The Rise & Future of Medicare for All: Advancing the Single-Payer Movement in the 21st Century

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THE RISE & FUTURE OF MEDICARE FOR ALL:

ADVANCING THE SINGLE-PAYER MOVEMENT IN THE 21st CENTURY

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The Rise & Future of Medicare for All:

Advancing the Single-Payer Movement in the 21st Century

Abstract

The U.S. health care system's lack of universal health insurance coverage and health security, combined with rapidly rising costs, have contributed to growing calls for health reform (Jones & Reinhart, 2018). Moreover, this sense of urgency is juxtaposed with a long history of reform failures, incremental approaches, and public mistrust in government interventions. Against this historical backdrop, to the surprise of many health policy-making stakeholders, a single-payer Medicare for All plan emerged as a serious policy topic debated by experts, presidential candidates, and legislators throughout 2019.

The goal of this thesis is to analyze why and how this occurred, and how to maintain support and build political momentum for Medicare for All in order to propel it towards a policy window. The problem statement underlying this thesis is: attempts for a single-payer policy have persisted and failed for more than a century, so a deeper understanding of the factors contributing to Medicare for All's current rise in prominence is needed to sustain its momentum. Understanding how Medicare for All has reached a window of opportunity and the state of the political environment for health reform enables identifying barriers and developing strategies to address these barriers.

This thesis uses John W. Kingdon's Multiple Streams Framework (MSF) to explain how a policy proposal gains traction and rises up the policy agenda. The methods used to provide context and analysis of the three streams and the current window of opportunity include 1) a quasi-ethnography

analysis, which is a qualitative method used to capture naturalistic observations by acting as a participant-observer for the policy process of Medicare for All; 2) a stakeholder network analysis of the Medicare for All Coalition; and 3) a series of key informant interviews with stakeholders of varying levels of support for Medicare for All. Political recommendations and strategies for future progress on Medicare for All were developed using a stakeholder commitment matrix and an analysis of political factors through the Kingdon's Multiple Streams model.

While similar single-payer proposals have failed to gain considerable traction in the past, the recent push for Medicare for All is unique in the scale of its grassroots movement and the level of its legislative and political consideration. Therefore, the conclusion of this analysis is that even if this particular attempt does not succeed, single-payer will continue to be offered as a policy solution until it is achieved.

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DISCLAIMER

The views, analysis, and conclusions presented in this paper are those of the author in their academic capacity and perspective of events. This document does not represent the official position or views of the Member or staff in the Office of Congresswoman Jayapal, nor the organizations or individuals who participated in the surveys and interviews. This paper is not an official governmental document.

CHAPTER 1: INTRODUCTION

The more than century-long history of health reform attempts in the United States is comprised of a few notable successes, many compromises, and several failures. The idea of a single-payer national health insurance program— one in which a single public agency provides financing for covered health care services (Christopher, 2016)— has often been a part of the political conversations across those many attempts. Despite favorable political conditions, universal single-payer policy has been consistently rejected. For example, in 1945, President Truman, whose political party held large majorities in both chambers of Congress, campaigned on a single-payer proposal. However, he faced mass organized resistance from key stakeholders, such as physician and hospital associations, labor unions, and insurers. The opposition issued warnings of socialism, government control, tax hikes, and poorer quality medical care— warnings that would continue to face every following major health reform attempt. The last major attempt at a single-payer policy dates back to a plan championed by Senator Edward Kennedy (MA) in 1971; it garnered little success, perpetuating the sentiment that a single-payer system was politically unviable in the United States.

Nevertheless, single-payer policy, rebranded as Medicare for All, has re-emerged alongside a social movement with considerable political attention following Senator Sanders's (VT) 2016 presidential run. By the 2018 mid-term election, health care became the top issue for voters, and a unique window of opportunity emerged when the Democratic Party regained control of the U.S. House of Representatives. Democrats, now able to decide the legislative agenda for the first time in ten years, offered Representative Pramila Jayapal, the lead sponsor of the Medicare for All bill

in the House, an opportunity to capitalize on this moment and gain unprecedented legislative, public and political support for a single-payer policy.

From February 2019 to February 2020, I undertook this doctoral project through a fellowship placement in the Office of Representative Jayapal. Serving as a health policy staffer, I was the main intermediary between the Medicare for All Coalition[1] and the Representative. My duties included executing various legislative actions and political strategies to expand congressional and public support for the bill, in conjunction with the supporting interest groups. This fellowship afforded me an intimate perspective on how this single-payer legislation was produced and promoted inside and outside of Congress. I documented my first-hand experience in the policy process and performed additional analyses by mapping the involved actors and engaging in qualitative interviews to understand perspectives on the political climate for health reform from stakeholders across the health policy spectrum.

My analysis was guided by the following questions:

1) How did Medicare for All gain further legislative, public, and political consideration?

2) Can the Medicare for All Coalition and political champions maintain its momentum within and outside Congress, and if so, how?

Through my personal observation and participation in the promotion of Medicare for All, I experienced the many successes, failures, and challenges of pushing single-payer policy. This offered me a unique perch to probe even more deeply in understanding the political factors contributing to or halting its progress. Therefore, the thesis's overarching goal is to provide a

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[1] The Medicare for All Coalition represents a diverse constituency of providers, nurses, labor unions, business owners, think tanks, and progressive advocacy organizations that support Medicare for All, meet monthly and work in coalition with one another. The coalition's members are analyzed in Chapter 4.

roadmap of what has been achieved so far, specifically through the Office of Representative Jayapal, and to deliver concrete recommendations and considerations for advocates and political champions to maintain and further momentum for Medicare for All.

This thesis uses John W. Kingdon's Multiple Streams Framework (MSF) to explain how a policy proposal gains traction and rises up the policy agenda. The model describes "windows of opportunity" that occur when there is a confluence of a societal problem, a policy solution, and political will. Kingdon describes these factors as three metaphorical streams related to the *problem, the policy, and the politics*. When all three streams align, a *policy window* is opened that can lead to policy change. When at least two of the streams align, other windows can open, such as a *problem window,* which occurs when the problem and policy stream converge. A *problem window* allows legislators to offer their policy as a solution to the problem and build further support (J. Kingdon, 1984).

Using the Kingdon Framework as a lens on the Medicare for All proposal, this thesis describes the deficiencies of the U.S. health care system that led it to be perceived as a societal problem (*problem stream*). It then analyzes how a window of opportunity (*problem window)* was activated by examining the environment in which the Medicare for All legislation (*policy stream*) was offered as a solution for the identified problem. This thesis further contextualizes the *policy stream* by analyzing the policy process and actions conducted by the Office of Congresswoman Jayapal and the Medicare for All Coalition. Then, it examines the current political climate as perceived by health reform stakeholders (*politics stream*) and determines the various enablers and barriers for Medicare for All's progress.

As similar single-payer proposals have failed to gain considerable traction, Medicare for All advocates and political champions need to understand the various enablers, barriers, and conditions of the current window of opportunity and the political levers that can be pulled or altered in order to continue momentum and be ready when the next policy window for health reform opens.

The methods used to provide context and analysis of the three streams and the current window of opportunity include 1) a quasi-ethnography analysis[2], which is a qualitative method used to capture naturalistic observations by acting as a participant-observer for the policy process of Medicare for All; 2) a network analysis of the Medicare for All Coalition; and 3) a series of key informant interviews with stakeholders of varying levels of support for Medicare for All. Political recommendations and strategies for future progress on Medicare for All are developed using a stakeholder commitment matrix[3] and an analysis of political factors through the Kingdon's Multiple Streams model.

The thesis is organized into six chapters. Chapter 1 serves as the introduction. In Chapter 2, the analytical platform starts with the problem statement which details the motivation for the thesis work, followed by an expanded explanation of the project design and the Kingdon framework. Then it provides a historical overview of health reform that led to the formation of the *problem stream* and the confluence of factors that contributed to the potential of a *problem window*.

Chapter 3 analyzes the opening of the *problem window,* by examining the Medicare for All "policy community" (the participants involved in the process of agenda-setting), the policy creation

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[2] Quasi-ethnography is an organized study, within a specific timeframe, of the perspectives, beliefs, and actions held by groups of people. (Murtagh, 2007).

[3] A stakeholder commitment matrix can be used to gauge present level of a stakeholder's commitment to a project, And the level of commitment needed to for success (Rath & Strong Management Consultants et al., 2002)

process of the Medicare for All legislation within the office of Representative Jayapal, and the policy actions that strengthened the *policy stream* and enabled it to couple with the *problem stream*.

Chapter 4 provides an analysis of the *politics* stream based on an analysis of the "Medicare for All Coalition" and qualitative review from key informant interviews with health policy-making stakeholders. The stakeholder analysis shows the network and relationships across the stakeholders, as well as a detailed layout of the influence, power, and strategic priorities of the groups involved. The qualitative analysis details significant themes and trends captured from stakeholders about the current political environment for health reform.

Chapter 5 provides recommendations, strategies, and identifies the barriers and enablers of Medicare for All for interest groups and policymakers to achieve further progress towards a policy window.

Chapter 6 summarizes the main results of Chapters 2 to 5 and discusses the broader implications of my findings.

CHAPTER 2: ANALYTICAL PLATFORM

2.1 Problem & Motivation Statement

The U.S. health care system's lack of universal health insurance coverage and health security, combined with rapidly rising costs, have contributed to growing calls for health reform (Jones & Reinhart, 2018). Moreover, this sense of urgency is juxtaposed with a long history of reform failures, incremental approaches, and public mistrust in government interventions. Against this historical backdrop, to the surprise of many health policy-making stakeholders, in 2019, a single-payer Medicare for All plan emerged as a serious policy topic debated by experts, presidential candidates, and legislators.

The goal of this thesis is to analyze why and how this occurred, and how to maintain support and build political momentum for Medicare for All in order to propel it towards a policy window. The problem statement underlying this thesis is: attempts for a single-payer policy have persisted and failed for more than a century, so a deeper understanding of the factors contributing to Medicare for All's current rise in prominence is needed to sustain its momentum. Understanding how Medicare for All has reached a window of opportunity and the current state of the political environment for health reform enables identifying barriers and developing strategies to address these barriers.

2.2 Thesis Project

2.2.1 Purpose & Design

From February 2019 to February 2020, the Office of Representative Pramila Jayapal, where I served as the Health Policy Fellow, was the host organization for my thesis project.

Congresswoman Jayapal is the Representative of Washington State's 7th Congressional District, co-chair of the Congressional Progressive Caucus (CPC), and the lead sponsor of H.R. 1384, *The Medicare for All Act of 2019.* She is a second-term Congressmember who previously founded an advocacy group for immigration reform and is known for translating her organizing skills into political strategy. As the lead health policy staffer for Representative Jayapal, I was tasked to help introduce the Medicare for All bill into the 116th Congress and act as the main intermediary between outside interest groups and the Office to organize and execute policy actions.

This role afforded me a first-hand perspective of how the single-payer legislation was produced and promoted in Congress. My duties included executing various legislative actions and political strategies, in conjunction with the Medicare for All Coalition, to expand congressional and public support for the bill. My fellowship was sponsored through the Congressional Progressive Caucus Center (CPCC), an independent entity (501(c)(3)) whose mission is to leverage the power of the Congressional Progressive Caucus, inside Congress, by creating critically needed infrastructure within the progressive community. The fellowship was intentionally designed for early to mid-career professionals with expertise in a policy area, commitment to progressive values, and no previous work experience on the Hill, so they could gain an immersive experience in federal policymaking.

2.2.2 Thesis Aims & Overview of Methodology
Aim #1. Provide an account of Medicare for All's policy and legislative process

The Office of Representative Jayapal served as the host entity for my doctoral project, where I analyzed the policy and legislative process for Medicare for All. I used a quasi-ethnography approach to capture naturalistic observations by acting as a participant-observer for the policy

process for Medicare for All. Quasi-ethnography is an organized study, within a specific timeframe, of the perspectives, beliefs, and actions of groups of people. The purpose of the quasi-ethnography is to explore the components and capture the "micro-level" context of the policy creation and building of legislative support for Medicare for All. As a participant observer in the policy development process, I was able to collect and study my observations and experiences to describe and analyze how Medicare for All became a proposed policy solution that gained further legislative support. (DeWalt & DeWalt, 2011; Murtagh, 2007).[4]

Aim #2. Examine the current political climate for Medicare for All by assessing the power and influence of the Medicare for All Coalition and the broader attitudes and beliefs across the spectrum of support of key health policy stakeholders

I sent a survey to members of the Medicare for All Coalition and used their responses to construct a stakeholder analysis matrix and a network analysis map. "Network mapping" can serve as a tool for 1) identifying stakeholders to include in environmental policy and planning processes; 2) evaluating the potential for communication, collaboration, and problem-solving among stakeholders; and 3) increasing understanding of the social landscape in which environmental decisions are made (Prell, 2012).[5]

Then, I conducted key informant interviews with stakeholders in the health policy-making community. Key informant interviews, qualitative in-depth interviews with people who are

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[4] Refer to Section 3.2 for full methodology.
[5] Refer to Section 4.2 for full methodology.

considered most knowledgeable about their community, can provide insight into the nature of problems and give recommendations for solutions.[6]

Aim #3. Deliver political recommendations, strategies, and identification of the enablers and barriers for sustaining and furthering Medicare for All's momentum towards a policy window.

Based on input from the quasi-ethnography, key informant interviews, and a Kingdon MSF analysis, I constructed recommendations and strategies. The recommendations included a stakeholder commitment matrix to determine where various stakeholders are currently in their level of support for Medicare for All, and where they ideally need to be to aid in its passage. By using a stakeholder analysis to identify the key actors and their positions, interests, alliances, and importance related to the policy, policymakers can more effectively engage with them to boost support for a given policy or program, and anticipate opposition and prevent potential misunderstandings (Schmeer, 2000).[7]

2.3 Theoretical Framework

Kingdon Multiple Streams Framework Model

This thesis utilizes the Kingdon MSF model to parse the particular components and influencing factors affecting Medicare for All's political journey. Kingdon developed the MSF model using interviews and documents to explain how agendas are set within the U.S. federal government (J. W. Kingdon, 2003). Kingdon's theory has been used frequently to analyze policy processes, especially in relation to health reform.

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[6] Refer to Section 4.4 for full methodology.
[7] Refer to Section 5.2 for full methodology.

According to the Kingdon MSF model (refer to Figure 1), the *problem stream* is defined as an issue's current condition that does not match the public's values and perception of their ideal state. Specifically, "for a condition to be a problem, people must become convinced that something should be done to change it." The *policy stream* is the existence of a policy solution. The policy has usually been tested at either the state or local level of government and can be replicated. The *politics stream* refers to the factors and events, such as legislative turnover, changes in administrations, and shifts in national mood, that can influence the body politic. Typically, high-level participants, such as Congressmembers, the President, and other high-profile administrators, are leading changes to the agenda. The policy stream is distinct from the political stream because rather than focus on the concepts of power, influence, and pressure, which affect what ideas will be acted upon in the political stream, the policy stream participants focus on the content of the ideas and growing legislative support (J. W. Kingdon, 2003).

Kingdon asserts that these three streams flow along different channels and usually remain independent of one another until certain circumstances when the streams intersect. The act of linking, or crossing between streams, is coined as *coupling*. When issues occur under favorable political circumstances and converge with an existing policy solution— in other words, when the problem, policy, and political streams couple— there is a window of opportunity during which policies are much more likely to gain visibility and traction, and to be accepted as part of the current policy agenda. This is known as the *policy window*.

Figure 1. Kingdon Multiple Streams Framework
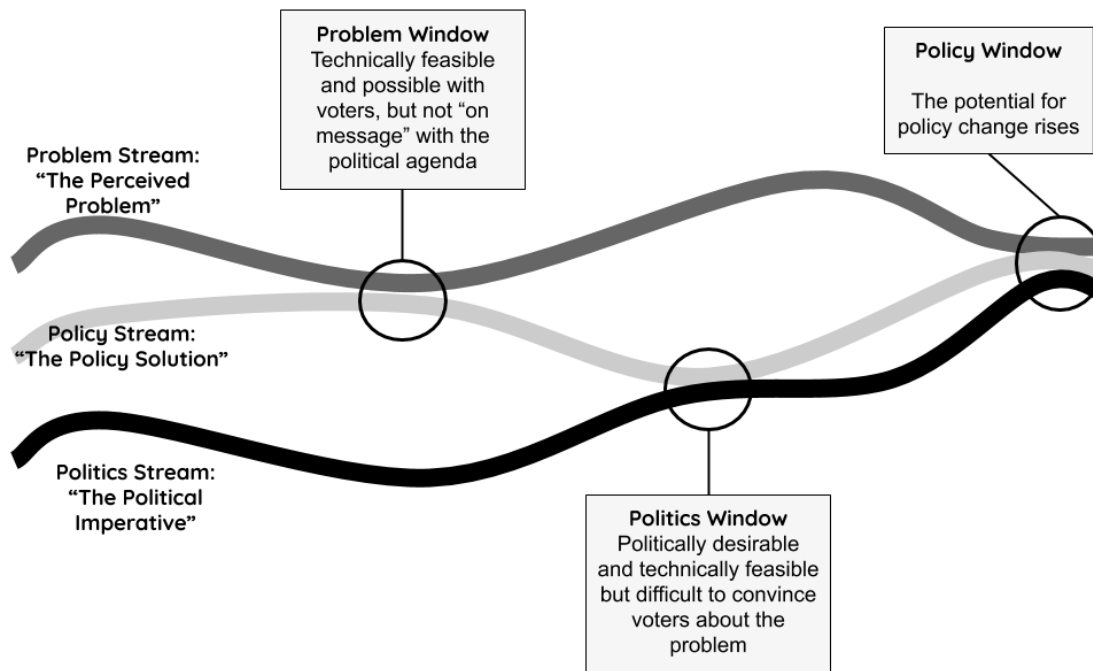
Source: Adapted from (J. Kingdon, 1984)

Kingdon maintains that the coupling of streams develops rather randomly and unpredictably, and *policy entrepreneur*s must be ready to act when these windows open since they are only open for a short period and do not open frequently (J. W. Kingdon, 2003). Policy entrepreneurs are individuals, such as politicians, lobbyists, advocates, academics, and civil servants, who invest resources to introduce and promote their policy idea as a policy solution that should be taken seriously on the decision agenda. Policy entrepreneurs should prepare policy solutions well in advance and be alert to windows of opportunity to push their proposals for the policy community, including actors inside and outside of government who generate and specify policy ideas and alternatives.

 For a policy idea to be taken up by the policy community, it must go through a process of policy actions that Kingdon calls "*softening up*" by the policy community and other actors. Softening up

actions aim to prepare and educate both the public and the policy community and require vital resources from policy entrepreneurs. Kingdon labels the first vital resource as a "*claim to a hearing*," which means that a policy entrepreneur has the positioning to speak for others or make decisions. The second resource regards "*political negotiating or bargaining*," which involves a combination of political know-how and technical expertise. The third, labeled by Kingdon as the most important resource, is "*sheer persistence*," which means that actors strongly advocate their ideas through many formats and in several settings and invest substantial resources to promote their policies (Kingdon, 1995).

Windows close if policy entrepreneurs stop investing their resources in gaining acceptance of that policy, if a problem has been addressed or solved, or if the conditions that opened the policy window cease to exist, or if policymakers were unable to reach a compromise (Kingdon, 1995).

2.4 Relevant Literature in Health Reform

"*At present the United States has the unenviable distinction of being the only great industrial nation without compulsory health insurance.*"

Irving Fisher, Yale Economist (1916)

2.4.1. Introduction

Throughout the past century of major health reform attempts in the United States, a single-payer policy was promoted by numerous champions, with little political or legislative success. However, in recent years, a single-payer policy, more commonly known as "Medicare for All", has reached an unprecedented level of public engagement and political precedence. Medicare for All was a major topic on the 2020 Democratic Presidential Primary debate stage; polling consistently showed a majority of Americans, ranging from 51% to 70%, in favor of Medicare for All from

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March 2017 to May 2020 (KFF, 2020; L. Stein et al., 2018). To give context to the recent rise of Medicare for All, it is important to review past attempts at single-payer legislation and the relevant history in which health reform has taken place.

First, it is essential to define what is meant by the term "single-payer" and "single-payer national health insurance," a term that describes any national insurance system that is mainly or entirely financed by one entity, whether or not it includes universal coverage. Furthermore, legislators and researchers often use the term "single-payer" to describe not just insurance reform, but more comprehensive adjustments across the health care system functions that aim to improve access, cost containment, and quality of care (Liu & Brook, 2017). In this thesis, I utilize the term "single-payer national health insurance" to specify a type of publicly-financed health insurance program that provides near-universal coverage. The use of "single-payer" broadly refers to a system that provides a single-payer national health insurance program and includes broader health care components, unless specified otherwise.

The single-payer system is a model used in several countries, such as Sweden, Denmark, England, Taiwan, Canada, and Australia. Each of these countries is a welfare state[8] that explicitly include medical care, public health, and the broader right to health, as constitutional rights. Meanwhile, the U.S. constitution does not guarantee its citizens any health protection (Heymann et al., 2013). Furthermore, it is important to note that each country with a single-payer system has a wide range of varying designs and differing levels of the role of private insurance. For example, Canada has a decentralized national public health insurance system called Medicare, which is administered

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[8] According to Britannica, "welfare state" refers to a system "in which the state or a well-established network of social institutions plays a key role in the protection and promotion of the economic and social well-being of citizens." (Encyclopædia Britannica, 2015)

provincially, provides a relatively narrow benefits package, and allows private insurers to provide supplemental coverage for benefits not covered by Medicare (Davies, 1999). In contrast, Taiwan has a centralized national health insurance system that provides broad coverage for medical services mostly delivered through a private provider system, and a much more limited role for private insurers (Cheng, 2019).

Single-payer systems are usually financed progressively through taxes and provide governments with considerable authority over the total expenditure on health (Hussey & Anderson, 2003). Overall, single-payer systems have consistently been able to provide equitable universal health coverage, contain costs, and streamline administrative processes (Cheng, 2019). In contrast, the U.S. health system consists of multiple insurance payers, both public and private, that, even in the aggregate, do not provide universal coverage, lacks price regulation, and requires complex administrative processes that burden consumers and providers.

2.4.2 Historical Overview of Health Reform Attempts

This section focuses on six major health reform attempts[9], describes relevant key events, and applies the Kingdon MSF model to understand what factors broadly contributed to each success or failure. These successes and failures shaped how the U.S. healthcare system operates today and provide invaluable lessons on the barriers that future reform efforts will face—and how they might be overcome.

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[9] Only major health reform attempts that gained serious consideration were described in detail. Refer to Figure 2 for which health reform attempts were considered not serious attempts.

Figure 2. Timeline of Major Health Reform & Single-Payer Policy Attempts in the United States (1900-2010)
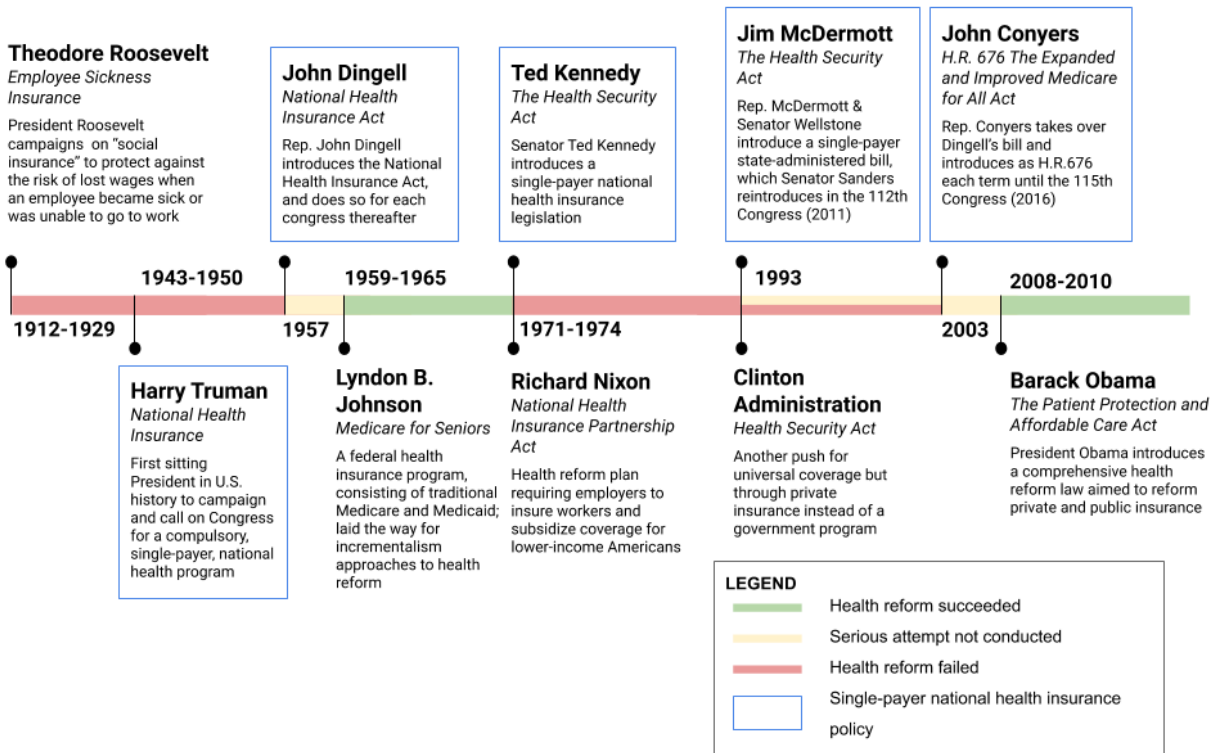
Source: Adapted from (J Oberlander & Marmor, 2015; Starr, 1982)

<u>Health Reform Champions vs. The AMA (1912-1950)</u>

At the start of the 20th century, several industrialized nations began implementing some form of a national public health insurance system. In 1911, Great Britain passed a National Health Insurance Act, under which workers, employers, and the government paid into an insurance fund that would cover costs when a worker fell ill. At that same time, the United States also debated the idea of "social insurance" to protect against the risk of lost wages when an employee became sick or was unable to work. The American Association of Labor Legislation (AALL), a progressive academic group, expanded on this idea by drafting a policy that proposed a health insurance model to cover medical expenses and lost wages, financed by workers, employers, and the government. Initially, the American Medical Association (AMA) robustly supported the proposal.

By 1917, the AMA reversed its previous position as the national climate against socialism was exacerbated by the Russian Revolution and the United States' entry into World War I. Meanwhile, the American Federation of Labor, the largest union in the country at that time, and the commercial insurance industry also denounced the idea of compulsory public health insurance. As the proposal was without a champion legislator and faced a successfully organized opposition campaign by the AMA, labor groups, businesses, and the insurance industry, it resoundingly failed. Consequently, private medical insurance started to become a profitable business as it became a "worker benefit" that included younger and healthier people into their risk pools (Hoffman, 2001; Starr, 1982).

At the brink of the Great Depression, national priorities shifted towards providing unemployment insurance and retirement benefits. Cognizant of the AMA's opposition to governmental provision of social health benefits, President Franklin D. Roosevelt decided not to include health insurance provisions in the Social Security Act of 1935, so as not to jeopardize its passage (Skocpol, 1995). Instead, President Roosevelt would have an unexpected influence on the U.S. health insurance system. During World War II, President Roosevelt instituted wage and price controls, with health benefits exempted and deemed tax-free.[10] Therefore, employers began offering health benefits as a way to attract workers. As a result, enrollment in group hospital plans tripled, which inadvertently solidified the prevalence of employer-based insurance in the U.S. health care system (Starr, 1982).

Following World War II, President Truman became the first sitting President in U.S. history to campaign for and call upon Congress to pass a compulsory, single-payer national health insurance program as part of his "Fair Deal" agenda. As a response, Senator Robert Wagner (NY), Senator James Murray (MT), and Representative John Dingell (MI) introduced 'The National Health

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[10] This tax-exempt status was confirmed by the Internal Revenue Code of 1954, signed by President Dwight Eisenhower.

