Rebounding with Medicare: Reform and Counterreform in American Health Policy

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Abstract America's major health care programs were all enacted on the rebound from defeat of more expansive progressive ideas. Chastened reformers have typically adopted rebound strategies that accommodate some sources of opposition, incorporate elements of counterreforms, and reflect intervening institutional change. This dynamic has unfolded three times: from the Progressive Era to the enactment of Medicare and Medicaid in 1965, from the late 1960s to the expansion of Medicaid in the 1980s, and from defeat of the 1993 Clinton plan to the enactment of the Children's Health Insurance Plan in 1997 and the Affordable Care Act in 2010. Setbacks in the Trump era will require advocates of universal coverage to coalesce around a rebound strategy that similarly takes account of recent developments and recognizes the Affordable Care Act's limitations and political vulnerabilities. This article argues that Medicare provides a platform for such a strategy and that the next fiscally and politically feasible step is the creation of a new "Midlife Medicare" program that would extend protection to people fifty to sixty-four years of age.

Keywords Progressive reform, Medicare buy-in, Medicare Advantage, marketplaces, universal coverage

There is no way to understand the path of health care reform in the United States without understanding the role of counterreform. Every successful progressive reform in health policy has been adopted in response to a previous defeat and to the realities that counterreforms have created. The system that has emerged has been nobody's first choice, nor is it a synthesis that incorporates the best of competing perspectives. Rather, in the struggle over health policy, the major parties and interest groups have had to make

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second-best choices, serially adjusting their ideas and strategies in light of institutional and political realities created or set in motion by previous policies. That is what will happen again in the wake of the changes brought about by Republicans in the Trump era. I argue that those changes will lead Democrats to return to the framework Medicare offers and that a program that I call "Midlife Medicare" makes sense as a next step.

The central focus of this article is on rebound strategies: efforts to advance progressive reforms in the aftermath of setbacks. *Progressive reforms* here refer to proposals for extending publicly financed health insurance and access to medical care; *counterreforms* refer to alternative approaches to coverage more reliant on employer and individual financing, as well as measures intended to roll back public programs and expenditures. These categories reflect the general historical pattern of progressive initiative and conservative response in American health policy. Reforms and counterreforms include both defeated and enacted proposals. Starting out with a progressive defeat, the characteristic historical sequences have led to enacted reforms expanding coverage, but those measures have reflected the impact of counterreforms and intervening institutional change. The history of health care rebound strategies is the subject of the first section of this article. The second section turns to the strategic problems of responding to the Trump era and the logic of rebounding with Medicare.

Rebound Strategies and the History of Progressive Health Care Reform

All the largest public health care programs in the United States—Medicare, Medicaid, and the Affordable Care Act (ACA)—have their origins in the defeat of a more ambitious progressive vision. Chastened by political setbacks, advocates of expanded insurance protection have typically scaled back their proposals, accommodated some sources of opposition, and incorporated elements of counterreforms. This dynamic has unfolded three times: from the Progressive Era through the enactment of Medicare and Medicaid in 1965, from the late 1960s to the expansion of Medicaid in the 1980s and 1990s, and from the early 1990s to the enactment of the Children's Health Insurance Plan (CHIP) in 1997 and the ACA in 2010. I review this history to show how rebound strategies have successively reflected the effects of political defeat, counterreforms, and institutional change and to suggest that a new phase of progressive reform will need to take the same considerations into account.

Medicare as Rebound Strategy

Medicare is the paradigmatic case of health care reform as a rebound strategy—a rebound from a succession of defeats in the Progressive Era (when state-level campaigns for health insurance failed between 1915 and 1919), the New Deal (when the Roosevelt administration twice considered and rejected proposals to push for health insurance nationally), and the late 1940s (when Harry Truman proposed national health insurance but never got so far as developing legislation).

Although the proposals for publicly financed coverage evolved over the first half of the twentieth century, the political debates about the issue took on a stable rhetorical form. Substantively, the advocates of reform turned away from an early concern with lost wages to a sole focus on the costs of medical care, while also shifting their efforts from the state to the federal level. But they consistently conceived of their proposals within a social insurance framework, arguing that health insurance financed by taxes would provide for a more just and efficient distribution of the costs of illness, just as workers' compensation spread the costs of industrial accidents, unemployment insurance distributed the risks of unemployment, and old-age insurance offered protection in retirement. On the other side, key interest groups—employers, physicians, insurers—joined with ideological opponents of expanded public provision to frame their case as a patriotic defense of American values of individual freedom and limited government. In the World War I era, they denounced "compulsory" health insurance as a German idea; as the Cold War began in the late 1940s, they said "socialized medicine" was communist inspired. Their alternative was the "voluntary way" consistent with American traditions: freely chosen doctors and insurance plans with no government role. This framing of social insurance in health care as a threat to freedom became deeply embedded in American conservative discourse (Starr 2013, 2017).

Four aspects of institutional developments by midcentury led the advocates of publicly financed health insurance in the United States—unlike their counterparts anywhere else—to scale back their ambitions to a program for seniors. First, the defeat of both state and federal proposals opened the way for private insurance rooted in employment. At a time when the large, multidivisional firm was in ascendancy and private-sector unions were relatively strong, collective bargaining agreements became the logical alternative to government as a route for workers to gain protection against health care costs. Large employers had advantages in pooling risk and reliably paying for coverage out of payroll deductions that no other form of private organization could match.

Second, a key counterreform—the exclusion from taxable income of employer contributions to health insurance, formally codified in 1954—provided a government subsidy for employment-based coverage that undermined the drive for a universal, public program. Third, institutional change in the insurance market—the shift from community rating to experience rating as commercial insurers took market share from Blue Cross, which necessarily had to adapt, lest it be stuck with the highest-cost population—made it increasingly unlikely that the private market would ever answer the demands of seniors for health insurance.

Finally, Social Security's old-age insurance program had been successfully institutionalized, providing a foundation for development of a health insurance program for seniors. Building on that foundation took advantage not only of Social Security's legitimacy but also of the policy expertise that developed in the Social Security bureaucracy. Indeed, the idea for Medicare—at first only for limited coverage of hospital costs—came from those policy professionals in the wake of the defeat of Truman's national health insurance proposal. This constellation of institutional developments led to the Democrats' adoption of Medicare as a national campaign issue by 1960 and as a top legislative priority after Lyndon Johnson's landslide in 1964.

