

The Original – And Still the Best?

The Health Insurance Public Option and the Politics of Social Reform

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In late 2009, in an event space beneath the US Capitol plaza, a small celebration centered on a big decision. The Majority Leader of the US Senate, Nevada Democrat Harry Reid, announced he would support the inclusion of a public option in the health-care bill that would soon be considered on the Senate floor. As one of the policy experts who had pushed for the public option, I was in the audience – gratified that Reid had decided to fight for the goal yet unsure of what would come next. Earlier in the year, the House had passed its own health legislation, which included a Medicare-like public option. But from the moment it had become a major element of Democratic campaign proposals during the 2008 presidential race, the public option had been controversial – viewed as a step too far not only by Republicans and the medical industry, but also by many middle-of-the-road Democrats. Now, in signaling he would back it, Reid was also suggesting he could convince skeptical Senate Democrats to go along.

He couldn't. Within a few weeks, the public option was dead. Reid needed every one of the Senate's sixty Democrats to overcome a Republican filibuster, and Connecticut's Joe Lieberman, a moderate friendly to the insurance industry, insisted the provision be dropped. The Affordable Care Act (ACA) passed the next year, but the landmark law signed by President Obama did not contain the public option he had advocated for during his successful presidential campaign. Even in the many areas where few commercial insurers operated, the choice for those not eligible for Medicaid was private insurance or no insurance at all. A prominent Democratic idea seemed destined for the dustbin of history.

Ten years later, however, the public option was out of the dustbin – and back in the crosshairs. Yet this time, the attacks were mostly coming from the left of the Democratic Party. Among moderate Democrats, the public option was no longer dismissed as a liberal fantasy; it was seen as the sensible starting point for building on the ACA. Indeed, all of the middle-of-the-road candidates vying for the party's 2020 presidential nomination – from billionaire ex-Republican Michael Bloomberg to

eventual winner (of the primary and presidential election) Joe Biden – said they would back a public option.¹ The more progressive candidates, by contrast, said they would go well beyond the public option and fight for a universal Medicare program, aka “Medicare for All.” According to the leading voice of the left, Bernie Sanders, only Medicare for All could fix the problems in American health care; the public option, Sanders argued, would “essentially . . . maintain what I consider to be a dysfunctional and cruel health care system.”²

This chapter examines the rise, fall, and rebirth of the public option. My goal is not to retread familiar history, but to draw out the underlying political logic of the public option and consider whether that logic still applies a decade after the passage of the ACA. During the debate over the ACA, the public option was viewed by its opponents as a back door to universal Medicare. Now, however, many on the left believe they can open the front door. Is there still a case for the public option? Would it work – that is, substantially restrain prices and provide economic security to all Americans? And what kinds of dynamics *would* it unleash? Would it lead inevitably to Medicare for All? Would it be marginalized by its private competitors? Or would it achieve a stable equilibrium, and if so of what sort?

To tackle these questions, I draw on a burgeoning body of research on what political scientists term “policy feedback,” the processes by which large-scale public policies reshape public opinion, interest-group alignments, the capacities of government, and other fundamental features of the political world.^{3,4} The health-care public option was the most prominent major proposal since the 1970s for what Sitaraman and Alstott call a “competitive public option” – a public plan that would compete with private ones on a level-playing field. Those who supported it believed government insurance would be more efficient and equitable. Yet they also had a theory – sometimes explicit, usually implicit – about how this competitive public option would evolve over time and reshape American politics.⁵ The aim of this chapter is to draw out this theory, subject it to scrutiny, and tease out its implications.

¹ Tricia Neuman, Karen Pollitz, Jennifer Tolbert, Robin Rudowitz, and Wyatt Koma, “10 Key Questions on Public Option Proposals,” *Kaiser Family Foundation*, December 18, 2019, www.kff.org/health-reform/issue-brief/10-key-questions-on-public-option-proposals/.

² Bart Jansen, “Joe Biden, Bernie Sanders Spar Over Long Records on Trade, Entitlements, Guns and Iran as Primaries Push On,” *USA Today*, March 10, 2020, www.usatoday.com/story/news/politics/elections/2020/03/10/joe-biden-bernie-sanders-spar-over-trade-entitlements-guns-and-iraq/4965512002/.

³ Jacob S. Hacker and Paul Pierson eds., “New Policies, New Politics? Policy Feedback, Power-Building, and American Governance,” Special issue, *The Annals of the American Academy of Political and Social Science* 685, no. 1 (September 2019), <https://journals.sagepub.com/toc/anna/685/1>.

⁴ Jacob S. Hacker, “Medicare Expansion as a Path as well as a Destination: Achieving Universal Insurance through a New Politics of Medicare,” *The Annals of the American Academy of Political and Social Science* 685, no. 1 (2019): 135–153, <https://doi.org/10.1177/0002716219871017>.

⁵ Ganesh Sitaraman and Anne L. Alstott, *The Public Option: How to Expand Freedom, Increase Opportunity, and Promote Equality* (Cambridge, MA: Harvard University Press, 2019), 24–43, 78–80, and 202–222.

The main conclusion I reach is that the public option still has formidable advantages over Medicare for All. Although no one should underestimate how hard it will be to enact, it is certain to pose less threat to well-insured Americans than Medicare for All, to require less up-front public spending (and hence new taxation), and to face more divided opposition from the medical industry. A corollary, however, is that the specific design of the public option will have a major effect not only on the likelihood of its enactment but also on its future entrenchment and expansion. A pared-back public option of the sort that might have passed in 2010 is no longer up to the challenge. Instead, proposals with the most promise – I call them the “Public Option 2.0” – all put in place strong measures to guarantee universal coverage and expand the reach of public cost controls over time. Such a system, I argue, could move the nation a fair way toward Medicare for All. Designed properly, it could also create self-reinforcing political dynamics, drawing Americans together in pursuit of affordable health care for all, rather than tearing them apart.