Insurance Act' in 1945, the first bill to propose a compulsory medical insurance program. Although the bill initially received labor support, this shifted as unions, such as the United Auto Workers, began accepting their employers' offer to pay for health benefits and pensions. As benefits improved for workers, unions did not want to risk losing their brokered benefits as they believed they could negotiate for more moving forward.

Additionally, the AMA again opposed this effort for public health insurance. This time, backed by the American Bar Association, the American Hospital Association, the National Grange, and the U.S. Chamber of Commerce, and most of the nation's press, the AMA lobbied for voluntary and privately-provided insurance. Increasing tensions from the Cold War allowed the AMA to deploy an effective campaign around anti-communist messaging that labeled the proposal as "socialized medicine" and reinforced the notions of "freedom and choice" as American virtues that must be protected from government control (Starr, 1982). Despite President Truman's public assertions that his proposal was not "socialized medicine," the bill did not move far down the legislative process (Falk, 1973). Years after the bill was defeated, President Truman wrote:

> I have had some bitter disappointments as President, but the one that has troubled me most, in a personal way, has been the failure to defeat the organized opposition to a national compulsory health insurance program. But this opposition has only delayed and cannot stop the adoption of an indispensable Federal health insurance plan. (*The Evolution of Medicare: From Idea to Law*, 1965)

Comparing the AALL's and President Truman's health reform attempt through the MSF lens, each failure had differing contributing factors. The AALL proposal's policy stream was formed through a very technocratic process of academics without wide stakeholder buy-in and engagement and an

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underestimation of opposition by key interest groups. Its politics stream also lacked a Presidential and congressional champion, halting its potential for legislative and political progress. Meanwhile, President Truman's single-payer proposal had the necessary champions, but oppositional campaigns effectively undermined their influence and power within the administration and Congress. Shifts in national mood due to the rise in anti-socialism/communism attitudes within a postwar Congress and country also impacted the politics stream. It is also important to note that labor groups, which were key stakeholders, offered weak support and even opposition for both attempts. Specifically, for President Truman's proposal, labor support shifted as the need of a national health insurance plan became less of an issue for their constituency.

Medicare for Some

Beyond President Truman's attempt, the three streams have failed to converge for any single-payer national health insurance policy throughout U.S. history. As seen in Figure 2, from 1943 to 2003, the idea of a single-payer policy has waxed and waned repeatedly, ultimately failing to gain any considerable traction towards the national political agenda. Therefore, it was an incredible feat that the only successful health reform attempt of the 20th century included Medicare, a single-payer program. Medicare, originally designed to only provide hospital insurance for seniors, was championed by President John F. Kennedy. President Kennedy's bill failed to make it out of committee or gain significant legislative consideration as Chairman Wilbur Mills (AR), of the powerful House Ways & Means (W&M) Committee, opposed it. The policy stream became further weakened as support divided across three major proposals: 1) hospital insurance for seniors, 2) a state-based insurance program for the elderly poor, and 3) a voluntary insurance program for seniors to cover physician services.

While the policy stream was divided, the politics stream for Medicare became strongly activated by a growing grassroots effort by seniors and labor—interest groups that had not been effectively leveraged in previous health reform attempts. The politics stream was further primed by significant legislative turnover in the 1964 election that resulted in a Congress with a significant liberal Democratic majority, with Democrats gaining placements onto the W&M Committee instead of more conservative Southern Democrats. Chairman Mills, forced to consider the proposal more seriously, became a powerful policy entrepreneur for Medicare and made the stunning move of combining aspects of all three legislative proposals, therefore, streamlining the policy stream.

By restricting eligibility to the elderly (over 65 years of age), narrowing benefits to hospital and medical care, and carving out a role for private insurers, President Lyndon B. Johnson achieved a what was unattainable for the Truman administration and other reformers— passage of federal health insurance (J Oberlander & Marmor, 2015). The end result was the passage of "The Social Security Act of 1965", a federal health insurance program consisting of Medicare Part A, Part B, and Medicaid, with private insurers as fiscal intermediaries for Medicare's billing operations (Berkowitz, 2008). The bill passed by a significant majority and bipartisan support in the House (307–116) and in the Senate (70–24). Robert Ball, head of the Social Security Administration and key architect of the Medicare strategy, stated,

> We all saw insurance for the elderly as a fallback position, which we advocated solely because it seemed to have the best chance politically…we expected Medicare to be the first step toward universal national health insurance, perhaps with 'Kiddiecare' as the next step. (Ball, 1995)

Therefore, the hope was that by achieving a politically feasible level of reform, Medicare could eventually be expanded over time to all Americans (J Oberlander & Marmor, 2015). Instead, Medicare was incrementally improved and expanded over the coming decades and remained a program primarily aimed at those 65 and over, as well as those with disabilities.[11]

The Battle Between National Health Insurance Proposals

By the 1970s, the goal of implementing a national health insurance plan was shared by both Democrats and Republicans. Throughout President Nixon's administration (1969-1974), addressing health care was a top priority, in which he referred to rising health costs as a "massive crisis" (Millenson, 2018). Meanwhile, Senator Ted Kennedy led the second major movement in U.S. history for single-payer health care, by championing his bill, "The Health Security Act". President Nixon responded by introducing "The Comprehensive Health Insurance Plan" (CHIP). The two main pillars of CHIP were an employer mandate and a federally subsidized plan to replace Medicaid, which would be available to anyone not eligible for employee insurance or Medicare.

After facing significant opposition from health industry groups, Senator Kennedy sent his staffers to broker a compromise with Nixon's office. However, Senator Kennedy faced intense scrutiny from single-payer advocates who felt he already compromised too much, while President Nixon maintained opposition to a plan that did not include a role for private insurance. Soon after the failed compromise, both attempts at a national health insurance plan were halted, in large part,

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[11] In 1972, President Richard Nixon amended Medicare also to include persons with end-stage renal disease and permanent disabilities. From 1982 to 1997, changes made to Medicare included: an added hospice benefit; a program through which Medicare beneficiaries can receive benefits from a private health insurance plan; a prospective payment system for inpatient hospital services. Furthermore, President George W. Bush signed the Medicare Modernization Act (MMA), which established Part D, the prescription drug benefit, and expanded the role of private insurers through the Medicare Advantage program. (cite)

because Watergate destroyed Nixon's presidency. However, President Nixon's novel design elements continued to emerge in many subsequent proposals by both Democrats and Republicans.

The Demise of Clinton's Health Plan

By the 1990s, the next federal effort centered on expanding coverage through the private insurance industry. The politics stream for President Clinton's health reform legislation started similarly to President Johnson, as he won a landslide victory in the 1992 election and a Democratic majority in both chambers of Congress. However, that was the extent of comparability between the two efforts. President Clinton's 'Health Security Act' was developed by a Health Care Task Force[12]. The resulting proposal aimed to provide universal coverage through private insurance and maintenance of employer-sponsored coverage (KFF, 2009). Even though this approach was considered the "only politically viable" path, it was still met with fierce and united opposition led by the Health Insurance Association of America (HIAA) and the National Federation of Independent Businesses (NFIB). Small-business members of the NFIB and other business associations mobilized against the proposed employer mandate (Martin, 1997). Similarly, the AMA, the Christian Coalition, and the Tobacco Industry devoted substantial resources to oppose specific aspects of the plan. For example, AMA leadership sent a letter to its large network of doctors that they would "activate an unprecedented national network of physician," and they had "serious reservations…because it would limit choices by patients and physicians"(Pear, 1993).

The Clinton plan also faced the infamous and highly effective $20 million "Harry & Louise" television campaign.[13] The ads aimed to exacerbate uncertainties about the health plan by using

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[12] The Taskforce was chaired by First Lady Hillary Clinton and managed by presidential aide Ira Magaziner. It consisted of over 600 experts across 34 working groups (KFF, 2009).

[13] "Harry and Louise" was a year-long $20 million television advertising campaign funded by a health insurance industry lobby group known as the Health Insurance Association of America (HIAA)—now known as America's Health Insurance Plans

messaging that echoed similar anti-government sentiments around choice and freedom and inciting fears that the plan would cause people to lose their doctor. The ads included messages such as:

"Having choices we don't like is no choice at all. If they choose, we lose."

"I'm not comfortable with government-run health care."

"No Benefits Tax!"

"The government caps how much the country can spend on health care."

"I wouldn't want anybody to pick my doctor for me."

"Government monopolies."

"Rationing, waiting lines."

Republican legislators further broadcasted these types of messages as a counterstrategy to halt the plan altogether. Representative Richard Armey of Texas published a public letter in the *Wall Street Journal* stating, *"…*the Clinton plan is a bureaucratic nightmare that will ultimately result in higher taxes, reduced efficiency, restricted choice, longer lines, and a much, much bigger federal government."*, along with a flow chart to illustrate a "bureaucratic government takeover." Meanwhile, Democrats were divided on which health reform path to take. For example, Representative Jim Cooper (TN) introduced a different approach to a managed competition insurance plan, while Representative Jim McDermott (WA) and Senator Paul Wellstone (MN) introduced a single-payer policy that would provide a national health insurance system administered through states. The variety of health plans splintered the support of Democratic legislators, interest groups, and the general public.

(AHIP). The ad campaign ran from September 1993 to September 1994 in opposition to the Clinton health plan. Fourteen radio, print, and television ads were created and depicted a fictional suburban middle-class married couple distressed over various aspects of the health plan and urging viewers to call their congressional representative. (H. Johnson & Broder, 1996)

The Clinton health plan's complexity, slow legislative progress, and the uncollaborative technocratic process made it difficult to generate grassroots or movement-based support outside Congress and across health policy experts. Despite the Democrats holding the majority in both chambers of Congress, the bill was unable to gain the votes needed for passage. In reference to the Clinton plan's failure, Professor Robert Blendon, professor at the Harvard School of Public Health, stated,

> We have seen that although the "window of opportunity" might exist for major government action to address a particular policy issue, the tendency is for experts to overestimate the willingness of middle-class Americans to sacrifice and risk the uncertain consequences of major changes in their lives. Thus, if substantial reform is to be achieved during these windows of opportunity, the legislation must be more modest in its reach than many reformers may see as desirable. Finally, in designing strategies and choosing policy proposals, presidents must recognize and overcome the persistently high level of public cynicism toward government. (Blendon et al., 1995)

Lessons from Health Reform Attempts in the 20th Century

Each health reform attempt consisted of a unique combination of ideological differences, the strengths of various special interest groups, political champions, and economic conditions. These attempts were consistently faced with varying degrees of large-scale and effective organized opposition by the AMA, insurance industry, labor unions, and employers. The rare successes were achieved through significant compromise and policy design that included a role for private health insurers to minimize or neutralize these types of opposition. To analyze each major health reform

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attempt through the Kingdon MSF model, Table 1 provides the general state and conditions that contributed to or prevented a policy window.

Table 1. Kingdon Analysis of Major Health Reform Attempts in the 20th Century

Reform Attempt	Problem Stream	Policy Stream	Politics Stream	Policy Window
Roosevelt/ AALL	*Lack of social protection for wage loss and medical costs*	*Technocratic process without broad stakeholder engagement*	*(-) Lack of political champions; lacked grassroots support; changing national mood*	*X*
Truman/ Single-payer	*Lack of universal health insurance coverage*	*Truman proposal was turned into the revamped Wagner-Murray-Dingell bill*	*(+) President political champion & Dem-party majority in Congress* *(-) Changing national mood towards socialism; effective oppositional groups; lacked strong labor support*	*X*
Johnson/ Medicare	*Lack of universal health insurance coverage*	*Incremental approach that put several policy ideas from key stakeholders into one; included role for private insurers*	*(+) President political champion; legislative turnover of more liberal Democrats; opposition was met with robust grassroots effort of labor and retirees*	✔
Kennedy vs. Nixon	*Lack of universal health insurance coverage*	*Separate detailed proposals with opposing ideologies were constructed and a compromise version was not agreed to*	*(-) Opposing Administration and Congress; Political damage by Watergate*	*X*
Clinton/HSA	*Although there was still a lack of universal health insurance coverage, as the economy improved, the pressure of addressing this problem was lessened*	*Closed-door process that resulted in extremely complex policy; lack of grassroots and stakeholder engagement; divided legislators*	*(+) Democratic Administration and Congress* *(-) Faced with effective opposition from key health reform stakeholders; splintered legislative support; national mood shifted against the plan*	*X*

✔= stream primed   **X** =not primed

Using the Kingdon MSF lens for each major health reform attempt, it is clear that policy windows are rare, as only one had occurred during the 20th century. The problem stream was consistently primed, indicating that the health care system has continued to be in a less than ideal state as perceived by society and politicians. The policy stream consistently failed to connect to the problem stream, meaning the existing policies were not seen as viable solutions. In most instances of policy stream failure, the proposals involved a technocratic, closed-door process and lacked grassroots and stakeholder involvement, which resulted in divided or insufficient legislative support. The only sufficiently primed policy stream was Medicare. President Johnson's incremental approach to the policy and his notorious "arm-twisting" political skills guided Medicare to success. Otherwise, the politics stream was consistently insufficiently activated, even when the President's party held majorities in Congress. Furthermore, the public's support for health reform was often swayed by the changing political climate and effective oppositional campaigns. This indicates that even if the public and legislators widely acknowledge that the health care system is in need of reform, this does not necessarily provide the impetus to make it happen.

The 20th century's history of health reform provided certain takeaways for the Democratic Party:

1. Favorable political conditions, such as party-majority in both chambers of Congress, the Presidency, and favorable national mood, are not enough to achieve a policy window

2. Oppositional stakeholders consistently included provider and hospital associations, private insurers, business owners, pharmaceutical companies, and occasionally unions

3. Public concerns around "losing health care/plan", "government control", "long wait times", "rationing of care", and "losing choice", were an easily exacerbated fear that could sway the national mood towards opposition.

4. Legislators are often united on the need for health reform but divided on the best policy solution

5. Policy designs that were seen as more "incremental" and "minimized disruption" had a greater likelihood of moving down the legislative process

These lessons would translate into the central strategy for the next major reform undertaking by President Barack Obama. The Patient Protection and Affordable Care Act (ACA), the Obama Administration's legacy policy. The ACA did not build on Medicare as its prime plan of action but instead relied on coverage expansion through state-administered Medicaid as a less threatening proposal (J Oberlander & Marmor, 2015). In contrast to the Clinton health plan attempt, small-businesses were a powerful contributor during the crafting and passage of the ACA, such as the small-business health care exchange. Throughout the legislative and political process, small-business owners were often called upon to share the challenges they faced with the cost of health care.

The ACA required tremendous effort for its passage, despite its incremental nature and purposeful design to maintain buy-in from stakeholders across the health care sector. After a lengthy and contentious legislative process, the ACA achieved a policy window, and the House passed the final Senate bill with a 219–212 vote on March 21, 2010.[14] Forty years prior, President Nixon's more expansive public-private approach to health reform was a Republican plan, with Democrats unwilling to compromise. Yet, the passage of the ACA's public-private approach was a Democratic plan, garnering not a single Republican vote.

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[14] The final vote was highly partisan, with 34 Democrats and all 178 Republicans voting against it

Ultimately, the ACA made several significant achievements by bringing coverage to more than 20 million people, the expansion of Medicaid for many states, and incorporating important standards for insurance coverage, such as restrictions on coverage denial due to preexisting conditions and requiring plans to allow parents to keep their children on their policies until age 26 (Geyman, 2018). Its successes in bringing and implementing critical reforms to the private insurance industry, expansion to Medicaid and improvements to Medicare, and expanding access to subsidies for low-income people would deem it one of the most consequential and significant health reform legislation in U.S. history. Undoubtedly, the ACA significantly expanded coverage for many people who did not have insurance and achieved many critical reforms to the U.S. health insurance system. Nevertheless, it did not achieve universal coverage, as it was intended, and affordability and access to health care continued to worsen for the majority of the population (Hawks et al., 2020).

2.4.3 The Problem Stream

"Despite the passage of the Affordable Care Act in 2010, America remains an outlier in health care provision. It has some of the best hospitals in the world, but it is also the only large rich country without universal health coverage. And health care costs can be financially ruinous."

(The Economist, 2018)

Kingdon describes the problem stream as an issue's current condition that does not match the public's values and perception of their ideal state (J. Kingdon, 1984). Seventy percent of Americans believe the health care system is in a state of crisis; increasing access and improving cost of care are the top two health care concerns for voters in the 2020 Presidential election (Gallup, 2019; KFF, 2020). This section will present the problem stream by describing the deficiencies in

the U.S. health care system that have contributed to the lack of universal health insurance coverage and the rise in health insecurity[15].

The U.S. health care system consists of a variety of insurance programs that do not cover everyone, significantly higher spending than other wealthy nations, and administrative complexity (McCuskey, 2017). As an assessment of the effectiveness of the U.S. health care system compared to other industrialized nations, the Commonwealth Fund 2017 International Comparison Report (Refer to Figure 3) determined,

> Despite having the most expensive health care, the United States ranks last overall among the 11 countries on measures of health system equity, access, administrative efficiency, care delivery, and health care outcomes. While there is room for improvement in every country, the U.S. has the highest costs and lowest overall performance of the nations in the study, which included Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom". (Commonwealth Fund, 2017)

Figure 3. Health Care System Performance Rankings

	UK	AUS	NETH	NZ	NOR	SWE	SWIZ	GER	CAN	FRA	US
OVERALL RANKING	1	2	3	4	4	6	6	8	9	10	11
Care Process	1	2	4	3	10	11	7	8	6	9	5
Access	3	4	1	7	5	6	8	2	10	9	11
Administrative Efficiency	3	1	9	2	4	5	8	6	6	11	10
Equity	1	7	2	8	5	3	4	6	9	10	11
Health Care Outcomes	10	1	6	7	3	2	4	8	9	5	11

Source: (The Commonwealth Fund, 2017)

While all the other ten countries have an established some type of universal health coverage system, whether through single-payer or multi-payer systems, the United States remains unique in its type

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[15] Health insecurity is defined as the inability to secure adequate health care at present and the risk of being unable to in the future (Gama, 2015)

of multi-payer, voluntary, and employment-based health insurance system that leaves almost 8%, or 26.1 million people, without any insurance a decade after the passage of the ACA (U.S. Census Bureau, 2020).

Health care Spending and Affordability

According to OECD data, in 2018, the U.S. spent $10,586 per capita on health care, which is $3,000 more per capita than Switzerland, the second-highest spending country (OECD, 2020). Compared to other industrialized nations, the U.S. spends two times more per person on health care, despite utilizing fewer doctor's office visits and having shorter average hospital stays (Sawyer & McDermott, 2018). Furthermore, health spending in the U.S. has grown faster than other OECD countries despite efforts to control spending. In 2016, health spending consumed 17.2% of GDP, compared to just 8.8% for the OECD median (*OECD Health Statistics 2020*). According to a 2018 JAMA study, the key drivers of our health care spending are prices for labor, prescription drugs, medical goods, and administrative costs. It also concluded that the U.S. provides significantly fewer key health care resources, such as hospital beds and clinical providers, compared to the OECD median country (Papanicolas et al., 2018).

Figure 4. Health Care Spending as a Percent of GDP, 1980-2018

Percent (%) of GDP, adjusted for differences in cost of living

2018 data*:
- US: 16.9%
- SWIZ: 12.2%
- GER: 11.2%
- FRA: 11.2%
- SWE: 11.0%
- CAN: 10.7%
- NOR: 10.2%
- NETH: 9.9%
- UK: 9.8%
- AUS: 9.3%
- NZ: 9.3%
- OECD average: 8.8%
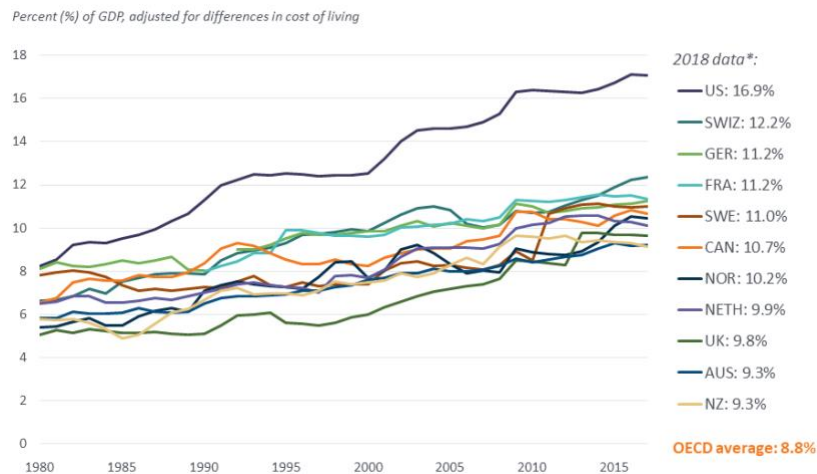
Health Insurance Structure and Financing

The U.S. health insurance system is currently a multi-payer system, established by a "shared responsibility" between the government, employers, and individuals. This system provides fragmented health coverage through a wide array of private and public sources, public being Medicare, Medicaid, Veterans Health Administration, TRICARE, private being employer-sponsored insurance, and other non-profit and for-profit carriers (Tikkanen et al., 2020). All other industrialized countries, except the U.S. have an automatic or compulsory enrollment process. The United States has the highest use of private insurance as the primary form at 68%, followed by Germany at 10.8%. Private insurance is not the primary form of insurance for most countries, but instead offer a publicly provided national health plan. The U.S. does not have a nationally defined benefit package, and covered services depend on insurance type (The Commonwealth Fund, 2016).

For pharmaceuticals, the U.S. spends nearly 40% more per person than the next highest country, Canada. Brand name drug companies appear to be approaching monopolistic levels as they participate in "delaying, preventing and suppressing the timely availability of affordable generic drugs in the United States" for the sake of profit (G. H. Jones et al., 2016). Most industrialized countries utilize a centralized negotiating power, price ceilings, or national formularies, as well as strict restrictions on monopoly pricing, which allow them to minimize abuses and price spikes from drug companies. Medicare and Medicaid combined represent 40% of the U.S. drug market, making it the largest purchaser of prescription drugs globally. In 2017, Medicare alone spent $185 billion on prescription drugs (CMS, 2019). Yet, the non-interference clause in President Bush's "The Medicare Modernization Act of 2003" mandated that the government cannot have a direct role in negotiating or setting drug prices in Medicare drug plans. Furthermore, due to the

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fragmented nature of U.S. health care financing system, the buying power is significantly smaller in negotiations from private plans with drug manufacturers.

Yet, drug-spending is only 9% of overall national health spending, while cost of medical services (i.e., services provided by hospitals and physicians) accounts for 53%. In fact, the rate of hospital costs continued to rise at 4.6%, compared with a 0.4% rise in drug costs from 2017 to 2018. On average, the U.S. has significantly higher prices for most health care services and prescription drugs compared to prices among other advanced peer countries (Figure 5). The U.S. federal government is able to administratively set prices of provider services through public health insurance programs. However, since most Americans have private health insurance, the federal government is limited in its ability to regulate provider and hospital pricing broadly.

Figure 5. Prices of Various Health Care Goods & Services in the U.S. Compared With Prices Among Advanced Peer Countries (2015)
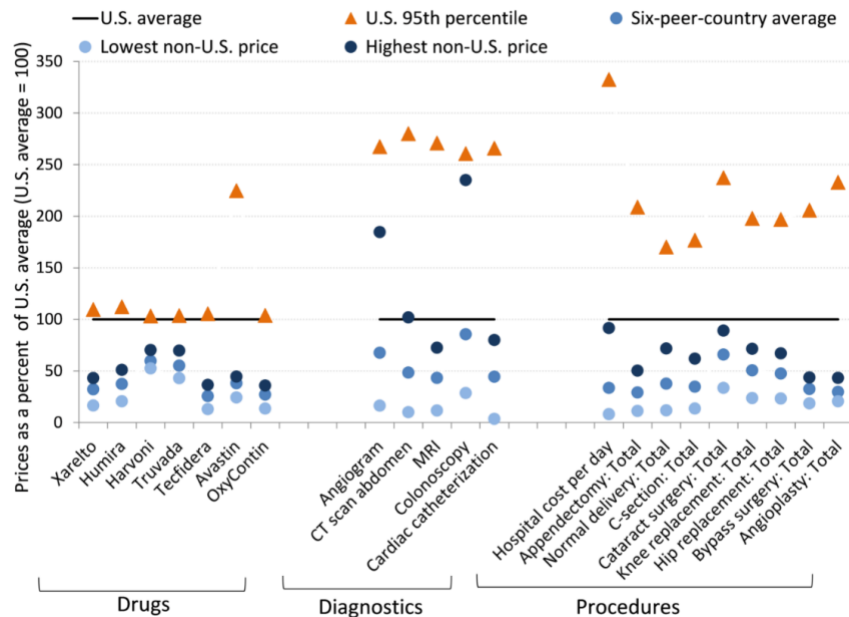
Source (EPI, 2016)

Furthermore, U.S. administrative costs, including billing and insurance costs, and physician practice and hospital administration overhead, are a significant contributor to health care spending.

On average, private insurers spend 13% of premiums on administrative expenses. In contrast, the traditional Medicare plan has administrative costs between 2 and 3%. American hospitals, on average, spend 8.7% of total revenues on billing and insurance-related costs, and 20-25% for total administration—the highest in the world (Gee & Spiro, 2019). Physician practices employ an average of two administrative staffers for every three clinical personnel. Hence, the U.S. has the highest administrative costs percentage in the world, by far (refer to Figure 6). One study determined that the U.S. administrative costs were $2,497 per person in the U.S., compared with $551 per person in Canada (Himmelstein et al., 2020).

Figure 6. Administrative costs percentage of health care spending in U.S. and other high-income countries

Administrative costs comprise a larger share of health care spending in the United States than in other high-income countries
Administrative spending as a percentage of total health expenditures, 2016*

Country	Percentage
United States	8.3%
France	5.7%
Austria	4.8%
Germany	4.2%
Netherlands	3.9%
Switzerland	3.8%
Belgium	3.8%
Australia	3.0%
Canada	2.7%
Denmark	2.4%
United Kingdom	2.0%
Japan	1.6%
Sweden	1.6%
Finland	0.8%
Norway	0.6%

Source: (Gee & Spiro, 2019)

Consequently, as health care costs and administrative expenses rise, the cost burden on individuals and families continues to worsen. A study conducted by the Cambridge Health Alliance determined that affordability "had worsened across all racial and ethnic groups and nearly all income groups" over the past twenty years. Additionally, it found that "among the uninsured, the proportion of adults unable to afford physician visits climbed from 32.9% to 39.6%. For people

with health benefits, the proportion unable to pay for doctor visits rose from 7.1% to 11.5%."
(Hawks et al., 2020).

Access to Care and Health Outcomes

Despite spending significantly more on health expenditures than other industrialized nations with universal health coverage, in 2018, the number of uninsured people in the United States rose to 27.5 million, compared to 25.6 million in 2017 (U.S. Census Bureau, 2019). The U.S. ranks last among other comparatively wealthy countries on key health care outcomes, such as infant mortality and life expectancy (Kamal & Cox, 2019). Significant progress has been made in closing racial gaps in coverage after the passage of the ACA, resulting in large coverage gains for groups of color. Still, compared to the current uninsured rate of 7.5% for Whites, Blacks and Latinos have disproportionately higher uninsured rates at 11.5% and 19%, respectively (Sohn, 2017).

Subsequently, access to care in the U.S. has ranked significantly behind other developing countries. Each year, one in five Americans skips doses or fails to fill prescriptions because of high prices (Quigley, 2019). In 2019, a Gallup survey found that "more than 13% of American adults— or about 34 million people—report knowing of at least one friend or family member in the past five years who died after not receiving needed medical treatment because they were unable to pay for it" (Witters, 2019). While a health care system might not be expected to prevent death in all instances, the United States achieved the highest amenable mortality rates, deaths considered preventable by timely and effective care, compared to other comparable OECD countries (Kamal & Cox, 2019).

