An audio interview with Prof. Rosenbaum is available at NEJM.org

not be higher, either for family-planning access or for justice.

Disclosure forms provided by the author are available at NEJM.org.

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1. Jane Does 1–3 v. Gillespie, No. 15-3271, F.3d (2017) (http://media.ca8.uscourts.gov/opndir/17/08/153271P.pdf).
2. Centers for Medicare & Medicaid Services. Clarifying "free choice of provider" requirement in conjunction with state authority to take action against Medicaid providers. Letter to state Medicaid directors. April 19, 2016 (https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16005.pdf).
3. Defund Planned Parenthood Act of 2015, H.R. 3134, July 21, 2015 (https://www.cbo.gov/publication/50825).
4. Gonzaga University v. Doe, 536 U.S. 273 (2002).
5. 135 S. Ct. 1378 (2015).

DOI: 10.1056/NEJMp1711490

Which Road to Universal Coverage?

Henry J. Aaron, Ph.D.

According to a June 2017 poll, Americans agree by a 60-to-39 margin that the federal government bears a responsibility to ensure health care for all Americans; 33% said that they favored a "single-payer" health system, 12% more than in 2014.[1] The prevailing belief that the government should actively promote broader health insurance coverage contrasts strikingly with the nearly successful effort this year to repeal the Affordable Care Act (ACA), executive orders that threaten to destabilize ACA marketplaces, and repeated calls by the majority party in Congress to slash Medicaid spending.

As of 2016, the Census Bureau reported that 216 million Americans were covered by private, employer-sponsored, or individually purchased plans. Government plans — mostly Medicare, Medicaid, and Tricare (the military health system) — covered an additional 119 million people. Altogether, 91.2% of the population was insured. The 8.8% without insurance was the lowest proportion in history, down 4.5 percentage points since 2013, just before implementation of the major provisions of the ACA. Spending on health care stood at $3.4 trillion, 18.3% of the gross domestic product — the highest on record.

Two broad strategies exist to extend insurance coverage. One is exemplified by a House bill (H.R.676), introduced by Representative John Conyers (D-MI) and 120 Democratic cosponsors on January 24, 2017, and by a Senate bill (S.1804), introduced by Senator Bernie Sanders (I-VT) and 16 Democratic cosponsors on September 13, 2017. Each would replace the current insurance system with a national, tax-financed system. The other approach would extend various components of the current public–private system to fill in coverage gaps.

How would each approach work? And which is more promising?

Although S.1804 is vague or silent on some key issues, it is more fully developed than H.R.676 or any other proposal for full government-managed coverage. After a 4-year transition period, S.1804 would replace all current coverage — private and public (other than veterans' health care and the Indian Health Service, which would remain as separate systems) — with a unified national system. Private insurance that duplicates coverage outlined in the bill would be barred.

All U.S. residents, including undocumented residents, would be provided coverage encompassing essential health benefits as defined in the ACA. S.1804 would bar balance billing of patients and patient cost sharing, other than up to $200 a year for prescription drugs. In ACA terms, coverage would be at the "platinum plus" level, which is substantially more generous than most current plans, public or private.

Long-term care services would remain a joint federal–state responsibility through Medicaid. States would be barred from tightening Medicaid eligibility rules.

During the 4-year period before conversion to the new insurance system, people older than a gradually lowered age threshold would be permitted to buy in to Medicare at an unsubsidized community rate. All licensed physicians and Medicare-approved institutional providers would be eligible to provide service. Payment arrangements would be "consistent with" Medicare's procedures and methods but are otherwise unspecified. A national health care budget would cap spending on included services.

S.1804 would move roughly 40% of all health care spending

— approximately $1.3 trillion in 2017 — now financed privately or through state budgets onto the federal budget. This sum equals nearly three quarters of the current yield of the personal income tax. Although Senator Sanders separately released a menu of taxes that might be imposed to cover these added budget costs, S.1804 is silent on which taxes would be raised or by how much.

A different road to reach, or come very close to, universal coverage is available. It involves broadening or deepening the channels through which more than 9 of 10 Americans are now insured. People under 65 years of age could be allowed to enroll in Medicare. This extension would have an important side benefit, since it would lower premiums for employers and younger workers by removing older, more costly workers from the insurance pool and thereby easing employer-sponsored coverage.[2] Similarly, more people could be permitted to buy in to Medicaid. Federal policy could encourage states to raise Medicaid's income eligibility limits, which now vary enormously and in some states virtually bar eligibility. For example, income limits for Medicaid for parents in a family of three range from $45,128 per year in Connecticut to $3,675 per year in Alabama.[3] The 2-year waiting period for people found to be eligible for Social Security disability benefits before they qualify for Medicare coverage could be eliminated.

The ACA health exchanges can be used to broaden coverage and even to move gradually to a single uniform national system. Refundable tax credits and cost-sharing subsidies can be increased and extended to people with incomes above current eligibility thresholds. Fixing the "family glitch" — the provision under which employees with families qualify for tax credits as if they were applying for single coverage, despite their need for more costly family coverage — would also increase affordability. The insurance exchanges can simplify and reduce the costs of insurance administration, thereby helping small businesses to offer coverage.

At present, either the single-payer or the incremental approach to universal coverage may seem fanciful. But political winds shift, and it is important for those dedicated to expanding insurance coverage to determine how best to proceed when they do.