5.1 A BRIEF HISTORY OF THE PUBLIC OPTION

The public option burst into the health-care debate during the 2008 presidential campaign. Yet the idea has a long lineage – one that well predates the proposals I wrote starting in the early 2000s that helped push the idea into the spotlight.^{6,7,8,9} Most notably, Medicare itself has evolved into something of a public option, albeit one limited to the elderly and disabled. That’s because Medicare beneficiaries have long been able to choose between regulated private plans that contract with Medicare and the traditional public plan. This feature of Medicare is very similar to the framework for a public option I developed. Under this system, now labeled “Medicare Advantage,” the public option is the default and beneficiaries must affirmatively choose private plans available in their region. In turn, these plans are heavily regulated and, in theory at least, paid amounts that reflect the expected cost of treating beneficiaries to discourage them from trying to select healthier patients. Today, roughly a third of beneficiaries are enrolled in private plans through Medicare Advantage.¹⁰ The remaining two-thirds

⁶ Jacob S. Hacker, “Medicare Plus: Increasing Healthcare Coverage by Expanding Medicare,” in *Covering America: Real Remedies for the Uninsured*, eds. Jack A. Meyer and Elliot K. Wicks (Washington, DC: Economic and Social Research Institute, 2001), 73–100, www.jacobhacker.com/assets/qa_medicare-plus.pdf.

⁷ Jacob S. Hacker, “Health Care for America: A Proposal for Guaranteed, Affordable Health Care for all Americans Building on Medicare and Employment-Based Insurance.” *Economic Policy Institute*, Briefing Paper No. 180, January 11, 2007, www.jacobhacker.com/assets/9_health_care_for_america.pdf.

⁸ Jacob S. Hacker, “Medicare Part E (for ‘Everyone’),” November 14, 2017, www.jacobhacker.com/assets/hacker-medicare-part-e-11-14-2017.pdf.

⁹ Jacob S. Hacker, “The Road to Medicare for Everyone,” *The American Prospect*, January 3, 2018, <https://prospect.org/health/road-medicare-everyone/>.

¹⁰ Gretchen Jacobson, Anthony Damico, and Tricia Neuman, “A Dozen Facts About Medicare Advantage,” *Kaiser Family Foundation*, November 13, 2018, www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/.

are in traditional Medicare, though most also have supplemental private insurance that reduces Medicare's out-of-pocket costs.¹¹

Though Medicare's system was my basic model, I argued for a number of significant departures from its template. One was a requirement that benefits packages for the public option and private plans be more or less the same. In Medicare Advantage, private plans are attractive to Medicare enrollees in major part because they cover a wider range of benefits and, unlike Medicare, offer integrated prescription drug coverage. (Those covered by traditional Medicare must buy a stand-alone private plan under Medicare Part D.) This tilts the playing field in favor of the private plans. In addition, the requirement that beneficiaries get their drug coverage from private plans eliminates the ability of Medicare to bargain for lower drug prices – a major potential source of cost savings that the pharmaceutical industry has so far successfully resisted.

Another precondition for a successful public option that I emphasized was a much better system for paying private plans. The current approach is flawed in three major respects. First, it offers an explicit subsidy to private plans, which should be eliminated. Second, it does not adequately adjust for the actual cost of treating enrolled beneficiaries; better "risk adjustment," both prospective and retrospective, would better discourage the selective enrollment of healthier patients and disenrollment of less healthy ones. Finally, payments to plans are not set through true competitive bidding. Plans should instead be required to bid to provide standardized benefits, and payments to plans should be based on a weighted average of plan bids within its geographic area, as opposed to the current approach.^{12,13}

These proposed changes were so important because, by 2008, the public option was not seen as an alternative to the basic policy framework that inspired much of the ACA – a framework in which uninsured Americans would be able to choose among subsidized and regulated private plans. Instead, it was seen as a crucial addition to that framework. In the House legislation, for example, larger employers were required to insure their workers or pay a mandated contribution; those without workplace coverage were given access to Medicaid (if they had lower incomes) or to a new insurance purchasing pool run by their states; and this pool would make available both private plans and a national public option modeled after Medicare.¹⁴

¹¹ Juliette Cubanski, Anthony Damico, Tricia Neuman, and Gretchen Jacobson, "Sources of Supplemental Coverage Among Medicare Beneficiaries in 2016," *Kaiser Family Foundation*, November 28, 2018, www.kff.org/medicare/issue-brief/sources-of-supplemental-coverage-among-medicare-beneficiaries-in-2016/.

¹² Jacob S. Hacker, "Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement," *Institute for America's Future and the Berkeley Center on Health, Economic and Family Security*, Policy Brief, Berkeley, CA, April 2009, www.jacobshacker.com/assets/6_hacker_healthy_competition.pdf.

¹³ Steven M. Lieberman et al., "The Case for Reforming Competitive Bidding in Medicare Advantage," *Brookings Institute*, May 10, 2018, www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/05/10/the-case-for-reforming-competitive-bidding-in-medicare-advantage/.

¹⁴ Affordable Health Care for America Act, H.R. 3962, 111th Cong. (2009).

Thus, the public option would be available alongside regulated private plans to anyone who lacked coverage through Medicaid or an employer.

The case I made for this sort of public option can be summed up in what I called the “three B’s” of public plan choice: a Medicare-like plan would be a *backup* in places where insurance competition was weak, a *benchmark* for competing private plans, and a cost-control *backstop*, bringing the consolidated purchasing power of the federal government to bear in a larger share of the market.¹⁵ The last “b” was particularly crucial. Medicare’s per capita spending has grown much more slowly than per capita expenditures for private insurance on a comparable set of services, and this cost-control advantage has grown over time.¹⁶ Moreover, I envisioned a major effort to improve Medicare price and volume regulations and integrated payment methods over time. Thus, the public option wasn’t simply designed to make coverage available. It was designed to be a major cost-control measure whose scope would grow over time as the public option expanded and became more closely integrated with Medicare itself (with the two systems ultimately merging, at least in the proposals I developed).