Although comprehensive health reform was enacted only a decade ago, the high numbers of uninsured and underinsured persisted, and the state of health insecurity worsened. Therefore, the

problem stream was once again primed to demand attention from policymakers, while a series of coinciding political events unfolded that led to the rise of Medicare for All.

2.4.4 The Rise of Medicare for All

"If the repeal and the replace bill is enacted and signed into law, Democrats will face a challenge as to what their health care message will be in 2018 and 2020. It's very likely that many Democrats would turn to single-payer as the next step."

Larry Levitt, Vice President, Kaiser Family Foundation (2017)

According to Figure 7, the timeline of the rise of Medicare for All began shortly after the ACA was signed into law in 2010. The goal of the ACA was to continue building on its initial infrastructure to eventually achieve universal coverage. However, the ACA was passed in the Senate by a thin margin and a stark partisan split, which laid a shaky foundation for fierce political battles determining its survival or replacement. By 2012, the ACA was significantly weakened when the Supreme Court of the United States deemed the mandatory Medicaid eligibility expansion unconstitutional. Since the ACA envisioned Medicaid as the source of coverage for low-income people, a coverage gap formed for people with incomes below the poverty line but too high to qualify for Medicaid or sufficient subsidies for a marketplace plan (Garfield & Orgera, 2020). By 2014, public opposition to the ACA grew to 51% (J. Jones, 2010). Public dissent grew due to many finding themselves in the coverage gap, rapidly rising insurance premiums, losing their existing plan, or unable to access their current doctor due to restrictive insurance networks in marketplace plans (Rovner, 2017). The Republican Party used the 2012 presidential election and the 2014 mid-term election to capitalize on these frustrations with a flood of negative ads about the ACA (Dalen et al., 2015).

Figure 7. Timeline of the Rise of Medicare for All

MEDICARE FOR ALL ENTERS THE RACE

Senator Sanders's 2016 Presidential platform introduces a single-payer policy under the title "Medicare for All." Senator Sanders runs a competitive campaign and amplifies the health care problem and the need for a policy solution

SINGLE-PAYER POLICY RISES IN POPULARITY

Senator Sander introduces Medicare for All bill, S.1804. It and HR 676 gains more co-sponsors than any single-payer policy previously received. For the first time, a national health plan receives majority of public support.

BLUE WAVE HITS MID-TERM ELECTIONS

The 2018 midterm elections allow Democrats to regain control of the House of Representatives. The Congressional Progressive Caucus welcomes more than 20 new members, expanding the caucus to 97 members of Congress.

2010

ACA BECOMES LAW

The ACA is signed into law. However, soon after, public support for the ACA declines, and attacks on the ACA become the centerpiece of the GOP during the 2012 and 2014 elections.

2014

GOP CONTROL OF CONGRESS

GOP wins control of both chambers of Congress and put forth multiple health proposals to "repeal and replace" the ACA.

2016

GOP AGENDA

A Republican president is elected. The GOP is divided on what approach to take- dismantle ACA protections or replace the ACA altogether. All proposals fail to pass the Senate.

2017

REPEAL & REPLACE FAILS

The GOP successfully passes tax legislation that weakens the individual mandate. Support for the ACA rises and garners significant grassroots support to stop the GOP from repealing the ACA. The GOP's final ACA repeal attempt, an amended version of The American Health Care Act, fails to pass by one vote.

2018

By 2014, the Republican Party (the GOP) won control of both chambers of Congress. By 2015, the GOP ramped up their attacks on the ACA, putting forth multiple attempts to "repeal and replace" the ACA by pushing through policy alternatives. However, soon after the Congressional Budget Office warned that the GOP health policy could cause tens of millions to lose their insurance and threaten those with pre-existing conditions, strong public disapproval ensued. A HealthDay/Harris poll showed only one in five Americans were happy that Republicans were making another push to repeal the ACA (The Harris Poll, 2017). Meanwhile, Senator Bernie Sanders was launching his first Democratic Party Presidential Primary campaign in 2016, with Medicare for All at the top of his progressive platform.

The Sanders campaign surpassed expectations and presented a serious challenge to former Secretary of State Hillary Clinton. By running a competitive progressive campaign, Senator

Sanders's amplification of the lack of universal health care as a "societal problem" gained

significant visibility, triggering the momentum for greater public support and the start of a

national movement for Medicare for All. By early 2016, the Kaiser Family Foundation's polling

(Figure 8) showed a "national health plan in which all Americans would get their insurance from

a single government plan" had garnered majority support for the first time in decades. The

support for Medicare for All was further fueled by Secretary Clinton's defeat in the general

election, which bolstered the conviction from progressive politicians and advocates that

incremental approaches were not garnering voter enthusiasm.

Figure 8. KFF Health Tracking Poll on National Health Plan
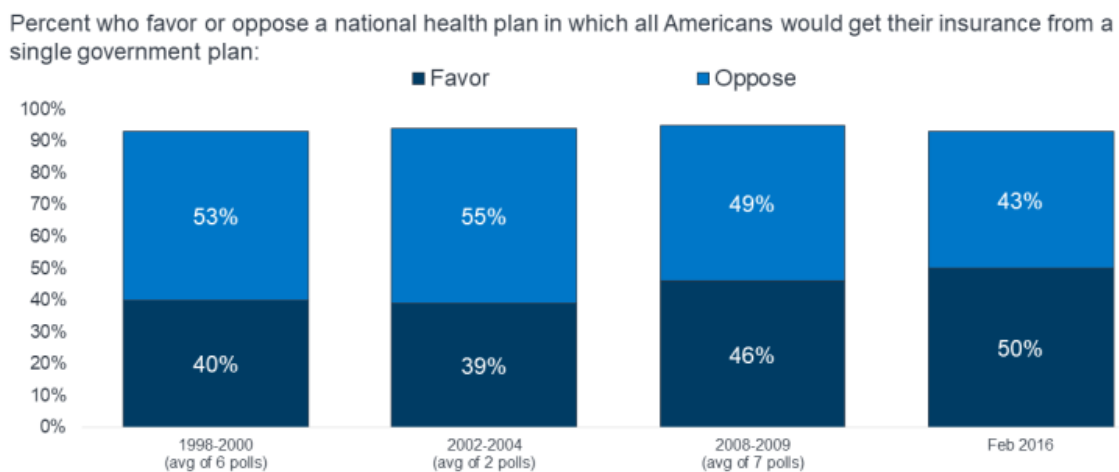
Source: (KFF, 2020)

At the start of 2017, Senator Sanders (VT) introduced S. 1804 'The Medicare for All Act of

2017'. The bill provided a significantly more comprehensive outline of a government-financed

national health insurance program, but was still deemed by some politicians and press as being

merely "aspirational" and "legislative expression" (Cassidy, 2017). Nonetheless, the renewed

enthusiasm for single-payer legislation translated into garnering significantly more legislative

support than in previous Congresses. Senator Sanders's S.1804 had 16 original co-sponsors, compared to his previous national health insurance bills that had zero co-sponsors; Representative John Conyers's (MI) H.R. 676, 'The Expanded and Improved Medicare for All Act,' gained 124 co-sponsors, compared to 62 co-sponsors in the previous Congress.[16]

At the same time, the Republican Party made further attempts to dismantle the ACA. For example, beyond the multiple health proposals from Republican legislators, Congress passed legislation that repealed the tax penalty associated with the individual mandate—thereby effectively invalidating the mandate itself (Fiedler, 2018). A large-scale grassroots advocacy effort was launched to lobby Republican members to oppose the GOP health plan. Democratic candidates ran on a united message that opposed the Republican Party's attempt at taking away key ACA protections. Consequently, the Democrats won back control of the House, creating a sustained shift in the politics stream. However, they were not necessarily united about what the next major health plan should be. Many candidates campaigned on "shore-up and build on" the ACA while others supported Medicare for All. Additionally, throughout the 115th Congress (2017-2018), Democratic legislators introduced a variety of proposals that would allow those age 50 or older to buy into Medicare, a state public option through Medicaid, and varying degrees of a Medicare-based public option.

Meanwhile, the position for lead sponsor of H.R. 676, the House Medicare for All bill, opened after Representative John Conyers stepped down from Congress, and his successor, Representative Keith Ellison, announced his run for Attorney General of Minnesota. Representative Pramila Jayapal responded by starting the Medicare for All Caucus, which consisted of 70 Members of

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[16] H.R. 676 was introduced into the House every Congress by Representative John Conyers since taking over the bill from Representative Dingell in 2003.

Congress. She then became the designated lead sponsor of the Medicare for All bill for the 116th Congress, alongside Representative Debbie Dingell (MI), wife of the late John Dingell. Simultaneously, she also became the elected co-chair of the Congressional Progressive Caucus (CPC), a membership organization in Congress that consisted of 78 members in 2018. The CPC expected their membership to increase by more than 20 members in the 116th Congress, which indicated the arrival of a freshman class of several progressive legislators who supported Medicare for All (Godfrey, 2018).

Figure 9. Kingdon Multiple Streams Model: The State of the Streams for Medicare for All at the End of 2018
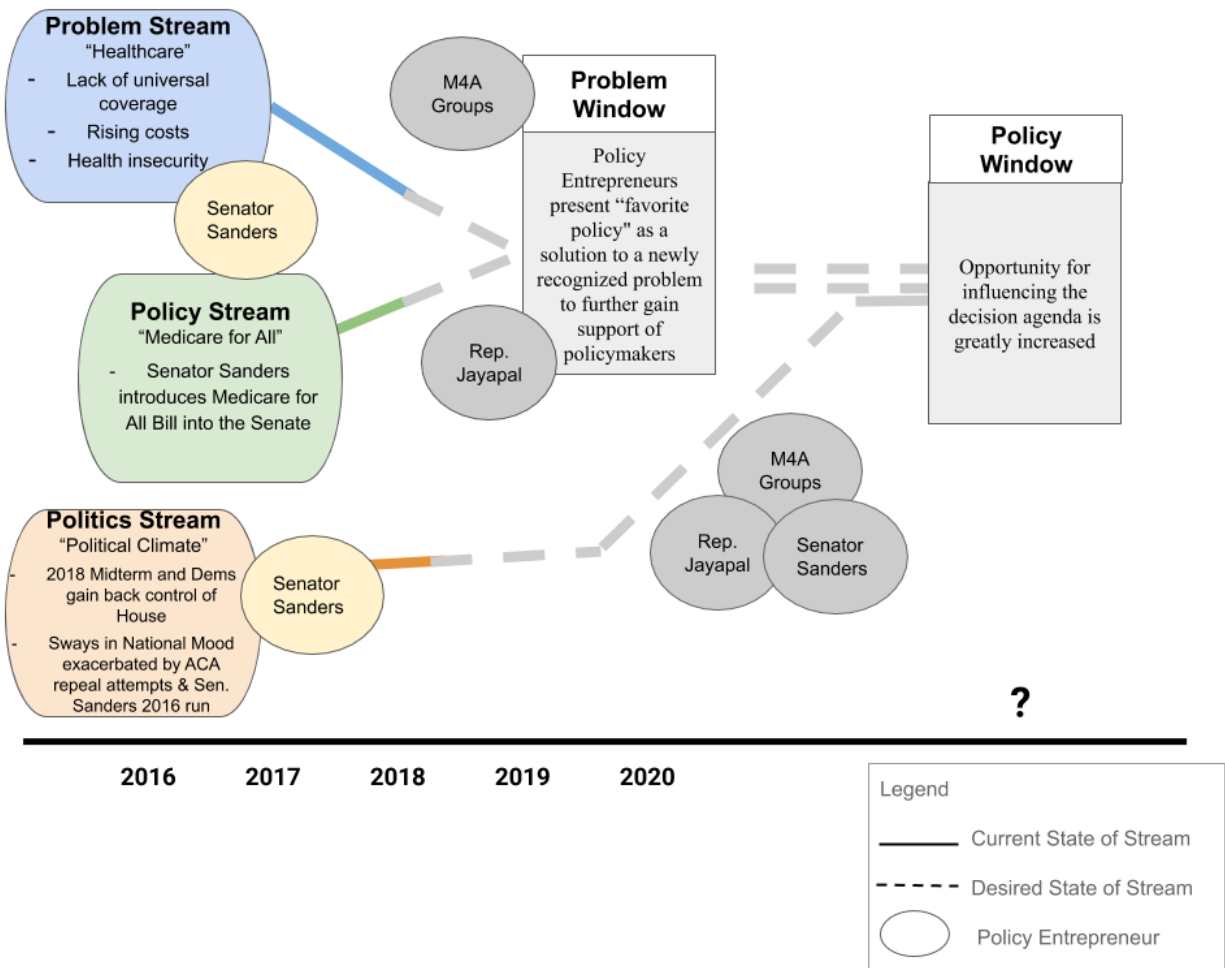
Source: Adapted from (Kingdon, 1995)

Figure 9 shows that, following the 2018 midterm elections, the three streams for Medicare for All in varying stages. The problem stream consisted of the many deficiencies of the U.S. health care system that has left 84 million uninsured or underinsured and so lacking health security and financial protection. Therefore, the problem stream was the most defined out of the three streams and primed for a policy solution. In contrast, the policy stream, initiated by Senator Sanders's introduction of the Medicare for All bill, was less mature as the legislation lacked critical details. Additionally, Rep. Conyers's Medicare for All bill was a mere 26-page outline of a single-payer plan that was not intended to receive serious legislative consideration. Therefore, Representative Jayapal prioritized the need to work on an expanded policy version to introduce into the 116th Congress.

Finally, the politics stream was initiated by the intense political aftermath of the ACA, which raised questions about the law's sustainability and limitations, such as the failure of many states to expand Medicaid. Then, it was further primed by Senator Sanders's 2016 presidential run and legislative turnover that resulted in a Democratic-majority House and a larger Progressive Caucus. However, the politics stream was the least ripened compared to the problem and policy streams. A Republican-controlled Senate and Presidency, in which there was no recorded support from a Republican legislator, and varying levels of support from Democratic members were substantial political barriers for Medicare for All. However, political barriers don't impede the potential for a problem window, as this window depends on the conditions within the problem and policy stream (J. Kingdon, 1984). With a Democratic Party-controlled chamber of Congress and a growing progressive movement, the Medicare for All Coalition and Representative Jayapal recognized an unprecedented opportunity to activate the problem window and further promote single-payer policy within and outside the House of Representatives.

CHAPTER 3. RESULTS: THE PROBLEM WINDOW

"I will tell you, Democratic politicians I never thought would utter the words have mentioned

single-payer to me in a non-joking way of late."

Len Nichols, Director of the Center for Health Policy Research & Ethics,

George Mason University (Klein, 2017)

3.1 Introduction

Single-payer advocates and political champions present Medicare for All as a solution to cost-containment, equitable and universal access, affordability, and reduced administrative waste, fragmentation, and complexity of the healthcare system (Morone, 2017). As the only congressional staffer directly working on Medicare for All legislation in the House, I was offered a unique position to observe, record, and participate in opening the problem window for Medicare for All throughout 2019.

The findings from the quasi-ethnography study I conducted in the Office of Representative Jayapal illustrate how the problem window was open and advanced for Medicare for All. This chapter contextualizes the policy stream's pairing to the problem stream by identifying the policy entrepreneurs, detailing the creation process, and analyzing the strategy and actions that generated legislative support. Finally, the discussion examines how the findings support that Medicare for All was in a specific window of opportunity, known in the Kingdon framework as the problem window.

3.2 Methodology

Much of the process and policy activities involved in creating the Medicare for All proposal were not documented publicly; therefore, many details of the policy stream have not been published or assessed. Due to my role as the health staffer and the liaison between Representative Jayapal and the Medicare for All Coalition. I acted as a participant-observer with complete participation, indicating that there is a risk of losing levels of objectivity in my analysis (Jorgensen, 1989). For most of the meetings or conversations with stakeholders and leaders across the Medicare for All Coalition, I was an active contributor. My methods for data collection were: for every meeting, I took handwritten detailed minutes and notes; I created an electronic storage of all e-mail correspondences, memos, and documents created during my fellowship; and during each recess week[17], I wrote journal entries about the status of various projects, my observations, and significant incidents that occurred during the previous weeks.

The quasi-ethnography results include direct summaries of observations and documentation from my journal entries, meeting notes, updates and strategy memos, official documents, and e-mail correspondences maintained throughout the quasi-ethnographic immersion. I organized the field notes to distinguish topics and select excerpts and evidence for the general interpretation and report. Lastly, I analyzed the data I collected through the Kingdon MSF model. However, due to the sensitivity and confidentiality of much of the data captured, this section only provides non-sensitive information, while the remaining data will be summarized and explored as part of my leadership journey statement for the DrPH program.

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[17] Recess week refers to the periods of time where Congress is not in session and Members were not at the Washington D.C. office.

3.3 The Policy Entrepreneurs

The key policy entrepreneurs of Medicare for All are: Senator Bernie Sanders of Vermont, who campaigned on Medicare for All during his Democratic Presidential run in the 2016 & 2020, and is the Senate Sponsor of 'The Medicare for All Act'; Representative Pramila Jayapal (WA), Co-Chair of the Congressional Progressive Caucus, Lead House Sponsor of 'The Medicare for All Act', and; the Medicare for All Coalition, an established coalition of progressive interest groups and Medicare for All Advocates consisting of think tanks, unions, health professionals, academics, and grassroots organizers.

3.4 Setting Up the Stage for the Problem Window

After launching the Medicare for All Congressional Caucus in July 2018, Representative Jayapal decided to involve a working group of members from the Medicare for All Coalition table, as well as disability rights organizations, to draft the Medicare for All legislation to include significantly more policy details than previous versions and build up more substantial buy-in across the groups. The bill writing process took more than seven months.[18]

Meanwhile, Representative Jayapal and Representative Mark Pocan[19] (WI) were elected as Co-Chairs of the Congressional Progressive Caucus (CPC), the second-largest ideological caucus[20] of the Democratic Party. As co-chair, she was offered more leverage to influence the legislative agenda and build up broader support for her bill amongst policymakers giving her "claim to a hearing." Under their leadership, the CPC took steps to build out critical infrastructure and grow

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[18] The bill writing process is detailed further in Section 3.5.

[19] Representative Mark Pocan was first elected as CPC co-chair in 2017.

[20] A congressional caucus is defined as "a group of members of the United States Congress that meets to pursue common legislative objectives." The CPC consists of 97 Democratic members. The largest Democratic Caucus is the New Democrats, a caucus of centrist ideology, which has 98 Democratic Members.

its influence in the House. They started by raising membership dues to fund the expansion number of CPC staff from one full-time staffer to three. They then fundraised $1.5 million to rebuild the Congressional Progressive Caucus Center, the non-profit organization that provided my fellowship.

Another significant event unfolding simultaneously was the run for Speaker of the House. Then Minority Leader Nancy Pelosi faced several other challenges from Members seeking to assume the powerful role.[21] Rep. Jayapal and Rep. Pocan laid out three propositions to Speaker Pelosi in order for the CPC to support her candidacy:

1. Committee assignments: Ensure a proportional number of progressive Members (the CPC represents 40% of the Democratic Caucus) are assigned to four powerful committees— Ways & Means, Energy & Commerce, Finance, and Appropriations.
2. Leadership positions: Expand the number of leadership positions and run progressives for those spots, as there were no progressive Members in top leadership roles.
3. Exclusion of PAYGO[22] from the rules package: Remove the PAYGO provision that requires short-term funding to be identified in order for a bill to be considered (unless waived by the Rules Committee).

The first two were easily met. The last demand was deferred for later consideration, but it was enough to earn support from the CPC for future Speaker Pelosi. However, the PAYGO discussion soon reappeared. At the start of every Congress, a rules package is passed to determine how Congress should operate and function. Thus, 2019 started with a rules package introduced by Leadership containing the PAYGO provision. This triggered Rep. Jayapal's use of "political

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[21] "Minority Leader" refers to the leader of the Party that has a minority number of Members in a chamber of Congress
[22] PAYGO, or "pay as you go", is "a budget rule requiring that new legislation that affects revenues and spending on entitlement programs, taken as a whole, does not increase projected budget deficits" (*Policy Basics*, 2009) .

bargaining" through a series of negotiations with the Rules Committee to convince the CPC not to sink the Rules package. As negotiations continued with Rules Chairman Jim McGovern (MA), Rep. Jayapal proposed that for the CPC to support the Rules package, she needed the Speaker's commitment to hold hearings on her impending Medicare for All bill. Chairman McGovern agreed to hold a hearing in the Rules Committee, which was unusual given the Rules Committee did not typically hold legislative hearings. After further negotiation, Chairman McGovern secured Speaker Pelosi's support to hold hearings in the Rules Committee and other committees of jurisdiction (Jayapal, 2020).

The several months following the 2018 midterm had shown how the CPC's improved legislative infrastructure had effectively shifted the policy agenda but still lacked power in significant aspects, such as the failed attempt to repeal the PAYGO provision. Nevertheless, the commitment to hold a historic hearing on Medicare for All set the stage for the 116th Congress, in which Rep. Jayapal and the Medicare for All Coalition used "sheer persistence" to garner the most successful legislative year in single-payer policy history thus far, as described in this chapter.

3.5 The Policy Creation Process

When bill drafting began in July 2018, Rep. Jayapal's office's legislative assistant who handled multiple policy priorities, led the writing process in partnership with the Medicare for All Coalition. The coalition had significant influence on a significant portion of the bill writing, with a few organizations in particular carrying the most influence on policy priorities. The staffer had strong relationships across Members' offices and progressive organizations and gathered a large number of co-sponsors and organizational endorsements for the bill early in the process. At the end of 2018,

Rep. Jayapal hired a new legislative director who wanted to manage the bill writing process more directly.

Moving Away from The Legacy of H.R. 676

My role as the designated health staffer in Rep. Jayapal's office began in February 2019, just a few weeks before the set introduction date for the Medicare for All bill. By then, most of the provisions were finalized. Additionally, a few fundamental policy changes from H.R. 676, Rep. Conyers's long-standing Expanded and Improved Medicare for All Act, had been decided. For example, the new bill draft removed the provision for mandatory conversion of all for-profit health care providers to non-profit status. This change was met with backlash from certain progressive groups that had been intimately involved with drafting H.R. 676. Also, since they were intertwined with the bill's history, they insisted that the new Medicare for All legislation be introduced in time for the same number assignation, as it had for every Congress since 2003 (Mokhiber, 2019). However, this would mean the bill would need to be introduced by mid-January, but the bill text was not ready. A delayed introduction was critical to allow time to build strong co-sponsor support for the bill and produce more thoroughly crafted text. In the views of many, doing so would help limit and shape the narrative from media or opposition who could claim that the bill had not received as much support as previously or it was not a detailed plan.

For example, on July 18, 2017, Sherry Glied, a former health-policy adviser to the Bush, Clinton, and Obama administration, was quoted in *The Atlantic* saying,

> Democrats are essentially using 'single payer' as an easy shorthand to convey that they want a health-care system that works better and costs people less. But just invoking the concept on its own doesn't say much about policy specifics. To some extent, this is the

flip-side of what Republicans did by advocating for repeal and replace [of the Affordable

Care Act] when Obama was president. For Democrats, single payer may even be a more

attractive proposition when there's a Republican president since they don't have to deal

with the hard trade-offs that would be at stake if a bill could actually pass. (Foran, 2017)

Despite the fact the delayed introduction of the bill caused anger for a small subset of advocates,

who utilized media to air their grievances (Mokhiber, 2019), this still proved to be a significant

launching point for Medicare for All. According to my conversations with Rep. Jayapal and the

Legislative Director for the office, they wanted to deliver a "battle-ready" bill that could be used

to galvanize the Medicare for All movement. H.R. 676 was a 26-page outline of a single-payer

national health insurance program. The lack of details in the proposal made it easier to build up

co-sponsors since it was clearly a messaging bill. However, it was not sufficient for the legislative

process Representative Jayapal was aspiring for in the 116th Congress.

Key Policy Discussions with Stakeholders

The goals of the bill text were to show that instead of being a messaging bill, Medicare for All

represented a "real policy" that could withstand the legislative process and reflected the interests

of key progressive groups. The final steps of the bill writing were to ensure that the text was

politically and technically sound while maintaining buy-in and relationships with key interest

groups. While several policy provisions had been negotiated across various groups, the following

are three examples of key discussions that occurred during the policy creation process of Medicare

for All:

Mandatory Nurse Staffing Ratios: National Nurses United (NNU) advocated for mandating

staffing ratios into the payment structure for all hospitals. NNU's long-standing priority has been

mandatory staffing ratios, which would require specific levels of direct care nursing staff according to the number of patients.[23] NNU won on this issue in California but it has otherwise been met with significant contention and failure of passage in other states, such as Massachusetts and Illinois. It was important to iterate the main goal of the bill was to establish a single-payer insurance system and not be distracted by another major policy topic of mandating hospital staffing ratios across all institutions. Also, it was important to minimize policy sections that could add to the rhetoric of "government-run health care." Eventually, an agreement was made to the use language that encouraged staffing ratios throughout the bill, as to mitigate reactions and analysis from reporters and health policy experts who would be assessing the bill and looking for any reason to politicize the text (See Figure 10).

Figure 10. Section 302(c)(2) National Minimum Standards of H.R. 1384

(2) NATIONAL MINIMUM STANDARDS.—The Secretary shall establish national minimum standards under paragraph (1) for institutional providers of services and individual health care practitioners. Except as the Secretary may specify in order to carry out this Act, a hospital, skilled nursing facility, or other institutional provider of services shall meet standards applicable to such a provider under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such standards also may include, where appropriate, elements relating to—

    (A) adequacy and quality of facilities;

    (B) mandatory minimum safe registered nurse-to-patient staffing ratios and optimal staffing levels for physicians and other health care practitioners;

Value-based Care: Physicians for a National Health Program (PNHP), a physician-advocacy organization, advocated that all value-based and pay-for-performance measures be banned from use for payments to providers. The group worked with the previous legislative assistant to include a broad ban on all value-based measures but had not exactly specified the alternative quality measures to be utilized. This physician group has a long history with single-payer advocacy and wanted to ensure the elimination of profit from the provision of care, further stating this policy

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[23] National Nurses United is the largest union of registered nurses in the United States, with close to 185,000 members. They are discussed further in Chapter 5.

provision was one of the organization's "top priorities." The bill text was maintained and section

614 explicitly prohibits value-based payment (See Figure 11).

Figure 11. Sec. 614(a)(3) Payment Prohibitions of H.R. 1384

SEC. 614. PAYMENT PROHIBITIONS; CAPITAL EXPENDITURES; SPECIAL PROJECTS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that tens of millions of people in the United States do not receive healthcare services while billions of dollars that could be spent on providing health care are diverted to profit. There is a moral imperative to correct the massive deficiencies in our current health system and to eliminate profit from the provision of health care.

(b) PROHIBITIONS.—Payments to providers under this Act may not take into account, include any process for the provision of funding for, or be used by a provider for—

(1) marketing of the provider;

(2) the profit or net revenue of the provider, or increasing the profit or net revenue of the provider;

(3) incentive payments, bonuses, or other compensation based on patient utilization of items and services or any financial measure applied with respect to the provider (or any group practice, integrated health care delivery system, or other provider with which the provider contracts or has a pecuniary interest), including any value-based payment or employment-based compensation;

Disability advocates: Representative Jayapal wanted to include a comprehensive long-term

supports and services (LTSS) provision in the bill, a policy provision that had not been part of the

Medicare for All program in Senator Sanders's 2017 bill. A key discussion for this section was the

eligibility criteria for coverage with the disability advocates. The disability advocates wanted as

broad a definition of eligibility as possible to ensure that anyone with limitations in one or more

"Activity of Daily Living" (ADL), or one or more "Instrumental Activities of Daily Living"

(IADL), would receive LTSS.[24] Already, the Office had agreed to significantly expanding the

eligible population by including those with limitations in performing one ADL, instead of two

ADLs, which is the HIPPA-endorsed standard used in private insurance and Medicaid. To include

any person who experiences limitations for one IADL was a substantially greater population.