Seeking universal coverage through a single unified national system holds out genuine attractions. After a difficult transition, it would most likely reduce administrative costs. It could break the link between coverage and one's job or place of residence. It could enshrine the principle that a civilized society assures high-quality health care to all.

But it also has critical shortcomings. Almost all Americans would have to surrender their current insurance coverage. They would have to trust a federal government that stumbled badly in rolling out ACA coverage that directly covers less than 4% of the U.S. population to successfully engineer a transition for more than 300 million people to a wholly government-run system. They would face what would almost certainly be the largest tax increase in American history to pay for it. They would have to trust employers, freed of the cost of employment-linked coverage, to transfer their savings to increased wages and salaries. They would have to believe that the national health budget would selectively purge useless or low-benefit care but not impair beneficial care or advances in medical technology. Contractual and other payment arrangements involving virtually every hospital, physician, and other provider would have to change.

The country faces formidable challenges, arguably at least as important as covering the 1 person in 11 who currently lacks health insurance coverage: restoring infrastructure, improving educational opportunities, maintaining Social Security benefits, providing for national security, and closing the deficit. The enormous increases in taxes precipitated by S.1804 or similar plans would make it hard to find revenues to sustain, much less increase, spending on these efforts.

Incremental approaches cannot promise to transform the whole health care system. But they do offer a way to chip away at the ranks of the uninsured without upending coverage of more than 90% of Americans. For example, from 1988 through 1993, a succession of individually modest legislative changes in Medicaid, enacted through the efforts of senior congressional Democrats such as Henry Waxman (D-CA) and signed by Republican President George H.W. Bush, supported an 11-million-person increase in Medicaid enrollment. In a similar fashion, extensions of Medicare, Medicaid, and ACA tax credits could expand coverage to many, if not all, of the currently uninsured. These measures could be pursued along with, rather

than instead of, efforts to deal with our country's lengthy menu of wants and needs.

When the political weather for expanding health insurance coverage is more clement than today's, lawmakers and advocates will need to choose how best to move forward: to take one parlous shot at transformational change or the much better odds of steady, if less spectacular, advance.

Disclosure forms provided by the author are available at NEJM.org.

From the Brookings Institution, Washington, DC.

This article was published on October 25, 2017, at NEJM.org.

1. Kiley J. Public support for 'single payer' health coverage grows, driven by Democrats. Washington, DC: Pew Research Center, June 23, 2017 (http://www.pewresearch.org/fact-tank/2017/06/23/public-support-for-single-payer-health-coverage-grows-driven-by-democrats/).
2. Starr P. The next progressive health agenda. The American Prospect. March 23, 2017 (http://prospect.org/article/next-progressive-health-agenda).
3. Kaiser Family Foundation. Medicaid income eligibility limits for adults as a percent of the federal poverty level. January 21, 2017 (https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level).

DOI: 10.1056/NEJMp1713346

How to Think about "Medicare for All"

James A. Morone, Ph.D.

In April 1946, President Harry Truman introduced a single-payer health plan and met the same reaction that would greet Senator Bernie Sanders (I-VT) and his colleagues when they proposed "Medicare for All" in September 2017. "It is believed by competent Congressional observers to have little chance of approval," reported the *New York Times* back in 1949. *Newsweek* was blunter: "No chance at all." Neither Truman nor Sanders even bothered to include financing for their plans. Truman had no more success with a scaled-back proposal to cover only people over 65 years of age, but 13 years later President Lyndon Johnson signed the Truman revision into law as Medicare, declaring that the United States was finally harvesting "the seeds of compassion and duty" that his predecessor had sown.[1] A proposal with no chance in one era had become law in another. Medicare proved so popular that it came to be a third rail of American politics — dangerous to touch. What lessons does Truman's success hold for today's "no chance" Medicare for All?

The usual metrics for evaluating policy proposals — vote counts, Congressional Budget Office scores, and tax calculations — are misleading because Medicare for All is an idea for the long run. For a more accurate assessment of its prospects, keep an eye on four key questions.

Is there a right to health care? The Affordable Care Act and the efforts to repeal and replace it raised fundamental ethical questions about whether Americans have a right to health care and, if so, whether government should secure it. The Medicare-for-all proposal responds with a strong claim for a right to roughly equal health care coverage for everyone. The American patchwork — superb health insurance for some; no health insurance for 30 million others; and shaky high-deductible, high-premium plans on the individual market and in many workplaces — is not just poor policy. It is wrong. It violates the norms of communal decency. Late-night talk-show host Jimmy Kimmel distilled this view when he tearfully responded to the House repeal-and-replace plan: "No parent should ever have to decide if they can afford to save their child's life. It just shouldn't happen. Not here."

Medicare for All is, first and foremost, an exercise in moral persuasion. It will become a serious policy proposal if it creates a major surge in public opinion. That's how "no chance" reforms win in the United States, whether it's the passage of Medicare or the right of same-sex couples to marry. On this measure, Sanders is making progress. Last time he proposed his plan, he stood alone; this time, 16 Democrats crowded beside him — including some leading contenders for the next presidential nomination. The difference sprang from the 12,029,699 votes Sanders racked up in the Democratic presidential primaries. To handicap the future prospects of the plan, watch what happens as candidates take it to the voters.

Won't the cost savings eventu-