I did not offer a fourth b-word, but many critics did, arguing that the plan was also a *backdoor* route to Medicare for All. Some who supported the public option made this argument, too.¹⁷ My view, however, was more conditional: although the role of the public plan would surely expand, its scope would depend far more on what happened with private employment-based insurance than on how well it fared in competition with private plans. Under the House legislation, for instance, most employers were expected to continue providing their own coverage, and the public option would only be available for those purchasing regulated and subsidized insurance outside the workplace. Unless that changed, even the most successful public option would cover tens of millions of Americans, not hundreds.

In light of this, it may be tempting to look back at the reform circus of 2009 and 2010 and see the public option as a sideshow. But while it certainly wasn’t in the main ring, it was an important part of the production. First, it was one of the most genuinely popular aspects of Democratic reform proposals. Polls showed not just that Americans liked it, but that they found a mandate to have coverage more acceptable if those required to be insured had the option of enrolling in a plan like Medicare.¹⁸ Second, it engaged progressive activists and politicians who were

¹⁵ Jacob S. Hacker, “The Case for Public Plan Choice in National Health Reform,” *Berkeley Law and Institute for America’s Future*, December 2008, <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.522.2310&rep=rep1&type=pdf>.

¹⁶ Juliette Cubanski, Tricia Neuman, and Meredith Freed, “The Facts on Medicare Spending and Financing,” *Kaiser Family Foundation*, Issue Brief, August 2019, <http://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing>

¹⁷ Kevin Sack, “Health Care Up to Public, Edwards Says,” *New York Times*, January 25, 2008, www.nytimes.com/2008/01/25/us/politics/25edwards.html.

¹⁸ Mike Lux, “The Public Option Fight Gets Engaged in Public for the First Time Next Week,” *Huffington Post*, November 25, 2009, www.huffpost.com/entry/the-public-option-fight-g_b_299970.

skeptical of the exclusive reliance on private insurance. Though the public option did not survive, a strong case can be made that it encouraged coalition-building that pushed out the boundaries of the possible, facilitating a law that was broader than it might have been otherwise.^{19,20}

Because it did not survive, however, we cannot know how it might have evolved had it made it into law. On the one hand, the public option that passed through the House was relatively weak – for example, it could not require that physicians who took Medicare participate in it, and it did not have authority to use Medicare’s rates. On the other hand, it would have created a focal point for expanded coverage and still offered considerable advantages over private plans, particularly in the many areas of the country where private insurers were scarce and providers highly consolidated. Moreover, US social policies have often started small and grown bigger over time, and there was good reason to think that a public option would expand and become more robust, at least if it were able to survive the initial political backlash.

Since the passage of the ACA, both the pricing advantage of Medicare and the weakness of the state-based insurance pools (now known as “marketplaces”) have become more and more apparent. So too, alas, has the ferocity of that initial backlash. In part because of the ceaseless Republican attacks on the law, far fewer Americans have enrolled through the marketplaces than expected, many of these state insurance pools feature a limited number of plan choices, and the nonprofit “cooperatives” championed by moderate Democrats as an alternative to the public option have largely gone bust.^{21,22,23} In sum, there’s little doubt that the public option would have provided a valuable source of coverage in the many areas of the country where private insurance competition is weak to nonexistent.

5.2 THE PUBLIC OPTION IN TODAY’S DEBATE

Still, it is now clear that the place of the public option in any future reform will depend on mechanisms of enrollment as much as on how the public option itself is designed. Simply adding a public option to the existing state marketplaces will not

¹⁹ Richard Kirsch, *Fighting for Our Health: The Epic Battle to Make Health Care a Right in the United States* (Albany, NY: Rockefeller Institute Press, 2011).

²⁰ Lawrence Jacobs and Theda Skocpol, *Health Care Reform and American Politics: What Everyone Needs to Know* (New York, NY: Oxford University Press, 2015).

²¹ Jayne O’Donnell, “Signs of Trouble – and Progress – as Obamacare 2019 Open Enrollment Nears,” *USA Today*, August 19, 2019, www.usatoday.com/story/news/health/2019/08/19/obamacare-2019-open-enrollment-nears-signs-trouble-progress/1996342001/.

²² Rachel Fehr, Rabah Kamal, and Cynthia Cox, “Insurer Participation on ACA Marketplaces, 2014–2020,” *Kaiser Family Foundation*, November 21, 2019, www.kff.org/private-insurance/issue-brief/insurer-participation-on-aca-marketplaces-2014-2020/.

²³ Sabrina Corlette, Sean Miskell, Julia Lerche, and Justin Giovannelli, “Why Are Many CO-OPs Failing? How New Nonprofit Health Plans Have Responded to Market Competition,” *The Commonwealth Fund*, December 10, 2015, www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

make a large difference unless the marketplaces reach a much larger share of Americans. The public option's scope will obviously affect whether and how quickly the United States reaches universal coverage. Again, however, it may well be even more fundamental to the capacity of the federal government to use its purchasing power to restrain spending over time. Small public option, small effects.

Indeed, the current public option plans with the most promise and prominence – the Medicare for America Act sponsored by Representatives Rosa DeLauro and Jan Schakowsky (on which I worked) and the Center for American Progress's "Medicare Extra for All" – largely bypass the marketplaces, allowing employers to directly buy into the public option or pay a contribution in lieu of providing coverage that funds the same public coverage. They also emphasize the need for automatic enrollment procedures (mainly through the workplace) and expanded federal subsidies to reach the roughly 30 million Americans who continue to lack coverage. Finally, these proposals do something that the House bill did not: they allow people to opt out of their existing employment-based coverage and enroll in the public option directly. All these features distinguish The Public Option 2.0 from its predecessors. They also raise important questions about policy design that have yet to be sufficiently tackled.

The rebirth of the public option also raises a more fundamental issue: Has its time come and gone? The case for the public option in 2009 and 2010 was primarily a political one. For one, it was far more likely to be enacted than a full-scale Medicare for All. For another, like other major social programs that coexisted with private alternatives, such as Social Security, it could have provided a foundation for the further expansion of national public coverage over time. Let us call these two distinct political virtues (or vices, depending on your point of view) *feasibility* and *expandability*. The public option could pass, and it could grow.

