

If It's Not One Thing, It's the Same Thing:
Political Barriers to Health Care Reform in the United States and the Viability of
Establishing a Single-Payer Health Care System

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Introduction

The health care debate in the United States is nearly as old as the country itself. Opening hospitals to treat seamen after the Revolutionary War is a far cry from passing the Patient Protection and Affordable Care Act (ACA), yet the debate has changed only in the specific legislative language of any given bill. From social welfare debates in the 19th Century, to the New Deal, to the establishment of the Children's Health Insurance Program, to the ACA, who will be covered and who will pay for it are questions state legislators and members of Congress have attempted to answer throughout generations. The current health care debate is no different.

With each major reform, health care, for better or worse, changes incrementally. Small changes are made to an existing system, often solving one problem while creating another. Presidents and lawmakers have tried to make sweeping changes—create a whole new health care system—to no avail. Presidents Truman in 1947, Clinton in 1993, and Obama in 2010 each attempted to create a universal health care system, a government-run system to ensure that everyone who needed care was able to get it. Congress thought otherwise, and instead of universal coverage, watered-down versions of Truman's and Obama's plans passed. Clinton's plan did not make it to the President's desk.

The United States is not the only country to face ongoing health care debates. The majority of developed nations—many of which outperform the U.S. in health care efficiency (Tandon et al., 2000), physical and mental health, health infrastructure and preventive care (*The Legatum Prosperity Index*, 2018)—ask the same questions when it comes to providing health care and paying for health care: Who gets care? How much do patients pay, versus insurance companies, versus the government? What services will insurers or the government pay for? And how well is the system working?

There is one key difference between the United States and its peer countries: in creating their respective health care systems, the U.S. and other countries made two very different choices. The U.S. chose to prioritize who deserves government assistance in obtaining health care. Throughout the rest of the developed world, be it the United Kingdom, France, Germany or Taiwan, health insurance coverage is universal, but the United States has “never decided to provide medical care for everybody who needs it” (Reid, 2009, p.2).

With each incarnation of health care reform, our legislators make choices. They choose new regulations, new requirements, and new modifications of a health care system that has been pieced together in that manner for decades. Legislators decide who is deserving of government assistance and who will fall through the cracks of the patchwork system. They decide how much they will be involved in regulation and how much the already enormous health insurance, pharmaceutical, and medical care industries can grow, often at the expense of individual Americans’ well-being.

Partisan rhetoric is strong, now more than ever, and legislators must stick to specific narratives, especially if they have a strong challenger in their next election, and particularly if they live in a state that is dancing between the red and blue lines. Through polling and survey data, it is clear that certain phrases resonate more with voters of particular political parties, but those phrases are often only a small piece of the health care policy agenda.

Part of the problem is that many Americans do not understand the difference between a single-payer and a multi-payer system, theories of risk pools, and that opening up a system to everyone can make it better for everyone. Many do not understand where their health care comes from and that even those with employer-sponsored health insurance benefit from government assistance. The narrative surrounding health care—in political ads, in the news, in Tweets and

Facebook posts, in speeches—is a strong opponent to true understanding of our health care system.

This paper seeks to answer three questions: what decisions brought us to our current health care system, what barriers stand in the way of achieving a more effective health care system, and what is politically feasible at this point in our nation’s history as we look to the 2020 Presidential elections? I will define key phrases and policy options related to health care and the current health care debate in the United States. I will analyze health care policy changes through a historical lens, finding lessons that can be learned from past reform efforts, both successful and not, and applying those lessons to current attempts at fixing a broken system. Finally, this paper will draw general conclusions about the 2020 presidential election, focusing on some of the Democratic candidates,¹ and make recommendations and predictions about how they might craft their health care policy platforms.

What, exactly, is single-payer health care?

We live in a political world of sound bites and 280-character limits, and it is difficult for American voters to see past the narrative spewed by politicians, lobbyists, spokespeople, and journalists. It can be just as difficult for candidates to condense their messaging into a Tweet or a one-minute Instagram video. Our health care system is complicated enough without the political rhetoric; and confusing terminology, contradictory messaging and false information make engaging in the health care debate convoluted at best.

¹ This paper assumes that President Trump will be the Republican nominee for the 2020 election. While much can happen between now and November 2020, extending the analysis beyond the Democratic hopefuls is outside the scope of this paper. Additionally, as is evident by the major health care reform initiatives analyzed in this paper, the Democratic Party tends to play a leading policy role in health care reform, particularly if additional spending is necessary.

Phrases such as “Medicare-for-All” and “universal health care” are used frequently, though not always consistently. Even more important is the fact that, though they may be used correctly, they are not always interpreted and understood correctly, and “worlds of difference emerge in the details of what exactly those phrases mean in practice” (Breuninger, 2019, para. 2). To avoid adding to the narrative cacophony, the following sections provide definitions of frequently discussed phrases and policy options that will be used throughout the rest of this paper.

Universal health care

A universal health care system, also referred to as universal coverage, is a system in which everyone has access to insurance coverage or a medical care provider (i.e. a doctor, hospital or clinic). Whether the system is entirely government-run, paid for through taxes or monthly premiums, or a mix of public and private entities, each person in a universal health care system is able to receive health care that is subsidized in some way, meaning the patient does not pay the full fee for the medical service they receive at the point of the physician visit. When President Barack Obama introduced the ACA, his goal was to provide universal coverage. Despite his attempts, the ACA falls short of universal health care due to compromises made during the law’s creation. Most developed nations, peer countries to the United States, have universal health care systems.

Single-payer systems

In a single-payer system, one entity, such as the government, pays for health care services (i.e. check-ups, various medical procedures, prescriptions). Medical care is a public service, like the fire department, public libraries or public schools. Providers can be either public or private—that is government employees or self- or privately-employed. The United Kingdom employs the

former, while countries like Canada and Taiwan operate with a single-payer, the government, which pays private providers. In a system like that of the U.K., tax payments are used to finance health care, while monthly premiums paid into a government-run insurance program finance health care models like Canada's. The United States' Medicare program and the Veteran's Affairs hospitals are two examples of single-payer systems in the United States, with the government paying health care providers for medical services.

Multi-payer systems

In a multi-payer system, multiple sources provide payment for health care services. This can be a combination of government payments and/or payments from private insurance companies. Typically, a multi-payer system will be mostly comprised of employer-sponsored insurance plans that cover the majority of the population. Most working Americans receive their health insurance through an employer. One of the major disadvantages of this type of system is that patients must navigate a complex array of in-network and out-of-network providers, and providers must contend with myriad insurance companies, each with its own coverage policies, payment schedules, and reimbursement systems.