Furthermore, since the services and supports defined in the bill included any type of service needed

for any ADL or IADL, this could significantly impact the cost-estimate of Medicare for All. The

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[24] Activity of Daily Living, also known as ADLs, are routine activities people do every day such as eating, bathing, toileting, getting dressed; Instrumental Activity of Daily Living, also known as IADL, "are not necessary for fundamental functioning but allow an individual to live independently in a community", such as preparing meals, shopping for groceries, laundry.

inclusion of LTTS was important to highlight the need for universal long-term care supports and services and to frame it as a critical selling point of the bill. After much discussion, the final bill version included a very broad eligibility standard but constrained the one IADL's criteria to a similar need of assistance in performing one ADL (See Figure 12).

Figure 12. Sec. 204(a). Coverage of Long-Term Care Services of H.R 1384

SEC. 204. COVERAGE OF LONG-TERM CARE SERVICES.

(a) IN GENERAL.—Subject to the other provisions of this Act, individuals enrolled for benefits under this Act are entitled to the following long-term services and supports and to have payment made by the Secretary to an eligible provider for such services and supports if medically necessary and appropriate and in accordance with the standards established in this Act, for maintenance of health or for care, services, diagnosis, treatment, or rehabilitation that is related to a medically determinable condition, whether physical or mental, of health, injury, or age that—

(1) causes a functional limitation in performing one or more activities of daily living; or

(2) requires a similar need of assistance in performing instrumental activities of daily living due to cognitive or other impairments.

Ultimately, the policy discourse ended with a 120-page bill introduced on February 27, 2019 as H.R. 1384[25] "The Medicare for All Act of 2019" with 107 original co-sponsors. The key changes made to the policy from previous versions were:

- Expand and specify the list of benefits covered

- Require no co-pays for prescription drugs (instead of a $200 yearly cap in Sanders's bill)

- Shorten the implementation transition period of the Medicare for All program to two years (instead of four years in Senator Sanders's bill)

- Specify a drug negotiation mechanism through competitive licensing

- Utilize a global budgets payment system for institutional providers and fee-for-service for individual providers with no payment incentives. Payment will be based on the historical volume of services, normative payment rates, projected changes in volume and type of services, and the provider's maximum capacity

- Include long-term services and supports coverage provision through the Medicare for All program (instead of through Medicaid in Senator Sanders's bill)

- Dedicate at least 1% of the budget for a just transition package for health workers impacted by the transition, including wage assistance, job training, pension, and education benefits for up to five years.

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[25] The full bill text can be found here: https://www.congress.gov/bill/116th-congress/house-bill/1384/text.

The following is a general summary of H.R. 1384 produced by the Office of Rep. Jayapal:

Table 2. H.R. 1384 Summary

	Single-Payer **H.R. 1384 (Medicare for All Act of 2019)**
General Description	• Creates a national health insurance program that would consolidate most current sources of coverage, including the current Medicare program, Medicaid, and all private insurance. • Offers comprehensive benefits including vision, dental, and long-term-care services with no cost-sharing. Defaults home and community-based care for long-term supports and services, instead of institutional care. • Supplemental insurance can be provided by private insurers to cover benefits not included in the program, but insurers cannot sell duplicative benefits. • Provides transitional financial support for five years for people who lose their jobs because of the new program. • Provides Secretary of Health drug price negotiation with competitive licensing. • Incorporates a national health budget and global budgets for institutional providers. • Retains the Veterans Administration health program and Indian Health Service.
Eligibility	All U.S. residents. The U.S. Department of Health and Human Services Secretary may include nonresidents among those eligible. The Secretary shall provide a mechanism for enrollment of those eligible including autoenrollment at birth.
How do people pay for coverage and health care	There would be no premiums and no cost-sharing. People might pay more in taxes, but the amount would vary across the income distribution
Health Care Cost Management	• Requires the Secretary to establish a national health budget and to allocate funds to new regional health administrators across the country. • The regional administrators would in turn negotiate global budgets with hospitals, nursing homes, and other institutional providers • Institutional health providers' budgets could not be used for nonpatient care including capital projects, profits, marketing, or payment incentives or bonuses. • Health providers would have to apply for approval of capital projects, such as purchases of new or replacement technology, which would be funded separately. • Doctors and other individual providers would be paid according to a national fee schedule established by the Secretary and would be reimbursed via a national electronic billing system. • The Secretary negotiates prescription drug and medical device prices.
Transition Period	• The transition to Medicare for All would occur in two years. • One year after the date of enactment, persons over the age of 55 and under the age of 19 would be eligible for the program. • Two years after the date of enactment, all people living in the U.S. would be eligible for the program.

Source: Office of Congresswoman Pramila Jayapal

The bill's introduction included a large and energetic press event with several Congressmembers, union presidents, business owners, doctors, and advocacy groups holding a rally outside the Capitol. Some single-payer advocates claimed that H.R. 1384 was the "first comprehensive, battle-ready" single-payer plan to be introduced in Congress (J. Stein, 2019). After the introduction of H.R. 1384, Senator Sanders reintroduced the companion bill, S. 1129 on April 10, 2019. His bill closely mirrored H.R. 1384 with the few differing policy choices previously mentioned.

However, a notable piece not included in H.R. 1384 was a pay-for provision to detail how the Medicare for All program would be funded. H.R. 676 had included a small list of various pay-for mechanisms, including increasing personal income taxes on the top five percent income earners, instituting a modest and progressive excise tax on payroll and self-employment income, and a small tax on stock and bond transactions. Senator Sanders published a white paper that listed financing options such as a 7.5% income-based premium for employers, a wealth tax, and a 4% income-based premium for households making more than $29,000 a year. While several cost-analyses had been conducted for single-payer policies, none were estimated based on the specific policy choices made in H.R. 1384. Furthermore, while studies had consistently shown that Medicare for All reduces the overall cost of the health care system, the "$32 trillion-dollar price tag" was the most publicly-known understanding of the cost. The cost of Medicare for All was undoubtedly a much-discussed topic across legislators and needed to be further addressed in order to gain more support for the bill. Given the office's limited capacity to create a cost-analysis and financing plan for H.R. 1384, and the fact that the bill would not pass through Congress, especially with a Republican Senate, the strategy focused on the education and messaging around Medicare for All's cost, along with other policy concerns, through the "softening up" process of the legislation, further discussed in the next section.

3.6 The Problem Window Opens: Softening Up Medicare for All in Congress

"The agenda, as I conceive of it, is the list of subjects or problems to which government officials,

and people outside of government closely associated with those officials, are paying some

serious attention at any given time."

John W. Kingdon (J. Kingdon, 1984)

The legislation introduction marked the opening of the problem window and the opportunity to build up legislative support. This section further details the major activities executed, specifically within the policy community connected to the House of Representatives. The policy community members will be referred to as "Rep. Jayapal," "the Office" (indicating me, the Legislative Director, and Communications Director), and "the Medicare for All Coalition." There are no policy actions documented from the Senate as no legislative progress was achieved other than bill introduction and original co-sponsor[26] support. The policy activities are categorized based on Mintrom's expansion of Kingdon's framework: "working with advocacy coalitions," "using and expanding networks," "scaling up change processes," "leading by example," and "problem framing" *(Mintrom, 2019)*. Table 3 provides examples of the types of strategies for each policy activity.

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[26] Original co-sponsors refer to a Senator or Representative who was listed as a cosponsor at the time of a bill's introduction, rather than added as a cosponsor later on (Cite).

Table 3. Type of Policy Activities by Policy Entrepreneurs

Type of Policy Activity	Example
Working with Advocacy coalitions	Educating the general and specialized public; crafting arguments for the different audiences; promoting the issue and keeping it alive in media; mobilizing popular concern; media connections; using dissemination mechanisms i.e. books, position papers, radio, TV; softening up policy community and building acceptance for the proposal; prompting public feedback about government performance
Using and expanding networks	Cultivating bureaucratic insiders, high profile/elite groups, elected officials, and others by keeping in touch with them and keeping them informed; neutralizing existing and potential opponents
Scaling up change processes	Trading ideas; scanning the environment in search of models and projects that could be transposed; staying tuned to the local policy conversation; developing proposals in advance of policy windows; redrafting proposals to overcome constraints
Leading by example	Engaging with others to clearly demonstrate workability of policy proposal as to reduce risk aversion; signal genuine commitment to improved social outcomes to win credibility and build momentum
Problem framing	Pushing for one kind of definition of the problem rather than another to convince policymakers; establishing a link between the problem and proposed solution; commissioning studies to outline performance declines; collecting evidence to support proposals; fostering sense of alarm regard current situation by highlighting indicators that dramatize the problem; diffusing symbols that would capture the problem in a nutshell and control prevailing image of the problem

Source: Adapted from (Mintrom, 2019)

3.6.1 Softening Up Strategy

Shortly after the bill was introduced, I sent a strategy memo to the Legislative Director with four priorities: coordinate with and engage key stakeholders (which Mintrom categorizes as using and expanding networks); maintain constant and consistent messaging and media across channels (working with advocacy coalitions); expand academic support around single-payer (problem framing) and; push for more congressional hearings on Medicare for All (scaling-up change processes). Within each priority, I also outlined a series of ongoing projects and targets for the Office to be achieved over the coming months that supported these "softening up" activities. Additionally, I created a roadmap (refer to Figure 13), to accompany the memo that outlined each week's policy actions, stakeholders, and what was discussed or achieved.

Figure 13. Screenshot of Sample Roadmap Documentation of Medicare for All Actions

MEDICARE FOR ALL STRATEGY			
Date	**Deliverable**	**Organization/Contact**	**Notes**
Week of March 17-23			
March 19	Meeting re: Follow up from bill launch	Consortium for Citizens with Disabilities	Established direct connection and communication with Disability RIghts Coalition; they will be sending their notes for future MFA draft
March 23	Kaiser Medicare Bill's Online Tool	Kaiser Family Foundation	Answered questions and clarified mistakes on KFF online interactive tool for comparing various healthcare reform bills; not yet released
Week of March 24-30			
March 25	Meeting re: hearing updates	Working Group (NNU, SSW, CPD, Labor Coalition for Single Payer, Public Citizen)	Established bi-weekly meetings starting April 8; discussed Medicare for America Strategy
March 26	Member-level meeting	Rep X	Discussed the "implementability" of MFA and cost/pay-for; SK sent LD MFA materials
March 28	Meeting re: SNAhP involvement in Rule's hearing, op-eds, and AMA	SNAHP	Discuss medical student participation in Rule's hearing overflow room and AMA events; students agreed to write multiple op-eds
March 29	WSJ op-ed: Case for Medicare for All	Robert Pollin	1000 word on why MFA can work and brings savings
March 29	Finalize Rules Witness List	LO, SK, Dingell, Sanders	Meet to review rule strategy for new date and witness list; sent final witness list suggestions to Rules

3.6.2 Key Policy Actions & Events

Table 4 outlines a timeline of significant policy actions made through the Office of Representative

Jayapal in cooperation with the Medicare for All Coalition.

Table 4. Timeline of Key Policy Events for Medicare for All

Date	Policy Action	Type of Activity	Description	Significance
February 2019	Bill Introduction	Advocacy	H.R. 1384 was introduced with 107 co-sponsors; the bill launch day was a press event with Congressmembers and activists speaking about the importance of Medicare for All.	Through purposeful coordination with various news networks, the bill introduction garnered significant media attention.

Table 4. Timeline of Key Policy Events for Medicare for All (Continued)

Date	Policy Action	Type of Activity	Description	Significance
April 2019	First Legislative Hearing in the Rules Committee	Problem-framing/Scaling-up change processes/Expanding Networks	The first-ever congressional hearing on a single-payer legislation was conducted in the Rules Committee on April 30, 2019.	Although the Rules Committee is not a committee of jurisdiction for health policy, the Office framed this as a "historical victory" for the Medicare for All movement. This also triggered the momentum for Representative Jayapal to secure additional hearings in other committees.
May 2019	CBO Report/Budget Hearing	Problem-framing/Expanding networks	Chairman Yarmuth, of the House Budget Committee, asked the Congressional Budget Office to provide a report on the design considerations for policymakers to establish a single-payer health care system; once the report was released, a Budget hearing was held on the report	Chairman Yarmuth shifted from being publicly skeptical about the political feasibility of Medicare for All to being publicly positive, which neutralized him as a potential opponent. The House Budget committee is a powerful as it oversees all federal budget processes.
June 2019-September 2019	Additional Legislative Hearings	Problem-framing/ Scaling-up change processes	Hearings on Medicare for All were held in Energy & Commerce (E&C) and Ways & Means (W&M) committees.	The E&C and W&M hearings were significant because they were the first legislative hearings in committees of jurisdiction and they are extremely powerful committees for health policy

<u>The Rules Hearing (Problem-framing/Scaling-up Change Processes/Expanding Networks)</u>

After H.R. 1384 was introduced, one of the most significant policy actions that galvanized momentum was the Rules Hearing that Rep. Jayapal had negotiated for earlier in the year. Typically, a hearing is the first step in the legislative process as it allows committee members to question witnesses representing various expertise on the measure. The Rules Hearing signified the first-ever Congressional hearing on Medicare for All and the first hearing on the topic of single-payer health policy in decades (scaling-up change processes). The hearing allowed for the first policy debate amongst Congressmembers on a Medicare for All bill, which laid the foundation for the subsequent conversation on single-payer in the House. Therefore, this section will provide a detailed account of the first-ever hearing conducted on Medicare for All.

To shepherd the process was a staff member who was brought in by Speaker Pelosi. A series of regular meetings with the Rules Committee Staff and the Office were initiated so that Rep. Jayapal's preferences could be included into the hearing process. The first step was to determine the witness panel. The witness panel allowed for four Democrat-selected witnesses and two Republican-selected witnesses. The Office put forth several lists of reputable experts, who were also single-payer advocates. Meanwhile, Chairman McGovern gathered the Democratic Members of the Rules Committee and Rep. Jayapal to discuss the purpose and format of the hearing. This meeting was helpful to identify which Members were supportive and who might express oppositional statements during the hearing (expanding networks). Following this meeting, a conversation was held with each office to determine particular points the Member would focus on for the hearing, as well as technical assistance and messaging guidance to assist in their preparation. (problem framing).

However, the witness list itself took many weeks to finalize. The lack of confirmation that a Medicare for All advocate would be on the list caused several groups to broadcast their concerns through the media. One article titled "Single-Payer Advocates Worry 'Medicare For All' Hearing Could Be A 'Farce' published four days before the hearing (Fuller, 2019). The negative reporting created a fragile situation where concerns from Chairman McGovern and his staff had to be managed by gently moving the process forward. The final list was not settled until April 28th, when Ady Barkan, a well-known Medicare for All advocate and lawyer who could no longer speak or move his limbs due to Lou Gehrig's disease (ALS), had reached out to Speaker Pelosi and requested to be on the panel. As a result, the witness list was expanded to include five Majority witnesses.

On April 30, 2019, the Rules Committee hearing commenced with the following Majority Witnesses: Mr. Ady Barkan (Founder, Be A Hero Organization), Dr. Dean Baker (Senior Economist, Center for Economic and Policy Research), Dr. Sara Collins (Vice President for Health Care Coverage and Access, The Commonwealth Fund), Dr. Doris Browne, (Immediate Past-President, National Medical Association[27]), and Dr. Farzon Nahvi (Emergency Room physician). The Minority Witnesses included: Ms. Grace-Marie Turner (President, Galen Institute), and Dr. Charles Blahous, (J. Fish and Lillian F. Smith Chair and Senior Research Strategist, Mercatus Center[28]).

The Rules Committee room, which seats 50 people, was filled with press. An overflow viewing room was set up to film short videos of advocates and Members expressing their support for

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[27] The National Medical Association is the largest and oldest national organization representing African American physicians and patients in the United States.
[28] The Mercatus Center at George Mason University is a free-market oriented, right-learning think tank.

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Medicare for All. The hearing format allowed Members 15 minutes to speak and interrogate witnesses. Each Majority witness provided a unique perspective to the argument for single-payer (problem framing). Ady Barkan shared his personal story and experiences with the health care system. Dr. Farzon Nahvi told accounts of his patients who were unable to accept his care because they feared the financial cost. Dr. Doris Browne described how a single-payer universal health care system was a critical first step to achieving health equity. Dr. Sara Collins described the state of U.S. health care, and, in particular, the deterioration of the employer-sponsored health insurance system. Dr. Dean Baker explained the economic benefits of a single-payer system and how financing could potentially occur.

The financing of a single-payer system was a focal point throughout the hearing, Chairman McGovern directed his questions to Dr. Charles Blahous, the author of The Mercatus cost-analysis report that determined the Medicare for All bill would cost $32.6 to $38.8 trillion in additional federal spending but that overall national health expenditures would go down $2 trillion over the next ten years. The Chairman reframed this report by stating,

> We're spending an awful lot right now, and we're not getting the result we want. In the worst-case scenario, the country would pay close to what it's already paying for healthcare and guarantee health insurance for 29 million more people.

Rep. Donna Shalala (FL), former Secretary of Health and Human Services under the Clinton Administration, stated,

> I'm perfectly willing to debate the cost issue and how we're going to pay for it. But we're here because the employee system is deteriorating in front of our eyes. The notion that an employer-based health care system is still the core solution for health care is dead and gone.

Most of the Republican Members used their time to describe what they perceived as the Affordable Care Act's "failures" to make the case as to why Democrats could not be "trusted" with health care. They also continuously pointed out that the Rules Committee was not a committee of jurisdiction in order to diminish the significance of the hearing. Others discussed the threat of "socialism" and "government control", sentiments that have been exercised consistently throughout the history of health reform, to argue against the bill. Rep. Tom Coles (R-OK) stated, "Even if you like your plan, you really can't keep it. This bill is a socialist proposal that threatens freedom of choice and would allow Washington to pose one-size-fits-all plans on the American people." Chairman Jim McGovern responded with "If my Republican friends want to use a lot of scary words like government takeover or socialism...have at it."

The nearly six-hour long hearing was not a heated debate but instead was a substantive policy discussion that covered a wide-range of topics, including implementation, financing, and the effects of a single-payer system on stakeholders. One reporter described it as "a polite exchange regarding various aspects of health policy and cost figures (Inserro, 2019)." The hearing offered a glimpse into the policy debate that would unfold in the House of Representatives. Over the months, the office's messaging on the counterpoints to Medicare For All were refined. Furthermore, the success of the Rules Committee hearing allowed for Rep. Jayapal to show that single-payer policies as a health reform approach could garner a serious policy discussion (problem-framing). As a result, she gained commitments from the Budget, Ways & Means, Energy & Commerce, and Small Business Committee to hold a hearing on Medicare for All (scaling-up change processes).

Another critical outcome of the hearing was that it provided a template for how the office would approach each hearing thereafter: 1) influence, as much as possible, the witness panel and structure of the hearing by including a provider, a policy expert, and a patient advocate; 2) prepare Members

who were allies of H.R. 1384 with hearing questions, talking points, and resources; 3) generate media attention on the significance of the hearing; 4) fill the committee room with Medicare for All advocates; and 5) create a nearby space for grassroots organizers and engage Members with that space by requesting they come to record short videos and speak with the advocates. This approach was replicated for the congressional hearings that were held in the Budget, Ways & Means, and Energy & Commerce Committees.

3.6.2 Series of Policy Actions

Beyond congressional hearings, the Office of Rep. Jayapal, in cooperation with the Medicare for All Coalition, engaged in a series of ongoing policy activities organized throughout the year (See Figure 14).

Table 5. Ongoing & Repeated Policy Actions for Medicare for All (M4A)

Policy Action	Type of Activity	Description	Significance
Medicare for All Caucus Meetings	Using/Expanding the Network/ Problem Framing	A series of meetings were held, each with a different topic. Usually, several members attended, along with 50+ staff, to hear from experts discussing various policy impacts of M4A.	Created a forum for disseminating messaging, information and updates on the progress of the bill to offices of members part of the caucus; quarterly caucus member-level meetings and staff briefings were held following its launch
Op-eds, Media and Video	Advocacy/Leading by example	Representative Jayapal consistently engaged in social media, TV, public events, and to talk about M4A	Through a robust communication strategy, Rep. Jayapal set an example of how to talk about the policy and political implications of M4A for other policy-makers

Table 5. Table of Ongoing & Repeated Policy Actions for Medicare for All (M4A) (Continued)

Policy Action	Type of Activity	Description	Significance
Co-sponsors building	Using/Expanding the Network/ Advocacy	Built co-sponsorship for H.R. 1384 to 119 Members, half of the Democratic Caucus	This was important as it helped advocates and Rep Jayapal frame M4A as "no longer a fringe-idea" but that it was mainstream amongst policymakers. This received some attention in the news with headlines such as "Majority of House Dems Now Support Medicare for All"
Key Leadership Co-sponsor support	Advocacy/ Leading by example/ Expanding the network	13 committee chairs and members of Democratic leadership became co-sponsors of H.R. 1384	Significant effort was made to add key Congressmembers to H.R. 1384, such as Rep. Hakeem Jeffries (Chair of the Dem Caucus) and Rep. Ben Ray Lujan (Assistant Speaker of the House)
Grassroots efforts inside Congress	Advocacy/ Using/Expanding the Network	Representative Jayapal and M4A Movement members cooperated in public activities such as: petition deliveries, press calls, and townhalls	This series of cooperative actions created a steady stream of activities inside the House Office Buildings to engage other Members to participate and speak about M4A
Coalition Expansion	Using/Expanding the Network/ Scaling up change processes	American Association of Physicians; AMA actions; racial justice coalition; economist letter; business coalition	This was also important to scale up change processes for other policymakers as it helped refute the idea that a limited group of people support M4A
Policy Analysis	Problem-framing	A variety of studies of research analysis were released on the economic benefits, financial savings to the health system, health benefits, and a meta study of the cost of single-payer policy	These studies provided empirical evidence for policymakers and advocates to use to dispute the cost argument of M4A and other oppositional talking points

Each policy action's purpose was to maintain the momentum, build up support, and achieve legislative wins for Medicare for All. For example, establishing the Medicare for All Caucus created infrastructure for Congressmembers and Medicare for All advocates to establish cooperative efforts (expanding networks). Over 2019, there were quarterly meetings. Each meeting featured a different educational briefing, such as "Making the Business Case for Medicare for All" where a panel of economists and business owners came in to talk about how Medicare for All would boost economic competitiveness (problem framing). Additionally, an advocacy toolkit was created and disseminated through the caucus to assist and encourage Congressmembers and staff to host townhalls on the topic of Medicare for All back in their districts (expanding of advocacy and using networks)

Building Up Bill Support: Using Advocacy & Expanding Networks

In order to expand networks of support, much effort was focused on neutralizing opposition of Medicare for All by key Congressmembers. A key aspect of policy advocacy is to neutralize an opposing political force that may be able to impede progress on a proposed policy (Rosenthal & Highley, 2013). Therefore, it was critical to effectively neutralize concerns held by Members who could create barriers in the legislative process. For example, in February 2019, Chairman John Yarmuth of the Budget Committee was quoted as saying "I'm not sure anybody thinks that can be done" in reference to Medicare for All. Although Chairman Yarmuth had been on H.R. 676, Representative Conyers's Medicare for All Act, he had chosen not to sign onto Representative Jayapal's bill. However, with mounting pressure from the Medicare for All Coalition and Representative Jayapal to hold a hearing on Medicare for All, the hearing was finally scheduled for May 22, 2019. After several discussions with the Budget Committee staff and advocacy organizations lobbying Chairman Yarmuth, he showed a shift in his framing of single-payer. In

his opening statement for the Budget Committee hearing titled "Key Design Components and Considerations for Establishing a Single-Payer Health Care System," he stated, "I believe it is no longer a matter of IF we will have a single-payer health care system in our country, but WHEN. I hope this report and upcoming hearings help advance that timeline." A few days later, after receiving many messages of gratitude and support from Rep. Jayapal and the Medicare for All Coalition for the Budget hearing, he became a co-sponsor for H.R. 1384.

The policy activity of getting other key Members of Congress as co-sponsors of the bill required a multi-pronged approach. Another scenario required significant one-on-one time with the staff of a high-ranking Member. Our meetings consisted of explaining the policy details and identifying their concerns. After gathering their feedback, I found outside experts who could validate the policy and address their questions. For example, one of their concerns was the effect a Medicare for All system would have on safety net and community hospitals. I reached out to the CEO of a large public hospital system from this Representative's district, who also happened to support single-payer policy. He detailed to me his reasons why a Medicare for All system would benefit his hospital system and explained that his hospitals treated high numbers of Medicaid and uninsured patients, often creating an unreliable revenue stream to keep the hospitals running. He believed that a Medicare for All system would be a "life-saver for safety-net hospitals" as it would guarantee that every patient was insured, in turn creating a more stable revenue stream, and patients who were less sick by the time they arrived. I relayed this information to the Representative's staff, connecting them with the CEO, and with other credible sources (problem framing). At the same time, the Medicare for All advocacy groups gathered members who were constituents of the Representative's district to go to their townhalls and make visits to the district and D.C. office of the Member, creating a constant stream of pressure with the singular ask for that Member to sign

onto H.R. 1384 (using advocacy). Rep. Jayapal also engaged in multiple member-level conversations to gain a commitment from the Representative that they would consider signing on (leading by example). After two months of combined efforts from the Office and the Medicare for All Coalition, the high-ranking Member became the 119th co-sponsor of H.R. 1384, bringing the number of co-sponsors to over half of the Democratic Caucus (expanding the network).

Academic Community: Problem-Framing & Expanding the Network

Growing the community of academic experts was a critical part of the policy process (problem-framing). However, I had difficulty finding a wide range of experts or academics who were willing to engage in further policy analysis and promotion of Medicare for All. While several economists and academics have been engaged with single-payer advocacy for a long time, the academic community needed to be represented by newer participants to show how the policy was becoming more mainstream academically.

Therefore, the single-payer academic community's[29] most active members began engaging with graduate students and younger physicians who showed interest in health policy. Through mentorship and co-authorship, a series of studies came out from newer authors, supported by the older generation of academics. These studies were used to make the economic and public health argument for a single-payer health care system, rather than solely relying on anecdotal evidence for a Medicare for All system (problem-framing). For example, instead of policy entrepreneurs saying "Medicare for All will reduce administrative costs and give everyone access to health care,

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[29] In the 1980's, Physicians for National Health Program founders Drs. David Himmelstein and Steffie Woolhandler, established the "single-payer academic community" which has since then published 100's of papers on health care-related issues, such as medical bankruptcies and health care costs by several physicians or policy experts. Drs. Himmelstein and Woolhandler are professors of public health and health policy in the CUNY School at Hunter College and adjunct clinical professors at the Albert Einstein College of Medicine.

saving lives and money", a study by researchers from Yale, published in the Lancet in February 2020, provided empirical evidence to say "Medicare for All will save 68,000 lives and $450 billion per year for the health care system" (Galvani et al., 2020). In another example, researchers at the University of California, San Francisco, conducted a systematic review of 22 cost analyses for national or state-level single-payer plans and found that regardless of the authors' political leaning, "86% of the analyses estimated that health expenditures would fall in the first year, and all suggested the potential for long-term cost savings" (Cai et al., 2020). Both studies were helpful and necessary tools to combat the oppositional messaging about the cost of Medicare for All.