Feasibility and expandability are obviously in tension. Insurers, pharmaceutical companies, and other health-care lobbies fought the public option so fiercely not because of what it was in the House bill – a relatively modest expansion of government's insurance role – but because of what it could become: a sizable competitor and price-bargainer with popular and political support. They recognized what reformers sometimes forget: policies change politics. Policies do not just deliver benefits, they create institutions that can be focal points for political mobilization, and they can change the resources and goals of political actors, from voters to interest groups to public officials themselves.

As noted, a large and growing body of political science research explores these policy feedback effects and provides a relatively sophisticated set of insights for thinking about them. These concepts and findings go beyond the traditional focus on the initial passage of laws to examine what makes them more or less likely to become politically entrenched and expand over time. This established literature – and recent work building on it to examine contemporary policy issues in our increasingly polarized political environment – provides timely guidance as experts, advocates, and officials debate the best ways of building on the ACA, and in

particular whether to embrace the public option or the bigger ambition of Medicare for All.

On the one side, backers of Medicare for All argue that the public option is half a loaf that does not need to be accepted when the whole loaf now lies within reach. Many also argue that anything that Democrats propose that involves a substantial expansion of public coverage will encounter fierce industry and Republican resistance, meaning a public option offers little political-feasibility advantage over Medicare for All. Finally, some Medicare for All advocates dispute that the public option would actually work, much less expand toward universal Medicare. In short, skeptics contest both the feasibility and the expandability of the public option.²⁴

On the other side, those who back the public option have refined their case by emphasizing the centrality of enrollment and strengthening their proposed public plan relative to what was seriously considered in 2009 and 2010. Public Option 2.0 proposals also put greater emphasis on the cost-control capacity of the federal government, which has become more and more apparent over time.²⁵ Some have also made a forthright argument for the public option as a stepping stone to Medicare for All – an argument generally made sotto voce, if at all, a decade ago.²⁶ Finally, most argue that Medicare for All, while a worthy goal, lies beyond immediate reach because of its high public price tag and the fierce resistance it would provoke. For those who make this last argument, feasibility still looms large.

The coming sections consider these competing arguments. The next looks at the basic political trade-offs involved in public option proposals and contrasts them with those raised by Medicare for All. The following two sections consider, in turn, the likely policy effects of the public option and the potential *political* dynamics it might unleash – that is, the kinds of policy feedback effects it is likely to create. Here I unpack some of the differences between existing public option proposals, drawing on the revealing contrasts among the plans offered under the banner by some of the Democratic candidates who were prominent in the 2020 presidential race. What form the public option takes, it turns out, matters enormously not only for its workability, but also its likely political effects.

5.3 RECONSIDERING THE POLITICS OF THE PUBLIC OPTION

In *The Public Option*, Sitaraman and Alstott define a public option as a policy guaranteeing access to a valued good at a controlled price alongside competing

²⁴ Adam Gaffney, “The Case against the Public Option,” *Jacobin Magazine*, July 19, 2017, www.jacobinmag.com/2017/07/trumpcare-obamacare-repeal-public-option-single-payer.

²⁵ Zack Cooper, Stuart V Craig, Martin Gaynor, and John Van Reenen, “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured,” *The Quarterly Journal of Economics* 134, no. 1 (2019): 51–107, <https://doi.org/10.1093/qje/qjy020>.

²⁶ Elizabeth Warren, “My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All,” *Medium*, November 15, 2019, <https://elizabethwarren.com/plans/m4a-transition?source=soc-WB-ew-tw-rollout-2019115>.

private alternatives.²⁷ They distinguish between “baseline” public options, in which private provision can top off the publicly offered good and “competitive” public options, in which private provision competes in the same general market. In health care, a baseline-style public option would take the form of less-than-complete public coverage, which people would supplement with private insurance. Although this is a common approach in other rich democracies, the form of public option under discussion here is one in which the public option and private plans are competing to offer similarly comprehensive coverage.²⁸

Medicare for All is *not* a public option – certainly not a competitive one, nor even a baseline version. All of the leading Medicare for All proposals are extremely comprehensive and thus would leave limited scope for private insurance. Virtually all of them, moreover, get rid of Medicare Advantage and thus would not allow people to choose regulated private plans as current Medicare beneficiaries do.

Competitive public options could, in theory, take many forms. In practice, existing proposals all largely follow a model that focuses on Medicare – the model I outlined earlier. There are compelling reasons for this focus: Medicare is not only familiar and popular; as noted, it’s also become more effective at containing prices over time, as consolidated provider groups have put growing upward pressure on private spending. Accordingly, advocates of the public option argue either for immediately expanding Medicare or for creating a “Medicare-like” plan that would merge with Medicare in the future. It is this general approach that I will contrast and compare with Medicare for All as I consider the feasibility and expandability of leading proposals.

For all the value of Sitaraman and Alstott’s book, its guidance here is more limited. With a few exceptions, theirs is an equilibrium analysis, in which they examine public options that have come to occupy a central place in US public policy and propose public options that they believe could come to occupy that place. These analyses and recommendations are vital. But critical to the pros and cons of the public option is the prospect of *disequilibrium*. After all, competition is a dynamic, often unstable process in which some competitors prosper and others do not. Indeed, the idea of the public option as a benchmark (Sitaraman and Alstott use the term “yardstick”) implies that public options should thrive or wither based on their comparative performance. It should come as no surprise, then, that both advocates and opponents of the health-care public option have strong and differing views about how it will fare in the competitive fray.

These competing forecasts highlight the biggest political trade-off posed by the public option. Compared with Medicare for All, it is less of a political lift, for reasons we shall explore. But it also leaves uncertain what the ultimate role of the public

²⁷ Ganesh Sitaraman and Anne L. Alstott, *The Public Option: How to Expand Freedom, Increase Opportunity, and Promote Equality* (Cambridge, MA: Harvard University Press, 2019), 27.