At that point, counterreform proposals contributed to what were, in effect, both a broadening and a narrowing of Medicare. Moderate Republicans countered with a plan that included coverage of physician as well as hospital care, except on a voluntary basis with subsidized private insurance. The American Medical Association countered with a proposal for more federal money for the states to provide medical care for the poor. Urged on by Johnson, Wilbur Mills, chair of the House Ways and Means Committee, famously incorporated the two counterreforms, turning the Republican counterproposal into Medicare Part B and the American Medical Association's counterproposal into Medicaid. This was not just an expansion of the legislation; concerned about excessive reliance on a payroll tax, Mills walled in Medicare Part A with Part B and with a separate program tied to welfare. Concessions to hospitals and physicians in Medicare's payment arrangements, however, ended up producing just the kind of explosive growth in the cost of Medicare that Mills had hoped to avoid, while the creation of Medicaid institutionalized a lower tier of coverage for the poor (in fact, only for those groups among the poor deemed to be deserving). For all its limitations, however, Medicare succeeded as a rebound strategy, creating a popular foundation for publicly financed coverage that reduced inequalities among seniors in health care and financial protection (Marmor 2000; Blumenthal and Morone 2009; Starr 2015b).

Medicaid Expansion as Rebound Strategy

In the late 1960s and 1970s, liberals expected to build on Medicare, not Medicaid, as the foundation for universal health coverage. Led by Senator Ted Kennedy, they called for a comprehensive program of national health insurance on the model that Truman had advocated. To President Richard Nixon, like other Republicans before him, a program fully financed by federal taxes involved too much government, but in 1971 and 1974 Nixon countered with his own national health insurance proposals, relying principally on an employer mandate for private coverage. Democrats spurned that offer and the chance for a compromise, expecting to win undivided control of the federal government and to enact a plan more to their liking in the aftermath of the Watergate scandal and Nixon's resignation. Instead, universal health coverage fell off the national agenda in the mid-1970s with the onset of stagflation and a shift in national politics to the right. Although Democrats won the White House with Jimmy Carter, he failed to push for national health insurance for fear of its fiscal consequences.

In 1972, under Nixon, Congress did expand Medicare to include recipients of Social Security Disability Insurance (after a two-year delay) and patients with end-stage renal disease, but those groups would be the last to benefit from expansions of Medicare eligibility, at least so far. Cost containment began taking priority, and instead of imposing greater planning and regulation, national policy increasingly called for reliance on market mechanisms. Nixon championed health maintenance organizations (HMOs) as a market-based counterreform, though legislation adopted in 1973 to aid their development did not initially produce much effect. Carter's legislation to regulate hospital costs, his major foray in health policy, failed to pass Congress. With regulation in retreat, the terms of debate shifted. In 1979 Senator Kennedy, who was a leader in moves to deregulate airlines and other industries, introduced a new proposal for universal health coverage that relied on competing private health plans rather than a single federal program, and he and other liberals increasingly reframed a universal program as being as much about containing costs as expanding coverage. As a rebound strategy, the 1979 Kennedy bill had some of the key elements of the approach Bill Clinton would adopt in 1993. But the election of Ronald Reagan doomed such efforts in the 1980s.

While Democrats were stymied on national health insurance, other changes in public policy and health insurance adopted in response to rising costs began altering the institutional structure of health care. In 1983 Congress adopted a Reagan administration proposal for prospective hospital

payment in Medicare; in the same period, HMOs and other forms of what now came to be called "managed care" began to take off in the private sector. In the ensuing years, the rise of managed care would transform Medicaid and Medicare and reinforce the emerging trend among Democrats to build private health plans into universal health insurance proposals.

The 1980s saw two efforts to expand publicly financed coverage—one a spectacular failure, the other a quiet success. The failure was the Medicare Catastrophic Coverage Act, proposed from within the Reagan administration, expanded and passed by a Democratic Congress in 1988, and repealed within a year under George H. W. Bush after the legislation elicited a backlash from seniors. (The added coverage for catastrophic medical costs, prescription drugs, and other benefits was financed entirely by premiums to be paid by seniors, especially by affluent seniors, many of whom already had coverage for those costs.)

The quieter and more durable expansion of public coverage during the Reagan and first Bush administrations came through a series of incremental Medicaid reforms. Reagan originally proposed turning Medicaid into a block grant, a measure defeated by the Democrats in Congress, though they did agree to other Medicaid cuts. Beginning in 1984, however, Henry Waxman, chair of the health subcommittee of Energy and Commerce in the House, succeeded in winning extensions of Medicaid eligibility for low-income pregnant women and children, first on an optional basis for the states and then as mandates. By 1990, Congress required states to phase in coverage for all children in families with incomes beneath the federal poverty line and all children up to age five in families with incomes up to 33 percent above the poverty line. Moreover, when the Medicare Catastrophic legislation was repealed, Waxman salvaged a key provision requiring state Medicaid programs to pay the cost of Medicare deductibles, copayments, and other expenses for low-income "dual eligibles."

This movement to expand Medicaid continued under President Clinton, who made aggressive use of state waivers to allow states to expand eligibility, often with increased use of managed care. By the mid-1990s, Medicaid had been transformed from a system of "welfare medicine" into a general program for financing a broad array of health and social services to low-income Americans and many in the middle class as well.

Rebounding from the Clinton Plan's Defeat (1): CHIP

The strategy for universal coverage that President Clinton adopted in 1993 exemplifies the pattern of reform proposals incorporating counterreforms

and adjusting to changed institutional conditions in health care. While polls showed high levels of discontent with the health care system at the time, there was no consensus even among Democrats about the direction of reform. Clinton sought a way to bridge political divisions with a hybrid proposal that combined ideas of social protection, individual choice, and competition. While the very name of Clinton's proposed Health Security Act recalled Social Security, the legislation did not call for an insurance program run by the federal government. Like Nixon's proposals, Clinton's relied chiefly on an employer mandate for its financing and on private insurance for coverage of the non-Medicare population (Medicaid would have been folded into the program). The under-sixty-five population was to choose among three types of private plans (fee-for-service, HMOs, and preferred provider organizations, all with the same broad benefit package) offered through state-based "regional health alliances" under a regime of managed competition and federally imposed caps on the rate of growth of the weighted average premium in a region. The caps on premium growth served as the functional equivalent of global budgets for regional health spending.