Medicare for All Messaging: Leading By Example

While details of Medicare for All were being more widely discussed than in previous Congress, there was still confusion on certain aspects of the bill. The types of messaging and education the Office focused on disseminating were often influenced by what had been said publicly by a person of important standing or by Democratic Presidential candidates. For example, in February 2019, in a *Rolling Stone* interview with Speaker Pelosi, she stated, in reference to Medicare for All, "Thirty trillion dollars. Now, how do you pay for that?"

Therefore, it was important to address the cost of Medicare for All as directly as possible. With the communications team, a video of Rep. Jayapal with a whiteboard "breaking down" how to pay for Medicare for All was created. First, it was important to emphasize the cost of our current system, stressing that projections show we will spend $50-55 trillion dollars over the next ten years on health. Based on the studies available, the messaging stated that Medicare for All would either cost the same or less than our current system, but also guarantee everyone coverage from "cradle to grave." Then, the video explained the breakdown of health spending, by highlighting the fact that

the federal government already pays for a majority of it but that families were also bearing so much of the burden because of their high private insurance premiums and out-of-pocket spending. Therefore, Medicare for All wouldn't necessarily require "new revenue"— all the money needed for Medicare for All was there, it would just require "re-routing of revenue from private to public" (which is undoubtedly another technical and political feat of its own but was not the point of answering how to "pay" for it). Then, it focused on the savings produced by "eliminating administrative waste and cutting prescription drugs by nearly half" that would allow Medicare for All to cover everyone. I spent significant time with Rep. Jayapal, briefing her on the most up-to-date numbers and rehearsing Medicare for All messaging against oppositional statements. She became well-practiced in the various talking points and went on several media venues to publicly talk about "how to pay for Medicare for All" (leading by example).

Also, the Office actively engaged with policy experts and academics who supported single-payer policy to echo similar points. For example, on May 21, 2019, 250 economists sent a letter to Congress endorsing Medicare for All, stating:

> Public financing for health is not a matter of raising new money for healthcare, but of reducing total healthcare outlays and distributing payments more equitably and efficiently. Implementing a unified single-payer system would reduce administrative costs and eliminate individuals' and employers' insurance premiums and out-of-pocket costs…a sensible Medicare financing system would reduce healthcare costs while guaranteeing access to comprehensive care and financial security to all. (J. Johnson, 2019)

Following the release of this letter, the Office circulated it via e-mail to every Member's office who was a co-sponsor of H.R. 1384. Then, Rep. Jayapal referenced the letter any time the cost

question was asked of her. Similarly, esteemed economists Emmanuel Saez and Gabriel Zucman from the University of California, Berkeley, published a series of op-eds on Medicare for All. *The Guardian* op-ed, titled "Make No Mistake: Medicare For All Would Cut Taxes For Most Americans" stated,

> Funding [Medicare for All] through taxes would lead to a large tax cut for the vast majority of workers. It would abolish the huge poll tax they currently shoulder, and the data show that for most workers, it would lead to the biggest take-home pay raise in a generation. (Saez & Zucman, 2019)

Robert Reich, former Secretary of Labor, created a series of instructive online videos circulated by the Office that explained Medicare for All, including addressing the cost question. Therefore, instead of focusing on specific "pay-fors", Medicare for All messaging highlighted experts who noted the savings and potential positive impact on the labor market as an effective alternative message. This framing shifted the narrative towards the economic benefits of the system, rather than letting the conversation be dominated by more politicized messaging, such as "middle-class tax hikes."

Additionally, throughout the 2020 Democratic Primary debates, the issue of "choice" of private plans came up repeatedly by opposition candidates. Polls were consistently being published that showed support dropped when you asked questions with framing such as "Do you support Medicare for All if it eliminates all private health insurance?" The framing was misleading because the bill didn't eliminate private insurers, but instead significantly diminished their role. It also seemed to purposefully exclude explaining that the policy design would allow all doctors to be in-

network.[30] On July 29, 2019, a poll by Morning Consult was published that followed up with the question "Do you support Medicare for All if it diminishes the role of private insurers but allows you to keep your doctor and hospital?"

As shown in Figure 15, the poll found that with this additional framing, support was even higher than when people were asked the question alone "Do you support Medicare for All?" The article concluded "the new data suggests that the consequences of that argument can be mitigated by clarifying that losing private insurers would not affect access to preferred providers." This gave us the ability to clarify the talking point that, "People don't want a choice of their plan, they want choice of their doctor. Medicare for All gives you even more choice because all doctors will be in-network." Congresswoman Jayapal presented the poll at the next Medicare for All Caucus Meeting while I provided materials with talking points and other relevant polling to the 50+ staffers who were in attendance.

Figure 14. Morning Consult Poll: Medicare for All Support
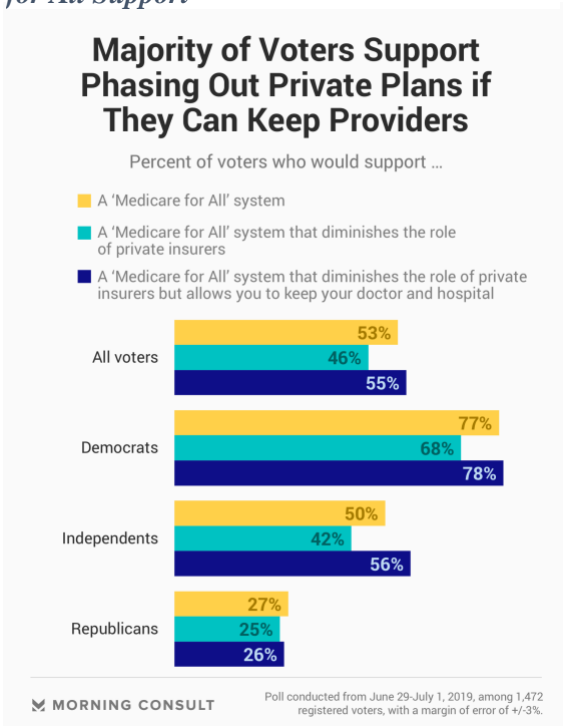
Source: (Morning Consult, 2019)

Another commonly stated belief was that Medicare for All meant Medicare rates for providers. This led opposition to say, "Medicare for All would shutter hospitals; they can't survive on

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[30]Under H.R. 1384, all providers would be "eligible participating providers"; there is a clause that allows providers to receive private contracts for services covered by Medicare for All but then they are not eligible for any payment from the program; providers are also allowed to receive private contracts for services not covered under Medicare for All.

Medicare rates". However, the bill does not actually reference the exact payment rate and instead states a "comparative rate system." Therefore, in conversation with provider groups, hospitals, and other stakeholders, the Office stated that the bill envisioned a payment rate between Medicare and the current all-payer average rate.[31] Since all-payer rate setting via global budgets has been implemented in Maryland, that model was helpful to loosely reference how a Medicare for All payment could be set. The Office began disseminating educational materials to create a better understanding on the mechanics of global budget payment models.

I found that it was not too difficult to get people to agree that the U.S. health care system needed to be improved but this did not mean they agreed Medicare for All was the right solution. Therefore, the Office also disseminated messaging on how other policies, such as a public option, may cover more people, but would not guarantee universal coverage, bring in the same savings of Medicare for All, and contain costs as effectively. This type of strategy was implemented over and over again as a tactic to educate Congressional Members and staffers about the details of the Medicare for All plan and to actively dispel misconceptions and attacks that were being publicly noted through ads, op-eds, and social media.

Growing the Advocacy Community: Expanding Networks

Expanding the advocacy community to include other stakeholders, such as racial justice organizations, businesses, and physician associations, was also critical. Racial justice organizations, like the National Association for the Advancement of Colored People (NAACP) had endorsed Medicare for All previously but were not actively engaged in promoting the policy,

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[31] The all-payer average rate is estimated to be 124 percent of current Medicare rates for hospital payments and 107 percent of current Medicare rates for physician payment.

as they had been focused on other legislative priorities. A few Medicare for All groups made a particular effort to engage the NAACP, along with several other racial justice organizations to prioritize Medicare for All. This effort culminated into a joint letter[32] to Congressmembers, which described why the need for universal health care was a racial justice issue and urged them to sign onto H.R. 1384. To promote the letter, the Office hosted a press call where Representative Jayapal, three other Congressmembers, and various racial justice organizations spoke about the release, the significance of the letter, and the importance of framing Medicare for All as a racial justice issue.

Furthermore, there were significant efforts made to grow more support among physicians and clinical groups. Since the AMA, the largest association of physicians, has explicit anti-single-payer language in their organization's doctrine, several advocacy groups, along with medical students, led a series of actions at the AMA conference in June 2019 to overturn its opposition. This involved a march of several hundred doctors, nurses, medical students, and community organizers outside the conference, and a smaller group disrupting the meeting's opening session. The effort resulted in a close vote of 47 "yay" and 53 "nay" on removing the anti-single-payer language. While the vote failed, several media outlets captured this as a signal that "single-payer continues to gain real momentum…Medical industry opposition might not be as monolithic as it first appears." (Scott, 2019). Shortly after, the AMA dropped out of the Partnership for America's Health Care Future (PAHCF), an alliance of hospital associations, pharmaceutical lobbyists, and insurance industry dedicated to preventing legislation that would lead to single-payer health care, expanding Medicare at any level, or providing a public option.

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[32] The letter was sent on July 10, 2019. It can be found here:
https://populardemocracy.org/sites/default/files/m4a%20racial%20justice%20letter%20with%20logos%207.10.2019.pdf

Additionally, substantial efforts were made by the Medicare for All Coalition members to encourage the American College of Physicians (ACP), the second-largest physician group in the U.S., to give a public endorsement of Medicare for All. On January 20, 2020, ACP released its endorsement and 2,000 physicians signed an open letter published in a full-page ad of *The New York Times* "prescribing" Medicare for All. Their support was particularly significant as it helped the Medicare for All policy entrepreneurs push back against the opposition from the AMA and show policymakers that a substantial portion of physicians believe Medicare for All is an effective policy for health reform. By August 12, 2020, the Society of General Internal Medicine also publicly endorsed Medicare for All.

3.7 Lessons from The Problem Window

While there were many successful policy activities throughout my fellowship, I identified four key challenges:

1. Getting the Message Across on Medicare for All
2. The Bureaucracy: The 435 Fiefdoms on the Hill
3. Power of Staffers: Gatekeepers of the Policy Process
4. Lessons From Other Health Policy Struggles

Getting the Message Across on Medicare for All

H.R. 1384 is, without a doubt, an ambitious bill. It seeks to transform almost every aspect of the health care system. Many health staffers did not have any level of training or background in public health, health care, or health policy. Finding champions, whether at the staff or Member level, was difficult as people were not comfortable speaking about the topic given its complexity as a policy

and the contentious politics surrounding the topic. Each week, a health staffer from an H.R. 1384 co-sponsor's office reached out to me for messaging guidance or technical assistance with understanding the policy.

For example, a message that was critical to set consistently across offices was the answer to "What is Medicare for All?" The most common misconception was that Medicare for All is Medicare-as-is-for-All. Traditional Medicare currently does not cover dental, hearing, vision and prescription drugs, and has a high deductible and out-of-pocket maximum. Therefore, it was important to provide easy messaging guidance that could help efficiently and effectively describe it, for example: Medicare for All takes Medicare and improves it- because while we know our seniors love Medicare, it still doesn't cover everything they need. That's why we improve Medicare to include comprehensive benefits, such as [dental, vision, hearing, primary care, mental health, prescription drugs, reproductive health, and long-term services].[33] And then we expand it to everyone. All this, with no co-pays, private insurance premiums, deductibles, or out-of-network doctors. Private insurance won't be able to cover the same benefits provided by Medicare for All, but they can provide supplemental insurance.

To get messaging disseminated, I created a "Medicare for All Newsletter" that went out at least monthly. The purpose of this newsletter was to keep the offices of H.R. 1384 co-sponsors informed of important developments for Medicare for All and provide messaging guidance and clippings to maintain attention and engagement from staff across Members' offices (using networks). I also created additional guidance materials and ran education sessions at the staff level. These sessions were designed to find the gaps in understanding and to align messaging across offices. For example,

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[33] Depending on the stakeholder, the list of benefits mentioned was adjusted accordingly to match their priorities.

some supporting offices casually referred to Medicare for All as "socialized medicine" and "government run health care" when they spoke about the bill. To remediate this, I explained to them the inaccuracy of using those labels, since Medicare for All maintains private delivery of care, and why those phrases can trigger negative sentiments about health care. I encouraged them to say "government-financed health care" instead.

While I believe the Office made progress, considerable gaps in understanding Medicare for All remain across offices and Members of Congress. In order to expand the number of political champions, a more robust effort will be needed to educate Members and staffers about the various policy provisions in the Medicare for All bill.

The Bureaucracy

Each of the 435 Representatives has a staff of about 10-13 full-time employees and several interns. Each office has a different protocol, human resources policy, strategy, and internal processes on top of the House's complicated legislative procedures. Several people throughout my experience referred to this structure as hundreds of "mini-fiefdoms" working simultaneously but not together. Furthermore, each day is difficult to structure as each staff member's agenda revolves around the Representative's schedule, which is dictated by unpredictable speaking orders in committee hearings and arbitrary timing for floor votes that requires the members and relevant staff to stop what they are doing and get to the floor to record their vote. Every day is filled with speaking events, meetings with constituents from the Representative's district, briefings, policy analysis, and drafting hearing remarks, floor speeches, or memos for the Member. It is very difficult to wield power and use influence in the House due to its massive and fragmented institutional structure.

Additionally, the low number of staff available to each office, due to constrained budgets, meant that each legislative staffer held a portfolio of a vast range of topics for which they were to provide expertise and assistance whenever the policy area came up for the Representative. Therefore, my position is considered a rarity on the Hill for being able to cover one legislative topic and specialize on a single policy. For example, one legislative staffer in the office was responsible for: Agriculture, Appropriations, Budget, Defense, Disability, Education, Environment, Financial Services, Foreign Affairs, Housing, Labor, Native Americans, Small Business, Social Security, Trade, Transportation, Veterans, and Women's Issues. She did not have any educational or professional training in any of the topics except foreign affairs, yet she was tasked with providing technical advice on each area. A majority of legislative or senior staff I met started on the Hill as interns, then moved up the proverbial ladder to their current positions, meaning they often had no technical training or directly related professional experiences outside of Congress.

Overall, this makes it difficult to align staff members in other offices with one's priorities because they are juggling an immense workload across a wide variety of policy areas and each Representative has a different policy agenda. This is a problem not only prone to health policy but also for any major legislative initiative. I had put on my list of strategy priorities: identify which Members have most potential to become Medicare for All champions and develop relationships with their health staffer. The goal was to expand the number of Members with Medicare for All at the top of their policy priorities.

However, I found that it was difficult to push health staffers to concentrate on Medicare for All as there were other health policy priorities that were further along in the legislative process, such as drug-pricing and surprise billing. Medicare for All was often not the most "urgent" or "top-of-mind" issue for many of my colleagues. For example, Rep. Dingell, H.R. 1384 co-lead, is on the

E&C Committee and Subcommittee on Health which are well-known for being exceptionally busy with committee activity. Rep. Dingell and her office expressed often that they wanted to focus more efforts towards Medicare for All. However, although they wanted to be stronger political champions, E&C left them with limited resources outside of the committee to put towards Medicare for All. For other offices, I found that the best way to engage health staffers on the topic was to invite their Member for a speaking role at a well-publicized Medicare for All. This way, if they needed any assistance with talking points, policy clarifications, or coordination for the logistics of the event, I was a ready resource for them.

The Power of Staffers

While Members of Congress are incredible wielders of power and decision-makers, the number and level of decisions made at the staff level everyday was astounding to witness. Before my fellowship, I was given the advice that as a staffer, I would "have a lot of influence but no power." My experiences showed me a different dynamic. While a Member of Congress certainly made many high-level decisions, they often served as the public-facing proponent and spokesperson for the hundreds of decisions made by staff members. This meant that staff could be very effective at setting priorities for the Member, and in some cases, blocking information and processes.

For example, when a committee Chairperson told Rep. Jayapal they would be willing to have a Medicare for All hearing, the Office reached out to the respective staff to begin the logistics and planning for such hearing. The Office was connected with an entry-level staffer who informed me that while he was enthusiastic at the prospect of a Medicare for All hearing, a recent change in senior leadership for his office positioned a staff member who was very opposed to holding the hearing. I encountered several instances like this one, where if exceptional persistence was not

pursued, the situation would have simply ended there. To make it easier for the committee staff, a proposal was drafted for the hearing that would soften the "Medicare for All" association and frame the hearing about "The Impacts of Universal Health Care" to broaden the policy discussion and include other Member's proposals. When this was rejected, the strategy needed to shift to directly communicating with the Chairperson instead of the senior staff to ensure the hearing would occur. Rep. Jayapal then went directly to the Chairperson to question the status of the hearing. The Chairperson indicated to Rep. Jayapal they had no idea there was anything delaying the hearing. A half hour later, the Office received a call from the senior staff member to coordinate the details of the hearing.

While the senior staffer may have been acting with their Member's best intentions in mind, or perhaps was even instructed to do so, staffers were often underrecognized as the power-wielders and gatekeepers they can be in the policy process. Another clear example of the power of staffers was exemplified during the process for drug-pricing legislation as described in the following section.

Lessons Learned from Other Health Policy Struggles

Medicare for All was far from the only health legislation being promoted in the House. Other policy topics were much further along the legislative process, such as surprise-billing and drug-pricing. The passage of drug-pricing legislation and the debate on surprise billing was a fight of miniscule proportion compared to the scale of Medicare for All would require. My experiences with these health policies gave me a small peek into the kind of top-down legislating, in-party fighting, lobbying efforts, and power struggles that would occur if Medicare for All ever started moving towards a vote.

<u>H.R.3</u>

H.R. 3, the major drug-pricing legislation introduced by House Leadership, was a micro showcase of what the power struggle looks like for influencing health policy. The bill drafting was particularly top-down and did not allow any input from the CPC. Rumors had spread that the bill would use an arbitration process as a means to set drug prices, which the CPC vehemently opposed. The CPC countered with a public letter stating their priorities for a drug-pricing bill and what provisions, such as arbitration, would lead them to oppose it. After months of waiting for the bill text to arrive, a copy was leaked by an outside source, which quickly circulated over e-mail. CPC began strategizing what amendments could be put forth based on the leaked text. Given that Rep. Jayapal was on the Education & Labor committee, she had an opportunity to put forward an amendment during mark-up of the bill.[34] Since the only jurisdiction Education & Labor had was for plans under ERISA[35], a legislative strategy was decided for Rep. Jayapal to put forth an amendment that would expand H.R. 3's inflation rebate not only to Medicare but also across all employer and group health plans.[36]

The night before the mark-up was spent negotiating with the Committee staff around the legislative text and whipping offices for their support. The amendment was technically difficult, and the Committee did not feel it was feasible to implement. Therefore, the Office suggested that the amendment be a study to determine how this could be done, and then include a "rules promulgation" that requires the contents of that study be implemented. This way the technical pieces did not have

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[34] A committee markup is the key formal step a committee takes for a bill to advance to the floor. This process allows for new draft text and the offering of amendments to the bill, including possibly a complete substitute for its text.

[35] ERISA (Employee Retirement Income Security Act) encompasses most private sector health plans, such as employee benefit plans.

[36] H.R. 3 originally included an inflation rebate for drugs, covered by Medicare, whose prices rise higher than the rate of inflation, that amount would be rebated back to Medicare.

to be determined before the mark-up but would have a guarantee that the inflation rebate would eventually apply. The morning of the markup, the Committee finally agreed to the text. Several labor unions wrote to Committee staff and Chairman in support of the amendment. Then, every legislative staffer in the Office called the offices of each Member of the committee to ask for their support an hour before the mark-up was to begin. The amendment passed through voice-vote (unanimously). Rep. Jayapal's amendment was the only one to make it through any committee that made a substantial technical change to the H.R. 3.

Over the coming weeks, rumors began circulating amongst labor unions and Members' offices that the rules promulgation would be removed from the final bill, reducing the amendment to only a study. When Rep. Jayapal's staff began discussing with the senior health advisor for Speaker Pelosi, he pointed to potential delays for the Congressional Budget Office score if the entirety of the provision was included.[37] Feeling that this was a not a valid reason, a coordinated inside-outside strategy was initiated to emphasize to offices and House Leadership why Rep. Jayapal's amendment, along with other CPC priorities, were critical to include into the bill. Rep. Jayapal made her concerns publicly known and stated in a press article, "I don't know why I'm having to fight so hard for an amendment that already passed through committee." The same article included statements from Pelosi's senior advisor who reiterated that part of Rep. Jayapal's amendment would be stripped out of the bill and stated, "Representatives Pocan and Jayapal are gravely misreading the situation if they try to stand in the way of the overwhelming hunger for H.R. 3 within the House Democratic Caucus and among progressive Members." Soon after the article, the CPC surveyed its members on whether they would vote against the rule for the bill, which would

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[37] "Score" or "CBO Score" is a term that "generally refers to a cost estimate conducted by the nonpartisan Congressional Budget Office (CBO). The agency is required by federal law to undertake a formal cost estimate for most legislative proposals (except appropriations measures) that are passed out of a House or Senate full committee. CBO cost estimates employ certain economic assumptions and require the agency to make particular projections over a period of time, usually 10 years" (*CBO Score*, n.d.).

block it from coming to the floor if their demands were not met. At that time, 18 members were needed to vote against the rule; the CPC then broadcasted that it had the numbers. In a final negotiation attempt with Speaker Pelosi directly, and Chairman McGovern present to facilitate the Rules process for the final text, Rep. Jayapal and Rep. Pocan were able to secure Rep. Jayapal's provision, as originally intended, and one other CPC priority that expanded the number of drugs that would be negotiated.

The H.R. 3 legislative process highlighted the challenges that occur when going against one's own political party and the levers that are important to manage. For example, committee placements were critical since the bill drafting was closed-door. Therefore, the only formal process to get changes made to the bill was through the mark-up, which required a Member to be on the dais in order to put forth an amendment. Second, since it was a highly partisan bill, Leadership was not able to go to Republicans for support to make up for potentially lost votes by the CPC. Furthermore, outside pressure from a broader coalition of organizations, including more moderate advocacy organizations and labor unions that have close relationships with Leadership, was critical to signal wide support. These conditions gave the CPC more leverage right before the final step of the legislative process. Scaling these circumstances will be critical for the CPC to exercise power and operate as an effective voting bloc in future serious attempts at health reform.

<u>Surprise Billing</u>

Another major health policy priority for the House was addressing surprise bills. Surprise bills can occur when someone goes to a hospital covered by their insurance network, but a doctor or specialist at the hospitals who treated them happened to be out-of-network. For example, if someone goes to the emergency room due to a medical emergency and happens to be treated by a

doctor who is not in-network for the patient, even though the hospital is, that patient will receive a surprise bill and may owe the entire cost of care. Research has shown that the increased buying of physician practices or creating of "physician staffing companies" by private equity companies have significantly contributed to a greater incidence of surprise bills, due to their physicians often being out-of-network (Appelbaum & Batt, 2020)

There were two bipartisan and bicameral bills introduced to address surprise-billing. One proposal would pay providers an average in-network rate for a surprise bill (also known as benchmarking) while the other called for an arbitration process that would allow the doctor and insurance company to go through an independent review to determine a fair price. Both would take the patient out of being liable for the surprise bill. The benchmarking bill became known as the "insurers" bill and the arbitration became the "physicians" bill. The correspondence I received on this issue were constant and it was the most requested meeting health policy topic by lobbyists across offices. I met with many doctors in their white coats who explained why arbitration was the best route for them and why benchmarking would collapse the insurance networks and their practices. All year long, both insurers' and doctors' groups were hosting opposing seminars to make the case for their policy position. CPC's involvement was limited as they did not support either bill, but the incessant lobbying led many progressive Members to begin opposing the benchmarking bill (which is ironic given they supported Medicare for All).[38]

By December 9, 2019, the Senate HELP committee and House E&C committee reached a compromise and put forth a bipartisan, bicameral bill that would pay doctors an average in-network

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[38] In September 2019, a New York Times article revealed that a provider group called "Doctor Patient Unity", which spent more than $28 million into ads opposing "government rate-setting that will lead to doctor shortages and hospital closures", was financed by two private-equity funded medical companies. (cite)

rate for bills up to $750, and bills above $750 would go to arbitration. This bill went through mark-up in the Education & Labor and Energy & Commerce, with Ways & Means the only committee left before it could go to a floor vote. However, a week after the compromise bill was introduced, Ways & Means Chairman Richard Neal introduced a one-page counterproposal that did not directly protect the patient from a surprise bill, using benchmarking or arbitration. Instead, it relied on "enhanced consumer protections" such as increased transparency from hospitals and providers. This one-page outline indicated that Chairman Neal was not willing to put the bipartisan, Senate, House, and President-endorsed bill through his committee, completely halting its chances of reaching a floor vote.

Even though addressing surprise billing was at a top priority for the Democratic Party, similarly to the Clinton health reform disaster, the existence of several competing policy solutions and effective lobbying against the solution with the most congressional and Executive support, resulted in a divided Congress that was unable to pass any legislation on the matter. The political unviability of the use of benchmarking for surprise billing, a policy fix that is miniscule in comparison to Medicare for All, contributes to the belief that major health reform is (nearly) impossible. Therefore, Medicare for All policy entrepreneurs may need to consider a more prominent role in pushing these "smaller" policies, in order to help build the political case for Medicare for All.

3.8 Discussion

Over the past century, a single-payer system has been repeatedly offered as a policy solution for health reform, but it has not aligned with the problem stream effectively to create a window of opportunity for more policy action, nor has it aligned with the political stream. Past single-payer bills gained a small number of co-sponsors or minimal policy consideration and debate. By the

end of 2019, over half the Democratic Caucus were co-sponsors of the bill, four Congressional hearings had been conducted, and single-payer policy had become mainstream in health policy conversations amongst Members and staffers. Policy entrepreneurs, such as Representative Jayapal and the Medicare for All Coalition, engaged in all three vital resources (claim to a hearing, political negotiating, and persistence) and a series of effective policy actions, all of which, for the first time, successfully aligned the policy stream of single-payer Medicare for All legislation to the problem stream.

Compared to previous health reform attempts, there were three key strategies that contributed to the successes of the past year and will need to be perpetuated for Medicare for All's momentum to grow: 1) an inclusive policy creation process; 2) inside-outside strategy with an emphasis on promoting education about the bill; and 3) coalition building. In contrast to other health reform attempts, Rep. Jayapal included a diverse group of stakeholders into the policy creation process, including physicians, nurses, labor unions, advocacy organizations, and think tanks. This also allowed for substantial buy-in and commitment from each stakeholder in the policy and political actions following the introduction of the Medicare for All legislation.

Another significantly different strategy for this single-payer push compared to previous attempts is the close cooperation with grassroots partners and various stakeholders, also known as an "inside-outside" strategy. From the bill drafting phase to building co-sponsorship for the legislation, almost every policy action was conducted in cooperation with the Medicare for All Coalition. This meant it was critical to know when the appropriate time was to apply inside or outside pressure for a particular policy action. The combination and timing of "inside-outside" strategy proved effective in gaining co-sponsors, building up attention for the congressional hearings, and achieving various legislative milestones, such as when the provider associations

endorsed Medicare for All. A clear and consistent communication stream was established between a diverse group of Medicare for All organizations and the Office of Rep. Jayapal, which was not always the case for legislative offices that led previous single-payer policy attempts (Hern, 2020). Furthermore, a significant portion of efforts were dedicated not only to promoting support, but also understanding of the bill.