²⁸ Roosa Tikkanen, “Variation on a Theme: A Look at Universal Health Coverage in Eight Countries,” *To the Point* (blog), *The Commonwealth Fund*, March 22, 2019, <https://doi.org/10.26099/xo56-8s85>.

option will be. At the same time, it leaves in place many of the existing interests that might be wholly or substantially displaced by Medicare for All. Among the feedback effects that policies can have, perhaps the most powerful is the elimination or sidelining of major organized interests. Airline deregulation, for example, quickly decimated the incumbent carriers, reducing any organized pressure on politicians to reconstruct the dismantled regulatory regime.²⁹ Medicare for All, if fully implemented, would have a similar effect on private insurers. A health-care public option, by contrast, would keep private insurers around, albeit within a more regulated market, and thus also preserve a major lobbying force that will work to limit the public option's reach.

One way to think about this set of trade-offs is as a *constitutional* process. As the scholarship on constitution-building has shown, incumbent elites generally need some assurance that their interests will be at least partially protected, and the prospects for such bargains hinge on uncertainty about which factions will be ultimately most likely to win in more open contestation.^{30,31} In the same way, the public option is likely to gain support if it offers some protections for existing private interests, especially commercial insurers and health-care providers, as well as genuine uncertainty about the extent to which the public option will grow over time. To achieve these conditions, however, requires designing the public option in ways that make it less likely to achieve the kinds of transformative changes envisioned by Medicare for All, at least at the outset.

But the transformative effect of Medicare for All is a weakness as well as a strength. Medicare for All poses an existential threat to the insurance industry; the public option does not. Some defenders of Medicare for All dispute that this really matters politically, since critics will call whatever progressives try to do a “government takeover.” But this understates the political liabilities of Medicare for All. Not only is the health-care industry certain to be fiercely opposed; Medicare for All also faces two other substantial hurdles.

The first is the difficulty of raising the necessary funds through new taxation – the magnitude of which would exceed any prior tax increase in American history as a share of GDP. The second is the reality that many Americans otherwise sympathetic to an expanded Medicare program (including beneficiaries themselves) can be scared into thinking that they will be worse off under Medicare for All, because it will displace or diminish the quality of their coverage. These liabilities – intense industry opposition, tax resistance, the fears of the currently well-insured – mean Medicare for All will require substantial progressive majorities, capable not only of

²⁹ Eric M. Patashnik, *Reforms at Risk: What Happens After Major Policy Changes are Enacted* (Princeton, NJ: Princeton University Press, 2008), 110–135.

³⁰ James A. Robinson and Daron Acemoglu, *Economic Origins of Dictatorship and Democracy* (Cambridge, UK: Cambridge University Press, 2006).

³¹ Charles Boix, *Democracy and Redistribution* (Cambridge, UK: Cambridge University Press, 2003), DOI:10.1017/CBO9780511804960.

passing a controversial law over fierce resistance, but also holding onto it through subsequent elections in the face of the inevitable backlash that such large-scale changes will provoke.

When these concerns are raised, advocates of Medicare for All generally offer two main responses. The first is that Medicare for All is based on a different political logic than the public option; by promising a dramatically better system and rallying Americans behind transformative change, it can overcome the hurdles on which more conventional reform approaches founder. The second is that Medicare for All plans typically embody a transition process that creates intermediate policies – including, in the leading proposals, a public option – that can smooth the path to full-scale Medicare for All.

The first argument is highly contestable. Public views on Medicare for All are polarized and malleable. Depending on the poll, modest majorities of Americans express support for the general goal, but support drops off quickly when the potential drawbacks, including higher taxes and the replacement of existing private coverage, are mentioned even innocuously.³²⁻³³ In any case, recent scholarship on public policy is not kind to the view that strong public support for a policy goal – in the absence of highly conductive partisan and interest-group configurations – is sufficient for major policy change. This is especially true in policy areas where the affluent and major organized interests hold different positions than do middle class and poor Americans, and health and social policies feature particularly large divides of this sort.³⁴⁻³⁵

The second response – that many advocates of Medicare for All envision a relatively lengthy, multistep transition – needs to be unpacked to be fairly evaluated. Some Medicare for All proposals (most notably, Senator Sanders's) do contain a legislated transition period. But these intermediate steps, lasting just four years in the Sanders plan, are unlikely to make it any easier to pass Medicare for All. That's because these proposals envision their wholesale replacement with a universal Medicare program with generous benefits and no private plans. Opponents of Medicare for All are not going to be more supportive simply because of a slightly delayed implementation of the entire program, nor do the intermediate steps seem designed to create political momentum for full implementation, given their relatively short expected life.

³² Ashley Kirzinger, Cailey Muñana, and Mollyan Brodie, "KFF Health Tracking Poll – January 2019: The Public on Next Steps for the ACA and Proposals to Expand Coverage," *Kaiser Family Foundation*, January 23, 2019, Fig. 6, www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/.

³³ Washington Post and ABC News, "Washington Post-ABC News poll, June 28–July 1, 2019," July 11, 2019, www.washingtonpost.com/context/washington-post-abc-news-poll-june-28-july-1-2019/23419a67-9e70-42e3-a96d-65d9255e29b/?itid=lk_inline_manual_2.

³⁴ Jacob S. Hacker and Paul Pierson, "Policy Feedback in an Age of Polarization," *The Annals of the American Academy of Political and Social Science* 685, no. 1 (2019): 8–28, <https://doi.org/10.1177/0002716219871222>.

³⁵ Martin Gilens, *Affluence and Influence: Economic Inequality and Political Power in America* (Princeton, NJ: Princeton University Press, 2012).

In short, the transition period in Medicare for All plans is a “staged” implementation of the full program. That should be contrasted with what I’ve called “sequencing,” in which early legislative steps are designed to ease the transition to a larger public program by creating essential policy infrastructure and supportive political dynamics.³⁶ Senator Elizabeth Warren, for example, backed away from the Sanders plan and offered a sequenced approach instead, in which she envisions a number of large-scale changes, including the creation of a highly robust public option, that she argues would pave the way for additional legislation creating Medicare for All.³⁷ This approach does indeed make the passage of her plan more likely. But, of course, it is also open to the criticism that it may not be able to achieve Medicare for All despite these big initial steps. In this respect, Senator Warren’s campaign proposal can be seen as an ambitious public option plan designed to create pressure for full-scale Medicare for All, which may or may not achieve that goal depending on post-enactment political and policy dynamics.

