwork of public and private insurance programs and cohere them into a single plan, Medicare for all. And the Affordable Care Act creates yet other programs that are now out there, other ways that people get coverage including through the insurance marketplaces, the expansion of Medicaid, and in that respect the ACA also represents an obstacle to single-payer.

AM So, if its an obstacle to single-payer and some people want to get rid of the Affordable Care Act, won’t these people actually favor the development of a single-payer system?

JO You know, there’s an interesting dynamic right now because I think the best allies that single-payer Medicare for all has are actually conservatives, particularly conservative justices. If we take a step back, remember that the Affordable Care Act represents a model of health reform that I would call ambitious incrementalism. It’s transformative in many ways but it’s incremental and it builds on private insurance very explicitly. If that model is thrown out, if it’s repealed by Congress or if the courts rule it illegal—and right now we have a case that we can talk about making its way through the court system where one federal judge has already ruled that the entire Affordable Care Act is illegal, if that case were to go through the court system and be upheld by the Supreme Court, I
think it would discredit and delegitimize the incremental model. And in that circumstance where there would be such chaos and tens of millions would lose insurance protections, I actually think it would provide a boost to Medicare for all.

AM That’s fascinating, that’s really fascinating. I’m not sure many people are conscious of the paradox that you mention and you describe very well in your commentary. Jon, thank you very much for your time and for contributing to the Journal.

JO Ah Alfredo, it was great talking to you and thanks so much for doing this!

[musical interlude]

AM Let’s now call Sherry Glied who is Dean at the New York University Robert Wagner Graduate School of Public Service. Good day, Sherry!

SG Good day!

AM So tell me, Sherry, you’re at the Robert Wagner School and was Robert Wagner one of the earliest Democratic proponents of the single-payer proposal?

SG His father was, so the one that we’re named after is the son who was the mayor of New York, but he had an illustrious family; and in fact, one of his—his father was one of the authors of the Wagner-Murray-Dingell Bill which was the single-payer proposal in 1945, ’47, yeah.

AM So do you feel committed to the father or not?

SG Well, I think I’m more committed to the son since that’s my school.

AM Okay, so tell me, Sherry, how many Americans today don’t have an insurance?

SG Well, the numbers vary and I’m going to try and get the number right for you. I think it is around 27 million.

AM Okay, and so where were we before the ACA? Before the Affordable Care Act?
So, it—so we were at about 50, and most people estimated that it was going to go up, so we are, we probably cut the un-insurance rate roughly in half.

That’s fantastic, and how many are today at risk of losing their coverage if the ACA is definitely repealed?

Well, I guess the reasonable number is between those two so I guess 27—another 27, 25 million people.

Okay, so many people believe that if we want to improve the insurance system, and if the goal is coverage, quality of coverage, we should do this incrementally, and so what is according to you—and I know you developed this idea in your commentary in the last issue of the Journal—what are in your view the ways to incrementally improve the Affordable Care Act?

So, I guess an important note here is that the way American politics works, the way American policy works, it’s most likely that we will make change incrementally. That’s just the way that our system is set up, and in fact if you look around the world at how other countries achieved universal health care it was typically on a relatively incremental, in a typically incremental way from one thing to the next. So, if we think about the US health care system today and think about what are the, the strategies we could use to incrementally improve coverage, I guess there are several directions we could go. One is to take the foundation of the Affordable Care Act and build on it in a variety of ways. And what would it mean to build on it? So, I think one of the things it would mean is to undo some of the things that the Trump administration has done through regulations, for example, to make it, to undermine much of the Act. So for example, they’ve allowed Medicaid programs to impose work requirements; they’re allowing the sale of short-term
health plans that don’t include the ACA’s benefits, and association health plans likewise, and also changes that Congress has made, for example repealing the individual mandate. So sort of the narrowest set of things we might do is just go back, kind of go backwards and get back to where we, where we once were before these changes were made, then you can kind of go beyond that within the framework of the Affordable Care Act. And I guess the best example of that is really Massachusetts where I was just looking at some numbers. The uninsurance rate in Massachusetts is under 4% which is, actually if you do the calculation, about the same as the uninsurance rate in Ontario in Canada. So, you know, they’ve actually come pretty close to universal coverage within the ways that other countries think about universal coverage. So, that’s without actually doing anything beyond what was, much beyond, what was in the original Affordable Care Act. Massachusetts retained the individual mandate; it has slightly more generous subsidies than much of the rest of the country; has a well-functioning insurance marketplace, robust economy which helps also, but with all of those pieces in place they’ve managed to get their uninsured rate pretty far down. And California which is a state more challenges in this respect also has done quite well in terms of getting its uninsurance rate well down. By comparison for example, California’s uninsurance rate is under 8% and Texas’s is over 18%. So, you can see how much state decisions within the framework of the Affordable Care Act can actually mean in terms of getting people covered. So, just stop there, so one set of possible strategies is to take those elements of the Affordable Care Act and diffuse them more broadly among states to really make everyone Massachusetts.
AM If we make everyone Massachusetts, what does it imply about reforming Medicare? The idea of extending Medicare to people from 55 to 65 would not be needed if everyone would be Massachusetts, for example.