Countries like Germany and France have multi-payer systems with universal coverage guaranteed by law. Insurance companies are non-profit and under strict government regulation. Their systems have significantly lower administrative costs because the system is designed to ease administrative burdens, quickly reimburse both providers and patients, and clearly establish what is covered and what is not. Because everyone is required to have insurance (also known as an individual mandate), the risk pool—or the group of people paying into the insurance plans, and thus providing funds with which to pay for health care services—in these countries is large,

which makes the system more efficient economically. Additionally, government regulation ensures that costs are kept as low as possible.

The United States' hybrid multi-payer system

Unlike most of our peer countries, which opt for either a single-payer system or a multi-payer system, the United States has a hybrid multi-payer system. Individual components of our health care system mirror those of other countries, “yet we’re like no other country, because the United States maintains so many separate systems for separate classes of people” (Reid, 2009, p. 21). In 2017, 67.2 percent of Americans had private health insurance plans (multi-payer), with 56 percent enrolled in an employer-sponsored health plan and 16 percent enrolled in a direct-purchase plan, a health insurance plan bought on the individual market. Government plans (single-payer) covered 37.7 percent of the population, with 17.2 percent enrolled in Medicare, 19.3 percent enrolled in Medicaid, and 4.8 percent enrolled in military health care. The uninsured rate was 8.8 percent² (Berchick et al., 2018). For the uninsured group, receiving medical care is akin to receiving medical care in most developing nations. They must pay for their care out-of-pocket. Almost everyone in the U.S. incurs some out-of-pocket costs, in the form of co-payments or monthly premiums, but the uninsured population pays for *all* of their care out-of-pocket.³

Nearly all insured Americans benefit from subsidies

According to data from the United States Census Bureau, in 2017, 16 percent of Americans received health insurance from direct-purchase plans, or plans “purchased by an individual from a private company or through an exchange,” including “coverage purchased

² These numbers are estimates based on data from the United States Census bureau and are not mutually exclusive, as many Americans fell into one or more categories during 2017.

³ In reality, not all uninsured individuals are able to pay for their care, but hospitals that receive federal funding for Medicare and Medicaid must triage and stabilize all emergency patients. This leads to providers who are not paid for their work, or uncompensated care.

through the federal Health Insurance Marketplace as well as other state-based marketplaces and...both subsidized and unsubsidized plans” (*Health Insurance Glossary*, 2016). Therefore, fewer than 16 percent of Americans have health insurance plans that are not subsidized in some way, such as through the federal government, state government, or an employer. Though many, particularly on the conservative side of politics, oppose government interference in health care or providing assistance to individuals to pay for their health care, they fail to recognize that very few do not receive such assistance. Much of this is due to the complexity of our health care system and implicit taxation or fees that individuals pay for their own health care. Individuals with direct-purchase plans through the individual market may qualify for federal subsidies like the Advance Premium Tax Credit. More implicit is the subsidy of employer-sponsored health insurance, whereby individuals contribute their portion of the health insurance premium using pre-tax dollars.

Medicare and Medicaid expansions and buy-ins

Policy makers, both at the federal and state levels, have introduced expansion and buy-in options to increase the number of people covered by Medicare, which covers individuals 65 and older, or Medicaid, which covers low-income individuals. The ACA allowed for expansions to the Medicaid-eligible population to most low-income adults with household incomes up to 138% of the federal poverty level (FPL). Thirty-seven states have chosen to expand Medicaid eligibility to at least 138% FPL, with some states expanding their eligible population beyond the 138% income threshold or to specific populations, such as single adults without children. Fourteen states have opted not to expand their Medicaid eligibility. To expand eligibility beyond ACA stipulations, states must apply to the Centers for Medicare and Medicaid Services (CMS) for *Section 1115 demonstration waivers*, which “allow states to innovate under Medicaid in ways

they are not otherwise permitted to do under existing Medicaid rules” (*Medicaid Waivers in the States*, 2018, para. 5). This allows states to specifically expand their Medicaid-eligible population based on their own identified need.

In the past couple of years, there has been considerable discussion around Medicare expansions as well. In the current debate, proposals for expanding Medicare to the entire population (Medicare-for-All) or expanding the age-eligibility from 65 years and older to 50 or 55 years and older are the main options being considered.

Medicare and Medicaid buy-in proposals have also been made. The buy-in options would allow individuals to opt-in to Medicare or Medicaid via the health care exchanges. Essentially, the individual market would include a public option, in addition to the other private options available.

History of Health Care Reform in the United States

With the 2016 presidential election came a reinvigorated discussion of the United States’ health care system. Senator Bernie Sanders (I-VT) sought the Democratic nomination with a single-payer platform, advocating for universal coverage in a government-run insurance system. While Sanders’ calls for expanding health care access energized a base of voters, the creation of a single-payer health care system has been on the minds of politicians and elected officials for more than a century.

Public responsibility and the rise of “socialized medicine”

Fewer than three months after the end of World War II, President Harry S Truman proposed a health plan to Congress, arguing that government should have a role in health care. He said, “The health of American children, like their education, should be recognized as a definite public responsibility” (President Truman’s Proposed Health Program, 2017, para. 1).

The program would provide funding to recruit medical professionals to rural and low-income areas that lacked adequate numbers of doctors, nurses, and dentists, as well as funding to build or update medical facilities in these areas. It called for the creation of a board of doctors and public officials to establish and enforce standards for medical facilities and designated funds for medical research. Finally, it would create a national health insurance plan.

Truman's health insurance plan would have been open to all Americans, but optional. Enrollees would pay monthly premiums, which would provide funding for all medical services. The federal government would pay doctors enrolled in the program. Additionally, the health insurance fund would compensate individuals for wages lost due to injury or illness.

The bill reached Congress as a Social Security Expansion. One of the fiercest opponents of the bill was the American Medical Association (AMA). Capitalizing on the anti-Communist sentiment that had spread throughout the country as the Cold War began, a public relations firm working for the AMA called the bill "socialized medicine," suggesting "that anyone advocating universal access to health care must be a communist" (Reid, 2009, p. 11). The individual or individuals who coined that two-word phrase may not have understood the genius of their work, but those two words have retained political power for more than seven decades. The fact that Senator Sanders refers to himself as a socialist does not help to separate the ideas of socialism and single-payer health care in the minds of voters, and more importantly in the minds of opponents to single-payer.