The mix of features in the Clinton plan, however, failed to win Republican support or to unify Democrats, and after the plan's defeat Clinton initially fell silent on the issue. But after being reelected in 1996 in the midst of a strong economic recovery and brightening fiscal outlook, Clinton returned to health care with a proposal to expand medical care for children. Enacted in 1997, the State Children's Health Insurance Plan (originally SCHIP, later CHIP after the name was shortened) emerged from a bipartisan congressional compromise and, consequently, had elements reflecting its joint parentage.

As a rebound strategy, CHIP had similarities to the two earlier strategies that resulted in the creation of Medicare and transformation of Medicaid. Like Medicare, CHIP represented a retreat from covering everyone to expanding protection for an age group that evoked public sympathy. Like the expansions of Medicaid, CHIP provided the states with federal funds that they could use to cover children in low-income families (in the original bill, families with incomes up to twice the poverty level).

But the need to gain Republican and conservative Democratic support resulted in a different structure. Unlike Medicare or Medicaid, CHIP was not an entitlement; it was a block grant that states could variously use to expand Medicaid, set up a separate CHIP program, or do some of both. By establishing CHIP on that basis, Republicans moved federal health policy in the direction of principles they favored for limiting federal expenditures. CHIP was thus a reform and counterreform rolled into one.

Rebounding from the Clinton Plan's Defeat (2): The ACA

Political defeat, counterreforms, and institutional change all helped shape the ACA. The defeat of the Clinton health plan was a formative experience for most of the political leaders and policy experts who returned to the issue of universal health coverage in the early 2000s. A principal lesson they drew from that defeat was the political necessity of building on existing forms of coverage to minimize disruption, public anxiety, and interest group opposition. Although the Clinton plan had included a mandate for employer contributions for private insurance, it eliminated most employer-based plans, as well as Medicaid, in favor of new choices to be offered on publicly regulated marketplaces. Democrats and advocacy groups increasingly took the view that this had been too much change and that they would need a strategy to fill in the gaps in the financing system instead of transforming it.

The presidency of George W. Bush reinforced this cautious outlook. During the 2000 campaign, in response to Al Gore's call for a Medicare prescription drug benefit, Bush had also committed himself to that objective, and in 2003 Congress passed legislation fulfilling that promise, a singular example of a Republican initiative that expanded publicly financed protection against health care costs. But it did so exclusively through private plans for drug costs, while also increasing payment rates to private plans for Medicare hospital and physician coverage (renaming them Medicare Advantage). The same legislation broadened provisions for tax-sheltered health savings accounts as a complement to high-deductible health plans for the non-Medicare population. Slow to take off in employer coverage in the 1990s, high-deductible plans began growing far more rapidly in the 2000s. The Bush counterreforms implanted the logic of the market more firmly in health policy.

Another Republican initiative for expanded coverage, the universal insurance plan adopted under Governor Mitt Romney in Massachusetts in 2006, crystallized the rebound strategy that Democrats would embrace in the ACA. The Massachusetts program relied on expanded Medicaid coverage (made possible through a generous federal Medicaid waiver) and state subsidies for the near-poor in a reformed nongroup insurance market. A key element in the Massachusetts reforms was an individual mandate for coverage, an idea that conservative policy intellectuals had promoted since the early 1990s and that Democrats had largely rejected. During the debate over the Clinton health plan in 1993, Senator John Chafee, a Rhode Island Republican, introduced a bill with an individual mandate that initially had

significant backing from members of his party. But just as the employer mandate had originally been a Republican proposal (from Nixon), only later to be disowned by Republicans, the individual mandate would follow the same path, originating among conservatives and Republicans and later disowned by them once Democrats accepted the idea.

In the run-up to the 2008 election, unlike the early 1990s, influential Democrats and reform groups coalesced on a rebound strategy, one that borrowed key elements from past Republican proposals and ultimately became embodied in the ACA. Like Romney's program, the ACA relied on an expansion of Medicaid for the poor (up to 138 percent of the poverty level); called for an individual mandate along with guaranteed issue, community rating, and other reforms to the nongroup market; and provided tax subsidies for premiums to make private insurance affordable for others with low to moderate incomes (from 100 percent to 400 percent of the poverty level). The ACA also called for a regime of managed competition in the nongroup market, but the management was light—the state-based insurance exchanges could act as mere clearinghouses, and states could allow insurance to be sold outside the exchanges to individuals not seeking subsidies. In contrast to the Clinton plan's regional health alliances, the ACA's state marketplaces served only a small share of the population and did not include federally imposed premium limits and global expenditure controls. As a result of the omission of a public option, the ACA would depend for its success entirely on private insurers, even though the "big five" private health insurers fought the legislation and the rest of the insurance industry was at best ambivalent about it.

In another concession, the ACA accepted high-deductible plans in both the nongroup market and employer coverage. While mandating a broad list of "essential health benefits," the law allowed plans at a "bronze" level (60 percent actuarial value) that Democrats in the past would have ridiculed as "barebones" coverage. The ACA did raise insurance standards for people who had the least protection, especially in the nongroup market, but it did not prevent employers from continuing to raise deductibles for people who previously had good protection.

Critics of the ACA may question whether all its many compromises were necessary since the legislation failed to win any Republican support in Congress. But at a time when Democrats could not afford to lose a single vote in the Senate, those concessions kept the entire Senate Democratic caucus together, including its most conservative members, such as Connecticut Senator Joseph Lieberman. It took a unified Democratic Party to pass on strictly partisan lines what might have been another era's bipartisan legislation.

Although Democrats frequently compared the ACA to Social Security and Medicare, one crucial difference was that for long periods after 1935 and 1965 Democrats continued to control Congress and were able to pass amendments and make course corrections in both programs. They had no such opportunity to fix problems in the ACA. The very circumstances of the law's passage in early 2010 (after losing a filibuster-proof majority in the Senate) forced Democrats to abort the final drafting process from House-Senate conference. Then they lost control of Congress altogether, enabling Republicans to push through various provisions weakening the law. In 2012 the Supreme Court made the Medicaid expansion voluntary for the states, and many Republican-controlled states refused not only to expand Medicaid but also to cooperate in individual enrollment in the exchanges.