Additionally, broadening the support within the academic community and further engaging supportive stakeholders was critical to show that momentum was building. In particular, the ability to point to evidence and reputable academics to support the positive claims about Medicare for All was necessary to gain support from unsure high-level Members. Furthermore, garnering support from organizations that had not been actively promoting single-payer, such as physician groups and racial justice organizations, allowed for tailored messaging. Significant investment will need to be made to further grow academic evidence on the impacts of H.R. 1384's policy decisions and to encourage newer supporting groups to become more active champions of Medicare for All.[39]

The quasi-ethnography captured key events and actions that led to the most productive legislative year for a single-payer policy. However, the policy stream is far from fully matured as much of the softening-up efforts were focused significantly more on the 'acceptability' of the legislation, compared to developing the 'technical feasibility.' With the current political barriers (Republican Senate & Administration) in the 116th Congress, the aim for the Medicare for All bill was to continue building support for the main tenets of a single-payer policy. However, in order to be prepared for a policy window, Medicare for All legislation will need significantly greater resources and investment into the policy development. There are several key policy provisions that have not

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[39] Strategies to address this are detailed further in Chapter Five.

yet been determined or defined, yet, these details will be critical to generate further legislative consideration. A more finely-tuned and nuanced bill will also be necessary as the politics stream shifts significantly more towards Medicare for All. Key provisions that require further definition and consideration are described in Section 5.3.1.

Furthermore, given the prominence of Medicare for All on the political stage during the 2020 Democratic Presidential Primary election, and the concurrent legislative support-building occurring in the House, the debate often affected the Office's strategy and priorities. Therefore, it was critical to establish the beginnings of a rapid-response strategy to shape the narrative inside the House and of the public. The need for a rapid-response to the unfolding political dynamics highlighted a limitation of the Kingdon MSF model, which claims the streams maintain independence from each other. However, as the factors and conditions within the politics stream for Medicare for All consistently influenced the policy process, the streams seem to have more interdependence then asserted by Kingdon.

Lastly, my observation of the U.S. political system allowed me to identify how roadblocks can occur for any major legislative initiative in the House of Representatives. The various procedural or committee rules creates a complicated labyrinth that can allow for the consolidation of power and blocking of progress by inside elected officials, staffers, and outside interest groups. Shepherding legislation requires intimate knowledge and understanding of the numerous junctures where progress can be maintained or halted. It also requires that policy champions, both at the Member and staff level, be positioned at various points throughout the process, as evidenced by the success of including progressive priorities in H.R. 3.

Representative Jayapal and the Medicare for All Coalition created an unprecedented window of opportunity in the House of Representatives that allowed Medicare for All to become a seriously considered policy for health reform. The inside-outside coordinated policy actions that contributed to Medicare for All's growing legislative support must be continued and replicated. Additionally, significantly more investment in Medicare for All's policy development will be necessary so that legislative activity and the softening up process can be sustained in the next Congress. As the journey so far makes clear, deep institutional and process understanding is critical in successful legislative outcomes in the House of Representatives, for Medicare for All, or any other major legislative initiative.

4.1 Introduction

"I will happily take the Danish health system, but you must also give me the Danish political

system…and it would surely help if you gave me the Danish people."

Uwe Reinhardt, Princeton University economist (Jha, 2020)

Medicare for All's politics stream developed due to the rise in urgency of addressing health care reform, Senator Sanders's 2016 presidential run, and a newly Democratic-majority House. By 2019, the stream had furthered matured, as evidenced by the fact that eight of the 21 Democratic presidential candidates campaigned on Medicare for All, including four Senators who were co-sponsors of Senator Sanders's bill.[40] Consequently, Medicare for All received significant attention at every Presidential Democratic Primary debate while advocates deployed extensive strategies to promote understanding of the policy to match, and encourage, the growing public interest in the proposal. Concurrently, The Partnership for America's Health Care Future, a group comprised of major pharmaceutical companies, insurance companies, and private hospital lobbyists, spent millions on TV ads using similar messaging against health reform that has been used over the past century. Polls indicated that public support for Medicare for All mildly fluctuated but remained at majority support throughout the primary cycle (KFF, 2020). Overall, the 2020 Presidential Primary election indicated the Democratic Party's significant shift to the left, as every candidate's platform contained substantial federal initiatives across policy topics, and especially in health care.

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[40] The four Senators on Senator Sanders's S. 1129 Medicare for All Act of 2019 were Senators Kamala Harris (CA), Elizabeth Warren (MA), Corey Booker (NJ), and Kirsten Gillibrand (NY),

The politics stream is influenced by national mood, interest groups, and administrative and legislative turnover. Throughout the 2020 Presidential Primary election, supporting advocates, political champions and oppositional parties were constantly debating the merits and drawbacks of Medicare for All. Furthermore, even though a Republican Senate and President were clear barriers for progress on health reform, the potential for administrative and legislative turnover was imminent due to the upcoming election. Meanwhile, the national mood was evolving as the public heard more about the proposal. Oppositional politicians and interest groups were particularly effective at amplifying Medicare for All's "32 trillion-dollar price tag" and "elimination of private health insurance." The same public concerns and fears shrouding past health reform attempts began to reappear which impacted Medicare for All's support from potential political champions.

For example, 2020 Democratic Presidential candidates, Senator Kamala Harris, Former Congressman Beto O'Rourke, and Senator Elizabeth Warren had each previously expressed staunch support for single-payer Medicare for All. However, as the campaign trail continued, each began evolving their message on what they envisioned for health reform. Former Congressman O'Rourke changed his stance to the "Medicare for America"[41] proposal by Rep. Rose DeLauro (CT) and Rep. Jan Schakowsky (IL), stating, "It responds to the fact that so many Americans have said, 'I like my employer-based insurance. I want to keep it. I like the network I'm in. I like the doctor that I see." Senator Harris was the first co-sponsor to sign onto Senator Sanders's Medicare for All bill. By late July 2019, her campaign released a new "Medicare for All" plan[42] that maintained a significant role for private insurers and stated,

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[41] Medicare for America is a proposal that provides a public option called Medicare for everyone but allows individuals and employers to continue purchasing gold-level private insurance plans

[42] Senator Harris's proposal, published on her campaign website, would require a 10-year transition to a system that would provide a Medicare program to everyone, that is publicly financed, but would allow private insurers to administer plans, similarly to the Medicare Advantage model.

Senator Harris was hearing from lots of voters real concerns, specifically about proactively

abolishing private insurance, the four-year transition, middle-class tax hikes, and so she

came up with her own plan to adjust for those that, frankly, is better than his. (Goodkind,

2019)

Senator Warren, who had become an outspoken proponent for Medicare for All, eventually

released two proposals. First, she released a Medicare for All financing proposal that would allow

her to say, "no taxes will be raised on the middle-class." The second proposal detailed a transition

plan that split Medicare for All into a two-bill path: a bill that would establish a "Medicare for All

public option" through budget reconciliation, then a legislative push for single-payer Medicare for

All. [43] The press and advocacy groups perceived this as Senator Warren admitting political

infeasibility of the Medicare for All proposal as a whole.

Similar to past health reform attempts, Medicare for All faced contentious debate, scrutiny, and

backlash. However, the efforts made by the national grassroots movement led by the Medicare for

All Coalition was unique to this health reform attempt. Therefore, analyzing the Medicare for All

Coalition, as well as the broader political environment for health reform, can elucidate the factors

that shaped the state of the politics stream and the bill's prospects for success. This section provides

the results from two methodological approaches. First, it presents the stakeholder network analysis

and mapping, which examines the power, influence, and connectedness of the Medicare for All

Coalition. Then, it provides the qualitative analysis results from key informant interviews

conducted with health policy-making stakeholders.

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[43] According to the House Committee on Budget, "Budget reconciliation is a special process that makes legislation easier to pass in the Senate. Instead of needing 60 votes, a reconciliation bill only needs a simple majority in the Senate. Reconciliation starts with the Congressional budget resolution. The budget cannot be stalled in the Senate by filibuster, and it does not need the President's signature" (House Committee On The Budget Democratic Caucus, 2018).

4.2 Methodology #1

The Medicare for All Coalition consists of many diverse organizations, such as progressive advocacy organizations, think tanks, unions, provider organizations, and a business coalition. This analysis is not all encompassing of the Coalition and focuses on the 11 most active organizations that also cooperated in various efforts with Representative Jayapal's office. Stakeholders included several leading non-profit organizations, think tanks, unions, and advocacy organizations from the Medicare for All Coalition. First, I sent a stakeholder survey to each organization.

My stakeholder survey contained questions about the details on the organizational history and key characteristics, its level of resources and institutional focus devoted to Medicare for All, the strategies and tactics utilized for Medicare for All, key collaborators, and future strategic plans and priorities. An email was sent to all 11 stakeholders in the sample, asking whether they wished to participate in the survey (Annex 1). The email included an "opt-out" link for stakeholders to unsubscribe themselves from the survey if they did not wish to participate. No respondents opted out. The data was gathered from April 2019 to February 2020. RedCap, a secure, online data capture platform, was used to collect and store the stakeholder survey data.

The data from these surveys was used to construct a stakeholder analysis matrix of these groups and determine their priorities, strategies, and their level of power and influence within the Medicare for All Coalition. Then, I utilized the Kumu online software to create a network analysis map (refer to Figure 19) that illustrated the size/power of each organization; the organization's primary and secondary collaborators and size of their network, and; the types of activities they undertook with primary collaborators.

4.3 Results: Stakeholder & Network Analysis of The Medicare for All Coalition

This section will provide a stakeholder network analysis of the Medicare for All Coalition based on the survey.

4.3.1 Organizational Characteristics & Level of Support

The Medicare for All Coalition consists of a diverse array of organization types. As shown in Figure 16, almost a majority of the groups identified themselves as hybrid 501(c)(3) and 501(c)(4) organizations. For example, The Center for Popular Democracy, a 501(c)(3), is the sister organization to The Center for Popular Democracy Action Fund, a 501(c)(4). This structure is consistent with the changing landscape of activism, as the 501(c)(3) organizations continue to use unique tax benefits, such as deductible donations, but due to the limitations on legislative lobbying, utilize a 501(c)(4) arm or sister organization to engage in political work (Pozen, 2018). Furthermore, all of these organizations, except for one union, are progressive advocacy/political groups, or single-issue (e.g., single-payer) focused organizations.

Figure 15. Results of Organizational Characteristics from Stakeholder Surveys (n=11)

90
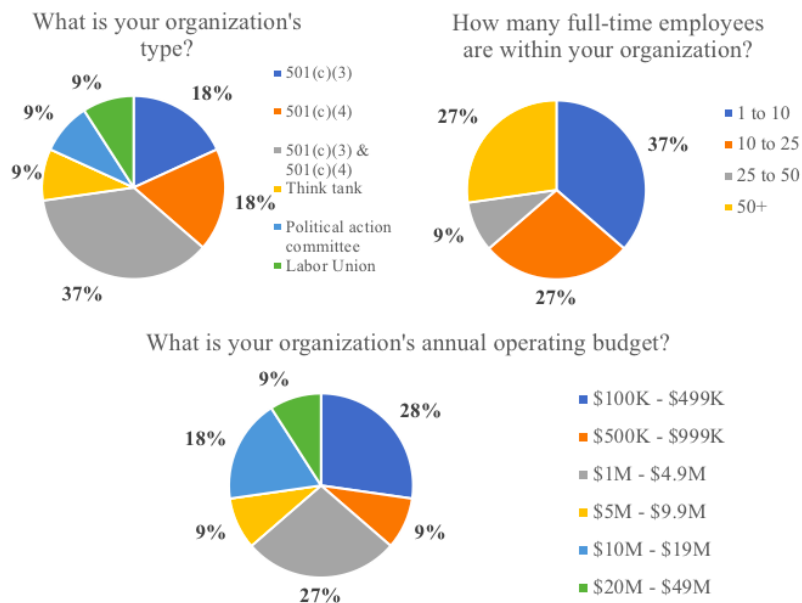
A third of the coalition consists of small organizations with one to 10 employees and an operating budget of $100,000 - $499,999, while 36% of the organizations have a $5 million to $49 million budget and have 25+ employees. The various levels of operating budgets indicate that while most of the organizations are relatively small, several in the coalition are large and well-financed.

Figure 17 shows half of the organizations spend up to 20% of their annual budget on Medicare for All activities, while more than 42% spend between 70% to 100%. Additionally, less than one-third of the organizations have Medicare for All as their sole issue area and were initially founded to support Medicare for All or single-payer policy. Therefore, more than half of the organizations are multi-issue advocacy groups, and Medicare for All is just one of their priorities.

Figure 16. Results of Level of Organizational Support from M4A Stakeholder Surveys (n=11)
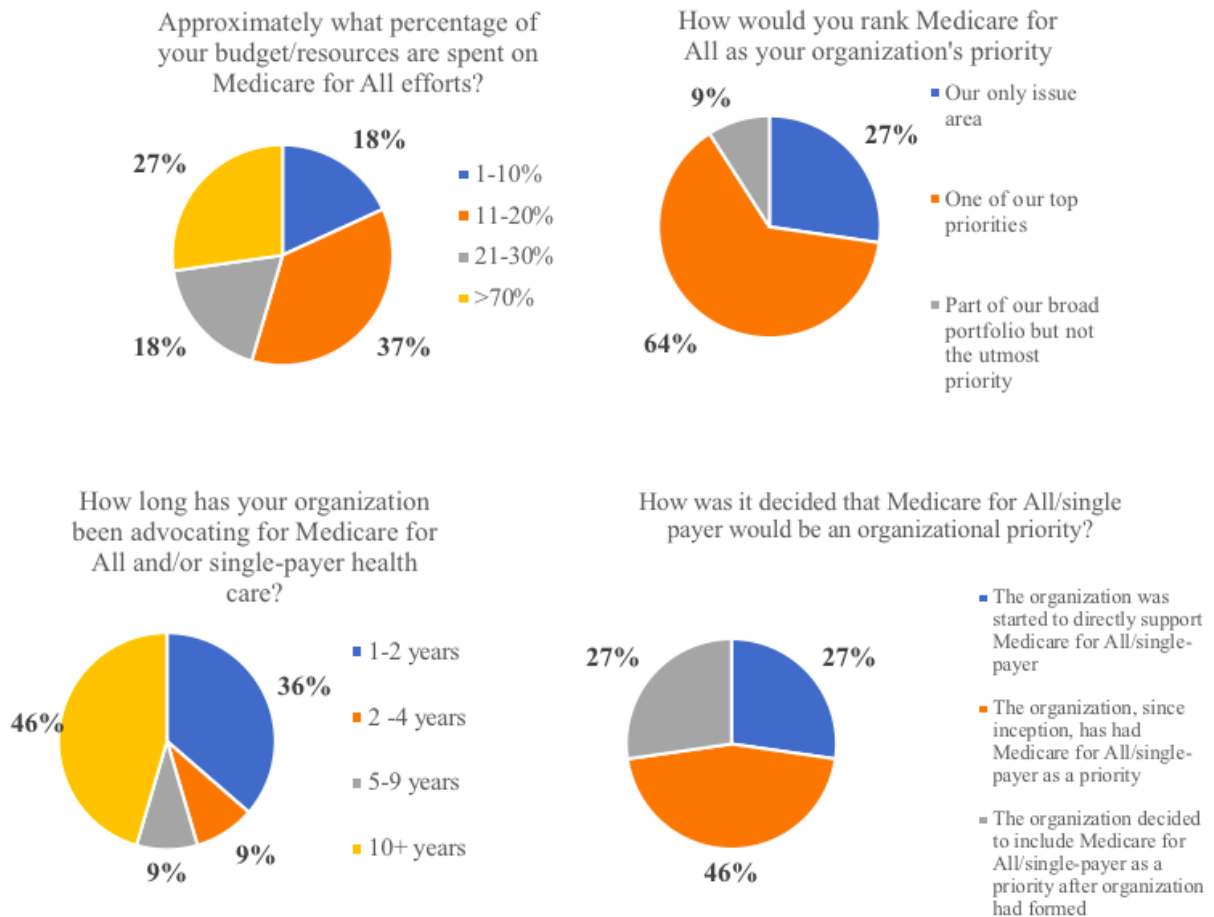
Furthermore, 45% of organizations were founded within just the last four years signifying new energy and growing momentum for Medicare for All. Over 55% have been in existence for five or more years, before Medicare for All became popularized from Senator Sanders's 2016 presidential run. Furthermore, other organizations have been established for several years but only recently prioritized Medicare for All. For example, one organization explained,

> Our health care advocacy has historically been part of our family economic security campaign. After we helped successfully protect the ACA, we decided to make an organizational shift to go on offense and Medicare for All is our north star.

Figure 17. M4A Movement Stakeholder Activities

What types of activities are most common for your organization on Medicare for All?
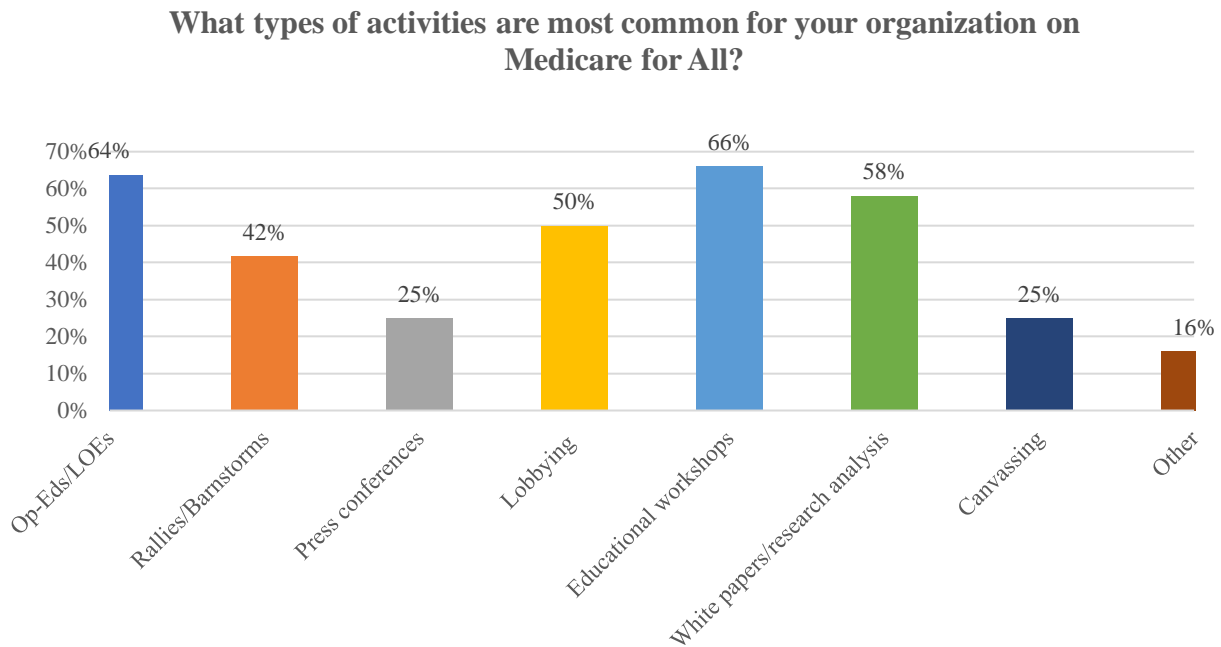
The organizations engaged in a wide variety of grassroots strategies, messaging, and educational activities to promote Medicare for All, both independently and collaboratively (refer to Figure 18). The most common activity was educational workshops, in-person or virtually, to engage new members and improve public understanding of the Medicare for All policy. Furthermore, most

organizations were actively involved with publishing op-eds to influence the mainstream media's presentation of Medicare for All. Other activities included activities specific to the organization, such as building coalitions amongst targeted constituencies or developing white papers about particular benefits of Medicare for All that are relevant to the organization's mission. The next section provides a stakeholder matrix to better understand the types of strategies each organization deploys, as well as their level of power and influence.

4.3.2 Stakeholder Matrix: Medicare for All Coalition

The stakeholder survey also asked a series of open-ended questions to capture each organization's priorities, strategies, and role in the Medicare for All Coalition. The matrix was constructed based on these responses collected by the stakeholder survey. The data for the power and influence section was determined by the size of their network based on the stakeholder map (Figure 19) and findings from the survey.

The stakeholder matrix (Table 5 on page 93-95) shows how each organization has a unique make-up, strategy, and expertise that they bring to the movement. For example, Businesses for Medicare for All is a small and recently formed organization created to serve a niche role in showcasing the effects of the employer-sponsored insurance system on small businesses, as well as building up support for Medicare for All across the business community.

Table 6. Stakeholder Matrix of the Medicare for All (M4A) Coalition

Stakeholder	Who are they?	What is their influence and Power?	What is their significance/role in the network?	What are their main strategies and priorities?
National Nurses United (NNU)	The largest union organization of registered nurses in the United States	The National leader and coordinator of the M4A movement table. They are one of the largest organizations supporting M4A (since 2009) and have considerable financial resources and networks across several unions.	Has been building significant grassroots work for single-payer/M4A. Worked closely on bill writing for H.R. 1384. Provides other orgs legislative and hill strategy and support, messaging, and policy analysis. Advancing the fight for MFA within the American labor movement.	Building a strong grassroots movement to support M4A through distributed organizing and canvassing, text banking, and other actions in communities. Legislative advocacy and policy development. Educating nurses to be leaders in the campaign for M4A. Supporting political candidates who support M4A.
Public Citizen	A non-profit, progressive consumer rights advocacy group and think tank	A well-established, reputable think tank who has several marked successes in support of liberal policies. They have been supporting single-payer since their inception in 1971.	Worked closely on bill writing for H.R. 1384. Provides other orgs policy analysis, advocacy, and lobbying support. Leads a campaign across the country to pass city council resolutions in support of M4A; provides regular training webinars.	Grassroots organizing, particularly around local/country resolutions, federal legislative advocacy, lobbying, research, educational efforts on both the hill and the general public, and the creation and dissemination of social media
Physicians/Students for a National Health Program (PNHP)/SNaHP	An advocacy organization of American physicians, medical students, and health professionals	PNHP was started by physicians and academics, to campaign for single-payer in 1986, small org that is mostly volunteer-based; serves as a prominent primary collaborator.	Authoring single-payer proposals and building the policy research case for single payer since the organization's inception. Expanding organizing through medical students who protested AMA conference.	Policy research; medical education and organizing; public education through traditional and social media (op-eds/LTEs in particular) and community talks.
Social Security Works (SSW)	An advocacy organization in support of Social Security	SSW is the only organization specifically connected to seniors, a critical group to better engage and gain buy-in for M4A.	Engagement with seniors about the impact of M4A, and a racial justice-centered "All Means All" campaign. Provides messaging and media strategy assistance for other orgs.	Utilizes an inside-outside strategy of educating grassroots of primarily seniors and people with disabilities about the impact M4A will have on them; drug pricing focus.

Table 6. Stakeholder Matrix of the Medicare for All (M4A) Coalition (Continued)

Stakeholder	Who are they?	What is their influence and Power?	What is their significance/role in the network?	What are their main strategies and priorities?
Center for Popular Democracy (CPD)/CPD Action Fund	Advocacy organization focused on base-building and building collective capacity for progressive policies	CPD has one of the most robust and well-resourced national networks across the groups. Ady Barkan, director of CPD campaign, was able to convince Speaker Pelosi to let him participate in the Rules Hearing on M4A.	Mobilize grassroots efforts and advocates as a rapid response to political dynamics or situations related to M4A. Half of affiliated groups are new immigrant organizations with constituents that the ACA excluded.	Base-building and policy advocacy, deepen and grow progressive infrastructure to support M4A.
People's Action (PA)	A merger of three national networks of community organizing groups that formed one national network of state and local grassroots organizations	PA has an expansive network and is able to quickly mobilize large numbers of advocates for grassroots actions. They played a significant role in stopping the 'repeal and replace' of the ACA. Recently made the organizational decision to shift towards an "offense" strategy and support M4A.	Broadening the multiracial working-class base of people directly impacted by the currently health care system, elevating their stories in the media. Anchored the direct action on the AMA for 30 grassroots groups including a walkout anddemand to withdraw from the PAHC, and a rally.	Provided on-ground support for city resolution campaign. Coordinates political education meetings, phone banks, public events and town halls to bring new people into the movement. Maintaining corporate accountability through direct actions. Building broad public support for the policy.
Progressive Democrats for America (PDA)	A progressive political organization and grassroots PAC	PDA has been lobbying for single-payer proposals since inception of their organization in 2004.	Petitioned Senator Sanders to run for President as a Democrat in 2016. Advocated for and helped build up co-sponsorship of a series of single-payer or Medicare for All proposals.	Raise public awareness and support. Identify, elect and support congressional champions of Medicare for All.
Businesses for Medicare for All	A non-profit started to directly promote M4A in the business community	As the "business community" of the M4A network, they have a critical role in promoting stronger M4A support as businesses have shown to be influential stakeholders in health reform.	Building a coalition of 3,000 businesses across the 50 states in support of M4A and highlighting the impact of the employer-based insurance system on businesses.	Organizing the business community. Educating the public and policy-makers. Changing the media narrative on the business case for M4A.

Stakeholder	Who are they?	What is their influence and Power?	What is their significance/role in the network?	What are their main strategies and priorities?
Labor Campaign for Single Payer (LCSP)	Union-funded group of several unions supporting single-payer policies	Unions are a critical and powerful stakeholder in health policy overall. LCSP has built up a large coalition of unions who have endorsed M4A. LSCP can help shift these unions to become more political champions.	Helping to move a critical mass of the labor movement into active support. Promoting working class interests in policy debates over how to pay for M4A, just transition for displaced workers, etc. Elaborating a critique of employment-based health insurance.	Deploy the resources and organizing capacity of the institutional labor movement into the fight for M4A. Our theory of change is that this is a fight against concentrated corporate power and requires the mobilization of a broad popular movement.
Our Revolution	Progressive political action organization that resulted from of Senator Sanders's 2016 presidential campaign.	Substantial national network that regularly posts online webinars that engage	Major partner in the push for local governments to pass M4A resolutions, focuses on making the economic case for M4A in virtual webinars, can draw large numbers to events.	Defeating Trump and push for M4A during the next 4 years, electing more M4A supporters to Congress, making the case for M4A as a public health benefit, and pushing Dem leadership in Congress and WH to move the ball forward.

Based on the stakeholder survey, I developed a map of the relationships among the various organizations using the Kumu software (See Figure 19). The stakeholder survey asked each group to identify its top three primary and secondary collaborators and the corresponding types of activities they execute together. After the data was inputted into the Kumu software, a map was produced to represent the organization's size and power, the connections between each group, and the types of activities and efforts they engage in with their main collaborators.

The size of the circles depicts the level of power and influence the organization has in the network. The level of power and influence was determined by using three factors: the size of the organization, the amount of funding invested in Medicare for All, and the number of other organizations that identified the group as a primary collaborator. For example, the question for "How many full-time employees are within your organization?" had four potential responses: 1-10, 10-25, 25-50, 50+. A response of "1-10 employees", was scored as "1"; a response of "50+ employees" was scored as "4." The average score of the three factors was inputted into the Kumu software, which matched the circles for each group accordingly. The colors of each circle indicate the organization's type.