After the Korean War began, Truman and the bill's authors were forced to abandon the bill. However, in proposing a single-payer plan, Truman opened discussions about the issues with health care in the United States. Between 1945 and the end of Truman's time in office in 1953, "the not-for-profit health insurance fund Blue Shield-Blue Cross grew from 28 million

policies to over 61 million” (President Truman’s Proposed Health Program, 2017, para. 4), indicating a widely felt need for health insurance. The growing number of people with health insurance undercut the urgency for greater reform—like Truman’s original health care plan. By not passing the Social Security Expansion, Congress set a course of incremental health care reform, as “existing public policies...shape subsequent policy outcomes” (Campbell, 2011, p. 962). In increasing awareness and opening discussions about health care, many more individuals sought insurance, but as the insured population grew, the need for universal health care took a back seat to other political issues.

Medicare and Medicaid: The deserving and undeserving poor

In his 1963 State of the Union address, President John F. Kennedy called on Congress to enact a health insurance program for the elderly. Amending the Social Security Act to include such a program had been a part of his administration’s legislative program since his election in 1960. When President Kennedy was assassinated and Vice President Lyndon B. Johnson assumed the presidency, he continued to advocate for the health insurance program for the aged, as well as other social welfare programs. These programs formed the cornerstone of President Johnson’s “Great Society.”

On July 30, 1965, at the Harry S Truman Presidential Library and Museum, President Johnson signed into law the Social Security Amendments of 1965, and President Truman, who had championed expanding health care almost two decades earlier, received the first Medicare card (President Truman’s Proposed Health Program, 2017). The Social Security Amendments of 1965 established Medicare and Medicaid, programs to deliver health care to the elderly, low-income mothers and children, and disabled individuals. The Amendments also made changes to the Old-Age, Survivors, and Disability Insurance program (OASDI) and Maternal and Child

Health and Child Welfare programs, increasing monthly benefit payments and overall appropriations for those programs (Social Security Amendments of 1965: Summary and Legislative History, 1965).

In passing these amendments, Congress made clear choices that there are Americans who deserve government support in obtaining health care—namely, old or disabled individuals, and women and children—and others who do not, such as unemployed individuals. The idea of the “deserving poor” was not new, but in debating who would and would not receive Medicare and Medicaid, deservingness was codified into the health care system. This established a framework that would guide health care reform for decades to come. Instead of working toward a health care system that would serve all Americans, Congress and state legislatures were empowered to decide who should receive assistance. Health care debates that followed would be rooted in that framework.

For example, current lawmakers (mostly Republican) are adding work requirements to Medicaid eligibility, further embedding deservingness into law. In states that are enacting work requirements, legislators and governors are saying that only those low-income individuals with jobs are deserving of health care assistance. This only serves to perpetuate inequity, widen socioeconomic gaps, and ignore more recent and relevant studies regarding social determinants of health.

A broken system

Addressing Congress and the American public on September 22, 1993, much like the speeches of Presidents Truman and Kennedy, President Bill Clinton called for “Americans to fix a health care system that is badly broken” (Skocpol, 1995, para. 1). He expressed the need for health care security for every American—“health care that’s always there, health care that can

never be taken away” (Skocpol, 1995, para. 1). His plan, the Health Security Act, was to provide universal health insurance coverage, while also reducing cost and administrative complexity, maintaining choice of plans and providers, improving, or, at the very least, maintaining quality of care, and providing equitable care that everyone has a responsibility to contribute to, within their individual capacity.

The plan was a competitive, market-based health insurance system, in which individuals would enroll in private health plans. In featuring a market-driven approach, the Health Security Act was a “blend of means generally associated with conservatives and ends generally associated with liberals” (Zelman, 1994, para. 17). The plan did employ a certain amount of government regulation, but only insofar as it ensured market competition. In the weeks after President Clinton’s speech, support for the plan was overwhelming among Democrats, and promising among moderate Republicans and key stakeholders. The plan was also the fodder of journalistic puns—*The New York Times* declared the plan “Alive on Arrival” (Skocpol, 1995)—important in that quipping headlines had power to influence support among the general public.

By the 1994 Midterm elections, support for the Health Security Act was waning. Aggressive, partisan media campaigns against universal health coverage, battles with health care industry stakeholders, quickly diminishing trust of Washington D.C. and lack of elite and middle-class support for major reform proved to be formidable opponents to the Clinton health plan. The Health Security Act would not recover (Skocpol, 1995).

National election-night survey results from the Henry J. Kaiser Family Foundation in 1994 showed 31 percent of respondents as less supportive of major health care reform than they had been six months prior to the election. Approximately half of those individuals cited that they did not think the government would do a good job as the reason for their change of mind. Fifty-

five percent of respondents thought the health insurance system should be run by private insurance companies, with that statistic jumping to 66 percent among those who voted for Republican House candidates. The survey also found that Republicans favored a more incremental approach to health care reform—expanding coverage to some uninsured groups, but not to everyone at once—while Democrats favored guaranteeing health insurance coverage for all Americans (National Election Night Survey of Voters, 1994).

If expansion did occur, voters were most concerned about expanding coverage to children first, then to low-income working uninsured individuals, echoing the rhetoric of the 1965 health care reform. Once again, the idea of deservingness played a central role in changes to health care. Fifty-one percent of voters were willing to increase the amount they paid in health insurance premiums or taxes to see these changes to the health care system implemented.

In addition to the failure of the Health Security Act, state-level reforms also failed around the country. While Medicaid was heavily debated in the 1960s, and support for the government program was not always abundant, by the 1990s, the Medicaid program had become a significant pillar of the U.S. health care system. Policy makers “turned willingly to the Medicaid program to expand coverage” (Grogan et al., 2017, p. 251), creating the State Children’s Health Insurance Program (SCHIP) in 1997. The program expanded to working parents in 2003. Both SCHIP and the expansion to parents allowed states to cover low-income children and their families through the existing Medicaid program. Most importantly, the two reforms passed with bipartisan support (Grogan et al., 2017). By the late 1990s and early 2000s, lawmakers saw the benefits of using Medicaid to expand coverage. By 2008, however, spending and enrollment had grown, and Republicans fought against the reauthorization of SCHIP, believing it “had gone too far in

expanding coverage, especially since many of the ‘truly deserving poor’ were still not enrolled” (Grogan et al., 2017, p. 251), specifically low-income, working, childless adults.