Despite all the Republican attacks, the law did record notable achievements in reducing the uninsured population while avoiding an increase in health care costs (Obama 2016). But in the run-up to the 2016 election, surveys showed the public continued to be just as divided over the reforms as it had been over the previous six years. The exit of major insurers from many of the ACA's marketplaces and a sharp increase in premiums in 2016 seemingly validated Republican charges that the program was in danger of imploding. While those claims exaggerated the difficulties, the ACA went limping into the Trump era.

Rebounding from the Trump Presidency

In keeping with the general patterns in the past, setbacks to reform in the Trump era altering both public policy and the institutional environment in health care will necessarily lead Democrats to adjust their own ideas and strategies when they eventually regain the initiative. Although the beginning of the Trump presidency is too early to assess its full impact, I suggest that Democrats are likely to come to see Medicare as the most advantageous and politically practical foundation for pursuing a more just and rational health care system and that extending Medicare to people in midlife and applying Medicare rates to more of the private insurance market will make sense as the next steps toward that end.

Counterreform and Institutional Change in the Trump Era

The history of conservative counterreform in health policy has been as checkered as the history of progressive reform. Just as Democrats have suffered defeats in the quest for universal health coverage and been forced to scale back their efforts, so Republicans have suffered defeats in radical

counterreforms and been forced to moderate their ambitions. Reagan in 1981 and Newt Gingrich in 1995 were both unsuccessful in turning Medicaid into a block grant; Gingrich also failed in his effort to convert Medicare into a voucher for private insurance. Instead, during the period from 1995 through 2006, when Republicans controlled both houses of Congress, they agreed to two expansions of public coverage (CHIP and the Medicare prescription drug benefit).

But it would be a mistake to infer from that history that Republican counterreforms have had no impact or that steps toward long-term retrenchment such as block granting Medicaid are inevitably destined to fail. The Medicare and Medicaid programs now have growing numbers of beneficiaries in private managed care, and high-deductible plans represent an increasing share—as of 2017, up to 42 percent—of the employer and nongroup insurance markets (Zammitti, Cohen, and Martinez 2017: fig. 11). Tax cuts enacted early in the presidencies of Reagan and the younger Bush created pressure to reduce federal health programs. As a result of the conservative defense of a strong role for state governments in health and social policy, southern and other ideologically conservative states have been able to maintain a policy regime with low taxes and limited social protection.

These general patterns—counterreforms favoring private over public alternatives, tax cuts creating pressure to reduce spending on federal health programs, and measures devolving key decisions on the states—were already in evidence in 2017, although Republicans were not able to go as far as their leaders wanted. On taking power, Trump and the congressional Republican leadership sought not only to "repeal and replace Obamacare" but also to convert Medicaid into a limited grant to the states on the basis of a formula that would sharply reduce its real value over time. After passing a bill in the House in May, however, Republicans failed to meet a September deadline for Senate passage of a corresponding measure requiring only a bare majority. But in tax legislation in December, Congress returned to health care and repealed the financial penalties associated with the individual mandate as of 2019, a step that the Congressional Budget Office (CBO) projected would reduce the number of people with insurance by 4 million in 2019, 12 million in 2021, and 13 million in 2026 (of which 5 million would come from the nongroup market, 5 million from Medicaid, and 3 million from employer coverage; CBO 2017b: 1, 3). Meanwhile, the Trump administration was waging a campaign of sabotage against the ACA, cutting open enrollment in the federal exchange from ninety to forty-five days and gutting advertising and outreach—measures, however, that

did not produce a significant decline in enrollment for 2018 (Pear 2017; see also Norris 2017). In a further step, Trump signed an executive order promoting the development of "association health plans," which would allow relatively healthy individuals to buy insurance separately, increasing adverse selection in the remaining nongroup market. Uncertainty about federal policy (e.g., about whether the government would pay for cost-sharing reductions) has also driven some insurers out of the ACA marketplaces entirely.

In separate measures, the Trump administration made clear its intention to cut back Medicaid, using its authority under section 1115 of the Social Security Act to waive federal rules for state demonstration projects. The US Department of Health and Human Services invited states to submit proposals to make Medicaid eligibility conditional on fulfilling work requirements and to introduce into Medicaid principles from commercial insurance markets, such as limited enrollment periods and the disqualification of beneficiaries who fail to renew in time. Nearly a third of all Medicaid spending flows through section 1115 waivers, and although some of the waivers have been in existence for decades and enabled states to expand Medicaid, the authority to continue them is discretionary (Rosenbaum 2017; see also Rosenbaum's article in this issue). In addition, under section 1332 of the ACA, the administration has considerable authority to modify rules for the nongroup insurance market. By rewarding states that follow its preferred choices and penalizing states that refuse to do so, the administration has the power to redirect health policy in the states toward conservative objectives, shifting risks from the federal government to the states and then on to low- and middle-income people who lose the coverage they have had through Medicaid or the ACA marketplaces.

Republican policy in the Trump era may have particularly harsh implications for older adults below the age of eligibility for Medicare. Two aspects of the legislation passed by the House in May would have had a severe impact on fifty- to sixty-four-year-olds in the nongroup market. Under that measure, instead of charging older adults three times as much as young adults, insurers could have charged them five times as much (or even more, if a state sought a waiver from that limit). In addition, instead of the income-adjusted subsidies for both premiums and cost-sharing under the ACA, the House legislation provided only far more limited, flat tax credits for premiums. Although those credits would have been higher for older adults, they would not have offset the increase in age rating, much less made up for the elimination of cost-sharing subsidies. In its analysis of the bill, CBO found that in a state that did not seek any waivers, a representative

sixty-four-year-old with income at 175 percent of the federal poverty level would see premiums rise from $15,300 to $21,000, premium credits fall from $13,600 to $4,900, and hence the net cost of insurance jump from $1,700 to $16,100—an 847 percent increase (CBO 2017a: table 5). Graham-Cassidy, the bill that came close to passage in the Senate in September, did not include any federal premium tax credits since it would have converted those credits as well as funds for the Medicaid expansion into a block grant to the states. But if Republican-led states followed the principles that their representatives in the House voted for (i.e., higher age ratios and flat premium credits), the burden falling on older adults would have increased in a similar fashion. Since Republicans came within one vote of passing the Senate bill and doggedly continue to promise to carry out their policies through legislative or administrative means, it would be foolhardy to think that the threat to older adults has passed.