SG That’s right. I mean in Massachusetts, in fact people 55 to 64 can buy that coverage on the marketplaces which for the moment, in Massachusetts, is probably a better deal than Medicare—there are subsidies that go up the income scale further, there are better cost-sharing subsidies in the programs and the plans that are sold in the exchanges actually do have those catastrophic limits in them in out-of-pocket spending. So, I think at this moment if you were in Massachusetts and things were working very well, there would not be a big appetite for buying into Medicare at 55.

AM And what about the expansion of Medicaid?

SG Well, that’s a big problem. So part of the reason that a place like Texas has such a high uninsurance rate is that they have not chosen to expand their Medicaid program. Now, one of the things that’s really quite encouraging is that there have been some state referenda on expanding Medicaid even in fairly red states—we’ve seen for example Utah, we’ve seen residents of the state voting in referendum to say please we want our state to expand Medicaid—and so even though there has been reluctance among red states to do expansions of their Medicaid program, we’re actually starting to see more and more states fall in, and on some levels this is kind of consistent with our prior experience. When the original Medicaid program started, it took quite a while until the last states joined the program, so you know one hope is that if, if everyone believed the Affordable Care Act were here to stay, then maybe a bunch of the states that have been reluctant up to this point expand their Medicaid programs would actually do so. It might
also be necessary for the federal government to offer some carrots or sticks to try and get those states to participate in the Medicaid expansion.

AM Another option that you mention in commentary is the options for states to go alone, you know to do their own insurance plans and expand Medicare or you know Medicaid or whatever other options. Do you think that’s realistic that we go in that direction?

SG Well, so I think one of the encouraging things there is that after all the reason we got Obamacare in some ways in the first place is that Massachusetts had done its expansion back in 2006 and it was actually the evidence that showed that that expansion was, could be done in a successful way and at modest public cost that encouraged lawmakers to proceed with the broader expansion across the whole country. So, I think that sets a precedent for thinking about trying to encourage states to take more aggressive steps to address health care problems in their own states, and we’ve actually seen several states move in that direction. So, California has just passed an individual mandate and has expanded subsidies; on the other hand, Maryland for example has its global budgeting for the—including the Medicare program. So, there is capacity or potential to do some things like this. I think it is notable that in Canada for example the way universal health insurance happened is that several—one province and then several provinces moved out in front of the rest of the country and set an example for the others. I think there are several challenges in this respect. One is that states are not well positioned to finance the entire cost of health care for their citizens, and one would want the federal government to participate in some ways, so it would be necessary to have a sympathetic federal government that would help states move in this direction and that would particularly insulate them in times that, in economic recessions for example. I think a second real
challenge for the United States is that there is such divergence of political opinion or opinions about the degree of redistribution that is appropriate among the states that one could easily imagine us being in the situation for quite a long time that coverage was substantially more generous and more available in some states than in others, and I think that would be a situation that might be politically very challenging.

AM Any solution that is proposed for a national insurance system sounds very complicated, right?

SG Yup.

AM And if the next administration would be overwhelmingly in favor of a single-payer plan and they would say we would you know implement it in the first 100 days and we would go, you know, for a totally new system, would you still be arguing that it is better to go incrementally and to build on the chassis of the ACA?

SG So, I mean, I don’t, there are lots of single-payer plans and there are many that I would support, not necessarily all of them, but I have to say, [Alfredo], I don’t see that as a plausible outcome of the next election. I just remember how incredibly hard it was to get Obamacare through when there were 60, 60 Democratic and independent senators, so I mean I think it’s great to hope and dream for something transformational, but it’s really hard to find examples in the history of American politics when that has ever happened, even Franklin Roosevelt had that kind of problem. So, you know, I think we need to be thinking about what we can do and not only what we aspire to do.

AM Okay, I got the message. Thank you very much Sherry—

SG You’re very welcome.

AM And thank you for your time.
Okay, take care.

[Song interlude]

Alright, at the end of these interviews, it appears that multiple options exist to improve what remains the Achilles heel of the US national insurance system that is quality coverage. But the likelihood of success of these options depends on the political mix in the House and Senate. If the next administration has the leverage to entirely rebuild the multi-payer system into a single-payer system, this may be an optimal option. Paradoxically, the Affordable Care Act would stand [on] the way of a single-payer plan and its complete repeal may strengthen the case against building up universal coverage step by step, incrementally. However, if the political mix is more moderate, there are other options that could drastically move us towards a universal coverage. These include re-introducing the components of Obamacare which have been rolled out recently, for example, restoring the individual mandate penalty. But we can also generalize Medicaid expansion, add a public option among the insurance plans, expand Medicare to people 50 years and older, better regulate the insurance market. Most of these options seems to be popular with the public across states, if not among politicians.

[Song background]

I’m grateful to all my interviewees for their time and willingness to share their ideas. I also thank Emily D’Agostino and Michael Costanza for comments and edits on an earlier version of the podcast. Francis Jacob composed the reggae tune interpreted by Nigerian master drummer and singer, Kofo the Wonderman. You can listen to and watch Francis and Kofo playing together in New York City on YouTube. This is Alfredo Morabia at AJPH. For more podcasts including podcasts in Chinese and Spanish, visit us at
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