One of the often-cited problems with the Clinton reform plan was that it was very disruptive to the existing health insurance system. Those with good insurance plans had little to no interest in changing their means of obtaining health care (Oberlander & Weaver, 2015). Through the lens of a behavioral economist, voters were, for the most part, demonstrating the typical human quality to be risk-averse in uncertainty. In other words, people generally fear the unknown and are less willing to risk their health insurance, even if they feel it could be improved and the unknown has the potential to be much better. In writing the Health Security Act, President Clinton and his team also failed to fully engage key stakeholders, leading many to see the plan as a complex proposal crafted by policy experts without input from the medical industry.

A time ripe for reform

Stepping into the Oval Office, the 44th president of the United States was well aware of the challenges his predecessors faced in trying to solve the problem of health care, and understood the particular political arena that would exist from 2009 to 2011. A Democrat in the White House and Democratic majorities in both chambers of Congress made a new national health care system seem more than a campaign promise. It could be a politically feasible option.

Health care reform was a central pillar of President Obama’s campaign. Voters echoed Obama’s priority—exit polls on election day in 2008 “showed that nearly 80 percent of voters wanted substantial changes in the U.S. medical system” (Reid, 2009, p. 10). Still, the political battle that ensued in the creation and passage of the ACA more closely resembles previous reform attempts than might have been expected, given the political climate in January 2009.

The crafters of the ACA wanted to avoid the issues that President Clinton faced, namely fighting the myriad health-related stakeholders, including insurance companies, trade associations and businesses. Unlike the Health Security Act, the ACA sought to “accommodate important interests, for example, by building on private insurance and making a deal with the pharmaceutical industry to not pursue strong cost controls in exchange for their support” (Oberlander & Weaver, 2015, p. 45). One of the main goals of the ACA was to expand insurance coverage, in the hopes of, at the very least, insuring every American. Following the reformers presumption that the best way to improve the system would be to build upon the existing system, the ACA attempted to bring the uninsured into one of the three buckets of health insurance: Medicaid, Medicare or private insurance (be it through an employer or through the newly created health care exchanges). They hoped this would “maximize the chances of securing both public and stakeholder support for reform” (Oberlander & Weaver, 2015, p. 45). As President Clinton aptly pointed out when discussing his own legislation, the system was not working that well to begin with, which is why he attempted large-scale reform. The ACA “represents an effort to place an additional series of patches on the existing patchwork of U.S. health care” (Oberlander & Weaver, 2015, p. 46).

Had the Democrats not had control of the Senate, the House of Representatives and the White House, the ACA, likely, would not have passed. It passed with only slight, partisan majorities in Congress (Peterson, 2018). In just under a decade, however, the benefits of the ACA have permeated everyday Americans in ways that have made it very hard to repeal, despite repeated Republican attempts. This is largely due to individual provisions of the law that are widely popular. Additionally, the rollout of benefits and costs associated with those benefits was carefully crafted, “offering concentrated benefits to constituencies while many costs are delayed,

diffused, or obscured” (Oberlander & Weaver, 2015. p. 39). Provisions such as coverage protection for individuals with pre-existing conditions and coverage for dependents under the age of 26 are so popular that they were key components of many Republican health care platforms in the 2016 and 2018 election cycles.

Barriers to effective health care

One of the biggest problems in trying to “fix” the health care system in the United States is that there is not a consensus on what exactly needs to be fixed. Most policy makers agree that health care spending is increasing rapidly and measures must be taken to keep health care affordable, but proposals for how to do that are diverse. Presidents Truman, Clinton and Obama wanted to fix the problem of non-universal coverage. Senator Bernie Sanders also seeks universal coverage but, in addition, would fix the complicated financing structure to better handle rising medical costs. On the other end of the political spectrum, Republicans would like to remove government control over health care. If we look to our peer countries around the world, we see that government regulation is imperative to being able to control costs and provide health care to everyone.

Polling data shows that the majority of Americans want at least broader coverage, if not universal, but when that requires more government intervention, support falls. To a patient waiting in the emergency room, preparing for surgery, getting a routine check-up or simply picking up a prescription medication, who writes the check to the health care provider is not necessarily at the top of their priority list, but it can be at the ballot box. In order to make our health care system more effective, the United States must reach a consensus about what it is that our health care system should do, dismantle the political rhetoric and narratives that dominate

health care discussions, simplify the financing system, and ensure that changes have enough time to take hold before they are subjected to court intervention and repeal attempts.

Nurturing people over profits

Each iteration of health care reform has increased the negotiating power of the for-profit health industry stakeholders in the United States, primarily the for-profit health insurance companies. Medical providers have also proved to be worthy opponents to coverage-increasing reform. President Truman fought the American Medical Association, and President Clinton fought a whole manner of stakeholders, including the insurance and pharmaceutical industries. In trying to avoid Clinton's pitfalls, Obama and Democratic congressional leadership made careful political calculations to pass the ACA, strengthening employer-sponsored coverage, relying on private insurance, and intervening as little as possible in the pharmaceutical industry. The coverage expansions offered by the ACA "depended on negotiating with these industries and securing at least their neutrality, if not their endorsement" (Peterson, 2018, p. 618). Throughout the years, health care industry stakeholders who would like to maintain the status quo have exercised their power to influence health care reform, and subsequently increased their bargaining power when their policy aims came to fruition.

Political parties aside, Americans "tend to believe that the private sector can run a medical system for less money than government can," despite "evidence from around the world suggest[ing] the opposite" (Reid, 2009, p. 25). Furthermore, in a Henry J. Kaiser Family Foundation survey, 58 percent of respondents said they would oppose a National Health Insurance plan if they learned that it would "eliminate private health insurance companies" (Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage, 2019). That opposition could be for any number of reasons. One may be that

respondents like their insurance plan and would prefer not to switch, a very real concern that Obama addressed during the crafting of the ACA. It could also be due to the inordinately strong belief that the private sector is more capable than government. In the 1990s, anti-government sentiment was high, impeding Clinton's health care plans. Our capitalist economy and emphasis on building businesses could be seeping into our thoughts toward health care, but successful businesses and large profits should not come at the expense of American health or life.