The long-term reductions in Medicaid and other health spending called for by Republicans also have major implications for stratification among health care providers. Recent decades have seen extensive consolidation of the ownership of hospitals and other health care facilities at community and regional levels, heightening disparities in private payment and resources among the different tiers of providers. While the dominant, consolidated "must-have" hospital systems have been able to extract higher payment rates from insurers, the weaker institutions—including most safety net providers—have been price takers (Berenson et al. 2012). The safety net providers long received less revenue because of the number of uninsured and Medicaid patients they treat, but as a result of the changed structure of the market they are now also paid less than the dominant providers for the privately insured. When the ACA's expanded coverage went into effect in 2014, it partially offset these disparities and strengthened community health centers and hospitals serving low-income communities, but the Republican counterreforms and budget cuts have the reverse effect. Already stratified by differences in payment levels and resources, community health services will become more unequal.

One of the central purposes of the ACA was to raise the minimum standards of coverage for both Medicaid and private insurance and thereby provide more equal protection against health care costs across class, racial, and geographic lines. Together, the Supreme Court, Trump administration, and Republican-led states have substantially frustrated that aim. The Court's decision in *National Federation of Independent Business v. Sebelius* (567 U.S. 519 [2012]), making the Medicaid expansion optional for the states, has contributed to continued, sharp disparities in insurance

rates. During the first half of 2017, the share of adults eighteen to sixty-four years old who were uninsured was 19 percent in the states that did not expand Medicaid, compared to 9 percent in the states that did (Zammitti, Cohen, and Martinez 2017: fig. 9). The Trump administration's use of its waiver authority to promote policies such as work requirements will also likely widen the disparities in policy regimes between Republican-controlled states that seek such waivers and Democratic-controlled states that do not. Medicaid's protections may be further eroded if in legal cases arising from new work requirements and similar policies the Supreme Court weakens or overturns the individual entitlement to Medicaid benefits (see Rosenbaum, this issue).

While the ACA still largely remained in place as 2017 ended, the law's accomplishments were in jeopardy from the repeal of the individual mandate, hostile administrative decisions, potential judicial reverses, and the continuing determination of some Republican leaders, particularly House Speaker Paul Ryan, to cut spending on health care entitlements, which could mean a return to the effort to turn Medicaid into a fixed grant to the states, declining in real value over time. Even seemingly small changes, such as prohibiting retroactive Medicaid benefits and requiring beneficiaries to reestablish eligibility every six months instead of every year, could result in significant reductions in coverage. Taken together, all these measures, especially the repeal of the individual mandate, have wounded the ACA, but no one knows for sure how deep the wounds will prove to be. Although Democrats will continue to try to preserve the gains of the ACA, the experience since the major provisions were implemented in 2014 has demonstrated the limitations and vulnerabilities of the law. Consequently, even as they try to bolster the ACA framework, Democrats may be ready to move in a new direction the next time they have an opportunity to take the initiative in health policy.

Midlife Medicare as a Rebound Strategy

The ACA has increased health insurance coverage through two distinct means: a reformed and subsidized private nongroup market and an expanded Medicaid program. Neither has worked out as well as expected or sufficiently entrenched the changes in coverage to protect them against erosion or reversal once party control changed hands (on variations in the entrenchment of social policy, see Starr 2015a). The strategic question facing Democrats is whether to continue relying on this two-pronged approach when they return to power or to turn toward an expansion of Medicare in one of various possible forms.

Democrats came around to the idea of a subsidized private nongroup market, backed up with an individual mandate, only after the 2006 Massachusetts reforms gave them encouragement that the model could win bipartisan support and minimize opposition to universal coverage. But as both politics and policy, it has not vindicated the hopes invested in it. Republican efforts to reverse the law have been unrelenting, and although public opinion surveys showed increased support for the ACA once it was in danger of repeal, Americans remain almost evenly divided about it. As of November 2017, favorable opinion of the ACA outpaced unfavorable opinion by only 50 percent to 46 percent (Kaiser Family Foundation 2017). To be sure, much of the opposition has been partisan and ideological in origin, but survey data also point to rational reasons for dissatisfaction with the law. Gallup data indicate that 29 percent of Americans—37 percent of women compared with 22 percent of men—still put off medical treatment due to cost in 2017, not significantly different from before the ACA (McCarthy 2017). Kaiser tracking data for December 2016 and February 2017 show a similar pattern (DiJulio 2017). Steep increases in deductibles in employer-sponsored insurance may be a key factor in the persistence of discontent, leading many of those who already had coverage before the ACA to believe that the law has done little or nothing for them, while others are getting help.

The ACA marketplaces have also proved to be a policy disappointment. The marketplace strategy failed to take account of increasing concentration and market power among both providers and insurers. While some marketplaces have worked well (particularly where states were strongly committed to them), many others have turned into monopolies, with high and rising premiums (Blumberg and Holahan 2017). Instead of providing an attractive model that could become a rival to employment-based coverage, the marketplaces have primarily offered coverage with high deductibles and narrow networks. Total enrollments have proved to be lower than expected, and the repeal of the individual mandate and the Trump administration's provision for association health plans will only aggravate that problem and increase adverse selection. While the premium credits buffer eligible consumers from the full effect of premium increases, rising premiums raise budgetary costs per enrollee, and many unsubsidized individuals in the nongroup market resent being forced into what is in danger of becoming a high-risk pool, where they have to pay more for coverage than they previously did. Democratic proposals for the next phase of progressive reform now have to take account of Republican countermeasures. Reimposing the individual mandate and shutting down the Trump-enabled

options for coverage outside of the ACA marketplaces do not seem likely to be popular centerpieces in a national Democratic rebound strategy.

The other half of the ACA coverage strategy—the Medicaid expansion—has worked out well where it has been carried out, but it has been even more vulnerable to red-state opposition. As a result of its dependence on state governments, Medicaid has always had drawbacks as a basis for universal coverage. Before the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, however, Congress could gradually ratchet up Medicaid mandates in the confident expectation that states would go along rather than give up all federal Medicaid funds. The Court's 2012 decision has not only enabled nineteen states to reject the expansion but also has given Republicans their own ratchet in the other direction. If Republicans in Congress reduce Medicaid mandates for the states, Democrats cannot later raise them back up without possibly running afoul of another court ruling. Waivers for work requirements and court decisions weakening the individual Medicaid entitlement could further weaken Medicaid's guarantee of coverage. With more than 70 million beneficiaries, Medicaid will remain central to health care finance. But if Democrats are going to make another push for a universal program, they are going to need a foundation for policy that is truly national in reach. Fortunately for Democrats, since Medicare already exists, they don't need to create a new national policy framework from scratch.