To sum up, the health-care public option faces less formidable political hurdles than does Medicare for All, but this comes at the cost of leaving in place key organized interests that could compromise the policy in the future. Medicare for All offers the opposite balance sheet: high barriers to passage and initial establishment, but greater prospect of immediately transforming the political context in ways conducive to its entrenchment. The typical transition provisions in Medicare for All plans change this ledger modestly if at all. They reduce the scope of initial change and thus are likely to ease implementation. Yet, opponents will recognize that these are only intermediate provisions. In fact, the transition periods may give opponents greater ability to scuttle the law before it is fully implemented.

The big policy divide, then, is between proposals that explicitly establish a Medicare for All system and public-option proposals that expand Medicare but leave open whether Medicare for All will be established in the future. In judging the latter proposals, both on their own and in comparison with Medicare for All, the two crucial questions are, first, how well would they work at achieving the policy goal of universal affordable health care; and, second, how would they evolve in the future? The next two sections take up these questions in turn.

5.4 THE (CONTINUING) CASE FOR THE PUBLIC OPTION

When I first proposed the public option, I cast it as a means of expanding Medicare that accommodated the “path-dependent” development of American health insurance. Unique among rich democracies, the United States came to rely on private health plans sponsored by employers to insure the majority of Americans, with its two main public programs, Medicare and Medicaid, designed to reach populations ill-served by the employment-based system: the elderly and

³⁶ See note 4.

³⁷ See note 26.

the poor.³⁸ Over the past generation, this system has gradually but inexorably eroded, with private health insurance less and less available in the workplace. Still, roughly half the US population continues to receive insurance through employment-based plans, and while those plans too often leave workers facing high costs, Americans remain relatively satisfied with them.

The public option accommodates America's unusual system in two distinct ways. First, it allows those without workplace insurance to choose between public and private plans, reproducing the basic structure of Medicare Advantage. (In some proposals, current Medicaid beneficiaries are folded into this framework of plan choice; in others, they remain insured through state Medicaid programs.) Second, public option proposals generally have some mechanism for ensuring that employers either cover their workers or contribute to the cost of coverage, in which case their employees would have the same choice of public and private plans as other Americans lacking workplace insurance. These provisions leave a substantial role for private health insurance in general and for employment-based private insurance in particular. They also leave a substantial amount of financing in the private sector. In doing so, they not only reduce the disruption to existing arrangements, but also the up-front tax costs of expanded coverage, while leaving open exactly how the system will evolve in the future.

Nonetheless, the new federal spending required for public option plans is not trivial. During the 2020 campaign, the more moderate candidates offered public option proposals that would require on the order of a trillion dollars in new ten-year federal spending.³⁹ These new federal costs pale, however, next to those implied by Medicare for All. According to independent estimates, Sanders's plan would require around \$30 trillion in new federal spending over a decade.⁴⁰

To be sure, this new spending would substitute for insurance premiums and other private payments. (Generally, experts find that total national health spending will remain similar to current forecasts in the initial years – despite universal comprehensive coverage – and then decline relative to forecasted spending over time, as the greater cost-control capacity of the federal government kicks in.⁴¹) Still, \$30 trillion is more than half as large as the entire amount that the federal government is projected

³⁸ Jacob S. Hacker, *The Divided Welfare State: The Battle Over Public and Private Social Benefits in the United States* (Cambridge, UK: Cambridge University Press, 2002).

³⁹ Linda J. Blumberg, John Holahan, Matthew Buettgens et al., "From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage Costs," *Health Policy Center* (Report), *Urban Institute*, October 2019, www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_option_s_compare_on_coverage_and_costs.pdf.

⁴⁰ Linda J. Blumberg, John Holahan, and Michael Simpson, "Don't Confuse Changes in Federal Health Spending with National Health Spending," *Urban Wire: Health and Health Policy* (Blog), *Urban Institute*, October 16, 2019, www.urban.org/urban-wire/dont-confuse-changes-federal-health-spending-national-health-spending.

⁴¹ Glenn Kessler, "Sanders's Apples-and-Oranges Comparison on Medicare-for-All Costs," *Fact Checker* (Blog), *The Washington Post*, September 19, 2019, www.washingtonpost.com/politics/2019/09/18/sanders-apples-and-oranges-comparison-medicare-for-all-costs/.

to spend in the next decade (\$52 trillion, according to the Congressional Budget Office⁴²), and would require very large tax increases or spending cuts.

Of course, the price tag of the public option will depend on the size of the public plan, as well as whether it attracts disproportionately unhealthy patients. The latter concern, I have noted, is reinforced by the experience of Medicare Advantage, where private plans have historically benefitted from favorable risk selection (and still do so today, though the ACA substantially reduced “excess” payments to private plans⁴³). Critics of the public option on the left rightly worry that, in the absence of an improved system for paying private plans, the public option could end up saddled with higher-risk patients.

Public Option 2.0 proposals, however, have much broader benefits than the current Medicare program, including an integrated prescription drug plan with the power to directly bargain for lower pharmaceutical prices. (Recall that a major reason why so many Medicare beneficiaries enroll in private plans is that they are able to offer broader benefits that encompass prescription drugs.) Moreover, the robust public option envisioned by these plans would have some big inherent advantages: a virtually universal provider network, greater capacity to bargain for lower prices, and the familiarity and popularity of Medicare. With a properly level field, one would expect private plans to play a role in regions of the country where highly integrated private plans are common and among consumers who highly valued the private plan “label.” But the public option would likely be the dominant player in much of the nongroup market.