The truth is the private sector cannot run a medical system for less money than the government. The United States far outspends other high-income countries, most of which have strong government regulation of their health care systems, if not an entirely government-run system. Nearly 20 percent of our gross-domestic product is spent on health care and we have the highest proportion of private insurance plans among high-income countries (Papanicolas et al., 2018). One of the reasons our health care spending is so high is that the United States has the highest administrative costs of any health care system in the world. But, the government-run Medicare program makes up approximately *one percent* of that spending (Frakt, 2018). Expanding Medicare to cover everyone would mean incurring some cost, however, it is unquestionably a more efficient system and maintains some of the highest levels of satisfaction compared to other health insurance plans (Riffkin, 2015).

Dismantling the rhetoric

From past attempts of reform, narratives and rhetoric have emerged, leading to misinformation and confusion about the health care system. Understanding and looking beyond those narratives is crucial to understanding what can be done to improve health care in the United States.

Between the 2016 presidential primaries and the 2018 midterm election, the Henry J. Kaiser Family Foundation found that there had been a modest increase in support for a national health plan, peaking in March 2018 at 59 percent favoring “a national health plan in which all Americans would get their insurance from a single government plan” (Public opinion on single payer, national health plan, and expanding Medicare, 2019), and not dipping below 56 percent in favor since. Results also show broad support for optional Medicare-for-all (74 percent), a Medicaid buy-in (75 percent) or a Medicare buy-in for those between 50 and 64 years old (77 percent). While support has increased, nearly half of the population surveyed are not ready for a major reform to establish Medicare-for-All.

Polling did not make clear whether individuals would continue to support the idea of a national health plan when they learned the details of that plan. In fact, questions regarding support for an increase in taxes to achieve a national health plan did not receive a positive response (Ibid). The report went on to say that, “public support quickly erodes when people hear further explanation about potential tax increases or increased government control” (Ibid, para. 1). This suggests that individuals are supportive of specific narratives, or supportive of the phrase “national health plan,” but not supportive of what that actually means.

The survey asked respondents about their feelings toward specific health care systems (“Do you have a positive or negative reaction to the following terms?”), giving the option to answer very or somewhat positive, very or somewhat negative, or no opinion. The five terms respondents were asked about were *Medicare-for-All*, *Universal Health Coverage*, *National Health Plan*, *single-payer health insurance system* and *socialized medicine*. Unsurprisingly, *socialized medicine* elicited the least positive responses, with 44 percent answering either very or somewhat positive. *Single-payer health insurance system* did not fair much better, with 48

percent having positive reactions. The other three categories garnered much more support: 62 percent with positive feelings about *Medicare-for-All*, 61 percent for *Universal Health Coverage*, and 57 percent for *National Health Plan*.

It is important to note that the positive responses only tell one piece of the story. In the case of *socialized medicine*, there were also 44 percent of respondents who had somewhat or very negative reactions, and 14 percent gave no opinion. The population is split when asked whether they have positive or negative reactions to the phrase, but the 14 percent without an opinion is also important. Without a clear understanding of what that term means, and given its longstanding power—and I suggest that there is a lot of misunderstanding—it is difficult to have a strong opinion. *Medicare-for-All* elicited a negative response from 34 percent of respondents, with four percent having no opinion. Similarly, *Universal Health Coverage* had a 33 percent negative response, with five percent of respondents having no opinion. Thirty-four percent of respondents had a negative response and nine percent had no opinion to *National Health Plan*. Finally, *single-payer health insurance system* had results most like those of *socialized medicine*: 32 percent had negative reactions and 20 percent had no opinion. The high proportion of those having no opinion about a *single-payer health insurance system*, once again, suggests that lack of understanding of what that means could play an enormous role in individual preferences.

It is also crucial to note that these options are not unique or mutually exclusive in any way. *Medicare-for-All* is a type of *Universal Health Coverage*, and could be a *single-payer system*.⁴ The term *socialized medicine* does not say anything about a health care system, but the

⁴ However, if Medicare-for-All were to pass as an optional buy-in or public option on the health insurance exchanges, health coverage in the United States would not be universal or single-payer. Medicare-for-All with an individual mandate, requiring all Americans to take part in the program, would be a universal, single-payer system. The necessity of including this caveat is

narrative around that term is so strong that respondents were split on its favorability, and many could not specify an opinion.

When survey data is separated by political party of the respondent, the extent to which individuals support various types of health care systems (or the phrases associated with them) follows party lines. Between November 2006 and January 2019, Republican support for government doing more to help provide health insurance to Americans dropped from 72 percent to 40 percent. Democratic support was steady, with 96 percent in favor of government doing more in 2006 and 94 percent in 2019.

When asked if the respondent favors or opposes “having a national health plan, sometimes called Medicare-for-All, in which all Americans would get their insurance from a single government plan” (Ibid), overall support was 56 percent. Among Democrats, that support rises to 79 percent. Among Republicans, it is just 24 percent. This stark party line suggests that messaging that includes phrases like “a single government plan” will not receive Republican support, regardless of the details of that plan. Even when including the 11 percent of respondents who “somewhat” opposed a national health plan, the total number of respondents who did not outright oppose a national health plan is less than the 40 percent of Republican respondents who said they were in favor of government doing more to increase coverage (Ibid). There is a disconnect between the survey responses to these two questions: the more specific a policy is, the less support it receives. Among Republicans, there is an understanding that government should play a role in expanding insurance coverage, but when that is framed in terms of a “single government plan” the support fades.

indicative of the many different meanings or understandings one can assign to a particular phrase such as “Medicare-for-All.”

These survey questions, though informative, could contribute to the narrative problem. Citizens generally have imperfect information about key political issues, leaving room for opposition groups to greatly impact the conversation, often framing policies and programs in ways that policy makers do not intend (Peterson, 2018). Without definitive explanations of what these plans would actually mean, it may be hard for respondents to fully understand the differences between them, making their preferences moot. Because the results vary greatly when respondents are broken down by political party affiliation, it is clear that party rhetoric plays a strong role in individual perceptions of health care policy options.

In terms of the 2020 presidential election, the difference between support of a phrase over support of an actual policy is significant for two reasons: 1) it indicates that by continuing to use phrases that poll well and avoiding those that do not, Democratic candidates may gain support for non-explicit health care platforms; and 2) in continuing to rally support for his health care plan without specifying any of the cost-saving or care-improving measures until after the election, President Trump may garner more support than Democrats would like or expect, especially from his base, which largely opposes tax increases.