From a political and economic standpoint, the fundamentals favor Medicare as a platform for both expanding coverage and containing costs. With no veto point at the state level, the program does not suffer from the limitations that right-wing power in the states creates for both Medicaid and the ACA's state-based marketplaces. Medicare enjoys greater public support than the ACA does, and it has a stronger legal foundation as an entitlement than Medicaid. Compared with Medicaid recipients and enrollees in the ACA marketplaces, Medicare beneficiaries face relatively few limits on choice of provider and are not only generally satisfied with their coverage but also well organized to protect it. Primarily because Medicare has a system of administered prices, costs in the Medicare program have risen more slowly than in the non-Medicare private market.

While Medicare is a complicated program, expanding Medicare to include more people is not complicated to explain. There is, however, one source of potential confusion: the tendency of many people, particularly on the left, to conflate Medicare and a "single-payer" system. As a result of the growth of Medicare Advantage plans, Medicare today is a marketplace, not a single payer; currently, about one-third of beneficiaries use the program to buy private coverage.

The Medicare marketplace differs from the ACA's marketplaces in three key respects that make it an attractive basis for expanded coverage. First, Medicare has a dominant public plan, large enough to ensure that nearly all providers accept its patients, who consequently do not face the relatively narrow networks typical of plans in the ACA marketplaces. Second, public Medicare is more than an option for beneficiaries; its costs also determine the basis (or "benchmark") for determining how much beneficiaries pay for Medicare Advantage plans. Beneficiaries pay higher premiums for a Medicare Advantage plan whose costs exceed the public Medicare benchmark in an area, and they pay lower premiums or receive more benefits when they enroll in a Medicare Advantage plan whose costs fall below the benchmark. In contrast, in the ACA marketplaces, the benchmark for determining how much consumers pay in premiums is the area's second-lowest-cost silver plan. But whereas silver-level plans cover only 70 percent of average expected costs, public Medicare provides coverage equivalent to the gold level (80 percent actuarial value). The pressures in the two marketplaces have produced dramatically different levels of protection. While the Medicare market has guaranteed gold-level coverage, the structure of the ACA market has pushed 92 percent of consumers into plans at the silver and bronze levels (Kaiser Family Foundation 2016).

Third, the Medicare program as a whole has effectively regulated prices paid to providers. Medicare rules bar balance billing (above Medicare rates) not only for seniors who choose public Medicare but also for those who choose a Medicare Advantage plan and use an out-of-network provider. The cap on out-of-network provider rates then limits what in-network providers can demand from insurers since they have an incentive to offer price concessions in return for greater volume. Price discipline on both the public and private sides of Medicare has thereby accomplished for seniors what the private sector has been unable to do for the under-sixty-five population. Unlike the rest of the US health care system, the Medicare marketplace resembles European health insurance systems that have multiple payers but more uniform, regulated rates of provider payment.

All these considerations argue for building on the Medicare framework, which is a different idea from building on Medicare's public plan alone. Nationally, and especially within the Democratic Party, there is strong support, at least as registered in opinion surveys, for "Medicare for all," though what people understand by that phrase is unclear. Some prominent figures such as Senator Bernie Sanders use it as a synonym for a national single-payer system that would eliminate private insurance, even though the Medicare program does not fit that description. In practice, state campaigns

for single-payer proposals have not fared well. In 1994 a single-payer referendum in California was defeated by a margin of 73 percent to 27 percent; in 2002, another such referendum in Oregon was rejected 79 percent to 21 percent; and in 2016, a third such referendum in Colorado lost by a margin of 80 percent to 20 percent (McDonough 2017). Vermont was never able to carry out a single-payer plan approved by its state legislature because of the magnitude of the taxes required. The appeal of single-payer proposals has typically faded once the critics are able to focus public attention on the up-front fiscal costs.

Advocates of Medicare for all—whether Medicare is defined as Medicare's public plan alone or as the Medicare program as it now exists—face several huge political obstacles. Even with net savings from reduced bureaucracy and reduced provider payments, a universal Medicare program would require a larger increase in taxes than ever enacted in peacetime. Yet many Americans—seniors, veterans, and employees with good health plans—already enjoy generous coverage and would see those new taxes as an added burden. Reformers may try to persuade people with employer-sponsored insurance that their wages would rise once taxes pay for health care, but that requires a difficult calculation for people to make, plus faith that employers will pass along all of their savings. Ending all private insurance would create a storm of opposition from both the protected public and a mobilized health care industry, which would see single payer as a mortal threat.

In addition, many seniors see Medicare as their program, and they fear—or can be made to fear—that extending the program to others will jeopardize their own health care. In the social insurance framework, Medicare is an earned benefit, and it is not surprising that many beneficiaries have drawn the lesson that Medicare should not be extended to people who have not earned it as they have.

There is a way, however, to expand access to Medicare that is more fiscally and politically manageable, would not set off institutional shocks, and should be acceptable to seniors. This more manageable step is to create a new part of Medicare for people fifty to sixty-four years old who do not have employer-provided insurance but have paid Medicare taxes and thereby earned eligibility for early access to the program. Other versions of this idea have called for a Medicare buy-in for people variously between the ages of fifty or fifty-five and sixty-four; the term *buy-in* suggests an option entirely financed by premiums. In contrast, the Midlife Medicare program I am envisioning would be conceived more broadly and financed with general revenue as well as premiums.

The rationale for Midlife Medicare rests on several moral and political considerations. The onset of health problems in midlife makes access to affordable insurance particularly important in those years; mortality and morbidity rates have been rising for Americans in midlife, especially for non-Hispanic whites with a high school education or less (Case and Deaton 2015). The difficulties that health care costs pose for older adults makes all the more objectionable the changes to the nongroup market being pushed by Republicans, which, as already mentioned, would put older adults particularly at risk.