The key variable that will determine the size of the public option, however, is not the relative balance of public and private plans outside the employment-based insurance sector, but how big that sector will be. This, in turn, depends on many factors, the most important of which is the relative cost to employers of providing insurance directly. Employers offer insurance because it is valued by workers; it is one part of the compensation they use to attract and motivate employees (for this reason, they do not really pay for it; workers do through lower wages and/or less generous non-health benefits). However, employers can provide insurance at a lower cost than individuals pay on their own, both because employment-based insurance is tax-subsidized and because they can pool risk and take advantage of economies of scale. The question for employers, then, is when the recruitment and motivating advantage of employment-based insurance is sufficient to justify sponsoring coverage.

As already mentioned, Public Option 2.0 proposals shape that calculus by providing a public route to obtaining coverage, by imposing a cost on employers that do not provide coverage themselves, and by the terms on which they require such provision,

⁴² Ronald Brownstein, “The Sixty Trillion Dollar Man,” *The Atlantic*, February 26, 2020, www.theatlantic.com/politics/archive/2020/02/sanderss-pricey-tax-and-spending-plans/607105/.

⁴³ Yash M. Patel and Stuart Gutterman, “The Evolution of Private Plans in Medicare,” *The Commonwealth Fund*, December 8, 2017, www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare.

including the generosity of required coverage and whether workers can opt out of it and enroll in the public option. Under the ACA, large employers are required to provide coverage or pay a penalty (if their workers receive subsidized insurance through the marketplaces). Public Option 2.0 proposals would turn this “play-or-penalty” approach into a true “play-or-pay” one, in which employers that chose not to insure their workers would be required to contribute to the cost of their coverage. Without getting into the specifics of these contribution requirements, it’s obvious that the lower this mandated contribution, the more likely it will be that employers choose to pay rather than play – and hence the larger the scope for the competitive public option.

Finally, the role played by the public option will depend on whether workers can enroll in the public option even if their employers offer coverage. President Joe Biden portrayed his campaign’s public option proposal as completing the unfinished business of the ACA. However, the Biden proposal departs substantially from the public option considered in 2009, because it would be open to all workers, not just those whose employers failed to provide qualified private coverage. In other words, Biden’s proposal would allow workers to opt out of employment-based plans even if they met the minimum standards set by the ACA.

Because the Biden public option is not particularly generous (it caps premiums, for example, at 8.5 percent of income), it is not clear that many workers would avail themselves of it.⁴⁴ Yet, in the face of the COVID-19 pandemic, Biden expressed support for a more ambitious public option, which would involve a much larger exodus out of public coverage. Indeed, critics of the public option on the right – and, yes, some advocates as well – forecast exactly the opposite outcome as do critics on the left: a rapid move to Medicare for All. Whether these fears (or hopes) are realistic is our next question.

5.5 FORECASTING THE FEEDBACK EFFECTS OF THE PUBLIC OPTION

In predicting the future role of the public option, its policy effects may ultimately be less important than its *political* effects. Research on policy feedback has identified three main channels through which policies, once enacted, reshape political possibilities. First, they shape public opinion and thereby future electoral dynamics. Second, they shape the universe of interest groups and the goals those groups pursue and coalitions they form. Third, in doing so, as well as by creating new administrative structures, they change the incentives and capacities of policymakers themselves.⁴⁵ The public option would likely have major effects at all three levels.

⁴⁴ See note 39.

⁴⁵ See note 34.

Americans tend to support social programs once they are in place, however controversial the policies were at the outset, and often that support crosses the partisan divide present at the program's creation. Social Security and Medicare are almost universally popular, and even more controversial programs, like Medicaid, have broader public support than the fierce partisan struggles over them suggest. Once in place, programs become familiar and provide tangible benefits. They also become a powerful basis for mobilization when politicians threaten those tangible benefits.

To play this role, however, programs need to be visible and understandable, clearly linked to public authority, and structured in ways that make benefits visible and costs comparatively hidden.⁴⁶ The public option meets this test. It has a ready analogue in an existing program that's highly popular, its financing would come through a mix of sources, including relatively hidden employer contributions, and it would offer a highly valued benefit. Once in place, Americans are likely to become more protective of it and more supportive of its expansion.

A crucial question is whether a public option can create a greater community of interest among Americans now divided by their differential access to good insurance (differences that of course closely track deep divides of class and race). If the public option is accompanied by an upgrading of both Medicare and private workplace plans, and if the public option is gradually integrated with Medicare, there is good reason to believe it could foster a broader sense of shared fate among those it covers.⁴⁷

A crucial issue here will be the future trajectory of Medicaid. Some Public Option 2.0 plans fold nonelderly Medicaid beneficiaries into the public option; others create strong incentives for states to enroll their nonelderly Medicaid populations in the public plan; still others retain Medicaid as a separate state-based program. Ultimately, covering poorer Americans through the same system as more affluent Americans is critical to overcoming the formidable barriers to social solidarity that are created by our current fragmented system.

How much such solidarity can overcome our nation's deep political divisions is open to debate. The polarization of American politics means that many fewer voters are "up for grabs," even incontrovertible policy effects may be viewed very differently by partisans on each side, and policies have generally become less important in comparison with partisan-linked identities in determining how voters assess candidates.⁴⁸ As noted, moreover, the views of organized interests play an outsized role in shaping policymaking. How policies affect the political capacities and aims of those organized interests will thus be critical.

⁴⁶ Suzanne Mettler, "Making What Government Does Apparent to Citizens: Policy Feedback Effects, Their Limitations, and How They Might Be Facilitated," *The Annals of the American Academy of Political and Social Science* 685, no. 1 (2019): 30–46, <https://doi.org/10.1177/0002716219860108>.

⁴⁷ See note 4.

⁴⁸ See note 34.

Employers' responses are particularly pivotal. If they see Medicare as an attractive means of insuring their workers, they are much more likely to climb on board. In the past, business opposition to social programs withered once employers realized they were a good deal. Although such dynamics are likely to be more muted in today's hyper-polarized context, a Medicare public option could appease or fragment key parts of the business community if a sizable share of employers now covering their workers saw the public option as an affordable alternative.