Ultimately, Democratic candidates will hear many of the same arguments against health care reform as we near November 2020 that their forbears did in the 1940s, 1960s, 1990s and, of course, as the ACA was crafted and implemented. Opponents of health care reform, especially Republican candidates for the presidency and offices throughout all levels of government, will focus on increased levels of government oversight into health care and decisions doctors make with their patients (Pear, 2019). Questions of “deservingness” will rear their ugly heads—even as the Republican ideas of who is deserving (i.e. individuals with pre-existing conditions or dependents under the age of twenty-six) has greatly expanded since 1965. Phrases like

“socialized medicine” will continue to be used in debates, in the news and online. The best option for Democrats may be to change the language around health care. In avoiding the word *Medicare* in describing a public single-payer program (Konish, 2019, para. 23), Democrats might be able to remove some of the politics from the conversation, even if only slightly. Significant health care reform will depend on dismantling these long-standing and largely successful narratives, or avoiding them as much as possible.

A complex financing system

The complexity of how our health care system is financed also presents a significant barrier to achieving meaningful reform. Financing for our health care system comes from a variety of sources. Individuals pay premiums for private insurance plans. Employers and employees, using pre-tax dollars, share the cost of premiums in employer-sponsored health insurance. Payroll deductions throughout an individual’s working life contribute to the Medicare program, which they can enroll in at age 65. Federal-level and state-level governments each pay a share of the funding for Medicaid. And federal taxes provide funding for a variety of health care components. The ACA’s “daunting complexity and mix of public and private entities almost assure[s] that few among the public [will] understand its impact or even recognize themselves as beneficiaries” (Peterson, 2018, p. 607). Additionally, our system relies on for-profit private insurance plans to pay a large portion of health care bills (Reid, 2009). Without those plans, a significant existing funding source would be eliminated, and an alternative source would be needed. Establishing that alternative source, be it taxes or premiums paid to a different insurer, can raise opposition. This makes change, and especially transition to a government system, incredibly difficult.

On the individual level, paying for actual health care services received can be equally confusing as “the distinction among health care costs, health insurance costs, and out-of-pocket expenses are often blurred” (What is “Affordable” Health Care?, 2018, p.2). The confusion associated with the costs of health care mars the fundamental reason for health insurance in the first place: “to transform uncertain risk into a predictable premium” (Ibid). This is the very reason why certain health care components that are central to other countries’ systems are necessary, but often debated in the United States. For example, the individual mandate—requiring everyone to be covered by the health insurance system—increases the number of people receiving coverage, thereby increasing the number of people paying into the coverage pool. Naturally, some of those people will not get sick or injured, which frees funding for those who do. The point of having insurance is to be able to adjust when catastrophe strikes, and increasing understanding of that concept will ease the process of reform.

Changing our health care system will require changes to the financing structure. Ultimately, “policymakers must consider whether the goal of a particular policy is to shift the cost burden to different stakeholders, or to fundamentally address financial barriers to care by promoting behavior change among consumers, medical professionals, or institutions to lower costs” (What is “Affordable” Health Care?, 2018, p. 6). Major reform will likely require both shifting the cost burden and promoting behavioral changes. The type of reform should dictate the priorities.

If we are to have Medicare-for-All (either as a universal system or as a buy-in), the cost burden will shift toward the government, which may, in turn, shift costs to tax payers. This does not mean the price of health care increases, which is a strong narrative that will prevent such change from happening. In fact, according to Dr. Steffie Woolhandler, a co-founder of the non-

profit organization Physicians for a National Health Program, “the evidence is fairly strong that, over the long run, you save a lot of money with single payer” (Konish, 2019, para. 21). A single-payer system would simply make some of the costs of health care more explicit. Currently, with the majority of the country receiving their insurance through their employer, the costs associated with their health insurance plans are implicit. Employees receive insurance coverage as an employment benefit, and may not know the total cost of that benefit, as they share the cost burden with their employer. Increasing taxes makes health care costs more explicit.

Experiencing the effects of policy benefits is key to longevity

The ACA falls short of universal coverage, and the lack of bipartisan support indicates that the Democratic majorities in both chambers of Congress in 2010 were necessary to pass the historical legislation. The crafters of the ACA considered possible points of failure of the Health Security Act of 1993, seeking to avoid falling into similar holes. Obama constructed his health care plan to build on “more conservative ideas of personal responsibility and competing private plans” (Peterson, 2018, p. 607), working within the system rather than trying to create a new one, but “the ACA could draw only slender, entirely partisan majorities in Congress” (Peterson, 2018, p. 607).

Still, Supreme Court action and repeated attempts to “terminate, cripple, or partially dismember” (Peterson, 2018, p. 605) the legislation—more than 60 separate votes between January 2011 and 2016, with five attempts at a full repeal—were not enough to entirely dismantle the ACA. This is largely “due to its particular balance and timing of benefits and costs and by being shielded long enough by election results and the constitutional separation of powers to have its benefits take root” (Peterson, 2018, p. 605).

As a bill makes its way through Congress, majority-party holders in each congressional chamber, ideological differences within parties, leadership structures, distribution of relevant information and the extent to which the president is involved and able to sway members of Congress, can significantly impact the course that bill takes. However, from a path-dependency model, which suggests that options available for any given decision are limited by past decisions, altering policies, once they have been implemented, is at the mercy of a much larger population—the constituency that is affected by the particular policy. When substantive benefits have been conferred on a large population, it becomes exceedingly difficult to undo that policy (Peterson, 2018). This is the key factor determining the lasting-power of the ACA, and while that might not be encouraging when looking to major reform, it does suggest that it will be hard to move backward from the passage of the ACA—and this has been proved with every failed attempt to undermine the law. This does not mean that the majority party can be overlooked, or the White House is powerless. Indeed, the Democratic majority in the U.S. House of Representatives after the 2018 Midterm elections has impacted the conversation about health care reform. The presidential election and Senate elections in 2020 will, similarly, have a major impact on how legislation moves forward, but the elections of 2022 and 2024 will play just as important of a role.

As we look to the 2020 elections, and all that might happen in between, one barrier that cannot be denied, or underestimated, is party politics. Partisanship is not a new concept or recent development, but since the late 1980s, “unity within each party—and with it separation between the two parties—[has grown] substantially, especially in the GOP” (Peterson, 2018, p. 612). Previous administrations’ attempts, successful or otherwise, to significantly reform health care, must also be considered, not as separate, individual incidents, but rather as important steps to

getting to where we are now, and partisan allegiances are an important component of that idea. According to a key strategist who worked with former-Speaker of the House Newt Gingrich, President Clinton's reform attempts posed a threat to "all Republican aims" (Peterson, 2018, p. 615). Gingrich and his staff thought Clinton's health reform would lead to a greater public dependency on the government, which would increase allegiance to Democrats as the givers of government benefits. When the ACA was signed into law years later, it served as a realization of those partisan fears.