Policy proposals are properly judged in part on the basis of how understandable they are and what they communicate symbolically; ordinary citizens will not have to master the intricacies of health policy to understand what Midlife Medicare means and the concerns it addresses. Seniors would be likely to support the idea; according to an April 2017 survey, 71 percent of seniors approved of a Medicare buy-in, compared to 82 percent for all age groups (Economist/YouGov Poll 2017: 83). Moreover, AARP welcomes as members all Americans fifty or more years of age and treats them as a single constituency (one reason to set the eligibility age at fifty rather than fifty-five). Midlife Medicare would have clear value not only to those who enroll in it but also to those who initially do not. Americans who continue to have employer coverage will have the assurance that if they need to retire early, they will have health insurance as good as they would now obtain at age sixty-five. Younger people would see Midlife Medicare, like Medicare itself, not just as a benefit to others but as a program eventually of benefit to themselves. In addition, by pulling the fifty- to sixty-four-year-olds out of the individual insurance pool, Midlife Medicare would make coverage for the population under age fifty substantially cheaper. Removing older adults from the individual market would accomplish the same goal of reducing premiums for twenty-year-olds that the wider age rating in Republican legislation was supposed to accomplish, but without the devastating impact on sixty-year-olds.

In 1998, President Clinton proposed a Medicare buy-in with a dual structure for premiums. Under the proposal, individuals sixty-two to sixty-four years old without employer coverage would have paid only $300 a month while enrolled and then an extra $10 to $20 a month for Medicare Part B after they reached sixty-five. Those who bought into Medicare between ages fifty-five and sixty-one would have paid a premium, estimated by the Clinton administration at the time to be about $400, sufficient to offset their entire cost (Broder 1998). In 2008, CBO costed out a Medicare buy-in for sixty-two- to sixty-four-year-olds who did not have

employer-sponsored insurance or Medicaid. Anticipating adverse selection, CBO projected monthly premiums of $633 on the assumption that those premiums would fully cover actuarial costs plus 5 percent for administration (CBO 2008).

Recent buy-in proposals have also structured Medicare buy-ins to be budget neutral, but these proposals now factor in the income-related subsidies that the ACA provides for marketplace plans. In 2017, Senator Debbie Stabenow of Michigan introduced a bill that would enable individuals at age fifty-five to apply the ACA premium credits toward coverage in Medicare Parts A, B, and D or in a Medicare Advantage plan (S. 1742, Medicare at Fifty-Five Act, 2017). Premiums paid by enrollees would be based on actuarial costs for the enrolled fifty-five- to sixty-four-year-olds, less the ACA premium credits. In the House, three Democrats have proposed a buy-in starting at age fifty that would allow individuals to enroll even if they are eligible for employer-sponsored insurance; under their bill, employers could contribute to Medicare buy-in premiums for their workers (H.R. 3748, Medicare Buy-in and Health Care Stabilization Act, 2017). CBO has not projected premiums under either of these bills.

The difficulty with budget-neutral proposals of this kind is that the premiums for a buy-in for fifty- to sixty-four-year-olds may turn out to be very expensive because of adverse selection. Allowing discretionary enrollment by employees with access to an employer plan would exacerbate that problem. At least at the beginning, eligibility for Midlife Medicare ought to be limited to fifty- to sixty-four-year-olds who do not have and are not eligible for qualified group coverage or Medicaid. The enrollment in Midlife Medicare would come primarily from the nongroup market and the uninsured population in states that have not expanded Medicaid. In view of experience under the ACA, Midlife Medicare is not likely to lead employers in significant numbers to drop their health plans, and since employers are legally barred from discriminating against employees on the basis of age, they could not drop coverage selectively for older workers. Midlife Medicare would serve as an alternative to the ACA marketplaces for older adults; as in other Medicare buy-in proposals, the new program would be a separate risk pool from both "senior" Medicare and the nongroup market, and it would not draw on the Medicare trust funds. But as in Medicare, premiums for private Medicare Advantage plans would be based on a public Medicare plan benchmark, not the second-lowest-cost silver plan in the area; all current Medicare rules regarding providers and provider payment would apply. Public funding would consist of the ACA premium credits (scaled up to an 80 percent actuarial value Medicare

benchmark) and cost-sharing reductions, plus general revenues to offset adverse selection, which could be in the form of a reinsurance fund. In addition, the provisions for Midlife Medicare could eliminate the ACA's cliff at 400 percent of the poverty level, capping premiums for all enrollees at 9 percent of income. The basic concept would be to create a program with the features that have made Medicare attractive to the middle class as well as the poor and kept costs per enrollee under control.

As a result of the repeal of the individual mandate, enrollees might try to dart in and out of the program for coverage of large medical expenses, aggravating adverse selection. One way to limit that risk would be to require enrollees in Midlife Medicare to sign an agreement to maintain coverage in the program until age sixty-five, with a list of defined exceptions such as financial hardship or enrollment in a group plan as a result of a change in employment. If an enrollee dropped coverage without satisfying any of the exceptions, unpaid premiums for Midlife Medicare could be recaptured through later adjustments to Social Security benefits.

Midlife Medicare could draw support both from those who see it as a first step toward Medicare for all and from those who see it as a valuable but delimited program in its own right. There is more than one way to build on Medicare. The Midlife Medicare model could be extended either by reducing the age of eligibility or by extending elements of the program to the other segments of the health insurance market. Even without extending Medicare coverage or the public Medicare plan, reforms could extend the scope of Medicare's provider rates. Medicare already regulates provider payment in private insurance, that is, in Medicare Advantage. Applying that same regime to plans in the ACA marketplaces—capping payment to out-of-network providers at Medicare rates, effectively limiting what in-network providers can demand—could help control costs in the nongroup market, even if the caps were set at a somewhat higher level than Medicare, as Song (2017) and Holahan and Blumberg (2018) have proposed. Extending the Medicare rate-setting system to out-of-network providers in all private insurance plans would achieve much of the savings from a single-payer system.

While Midlife Medicare would not be the preferred policy of private insurers, it would not threaten to nationalize the industry as single-payer models would. Insurers have a profitable Medicare business; Midlife Medicare would no doubt be more acceptable to them if it provided access only to Medicare Advantage plans (as called for in some Medicare buy-in proposals in the past). But after the ACA experience, Democrats cannot repeat the mistake of creating marketplaces without a strong public plan.