It is harder to be sanguine about the response of private insurers. Still, Medicare Advantage has attracted strong support from private insurers, and many insurers might well prefer a framework based on the Medicare model than the current ACA marketplaces (which are small in size and have not proved very attractive to the largest insurers). Insurer opposition could also be reduced by a robust effort to respond to potential displacement in the industry with retraining and other transitional assistance.

The fundamental question with insurers, however, is whether they will have the incentives and capacity to compromise the public option once it is in place. The history of Medicare's payment policies and the Medicare Advantage program provide some grounds for optimism; in general, Medicare has become more capable of restraining prices, and its system for paying plans has improved. Investing more in the administrative tools and powers of Medicare would increase the chance that this positive trend would continue.

Here, though, the capacities and incentives of policymakers are crucial. There is little prospect that the polarization of public officials will lessen in the near term, and thus legislative gridlock and persistent opposition efforts are likely to be a continuing barrier to salutary updating of all public policies. As the experience of the ACA suggests, "hardwiring" critical features of program design is essential to reduce the capacity of program opponents to undermine it over time. Such hardwiring, however, can undermine the ability of public officials to respond to changing circumstances, a problem that is particularly acute if the public option remains stuck in place alongside a dynamic market. There is no easy resolution of this dilemma, but it puts a premium on a governing structure for the public option that includes worker and consumer representatives and has the authority to pursue changes through fast-track procedures.

Equally important are up-front measures that increase the chance that the public option will grow in the future, such as dedicated financing that increases as enrollment does. If the public option is to start with a limited set of benefits, for example, the process by which these benefits are expanded should be written into law, or at least structured so that expansion is the most likely outcome. The tension between feasibility and expandability rears its head again here, but designers of a policy can improve the prospects for entrenchment and expansion even when opponents prevent them from hardwiring program growth into legislation. By thinking about sequencing as well as staging, advocates can improve their chance of putting in place

initial legislative steps that create self-reinforcing political effects that push toward a better policy.

Finally, a look at existing proposals suggests that the comprehensiveness of the public option – how good its benefits are and how high its premiums might be – is something of a double-edged sword when it comes to policy feedback. For example, a more comprehensive benefit will be more popular for those enrolled, but it's also likely to provoke greater backlash from existing Medicare beneficiaries unless their benefits are similarly enhanced. For this reason, I have argued that a precondition for a successful Public Option 2.0 is a major commitment to upgrade Medicare's benefits for older and disabled Americans.

A more comprehensive benefit is also likely to attract more people and encourage more employers to drop private coverage. This is especially true if private workplace plans are required to provide similarly comprehensive benefits – employers required to upgrade their plans would surely be more likely to drop them. If the goal is to move quickly toward Medicare for All, all this would be a big plus. But it would make the public option more difficult to enact and potentially collapse private insurance so quickly that the law would provoke broad public and industry backlash. For this reason, among others, there's a case for gradual upgrading of both the standards for private plans and the generosity of public benefits (in the public option and Medicare, which should be integrated over time) – with this upgrading built into the initial law to the fullest extent possible.

The policy feedback effects of the public option thus depend crucially on a combination of program design and future political circumstances. Nonetheless, the public option would almost certainly grow in scope over time as it became familiar and gained citizen and business support. Employers' retreat from employment-based insurance is a long-term trend, and Public Option 2.0 proposals would create attractive opportunities for employers to insure their workers without directly providing coverage. Within the public framework, the balance of public and private plans is harder to forecast, but the public option would likely have at least as large a share of the market as traditional Medicare does (two-thirds). The result would not be Medicare for All – at least not without additional legislation – but it would be a system in which the public sector's coverage and price-setting power would encompass a sizable share of the market.

5.6 BROADER LESSONS FOR PUBLIC OPTION POLICIES

The rebirth of the public option has brought the nation full circle. As in the late 2000s, advocates of expanded coverage are debating once again how to overcome the hurdles imposed by the path-dependent development of our exorbitant and incomplete system. Unlike then, however, would-be reformers begin with a much more favorable policy situation. The ACA is battered but intact, and it has reduced the share of Americans without insurance dramatically. Moreover, Democrats have

moved substantially to the left on health care, with the public option now seen as a basic building block of reform, not a potential add-on.

To some, in fact, the ground has shifted so much that the public option is no longer relevant. According to these advocates, Medicare for All is now within reach and the public option is overly timid. As I've argued, however, Medicare for All continues to face a steep uphill battle. As hard as it surely will be to enact a robust public option, it is much less likely to provoke backlash among the currently well insured (both Medicare beneficiaries and those happy with their workplace plans) or to face fierce opposition from the medical industry. And all available estimates suggest that even Public Option 2.0 plans will require far less up-front public spending, and hence new taxation, than will be needed to establish Medicare for All.

The proposals I have labeled "Public Option 2.0" are substantially different than the public option plans seriously considered in 2009 and 2010. All put in place strong measures to guarantee universal coverage and expand the reach of public cost controls over time. All emphasize the need for a level playing field between public and private plans – not the current tilted field seen in Medicare Advantage. And all aim to gradually move Americans out of employment-based plans and harmonize Medicare, Medicaid, and the public option over time. As a result, all these proposals are likely to move the nation substantially toward Medicare for All, though not as far as advocates of universal Medicare might like.

The basic trade-off posed by the public option (in health care, but likely in other policy domains, too) is between feasibility and expandability. Unlike complete public provision, public option proposals are less likely to face scorched-earth opposition from private competitors. But they're less likely to face such opposition precisely because they leave in place formidable private interests that will seek to use both their market and political power to gain an edge. Thus, a critical focus of those seeking to establish public options must be how to constrain competition so it delivers social value and insulate the public option from political efforts to limit its role.

This leads to a second fundamental conclusion: public options, much like political constitutions, are frameworks for contestation rather than fixed entities. Indeed, they are more likely to gain the support of affected interests when their future effects remain in doubt. Thinking about these "constitutional" elements of policy design reminds us that policymaking is an unfolding process, in which today's enactments shape the likelihood and character of subsequent ones. The public option opens up possibilities – not just in the moment, but also in the future.