The relationship map (Figure 20) also shows the type and level of collaboration between various groups. For example, the blue line connecting Public Citizen and People's Action indicates they

are primary collaborators, and their efforts together include the "city resolution campaign" and

"petitions" for Medicare for All.[44]

Figure 18. Relationship Map of Medicare for All Coalition[45]
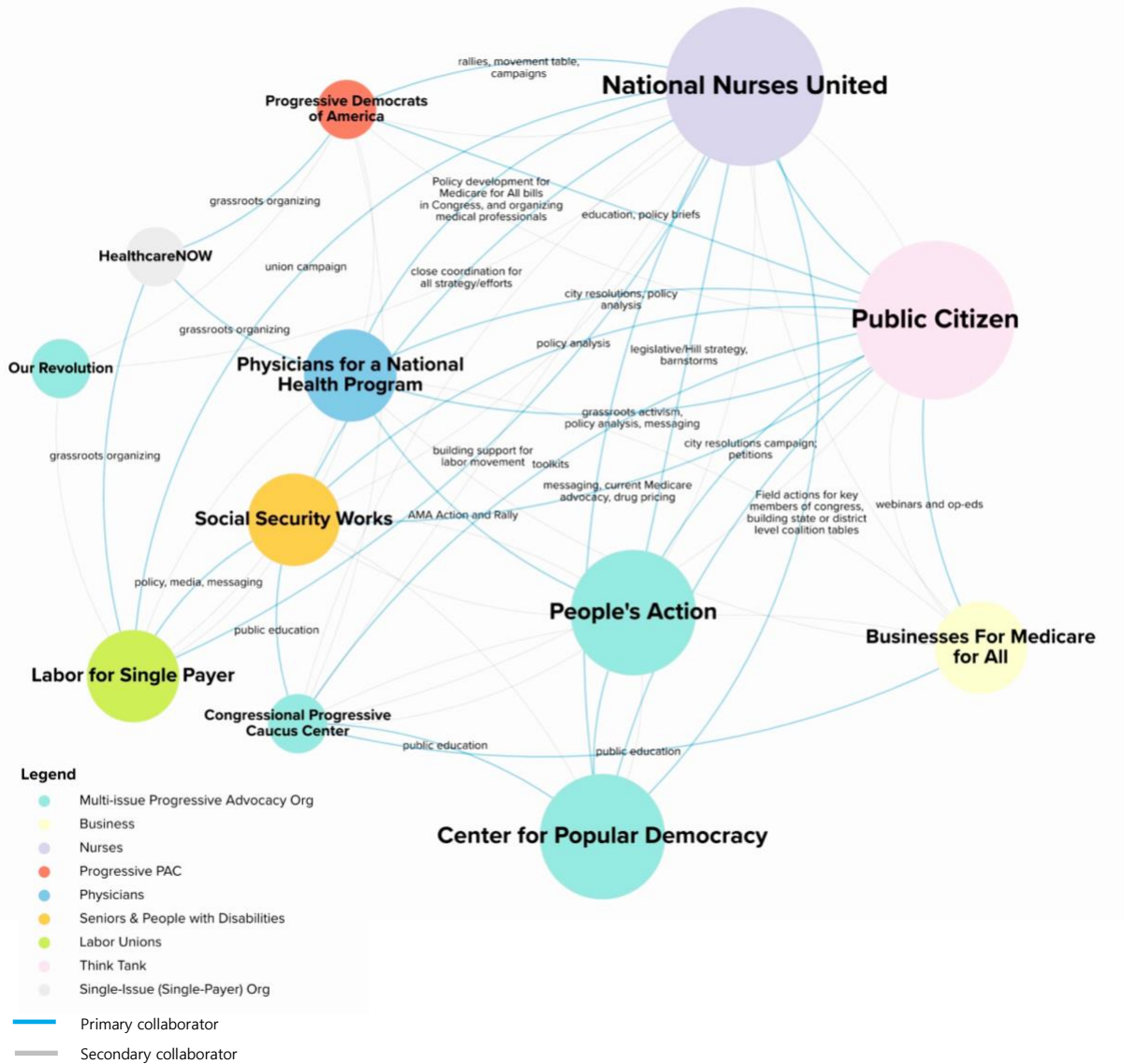
Figure 19 shows that The Medicare for All Coalition often execute strategies and activities in coordination with each other. Each organization collaborates with every other member in the Medicare for All Coalition within two degrees of separation. The map also indicates that National Nurses United and Public Citizen were the most recognized as "primary collaborator" by other organizations. National Nurses United (NNU) serves as the Medicare for All Coalition leader, a consortium of advocacy groups that meet monthly to discuss and coordinate grassroots, legislative, and political strategy. NNU considered all the other organizations as primary or secondary collaborators. Additionally, Public Citizen was most recognized for its expertise in providing policy briefs, memos, and toolkits on topics related to Medicare for All. Social Security Works was the second most identified as a "primary collaborator" emphasizing their expertise for crafting messaging and engaging media.

Lastly, the survey asked organizations to identify the three significant challenges they face and what their organization needs to be more effective. The responses are shown in Table 6:

Table 7. Medicare for All Coalition Members' Identified Challenges and Needs

Identified Challenges & Barriers	Suggestions for Addressing the Challenge
Oppositional messaging, public media, and advertising campaigns influence on public misconceptions	- More refinement on messaging and framing - Effective communications strategy - Need stream of Medicare for All surrogates consistently on major TV networks - Need rapid response and proactive advocacy and research - Elevate and amplify people's "health care stories"
Coalition structure and coordination of efforts	- Need more funding/financial resources for all organizations involved - More centralized movement structure - Better coordination between organizations and efforts - Broaden coalition and bring in various health stakeholders

Table 7. Medicare for All Coalition Members' Identified Challenges and Needs (Continued)

Identified Challenges & Barriers	Suggestions for Addressing the Challenge
Limited influence in Congress	More political champions on the Hill advocating for Medicare for All

The stakeholder analysis of the Medicare for All Coalition determined several key findings. First, the Medicare for All Coalition is diverse and represent a large constituency of physicians, nurses, business owners, labor unions, progressive advocacy organizations, and think tanks. Second, these organizations vary in size, and the most powerful and influential groups in the coalition have the largest operating budgets and resources available for Medicare for All efforts. Furthermore, single-payer advocacy organizations have been in existence before Senator Sanders ran on Medicare for All, but there is a recent surge of energy that is reflected by several new entrants to the coalition in the last few years. Each organization within the coalition has unique expertise, target constituency, and strategic approach to advocating for Medicare for All; each also has varying priorities within the Medicare for All legislation. Lastly, each organization noted similar challenges around messaging, available funding and resources, and coordination of coalition efforts.

4.4 Methodology #2

To evaluate the attitudes and beliefs of the broader political climate for Medicare for All, I conducted key informant interviews with 27 stakeholders across the spectrum of support for Medicare for All. Using purposive sampling, I applied knowledge of the health policy-making community to select expert informants in a nonrandom manner representing a cross-section of

stakeholders. Table 7 shows the experts consisted of Congressmembers, clinicians, business owners, lobbyists, health industry staff, congressional and committee staff, and health policy experts who held varying levels of support of Medicare for All (M4A). The sample included: Pro M4A (n=10), Neutral M4A (n=8), and Against M4A (n=9). "Pro" stakeholders expressed supportive inclinations for both the Medicare for All policy and the political feasibility of the legislation. "Neutral" stakeholders expressed either supportive or neutral inclinations for the policy and were neutral or negative on their outlook of the politics. "Against" stakeholders expressed opposition to both the policy and the politics of Medicare for All.

Table 8. Key Informant Interview Experts

PRO M4A		NEUTRAL M4A		AGAINST M4A	
1	Think Tank	1	Think Tank	1	Think Tank
2	Congressional Staff (House/Personal)	2	Congressional Senior Staff (House)	2	Physician Association Representative
3	Advocacy organization	3	Health Insurance Company Employee (Mid-level)	3	Health Insurance Company Employee (High-level)
4	Congressional Staff (Senate/Committee)	4	Hospital Administrator	4	Hospital Administrator
5	Congressmember	5	Health Policy Expert	5	Pharmaceutical Employee
6	Health Policy Expert	6	American Association of Colleges of Nursing Representative	6	Insurance Lobbyist
7	Labor Union Representative	7	Health Care Industry Lobbyist	7	Health & Human Services Staff
8	Physician	8	Congressional Committee Staff (House)	8	Congressional Committee Senior Staff (Senate)
9	Nurse			9	Small Business Owner
10	Small Business Owner				

The interview included questions in three domains (Refer to Annex 2 for interview guide):

1. Assessment of the current state of the health care system (problem)

2. Policy preferences for health reform (policy)

3. Analysis of the current political environment for major health reform in general and specific to Medicare for All (politics)

The semi-structured interviews took an average of 45 minutes and were conducted either in-person or over the telephone. Before the interview began, each participant was read a set of instructions describing the purpose of the interview, that the interview would be audio-recorded, all information would be de-identified, and that they did not need to respond to every question. They were also informed that the interview could be stopped at any time. In addition to the audio-recording, I took notes, and wrote down key quotes throughout the interview. These interview recordings were then uploaded into an encrypted online storage site and labeled based on interview date, level of support for Medicare for All, and the type of stakeholder. Then, the recordings were transcribed using Otter, a transcription service, and reviewed for accuracy. The recordings and transcriptions were then uploaded into ATLAS.ti, a qualitative data analysis software.

Based on my notes from the interviews, I developed a codebook of several initial codes representing concepts per section of questions. Each transcript was analyzed through ATLAS.ti to quantify and further assess their opinions. When I identified a revealing remark, I paused the audio and tagged the quote to indicate what code(s) I saw occurring within that comment. For example, if someone stated, "the health system is not functioning well," the time segment and corresponding text in the transcript were marked as "PROBLEM: dysfunctional" to indicate the code and question segment. The codebook provided valid and reliable identification of trends and themes, but the identification was not limited to the codebook. If specific themes emerged after the initial coding, those statements were named accordingly. Each interview was reviewed at least twice to ensure that all data was identified. The coding allowed for quantification and identification of codes

according to the stakeholder and level of support for Medicare for All. If there were multiple indications from different interviews of the same code, this was then grouped. Then, by analyzing those quotes within the same code, a theme was labeled. After this grouping, some themes overlapped and were consolidated. Then I extracted vivid examples to illustrate the significance of each theme.

4.5 Results: Key Informant Interviews

The results of the qualitative analysis are presented in two formats: 1) tables with quotes representing broad attitudes and beliefs pertaining to each section topic to show commonality or differentiation between the levels of support; and 2) thematic analysis with key quotes and context to show trends across stakeholders.

4.5.1 Attitudes and Beliefs Across The Levels Of Support For Medicare For All

For the first section of questions focusing on "the problem," 92% of stakeholders believed that the U.S. health care system does not function well. This indicated that regardless of the support level of Medicare for All, stakeholders were in broad agreement that the health care system is not working well. Table 8 shows that those in the "Pro" category mostly focused on health care system's complexity and the inequities in access and outcomes based on income. Those in the "Neutral" category shared similar sentiments to those in the "Pro" and sometimes mentioned the health care system's positives to balance their answer. Those in the "Against" category also shared similar sentiments of dysfunction in the system but were more inclined to speak about the positives of either recent health reforms or clinical outcomes. A few respondents in the "Against" category also mentioned "individual responsibility" with statements that described

situations such as if a person decides to drink, smoke, or not eat well, and they get sick, it should

not be up to someone else to take care of them.

Table 9. Results from Key Informant Interviews: The Problem

THE PROBLEM: How well does the U.S. health care system function?		
Pro M4A	**Neutral**	**Against M4A**
Dysfunctional. "*Very Poorly. It's so complicated and difficult to navigate. I have to spend so much time and resources just to figure out health care for myself, let alone for all my employees. And in the end, we all end up with not great coverage.*" [Business owner] "*Terribly- causes a lot of stress for people and it is incredibly difficult to navigate*" [Congressional Committee Staff] "*It functions terribly. It is possible to buy your way into high quality care, but for the vast majority of people, the health care system is a huge resource suck that leaves you unable to access care when you need it.*" [Think Tank]	**Dysfunctional.** "*We are, without question, the lowest-performing health care system in the industrialized world. But it is better than where we were ten years ago*" [Health Policy Expert] "*From the perspective of working within the health insurance space, but also previous work on the provider side, you know, our health care system is very broken…The health care system has not adapted fast enough of what people are really looking for There's not a lot of communication or incentives to communicate because everything is based on the payment model that is still primarily fee for service.*" [Insurance Employee]	**Dysfunctional.** "*I think it's pretty dysfunctional. I think some of that dysfunction is Congress. Some of that is the accidental piecemeal way it's come together over the years.*" [Insurance Lobbyist] **It could be better, but we are still doing fine.** "*Not very well, it doesn't take care of everyone very well which is sad for such a wealthy country. But some of the changes that are being made are good and we are heading in the right direction. I think Obamacare has begun to push us in the right direction.*" [Physician Association]

Table 9. Results from Key Informant Interviews: The Problem (Continued)

THE PROBLEM: How well does the U.S. health care system function?		
Pro M4A	**Neutral**	**Against M4A**
	It could be better, but we are still doing fine. "*Not very well. There are certain parts of it that work okay. For all the trash on the employer system, most people who get employer provided health insurance are relatively happy with it.*" [Think Tank]	**It could be worse.** "*Certainly, we spend more on health than other nations, but we are getting a good return on that investment on very important health outcomes, like heart disease, stroke, cancer- we are getting superior results.*" [Think Tank] **Individual responsibility.** "*We have so many people who have diabetes and smoke and don't take care of themselves. Those people are the reason why our health care system is so expensive.*" [Committee Senior Staff, Senate]

For the second section, "the policy", Table 9 shows a noticeable trend within each level of support for Medicare for All. Every stakeholder in the "Pro" category described at least reducing or eliminating the role of private insurers in providing primary insurance. "Pro" stakeholders also emphasized why a public option was not their policy preference. Three mentioned that the only incremental reform they would support is lowering the Medicare age for eligibility. Almost half of the "Neutral" stakeholders stated the importance of expanding upon a government program that is already built rather than starting a "new" one. However, almost all neutral, and two "Against" stakeholders mentioned that they thought a single-payer system was the best route from a policy perspective but was not politically feasible.

Furthermore, the stakeholders in the "Neutral" and "Against" categories mostly focused on targeted improvements and policies, such as reconfiguring payment incentives or improving electronic medical records systems. Only the stakeholders in the "Against" categories mentioned capital markets and improving competition.

Table 10. Results from Key Informant Interviews: The Policy

THE POLICY: What policy provisions should our next health reform include?		
Pro M4A	**Neutral**	**Against M4A**
Systems change. "*Get rid of all private insurance. Care is free at point of service.*" [Nurse] **No public option.** "*Public option empowers the insurance industry and weakens Medicare or the possibility for Medicare expansion.*" [Health Policy Expert] **Expanding Medicare.** "*We would absolutely favor expanding Medicare to age 50. But, only if Medicare Advantage is more limited.* [Think Tank]	**Systems change.** "*If I could choose any policy I want, of course I'd have a single-payer system. But since that's too difficult, I think there are other important fixes we can make that would be very significant.*" [Think Tank] **Targeted Areas.** "*I would reconfigure the incentives for providers so that we're paying more for primary care and family medicine. Not less for specialist but just right-sizing that differential.*" [Academic] **Prevention.** "*We need to focus on improving prevention medicine in this country*" [Industry Lobbyist] "*Preventive medicine, community health, and community clinics would be accessed by all people free of charge.*" [Nursing Association]	**Targeted Areas.** "*There is rapid consolidation occurring in the hospital industry. We need stronger regulation on private equity's role in health care so that our smaller and rural hospitals can better compete.*" [Hospital Administrator] **Capital Markets.** "*Capital markets have a role in health care, government intervention so far just hasn't been enough. Private insurance should be allowed to compete, just under more regulation*" [Committee Senior Staff, Senate]

For the third section, "the politics", the theme of polarization was consistently mentioned across levels of support and seen as a major barrier for health reform. There were also widely varying

opinions on how Congress would react to an Administration that prioritized Medicare for All

across stakeholders and levels of support. Stakeholders across support levels also mentioned the

influence of the health care industry on policy-making. "Neutral" and "Against" stakeholders

mentioned that too many health care companies had too much money in the system for there to

be a disruptive change, such as single-payer. Also, a few "Neutral" and several "Against"

stakeholders iterated the importance of choice and the notion that people like their health plans.

Lastly, only "Pro" stakeholders mentioned the influence and impact of the grassroots movement,

while some "Neutral" stakeholders minimized the ability of progressive groups and politicians to

affect the political environment.

Table 11. Results from Key Informant Interviews: The Politics

THE POLITICS: What is your assessment of the political environment for health reform?		
Pro M4A	**Neutral**	**Against M4A**
Congress. *"If we elect a President who has Medicare for All on the top of their platform, I'm hoping it'll be like it was with Trump and the Party will fall in line. Probably not the Senate, even if we had the majority, but probably the House."* [Congressional Staff, House] **Money.** *"The insurance and pharmaceutical companies have a lot more money and influence in politics than we do.* [Labor] **Grassroots.** *"Other single-payer attempts haven't seen the same kind of grassroots movement we've been able to generate in the last few years."* [Advocacy Organization] **Polarization.** "*Health reform has always been so politically divisive, and especially now in times where polarization is just so intense, Medicare for All is being painted as this radical idea, but it's not."* [Medical Provider]	**Congress.** *"Not only are the Republicans against it, half of the Democrats are not there yet, and a lot of the ones that are, it isn't their top priority."* [Committee Staff] **Money.** *"There is too much skin in the game and these big companies don't want to give up anything."* [Industry Lobbyist] **Polarization.** "*There's so much polarization in this country and health care has become just so politicized, I think it'll be impossible to get anything through that isn't completely partisan. And we saw what happens when that happens.*" [Congressional Staff] *"Politics are just so toxic right now. I think it's really hard to get things done in such a negative political culture. It's what is standing in the way of major reform."* [Nursing] **Grassroots.** "*Any seemingly progressive win was really just Leadership giving them what they already knew they'd be willing to give. I don't think the groups have that much influence on the real decision-makers, especially in health policy."* [Congressional Senior Staff, House]	**Congress.** *"I think Congress will have too much on their hands to do anything with major health reform, but there are plenty of small fixes they can easily make."* [Pharma Employee] **Money.** *"Medicare for All can seem nice on paper but in reality, it's impossible to figure out, especially how you're going to get the taxes and financing for it."* [Committee Senior Staff, Senate] **Polarization.** *"The really heightened polarization around almost anything that has to do with health care makes it a very challenging environment to get things done."* [Insurance Government Relations] *"When it comes to Medicare for All or any comprehensive change in health care, the polarization in politics is going to kill it even more than the work of the Partnership for America's Health Care Future."* [Insurance Lobbyist] **Choice.** *"Nobody wants to get rid of their private plan. Seniors love Medicare Advantage. Above all, Americans want choice."* [Think Tank]

The following results provide the identified overarching themes that were prevalent across stakeholders and levels of Medicare for All support.

Problem Stream Themes:

The System Isn't Working

> *"Terrible."*
>
> [Nurse, Pro]

When asked "how well does the U.S. health system function?" every interviewee, except two, indicated that the health care system was working between "not well" to "terribly." Many cited various health statistics, such as life expectancy and maternal mortality, compared to other similarly wealthy countries. Additionally, across the levels of support for Medicare for All, multiple stakeholders referred to the U.S. health care system as some variant of a "sick-care" system and specifically tied it to the business model of the private insurance system. The "Neutral" Insurance Employee noted,

> The U.S. does a terrible job at preventative health care because that is not how the compensation structure for doctors, hospitals, insurance companies, etc. is structured. So, we have much more of a disease care system than a "health" care system.

Several other "Neutral" stakeholders emphasized similar sentiments and the need for preventative care in the next steps of health reform. In both "Pro" and "Neutral" groups,

interviewees described that financial fear caused many patients to avoid care, thus making them sicker and more expensive to the health system by the time they arrived at the hospital.

Complexity of the System

"I think even for people who have good insurance and access to doctors and hospitals and labs and x-rays, the complexity of the system is so great that it's just not easy to access and it's quite confusing compared to what I know about other countries and other systems that just seem to work much better."

[Physician Association, Against]

Across stakeholders, most people agreed that the health care system is overly complicated and makes it difficult for patients to access care. When describing the complexity, four stakeholders across the levels of support highlighted how difficult health care terminology and insurance models are to navigate. Five stakeholders across the levels of support described the juxtaposition of a complicated system against the goals of patients: *"If they're sick, they just want to know that at the end of the day, they aren't going to go bankrupt if they get help."* Two "Neutral" and seven "Against" interviewees noted the need for greater transparency in hospital pricing for services to help better inform patients as consumers. For all "Pro" stakeholders who spoke on this subject, they felt that patients should not have to "try to figure out" the system, but instead, it should be streamlined and directed towards patients.

Clinical Care & Technology

"We're really good at seeing new technologies and new cures. There's a lot of innovation

happening, and our doctors are well-trained."

[Pharma, Against]

When asked, "What does the health care system do well?", the above quote captures what virtually every stakeholder said. Everyone agrees that the U.S. health system is good at producing innovative technologies and well-trained clinicians. "Pro" and "Neutral" stakeholders emphasized that even though novel technologies and drugs were being developed, they pointed out that these innovations were not accessible to many people. Some also specified that innovation was happening at a "small scale" within hospital systems or tech start-ups, but not on a larger scale throughout the health care system. Most stakeholders noted that they thought the education system for doctors and medical facilities were of good quality.

While specific services, like surgical procedures and cancer treatment, were broadly stated as a positive aspect of the health care system, several indicated the deficiencies in delivering quality care overall. For example, almost half of the informants mentioned the issue of the lack of continuity of care and the associated worsening of health outcomes due to it.

Concept of Affordability

"No one should have to decide between paying for their daily needs or medical care."

[Congressional Staff, Pro]

When participants were asked to describe what it means for them to be able to "afford" care, 40% used the examples of affording daily needs, such as rent or food, as a standard for

affordability. Some used other abstract measurements, such as "the cost does not prevent their use of service." Another 50% of respondents said that it should be on a sliding scale dependent on income, with a mixed response on how that sliding scale would be structured. Many referred to the ACA standard of 9.5% income for premiums as their standard of choice, while others indicated that it should be closer to 5% for all out-of-pocket costs. Multiple stakeholders referred to caps on deductibles and out-of-pocket costs at the same level of the statistic that "40% of people can't afford a $400 emergency." Only three respondents, who were all "Pro" Medicare for All, said that access to care should not be premised on the ability to pay and that medical services should always be free at point of care.

The Deterioration of Employer-Sponsored Health Insurance & Union Bargaining

"Right now, I'm paying 100 percent of our employees' health insurance. Each year it just keeps going up and up and each year, I don't want to give my employees less benefits but then my husband and I worry about how we will get raises to our employees."

[Business Owner, Pro]

The "Pro" Business Owner, the "Pro" Labor Union Representative, and the "Against" Business Owner had similar diagnoses of the health care system but didn't necessarily agree that Medicare for All was the only or best solution. All agreed that the cost of employer-sponsored insurance was rising too quickly. The "Pro" Business Owner described it as "crippling" and expressed concerns that it would eventually get in the way of her staying competitive. The "Pro" Labor Union described how negotiating health benefits took the most time at the bargaining table and the sacrifices unions often have to make to get quality plans. The "Against" Business Owner

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described how the quality of the plans he selects for his employees is "not as good as it used to be" but mentioned his concerns with a potential tax increase that might be needed to fund a single-payer system.

The topic of employer plans was also brought up by several stakeholders across levels of support. The "Pro" Think Tank noted the issue of tying health care to employment and the number of people who stay in jobs to keep their insurance, while the "Against" Think Tank expressed that the state of employer-based health care was a result of the ACA and explained, "that's why the government shouldn't be trusted to do health care," to indicate that health care should be managed by private companies and the "free market" instead.

Policy Stream Themes:

Pragmatic Incrementalists with Transformational Philosophies

"In the short term, I definitely support public option, Medicaid expansion, and tinkering a lot with the ACA. I think in the long-term, I personally really love the whole Medicare for All, it's just I also know it's going to be one of those political nightmares."

[Insurance Employee, Neutral]

Only five participants had complete opposition to single-payer health care as a policy. Many expressed similar sentiments to the previous quote, either indicating that they prefer or are indifferent about a Medicare for All system, but they don't believe it is politically feasible. Several also said that if the U.S. was "starting from scratch" then a single-payer system would make more sense. Other stakeholders referred to a "trauma" they experienced working in health

policy, especially during the ACA, that has led them to believe that only incremental change is possible. The "Neutral" Health Policy Expert said,

> I would totally support and love to see Medicare for All. So, my fears, my concerns about it all, my pragmatic political judgment calls, are from having been through this rodeo enough times and studied all the other times we've been into this rodeo, to know what happens and how it plays out.

An "Against" Health and Human Services Staff Member stated,

> The ACA was an exceedingly painful experience as somebody who was staffing at the time...I think I'm also a little scarred. Which is why I find some of the people now pushing for Medicare for All and trashing the ACA, I don't know if they have amnesia or just weren't involved with how difficult it was actually getting to the point of the ACA blows my mind. I think they think Obama sold out as opposed to how hard it was actually achieving what he achieved.

These sentiments represent a generation of health policy staff and experts who have difficulty supporting Medicare for All not because of the policy, but because of the political contention they experienced in past health reform attempts.

Slogan

"*Medicare for All is largely a clever and semi-successful marketing slogan for single-payer.*"

[Health Policy Expert, Neutral]

"It's a slogan for whatever your universal health care plan is."

[Think Tank, Neutral]

"It's a bumper sticker or a marketing tool."

[Health & Human Services Staff, Against]

When asked "What is Medicare for All?", several of the "Neutral" and "Against" stakeholders described it as only a slogan and not an actual policy idea. Some specified further and said it was a tool to help simplify the complicated concept of "single-payer." The "Against" Insurance Lobbyist stated,

> I think it was a smart move by single payer advocates to use the word Medicare because they think people generally look fondly upon Medicare. But what we are really talking about is a single payer system and we need to talk about the pluses and minuses about that.

Politics Stream Themes:

The Power of Physicians and The Surprise Billing Fight

"We've not gotten any provider buy-in for the surprise billing work which is much more mild [than Medicare for All,.[the policies] don't have that much of an effect and only affects a small number of specialists- that still seems to be very difficult."

[Congressional Staff, House, Neutral]

Across the level of support for Medicare for All, there was a general consensus that lobbying and influence from the health industry would be one of the most significant political barriers for comprehensive health reform. The "Pro" Advocacy Organization said, "the opposition has a lot more money than all the groups combined that support Medicare for All" and continued to describe how physician organizations had utilized their resources for effective campaigns to block legislation, such as for surprise billing. The "Neutral" health policy expert discussed how "…even with surprise billing, which is so tiny in the grand scheme of things, and yet you see how difficult this is…and it's just a case example of how difficult it is for Congress to negotiate this stuff."

The "Pro" Congressional Staff described how her office received endless calls and doctors' visits from her Congressmember's district:

> They sent doctors every month, which really freaked out my boss since the hospital in her district is the largest employer there. It was also surprising to see which Members supported which surprise-billing bill because it didn't seem to be based on if they were left or moderate, even though benchmarking is obviously more to the left than arbitration.

The surprise billing legislative process was often used as an example of how effective provider organizations are in deploying mass campaigns to maintain their priorities. Also, the Congressional staffer noted how her boss was influenced not necessarily by the policy, but by the politics of having a major hospital in her district.

"Other" Political Barriers

"The notion of doing any level of health policy-making without having done any substantive

campaign finance reform is worrisome to me."

[Congressional Senior Staff, House, Neutral]

"[Medicare for All] forces providers, patients and taxpayers to be a part of and pay for a system

that isn't going to work well"

[Physician Association Representative, Against]

When discussing the political barriers to health reform, five stakeholders, across each level of support for Medicare for All, discussed the importance of campaign finance reform. Even avid supporters of Medicare for All indicated that they believed "a Medicare for All system will never happen unless we have comprehensive campaign finance reform." A few "Neutral" and "Against" stakeholders described the public's aversion to taxes and policies that "take away choice," as deep-rooted barriers that were unlikely to be shifted. Furthermore, the cost of Medicare for All as a major political barrier was identified by two "Neutral" and half of the "Against" stakeholders. The "Against" Insurance lobbyist specified "All we're really doing is talking about shifting the cost, we're not talking about eliminating the cost really, which I think is actually more controversial." This indicated that while often the narrative of the "cost of Medicare for All" is fixated on the high price-tag, more than half of the stakeholders understand that the concern was not about the overall cost of single-payer, but the immense political challenge of shifting money away from the private sector and into a public fund.

Buy-In From Other Stakeholders

"The AMA almost lost that vote [on opposing single-payer], a lot of doctors are pretty liberal

and want universal coverage."