2018 Midterms

The 2018 Midterm election cycle was dominated by conversations regarding health care. In 2017, congressional Republicans failed to "repeal and replace" *Obamacare*, a label Republicans gave the ACA nearly a decade ago, and Republican campaign platforms in 2018 focused less on repealing the law, than they had in 2010 and 2014, and more on the benefits of the ACA that served their constituents (Hall & Tolbert, 2018). One of the most common ACA benefits to be highlighted in Republican campaign ads and literature was insurance coverage protection for people with pre-existing conditions. Across party lines, strong support for this provision throughout the country meant nearly all candidates supported those protections. This put some Republicans in a difficult position, as they "had to defend prior positions that many argue would undermine these protections, including backing repeal of the ACA or supporting current legal challenges to the ACA that, if upheld, would eliminate these protections" (Hall & Tolbert, 2018, p. 3). On election day, Democrats took control of the U.S. House of Representatives, which "will have substantial implications for health care policymaking over the next two years" (Wynne, 2018, para. 2).

The 2018 Midterms illuminated the staying power of the ACA. With many of the law's benefits being in place for about eight years, it became difficult for candidates to speak too strongly against its provisions, and “while many Republican candidates still oppose[d] the ACA, the simple message of repealing the ACA risk[ed] alienating moderates and even some Republican voters who have benefited from the ACA's coverage expansions and insurance market changes” (Hall & Tolbert, 2018, p. 5).

State Medicaid expansions also played a key role in the 2018 Midterms. Three states—Nebraska, Idaho and Utah—endorsed expanding Medicaid via public referenda. All three states had Republican leadership that had been blocking expansion. In Montana, the opposite result occurred. Voters opted to stop funding their Medicaid expansion starting in July 2019, which would make 129,000 Montanans ineligible for Medicaid. In April, the Montana legislature decided to extend the expansion, however it added work requirements and higher premiums for enrollees, so thousands of Montanans are still likely to lose their health insurance coverage (Katch, 2019). In Maine, Kansas and Wisconsin, Democratic governors were elected, making Medicaid expansion more likely in the coming years (Wynne, 2018).

Since the 2018 election, there have been numerous Congressional proposals for health care reform, and states have also been working to combat the changes made to health care under the Trump administration. The repeal of the individual mandate and continued legal challenges to the Affordable Care Act's constitutionality have led to state-level individual mandates in Vermont, New Jersey, Massachusetts and Washington D.C. (US of Care 2019 Potential State Policy Trends, 2018). As of May 2019, seven states have used Section 1332 State Innovation Waivers, waivers granted by CMS to states to pilot programs to help increase access to care, for

reinsurance programs to help lower premiums in the health care marketplaces (Tracking Section 1332 State Innovation Waivers, 2019).

Current proposals and looking to 2020

Seemingly moments after the 2018 election cycle ended, Democrats around the country started gearing up for the 2020 Presidential election. The Democratic field continues to grow, but one thing that candidates all have in common is that they support the expansion of health care coverage, an issue Americans increasingly rank as their top issue (Breuninger, 2019). Single-payer or Medicare-for-All, more than other issues, “highlights the wide gulf between progressive Democratic candidates who view the proposal as a way to address affordability and access challenges and conservative Republican candidates who characterize the proposal as a step toward socialism” (Hall & Tolbert, 2018, p. 4). Some Democratic candidates, like Senator Bernie Sanders, continue to push for a progressive approach, which may help them in, what is sure to be, a highly contested primary season. Others hold a more fluid stance on what the best option for health care reform is, keeping the general election in mind as they are on the campaign trail.

As of May 2019, 22 notable individuals are gunning for the Democratic nomination (List of registered 2020 presidential candidates, 2019). The following analysis will highlight some key policy stances, but is not a comprehensive analysis of all the candidates. I include specific policy options as well as comments on the general environment of the 2020 election cycle as it is forming to show that the candidates will face some of the same political issues that have presented challenges to health care reform since President Truman.

Candidates’ health care policy platforms are falling into three main health care reform agendas: Medicare-for-All, Expansions to Medicare, and Incremental Reform. Some of the candidates have put all of their energy behind one mode of reform, while others tip toe back and

forth from one to another, perhaps waiting to see which way the wind is blowing closer to election day.

Medicare-for-All: the Major Reform Platform

This platform, which energized voters in 2016 and defined far-left candidates during the 2018 Midterms, advocates for a single-payer, government-run health care system, in which everyone will receive coverage. Senator Bernie Sanders (I-VT) re-introduced his plan for a single-payer system, the Medicare for All Act of 2019, in the Senate this year. Senators Elizabeth Warren (D-MA), Kirstin Gillibrand (D-NY), Kamala Harris (D-CA), and Cory Booker (D-NJ) are co-sponsors on the bill. Some, not all, of the co-sponsors of the bill are tailoring their presidential health care policy around establishing a single-payer system.

Expansions to Medicare: the Pragmatic Platform

This platform falls between pushing for a single-payer health care system and advocating incremental changes, as has been done in the past. One of the key issues facing the candidates who are advocating this type of platform is that it is not explicitly clear what their policy plans are. For the most part, those arguing for expanding Medicare have said that they would like to expand Medicare eligibility to those aged 50 and over or 55 and over, or offer a buy-in option on the health insurance exchanges. Many of the same candidates have also expressed support for Medicare-for-All, including Senators Harris and Booker, who have both co-sponsored Sanders' bill but who also talk about being realistic, suggesting less than whole-hearted support for the bill.

Incremental Reform: the Status Quo Platform

Candidates promoting this third agenda do not have the black-and-white policy option of the Medicare-for-All candidates. The messaging behind the incremental approach is, largely, that

a single-payer system is a good goal to have, something that might be achievable in the future, however thinking about how we might expand Medicare or Medicaid eligibility, or make improvements to the ACA, is something that could fix the problem now. One such improvement to the ACA would be to stabilize the individual market. Candidates across the board are recognizing that premiums are too high for many Americans, and tactics such as reinsurance programs, which individual states have opted to implement, can help to stabilize the market (Hall & Tolbert, 2018). The candidates in this group are those who have not taken a strong stance on health care reform, but have left the door open for any number of options as the race continues.