Although some hospitals and other providers would lose revenue as a result of shifts of patients from non-Medicare private insurers to public Medicare or Medicare Advantage, they would also benefit from Midlife Medicare's coverage of patients who would otherwise be uninsured or paid for at lower rates by Medicaid.

Midlife Medicare would raise many other questions of policy design beyond the scope of this article. My aim here has been only to suggest a general direction for a rebound strategy that, like those in the past, would take account of political reverses, counterreforms, and institutional change. Although health policy in the United States has been path dependent, that does not mean it is condemned to follow only one path. When Democrats enacted Medicare and Medicaid in 1965, they opened two paths for pursuing universal coverage. After initially expecting to take the Medicare route, they turned to Medicaid from the 1980s to early 2000s and then adopted a model invented by conservatives when they made the individual mandate a lynchpin in the ACA's reformed individual market. Now, in the wake of setbacks under Trump, they can return to Medicare.

As Democrats look for answers to Republican counterreforms, a variety of ideas will no doubt be on the table. Much will depend on the timing of a Democratic return to a measure of national power and other demands for resources in the wake of Republican tax and budget cuts and neglect of such issues as climate change. Many Democrats will support Medicare for all, while others will want to restore as much of the ACA as they can. I am proposing Midlife Medicare not as the sum total of desirable new policies for health care but as a focal idea in a rebound strategy that would necessarily have other elements. Midlife Medicare offers the opportunity to shift reform to a more satisfactory and ultimately more durable institutional framework and to rebound from the setbacks of the Trump presidency.

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References

Berenson, Robert A., Paul B. Ginsburg, Jon B. Christianson, and Tracy Yee. 2012. "The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed." *Health Affairs* 31: 973–81.

Blumberg, Linda J., and John Holahan. 2017 "Stabilizing and Strengthening ACA Nongroup Markets." Urban Institute. September 30. www.urban.org/research/publication/stabilizing-and-strengthening-aca-nongroup-markets.

Blumenthal, David, and James A. Morone. 2009. *The Heart of Power: Health and Politics in the Oval Office*. Berkeley: University of California Press.

Broder, John M. 1998. "Clinton Proposes Opening Medicare to Those Fifty-Five to Sixty-Five." *New York Times*, January 7.

Case, Anne, and Angus S. Deaton. 2015. "Rising Morbidity and Mortality in Midlife among White Non-Hispanic Americans in the Twenty-First Century." *Proceedings of the National Academy of Sciences of the USA* 112, no. 49: 15078–83.

CBO (Congressional Budget Office). 2008. *Health Care*. Vol. 1 of *Budget Options*. December. Washington, DC: CBO.

CBO (Congressional Budget Office). 2017a. "Cost Estimate: HR 1628, American Health Care Act of 2017." May 24. Washington, DC: CBO.

CBO (Congressional Budget Office). 2017b. "Repealing the Individual Health Insurance Mandate: An Updated Estimate." November. Washington, DC: CBO.

DiJulio, Bianca, Ashley Kirzinger, Bryan Wu, and Mollyann Brodie. 2017. "Data Note: Americans' Challenges with Health Care Costs." Henry J. Kaiser Family Foundation, March 2. www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/.

Economist/YouGov Poll. 2017. April 2–4. d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/divhts7l9t/econTabReport.pdf.

Holahan, John, and Linda J. Blumberg. 2018. "Capping Provider Payment: An Alternative to a Public Option." *American Prospect*, Winter, 70–71.

Kaiser Family Foundation. 2016. "Marketplace Enrollment by Metal Level." March 31. www.kff.org/health-reform/state-indicator/marketplace-enrollment-by-metal-level/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Kaiser Family Foundation. 2017. "Kaiser Health Tracking Poll: The Public's Views on the ACA." November 17. www.kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&group=Age::18-29::30-49::50-64.

Marmor, Theodore R. 2000. *The Politics of Medicare*. New York: Aldine de Gruyter.

McCarthy, Justin. 2017. "U.S. Women More Likely than Men to Put Off Medical Treatment." Gallup News, December 6. news.gallup.com/poll/223277/women-likely-men-put-off-medical-treatment.aspx.

McDonough, John E. 2017. "Questions for New Single-Payer Advocates." *Milbank Quarterly*, October. www.milbank.org/quarterly/articles/questions-new-single-payer-advocates/.

Norris, Louise. 2017. "Ten Ways the GOP Sabotaged Obamacare." healthinsurance .org, May 17. www.healthinsurance.org/blog/2017/05/17/10-ways-the-gop-sabotaged -obamacare/.

Obama, Barack. 2016. "United States Health Care Reform: Progress to Date and Next Steps." *Journal of the American Medical Association* 316, no. 5: E1–8.

Pear, Robert. 2017. "Obamacare Sign-ups at High Levels Despite Trump Saying It's 'Imploding.'" *New York Times*, December 27.

Rosenbaum, Sara. 2017. "Weakening Medicaid from Within." *American Prospect*, Fall, 17–19.

Song, Zirui. 2017. "Using Medicare Prices—Toward Equity and Affordability in the ACA Marketplace." *New England Journal of Medicine* 377, no. 24: 2309–11.

Starr, Paul. 2013. *Remedy and Reaction: The Peculiar American Struggle over Health-Care Reform*. New Haven, CT: Yale University Press.

Starr, Paul. 2015a. "Built to Last? Policy Entrenchment and Regret in Medicare, Medicaid, and the Affordable Care Act." In *Medicaid and Medicare at Fifty: America's Entitlement Programs in the Age of Affordable Care*, edited by Alan B. Cohen, David C. Colby, Keith Wailoo, and Julian E. Zelizer, 319–31. New York: Oxford University Press.

Starr, Paul. 2015b. "The Health-Care Legacy of the Great Society." In *LBJ's Neglected Legacy: How Lyndon Johnson Reshaped Domestic Policy and Government*, edited by Norman J. Glickman, Laurence E. Lynn, and Robert H. Wilson, 235–58. Austin: University of Texas Press.

Starr, Paul. 2017. *The Social Transformation of American Medicine*. Updated ed. New York: Basic Books.

Zammitti, Emily P., Robin A. Cohen, and Michael E. Martinez. 2017. "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–March 2017." August. www.cdc.gov/nchs/data/nhis /earlyrelease/insur201708.pdf.