What to expect as the calendar nears November 2020

Some believe that no Democrat will get the 2020 nomination without supporting single-payer, but the very fact that so many current Senator presidential candidates are signing onto to Sanders's bill while also falling into the middle of the health care reform debate indicates that this is not the feeling of political operatives everywhere. In coming out in support of single-payer, they are not closing the door on the possibility, yet they are giving themselves a more pragmatic spot to land if single-payer proves to be too politically harmful or difficult.

Presidential hopefuls who were candidates in 2018 may need to change their positions on health care as they face a national voter base. Candidates such as Senators Gillibrand and Warren, Democrats who were re-elected to the U.S. Senate from New York and Massachusetts respectively, traditionally blue states, could "safely argue for a Medicare-for-All proposal" (Hall & Tolbert, 2018, p. 4) during their Senate races. Pro-Medicare-for-All positions did not impede their re-election in New York or Massachusetts, and likely will be helpful in the primaries. Finding solutions that will appeal not only to Democrats but also to Moderate or Independent voters, and even Republicans voters, will be necessary later on.

Meanwhile, “Democratic senatorial candidates in traditionally red states, [who faced] strong attacks from Republican opponents on the issue, [took] more nuanced positions or stated their opposition to the idea” (Hall & Tolbert, 2018, p. 4). Beto O’Rourke, who ran for the U.S. Senate in Texas against incumbent Ted Cruz, offered support for universal coverage, but not Medicare-for-All as the only approach to reaching universal coverage. He highlighted “solutions such as Medicaid expansion, ACA market stabilization, and creating a public option on the exchanges, while acknowledging that single-payer would also achieve this goal” (Hall & Tolbert, 2018, p. 4). Though O’Rourke lost his election, he certainly won support from liberals across the country, and retaining the pragmatism he employed during his Senate run may be his best option going into 2020.

For voters, electing a Democratic president is not the same thing as improving health care. Obama’s presidency is proof that politics cannot be removed from the discussion. Survey data that shows less support when voters know more about any particular health care plan is unsettling, and Democratic candidates must compete against a Trump administration plan that has no disclosed details. Increased clarity from the Democratic party, statements made without the veil of “liberal” or “conservative” narratives, will be significant as the Democratic field narrows. It will be even more important after Inauguration Day in 2021 as the next Congress gets to work on the health care flavor of the day.

Recommendations for a more effective system

From failed attempts at a National Health Plan in 1947 and 1993, to successful incremental approaches in 1965 and 2010, it is clear that sweeping reform of the United States’ health care system is not likely in the immediate future. Survey results from 2019 indicate that an incremental approach to reach universal coverage is largely favored, with 85 percent of

Democrats and 69 percent of Republicans favoring expanding Medicare eligibility to age 50, and 85 percent of Democrats and 64 percent of Republicans favoring offering a Medicaid buy-in for those who do not receive employer-sponsored insurance (Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage, 2019). More gradual approaches “are more palatable than a switch to a single government plan” (Konish, 2019, para. 11). Therefore, we should build upon already-working systems toward universal coverage, using existing infrastructure to bring health insurance coverage to all Americans.

A secondary goal then must be to ensure the health care system is about fostering a healthy population, not a healthy capitalist industry. That does not mean that insurance providers or medical care providers should not be compensated, but they should not be compensated at the expense of any one person’s health or well-being.

An optional Medicare plan, open to all and purchased on the health insurance exchange markets, is the best feasible option currently. Democratic candidates for President, as well as Congressional, state-level and municipal candidates should push this agenda and work to make it possible. With time, this could lead to Medicare-for-All, in the incremental fashion that is digestible for the majority of the country. The benefits of this type of reform are numerous. The many Americans who already receive, and are happy with, employer-sponsored insurance will not be forced to change insurance plans or providers, though they would be allowed to. Individuals just outside the income brackets for premium tax credits or other government subsidies on the individual market will have an easier time paying for their health care. Those already enrolled in Medicare will continue to receive their benefits.

A crucial element of reform that cannot be underestimated is time. No matter who is elected in 2020 or what reforms make their way to the Oval Office, new laws need enough time

to let their benefits “kick in, mature, gain media attention, and become expected by tens of millions of individuals” (Peterson, 2018, p. 641). Of course, that is easier said than done, and the media attention could be the very thing that undermines the benefits offered. However, as we saw with the ACA, it is possible.

Conclusion

Through incremental changes over the last several decades, a collection of decisions made by a multitude of leaders, the United States’ health care system has been adjusted, little by little. The result is a system that is so complex, with so many stakeholders and variables, it is difficult to call it a “system.” It is hard for individuals to make meaningful decisions about their own health care because it is hard to understand what those decisions might mean, in the short run and the long run.

Until the United States—legislators, voters, medical providers, and patients of all ages—makes the decision to prioritize the health of our nation over the health care system, we will continue to put bandages on the situation, we will continue to patch holes and wait for new ones to form. The election in 2020 will be very important, but subsequent elections, especially in 2022 and 2024, will have as big or bigger of an impact on the longevity of whatever reform happens in the coming years.

To the extent that we’ve made incremental changes to our health care system, we have relieved pressure on the system, fixed small things, but we have delayed the time when a major decision will need to be made. We are on a political merry-go-round, with narratives that continue to build, continue to disseminate party rhetoric, and continue to widen the gap between red and blue. These narratives make it nearly politically impossible to make substantive changes as the debate keeps going. Even the most significant health care reform of the last twenty years

barely passed because political compromise is almost unheard of. So few Americans understand how inaccurate the narratives they hear and the narratives they tell are.

Despite the narrative and political gridlock, single-payer is possible. In the 1990s, Taiwan decided it needed to re-vamp its health care system. It looked to other countries, identifying things they did right and things that would not work. They followed the example of more successful systems and created a new system, which could be an example for the U.S. to follow. I believe the best way to fix health care in the United States is to move to a single-payer system, the sooner the better. It will not be easy, and there will be a lot of dissent, however, in so many countries like the United States, it works. We cannot remove politics from the debate, but if we focus on cooperation rather than partisanship, we may get closer. Incrementalism is not ideal, though it seems to be the path we must take, but we must decide that it is a path leading directly toward single-payer.

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