[Physician, Pro]

"If you go slightly above Medicare rates, even if you go 110% Medicare rates for hospitals, I

think you can start getting buy-in from some rural hospitals. There are certain hospitals that are

struggling and serve primarily Medicare and Medicaid and uninsured patients today, the fact

that you are not going to have no uninsured patients is sort of a gift to the hospitals…"

[Think Tank, Neutral]

The quotes above present the types of advice given when discussing which stakeholders had

room for moving their support more positively towards Medicare for All and how to obtain their

buy-in. Several stakeholders indicated that physicians, particularly those providing mental health

and primary care doctors, as well as the younger and more politically liberal generations, were

key groups that needed to be better represented in the Medicare for All Coalition. Rural and

safety-net hospitals were also identified as a potential group that could be brought in through the

assurance of payment from every patient and an overall higher payment rate. The "Neutral"

Hospital Administrator also noted that his hospital would greatly benefit from not having to deal

with the administration of employer-sponsored insurance for their employees and covered

patients. However, the administrator also specified that they supported Medicare for All but that

a "Medicare Advantage for All" plan was more politically feasible.

Polarization

"Health care as a whole right now is so politicized that sometimes it's better to do the micro changes from a political standpoint, not necessarily from an efficiency standpoint, just because as Congress and the White House swing from party to party, each party is going to try to eradicate what the other party did because health care is a political football and that actually hurts patients at the end of the day."

[Congressional Senior Staff, Neutral]

"You have all of the interests, you have AHIP, Pharma, and the hospitals and doctors sitting down together. But I actually don't think that has as much effect as simple polarization in politics. All the industries together, yes, they have financial resources, but I don't think they actually move people as much as we think they do. I think it's going to be polarization. In modern politics where you have one third of the country devoted to anything Donald Trump says, one third of the country devoted completely against anything Donald Trump says, and the other third, essentially not paying attention."

[Insurance Lobbyist, Against]

Multiple stakeholders across each level of support expressed that increasing polarization poses a significant barrier to health reform. Several specified the polarization in health policy ideologies and others referred to the broader polarization within the socio-political system. "Pro" stakeholders pointed to polarization as a contributor towards "fear-mongering" of Medicare for All by conservative politicians. However, "Neutral" and "Against" stakeholders identified polarization as a barrier for any level of reform. Several agreed that there was more consensus to address "smaller issues", such as drug-pricing, but as the "Neutral" Congressional Senior Staff"

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stated, *"There is no political momentum for a major health reform. There is nothing that we all can agree on."*

Public Opinion

"I think we have to change the cultural norms in our country around health care, we kind of saw when they tried to repeal the ACA, it was difficult because it's really hard to take things away from people once you give it to them."

[Congressional Staff, Senate Committee, Pro]

"People like Medicare for All, but that's because they don't understand what it means. Taxes. No more choice. Waiting lines and rationing of care."

[Think Tank, Against]

Overall, there was broad agreement among stakeholders that public opinion was not fully evolved or ready for the politically contentious aspects of Medicare for All. All "Pro" stakeholders stated that public opinion needed to be further shaped. Some noted that there is still public confusion on what exactly Medicare for All entails but also added that once misconceptions were clarified, support for Medicare for All is strong according to polls. Additionally, some "Pro" stakeholders also pointed to the growing support and comparing the support of Medicare for All versus the ACA. One "Pro" Advocacy Group stated,

> The people are ready for transformational change. We tried incrementalism for a long time and see where it got us. The fact that anywhere close to half of Republicans support

Medicare for All is astounding. I worked on protecting the ACA and I never saw that

kind of support from Republican voters.

While "Neutral" and "Against" stakeholders pointed to "American values" around choice and

freedom as priorities for the public that could not be changed, half of the "Neutral" stakeholders

believed that views against "government control", "socialism", and "taxes" could potentially be

shifted; some noted the leftward movement of the Democratic Party during the Primary election

as evidence that these terms were not as harmful towards Democratic voters.

Predicting 2021 and Beyond

"I believe that if we don't deliver a bold solution and really change the circumstances for people

in terms of their health care, then we will end up back where we were in 2016 and elect another

Trump."

[Congressmember, Pro]

"There's too much to address in 2020, and beyond first and foremost, climate change. Health

care reform has this impact of what I call "sucking all the political oxygen out of the room," so

there's no other space to do anything else…And then it's a repeat of Truman but bigger. We lose

one or both houses of Congress. We don't get anything done. We've blown it not just for health

care but we've blown it for everything else that we care about as progressives."

[Health Policy Expert, Neutral]

"Even if we do win back the Senate, there are a lot of scared Senators. Anything related to health

care will be incremental. I don't see another ACA, I don't see anything major. I think whatever

would pass under a Democratic legislature and administration would be a way watered down

than whatever the house version was."

[Congressional Senior Staff, Against]

Each stakeholder guessed what they thought the political environment would look like after the 2020 Presidential election. There were widely varying responses, but most indicated that they didn't think a Medicare for All system was possible during the next presidential term, even with an administration that prioritized it. One "Neutral" informant stated, "Medicare for All looks great on paper, but the politics is not there yet. It is unrealistic." However, while several "Against" stakeholders indicated they believed a Medicare for All system is entirely impossible, the majority of stakeholders indicated that at some point in the near or distant future, the health care system will eventually be single-payer.

Even within supporters of Medicare for All, there are varying perspectives on the future of single-payer. The "Pro" Congressional Senate Committee Staff noted,

> I think we could start knocking pieces of the Medicare for All transition. We would definitely push for all of Medicare for All, I just don't know where we end up…I think it's important to deliver real benefits to people as soon as possible and show results.

Others expressed that they expected a Presidential Administration and Democratic-majority Congress to be enough to start the process of pushing Medicare for All down the legislative process.

4.6 Discussion

Medicare for All Coalition Stakeholder & Network Analysis

The stakeholder analysis revealed that the Medicare for All Coalition group is closely interconnected. The Coalition is a mix of organizations, some of which have been advocating for a single-payer system for decades, while others are new entrants that were formed in response to the growing momentum over the last few years. With the expansion of the coalition, it is possible that this may exacerbate a financially-constrained issue-based advocacy space where groups are competing with each other for resources. Furthermore, the few larger organizations with significant financing and have positioned themselves as prominent actors within the coalition. However, overall, the size and resources of most of these organizations are small compared to other health policy and advocacy groups[46] that do not support Medicare for All.

Of note, a significant proportion of the efforts and activities of the Medicare for All Coalition are dedicated to education campaigns. This is indicative of the complexity of a Medicare for All single-payer policy. Often, the media has framed supporters of Medicare for All as ignorant of the policy details, and that once they know what Medicare for All really means, they are no longer supportive (Altman, 2020). Therefore, it is critical that every ambassador, member, and advocate from each group is well-versed on the policy details and able to refute negative talking

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[46] The Urban Institute has a $90 million operating budget; Centers for American Progress has $50 million; FamiliesUSA has $40 million. These are prominent left-leaning organizations that do not support Medicare for All.

points. This will require substantial resources dedicated towards providing accessible and easy-to-comprehend educational materials and briefings on Medicare for All.

Additionally, while there are varying levels of power, influence, and resources for each organization, it is clear that no organization can be entirely effective on its own. Almost every major activity or action is performed in conjunction with others in the movement, and each organization has a particular area of expertise that it can contribute to providing a comprehensive response in promoting Medicare for All. The only organization that exhibits implicit "leader" status is National Nurses United. They are an influential and effective organization for Medicare for All, but every campaign is branded as a "National Nurses United Campaign for Medicare for All", instead of a "Medicare for All Campaign", potentially taking away from the message that the movement is supported by a broader coalition than just the nurses' union.

Key Informant Analysis

A few overarching themes emerged from the key informant interviews. There is clear consensus that there is a "problem" with the health care system— the level and exact diagnosis of that problem varies, but overall, stakeholders indicated that the health care system needs to be significantly improved. There is also broad agreement that polarization is a major barrier to health reform, with many indicating it as the greatest hindrance for health reform in the near future.

Unsurprisingly, there are varying opinions on what policy is the right solution and the political feasibility of health reform, overall. A majority of stakeholders shared some sentiment indicating that a Medicare for All system could be the eventual outcome for the U.S. health care system.

Nevertheless, a significant portion of these stakeholders believe that the current political stream is not aligned with Medicare for All and may not be in the near future. Furthermore, the qualitative interviews revealed that not all Medicare for All supporters have the same priorities for what a single-payer bill should ultimately look like. Some expect the bill, as is, to become law. Others expect there to be significant compromise in order for the bill to gain passage. History has shown that a divided constituency was detrimental for past health reform attempts. Thus, it will be critical for Medicare for All advocates and champions to privately come to consensus as much as possible on what their non-negotiables and negotiables are when Medicare for All, or a future single-payer bill, is subjected to amendments and mark-ups.

Additionally, the surprise billing fight illustrated how difficult it is to compete against organized opposition by physicians. Medicare for All Advocates like to highlight the popularity of doctors in reference to "choice", as the role of physicians and hospitals in the rising costs of the health care system are often not mentioned. Doctors are the second most trusted profession in the country, after nurses (Brenan, 2018) Therefore, it's easy to frame insurers and pharmaceutical companies as the "villains", but politically, it is very difficult to frame doctors in a negative light. The Medicare for All policy entrepreneurs will have to balance expanding buy-in from providers and hospitals, while also highlighting the effective oppositional strategies of provider associations that have stopped the passage of critical health policies.

Moreover, the indication from many that Medicare for All represented a "slogan" and not actual policy signifies that there is still substantial "softening up" that needs to occur. Many of the policy actions described in Chapter 3 targeted the policy community within Congress. By the end

of 2019, the policy had received hearings and greater discourse amongst legislators and their staff. However, the key informant interviews show that many of the policy actions reverberated in an echo chamber and did not make it out to the general public. Experts, who were not directly involved in Medicare for All efforts, were often unaware of any of the names of the interest advocacy groups, the politicians (other than Senator Sanders), and any of the legislative achievements. Therefore, the Medicare for All community will need to make deliberate efforts to broadcast legislative victories and their significance through mainstream networks in order to build a broader engagement.

Lastly, throughout the key informant interviews, almost all objections to Medicare for All were for political, not policy reasons. The most indicated barriers were polarization, industry influence, and public opinion (related to "taxes" and "choice"). The cost of Medicare for All itself was not noted as the top political barrier by most key informants. Instead, stakeholders specified that the shifting in financing that would affect revenue was the major barrier. Several cost-analyses report that a single-payer system would not cost significantly more (and sometimes significantly less) than the current overall health expenditures in the U.S (Cai et al., 2020). Nevertheless, the exact financing and implementation of the transition process to a single-payer system is a technical and political feat that will eventually need to be effectively answered in order to better align the policy stream with the politics stream.

This analysis concludes that the politics stream for Medicare for All is still the least ripened stream within the Kingdon Framework. A policy window would require, at minimum, a change in administration into a President who has single-payer as a top priority, a greater Democratic

majority and Progressive Membership in both chambers of Congress, as well as strong public support for Medicare for All. When these changes occur, and the political stream is more aligned with Medicare for All, then policy entrepreneurs must be prepared to raise the policy up the national agenda. In the meantime, there are several meaningful policy and political strategies that can be executed to maintain momentum and further prime all three streams.

CHAPTER 5. RECOMMENDATIONS

"Compulsory health insurance, whatever the details, is an ideological controversial matter that involves enormous financial and professional stakes. Such legislation does not emerge quietly or with broad partisan support. Legislative success requires active presidential leadership, the commitment of an Administration's political capital, and the exercise of all manner of persuasion and arm-twisting."

Ted Marmor, Professor Emeritus of Political Science, Yale University

5.1 Introduction

While the idea of a single-payer policy is relatively easy to understand, the actual implementation of such a system causes some experts to warn that its political barriers and technical challenges are insurmountable. Building a single-payer system now is a distinctly different undertaking than it would have been had we started at the beginning of the 20th century when there were few health insurance options for anyone. To transition to a single-payer system now would require moving 200 million people away from several different types of insurance carriers and the substantial re-routing of over $1 trillion in private expenditures to public funding (Oberlander, 2016). Furthermore, history has shown that the public has significant opposition to disruptive changes in

the health care system. While 70% of Americans believe the health care system is in a state of crisis, "69% of Americans are satisfied with their health care coverage" (Gallup, 2019), representing an overwhelming comfort with the status quo of the U.S. health insurance system.

This chapter offers strategies for building continued support and momentum for Medicare for All and aid in the alignment of the three streams and provides a series of recommendations based on the lessons from the quasi-ethnography study and the insights compiled from my political analysis. The first set of recommendations describes the components within the policy and politics stream that need to be addressed in order to further prime these streams. The second set of recommendations provides a series of strategies to move key health reform stakeholders closer to the ideal level of commitment needed to enable progress for a policy window for Medicare for All.

5.2 Methodology

For the first set of recommendations, I developed a series of additional strategies to address distinct barriers within the politics and policy stream identified previously. The second set of recommendations is based on a stakeholder commitment matrix that identifies opportunities to broaden support for Medicare for All and neutralize current opposition. This chart displays where various stakeholders are currently in terms of their support for Medicare for All and what level of commitment is needed for Medicare for All's progress based on the key informant interviews, and insights from personal reflections and conversations with different groups during my quasi-ethnographic immersion. To construct the matrix, I compiled a list of different actors with a major role in influencing health reform. Then, I defined their current position on Medicare For All. There are multiple positions within the constituency of some stakeholders, so the differing levels of

support were noted. Finally, I forecasted where each actor needs to be to build momentum towards a policy window for Medicare For All.

5.3 The Future of Medicare for All

> *"In this age, in this country, public sentiment is everything. With it, nothing can fail; against it, nothing can succeed. Whoever molds public sentiment goes deeper than he who enacts statutes, or pronounces judicial decisions."*

President Abraham Lincoln, 1856

Therefore, this section describes the strategies for the development of Medicare for All's technical feasibility, considerations of other health policy proposals in the next Congress and establishing new policy entrepreneurs. Each strategy includes a series of detailed recommendations and measures to be taken in order to achieve the goal.

1. Continue Building Medicare for All's Momentum

a) **Invest in academic evidence and technical expertise needed to create comprehensive implementation and financing plans for Medicare for All.**

As Chapter Three identified, the policy stream is not fully primed as the Medicare for All policy needs significantly more softening-up. The softening-up process requires the building of legislative support and the 'fleshing out' of policy details to make a case for its technical and political feasibility. While H.R. 1384 is comprehensive legislation, there is still a significant need to address the mechanisms needed to make a single-payer plan realizable. Technical expertise and analyses are needed on:

1. A comprehensive cost-analysis[47] of a single-payer system according to the design of the Medicare for All policy;

2. A detailed design of the provider payment system for hospitals and individual providers under Medicare for All;

3. A detailed phase-by-phase financing plan for Medicare for All; and

4. A detailed transition plan that identifies how current revenues will be redirected to the Medicare Trust Fund, how individuals will gain coverage, and how the provider payment system would be implemented.

However, not all of these analyses are needed in the imminent future. Political calculations will need to be made to determine when these analyses would contribute optimally to the conversation. Otherwise, depending on how it is framed, if the findings are introduced too soon, the politics and policy stream may not be primed enough for the analytical findings, and public or legislative support could decline.

b) Minimize policy differences between the House and Senate Medicare for All bills.

History of health reform has shown that a divided policy community is detrimental to legislative progress. Therefore, Medicare for All's policy stream needs to be further streamlined by eliminating the differences between Senator Sanders's and Representative Jayapal's bills. Each has key policy differences that cause division as the Medicare for All groups advocate for one or the other. The companion bills should be as similar as possible to limit confusion on key policy

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[47] Several cost-analysis have been conducted for a single-payer system in the U.S.; however, the design choices and assumptions do not completely correspond with H.R. 1384; also, a comprehensive cost analysis should also include the potential downstream impacts on the economy, health equity, and overall health outcomes, not only the financial analysis.

components, such as long-term care coverage and financing structures for hospitals. Also, more unity on policy decisions allows for more accurate cost analyses that advocates and politicians can point to more confidently. Previously, Senator Sanders had political considerations while running for President that may have affected the policy decisions made for his version of the Medicare for All bill. Since he is unlikely to run again, this may create an opportunity to align the policies.

c) Continue the legislative record and conversation on Medicare for All in the House

Guaranteeing more congressional committee hearings on Medicare for All will be critical for the movement to continue its momentum, especially as Leadership's health policy agenda will not include single-payer. A commitment was already made by Small Business Committee Chairwoman Nydia Velazquez to hold a Medicare for All hearing in the spring of 2021. Ensuring that this committee holds a hearing as successful as previous Medicare for All hearings, as well as a hearing in an additional committee of jurisdiction, will help maintain the legislative conversation on Medicare for All in the House. Furthermore, the Medicare for All Caucus should continue to hold regular briefings and strategy meetings with Members and build stronger allies. In particular, there are several incoming freshman Members who have expressed strong commitment to Medicare for All and may be willing to use extensive resources in support of it.

2. Laying the Legislative Foundation for Medicare for All Under A Biden Administration

a) Ensure the Task Force Policies as the "Floor"

Vice President Biden campaigned on building on the ACA, providing a public option, and actively messaged against Medicare for All. When Vice President Biden assumes the Presidency, Medicare

for All's coupled problem and policy streams could start to unravel, as building up legislative support could be seen as contradicting Presidential priority. However, it is possible to position Medicare for All as a progressive priority in order to continue building up legislative support and refine its policy under a Biden Administration.

Furthermore, the newly 6-3 conservative majority Supreme Court will provide the decisive vote for the case that will determine the ACA's survival. Even under a Biden Administration, the lawsuit would most likely continue and the political will to push forward a public option could be diminished, as efforts will be directed towards the ACA's survival. If the ACA is struck down, the widespread urgency in finding a new solution could translate into more support for Medicare for All, similarly to the impact of the GOP's attempts at repeal and replace.

A Biden administration is most likely to prioritize a public option as the next step in health reform, especially if there is a Democrat majority in both chambers of Congress. This type of turnover could create a complicated political environment for Medicare for All advocates and political champions, as supporting Medicare for All could be labeled as "divisive" in the face of a Democratic Administration and Congress. Therefore, Medicare for All policy entrepreneurs will need to actively engage and influence Biden's public option legislation as it is developed. Simultaneously, they will also need to strategically push other incremental policies that help to incorporate aspects of the Medicare for All bill, all while maintaining legislative support for single-payer (detailed further in Section 5.5.3).

In May 2020, Vice President Biden and Senator Sanders set up six Unity Task Forces to unite the party after the Democratic Presidential Primary election. Each task force was charged with creating

the Democratic National Convention platform and providing a list of policy recommendations for Biden's presidential agenda. Representative Jayapal co-chaired the Health Policy Taskforce[48] with Former Surgeon General Vivek Murthy. Rep. Jayapal, fully aware that she would not be able to convince Vice President Biden to adopt Medicare for All, instead turned her strategy towards incorporating key provisions from the policy in hopes that it would lay a policy foundation for single-payer. Each policy on the list of recommendations required approval from the Biden campaign team for its inclusion. The Biden team also expressed its commitment to the final published document[49].

The Health Policy Task Force negotiated provisions, which included:

- The public option would be administered by the Centers for Medicare and Medicaid Services (CMS) and not private insurers

- Medicare would directly negotiate drug prices for all public and private purchasers

- Medicare benefits would be expanded to include dental, vision, and hearing

- Long-term supports & services workforce would be expanded; efforts would be made to eliminate institutional bias within Medicaid

- Waivers to receive federal support for statewide universal health care approaches would be available to states

- Implementation of global budgets for rural hospitals would be expanded

- The five-year bar for eligibility for Medicaid & CHIP for legal permanent residents would be lifted; DACA recipients allowed to access subsidies to the marketplace; undocumented immigrants would be allowed to access marketplace plans (without subsidies)

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[48] The Health Policy Taskforce consisted of four Biden appointees and three Sanders appointees. Biden: Vivek Murthy, Sherry Glied, Mary Kay Henry, Robin Kelly; Sanders: Pramila Jayapal, Don Berwick, Abdul El-Sayed.
[49] The full Unity Task Force recommendations document can be found at: https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf

Therefore, several aspects of Medicare for All, such as expanding benefits, drug negotiation, long-term care coverage, and use of global budgets, were agreed to by the Biden team. Following the platform's release, the Biden Campaign's commitment to the provisions was publicly diminished when it referred to the document as only "suggestions" (Newmeyer, 2020). However, Rep. Jayapal and Senator Sanders have consistently asserted that the platform serves as the "floor, not the ceiling." Therefore, if a Biden administration occurs, it will be critical to ensure that these negotiated policy recommendations are, at a minimum, maintained if not improved. Accordingly, a coordinated effort should begin immediately following the 2020 election to designate reliable progressive Members to lead bills that translate the negotiated Taskforce provisions into CPC-led legislation to be introduced in the 117th Congress.

Given the results of the 2020 election, a smaller Democratic majority House and most likely Republican Senate positions a public option policy as unlikely to gain precedence or priority in the 117th Congress. However, if a public option policy does begin to gain traction, the CPC will need to continuously monitor and preemptively influence the public option policy. A policy that is a Presidential priority will most likely be shepherded by House or Senate Leadership. If so, the process may be a very "closed-door" process, similar to the creation of H.R. 3. The CPC should publish a statement detailing their priorities and expectations for a public option policy. A major priority will be maintaining the public option as truly "public" by ensuring it does not develop into a publicly-financed/privately-administered model (such as Medicare Advantage). Such model would expand the role of private insurers within a public insurance program, add to the fragmentation of the insurance system, and position single-payer as even "more disruptive" to

implement. Therefore, a public option that is privately administered would be a major setback for Medicare for All policy entrepreneurs.

b) Deploy an "Interim" Medicare Expansion Strategy

While the efforts to maintain Medicare for All as part of legislative conversation are deployed, a separate campaign to pass a "Medicare Expansion" package may allow for broader buy-in from moderate health policy groups, unions, and Congressmembers. A Medicare Expansion bill should include lowering the traditional Medicare age, covering children, and expanding benefits, such as including dental, vision, hearing, and EPSDT[50], as well as an out-of-pocket cap. As lowering the Medicare age was already included into the Taskforce platform, this set a precedence of openness to this legislative path. Furthermore, as the AFL-CIO, the largest federation of unions in the U.S., has included lowering the traditional Medicare age to 50 and improving its benefits in its transition recommendations document to the Biden Administration,

In terms of strategy, the bill should be introduced with a moderate Congressmember as the co-lead who is placed on either the Energy & Commerce or Ways & Means committee. A moderate co-lead on these committees will help build broader endorsement across caucuses, such as the Congressional Black Caucus, and potentially congressional hearings. Furthermore, a coalition of outside organizations with close ties with past Democratic Administrations and House Leadership, such as Centers for American Progress, Center for Budget and Policy Priorities, or FamiliesUSA, can help set forth a serious legislative strategy for passage. This could also help to broaden the

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[50] EPSDT, or Early and Periodic Screening, Diagnostic, and Treatment, as a set of benefits, offers a comprehensive approach to medical, dental, and mental health care for children which emphasizes prevention and early intervention.

membership of the Medicare for All working table by establishing relationships with members of the Medicare Expansion coalition.

c) Support the passage of the state-based universal health care bill to promote political feasibility of single-payer efforts.

One of the Unity Task Force's key commitments was to expand the federal support available for states who are ready to pass universal health insurance systems, such as single-payer. The lack of federal support was a significant detriment for the 2011 attempt by Vermont Governor Shumlin.[51] Since they were unable to access sufficient funds, this resulted in a larger cost estimate and more extensive tax requirements. The opposition to such tax increases was so immense, Governor Shumlin abandoned the single-payer efforts and withdrew the plan. Representative Ro Khanna (CA) introduced H.R. 5010, The State-Based Universal Health Care Act, which would provide waivers to access the federal funding necessary to implement a state-based single-payer system.

Therefore, as state-based single-payer could be part of the Presidential agenda, significant resources should be dedicated to passing this bill into law so that other current attempts, such as in California, New York, and Colorado, will have a better financial assessment of their single-payer policies. More available federal revenue would result in less need for increased taxes, therefore building an improved political landscape for single-payer. While state-based single-payer

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[51] It is important to note that the Governor Shumlin's "single-payer" proposal was actually a "single-pipe" plan that used a system governed by a public-private partnership, and a third party would administer the program. Therefore, the Vermont proposal did not have the same level of savings that a single-payer system could provide (VerValin, 2017).

policies face their own unique political and technical challenges, improved feasibility for them could serve as a powerful argument for attempts at the national level.

a) Transform the CPC into a Medicare for All policy entrepreneur and create broader progressive infrastructure across Congressional offices and committees

The CPC was formed in 1991 by a small group of House lawmakers. Although the CPC is the second-largest caucus within the Democratic Party, its members' political and policy beliefs do not represent an ideologically unified platform. This is in contrast to Republican groups like the Freedom Caucus[52] or moderate, pro-business Democratic groups like the New Democrats, whose united platforms have allowed them to leverage their memberships to successfully sway the passage of legislation.

However, in the 116th Congress, the CPC expanded its membership to 97 members, increased its staff from a single Executive Director to a staff of four, and positioned itself as a more influential caucus than previous years. Yet, thus far, almost all efforts for Medicare for All made by Rep. Jayapal were through her personal legislative office, not through the CPC. The CPC's new "energy" should be translated into an influential policy entrepreneur of Medicare for All. In order for the CPC to become an engaged and active policy entrepreneur, it will need to undergo substantial governance and structural changes. Currently, 19 CPC members are not co-sponsors of the

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[52] The Freedom Caucus represents the most conservative ideological caucus in the House. The caucus utilizes a binding rule that requires members of the Caucus to vote the same way if 80% of the Caucus votes to invoke the rule for a particular measure (Rubin, 2017).

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Medicare for All Act and over a dozen members also have membership in the New Democratic Coalition. For the CPC to become an influential voting bloc, it will need to consider "stricter" policy support requirements of its Members. For example, it could require Members to co-sponsor a minimum number of key progressive legislative priorities, such as 'Medicare for All', 'College for All', or 'The Green New Deal'. It could also require Members to vote with the CPC recommendation a certain percentage of the time. Doing so may temporarily reduce the number of CPC Members, but the membership would represent a more actively engaged constituency. Additionally, current CPC co-chair Mark Pocan is not seeking re-election for this position due to a newly imposed two-term limit. As sole chair, Rep. Jayapal may be able to align the CPC with her priorities and direct its resources towards promoting single-payer and other relevant efforts.

Furthermore, committee placements are critical to influencing and passing major legislative initiatives, as evidenced by Rep. Jayapal's seat in the Education & Labor Committee that allowed her to be the only Member to include a substantial amendment into H.R. 3. The House Medicare for All Act would have to go through at least five Congressional Committees to make it to a floor vote, including the powerful Ways & Means and Energy & Commerce committees. Currently, 46% of the W&M Democratic Members are co-sponsors of H.R. 1384, as are 48% of the E&C Democratic Members, including the lead co-sponsor Rep. Debbie Dingell. Therefore, additional progressive champions of Medicare for All will need to be assigned to these important committees to achieve the similar impact that occurred for President Johnson's Medicare. Committed CPC Members can help raise Medicare for All onto the committee agenda, influence Chairpersons who hold consolidated power, and shepherd the bill through any hearing or mark-up process it could face in the future.

Lastly, building a pipeline for stronger Medicare for All advocates within Congress at both staff and Member level is critical. It is challenging to get a position within Congress without prior legislative experience unless through a fellowship or internship, which are rare. Therefore, to have more staff-level policy champions for Medicare for All, the CPC should put more resources to bringing in those with technical training, significant professional experience or backgrounds in grassroots organizing, and progressive values into offices and committees on the Hill. I believe this will also have an upstream effect on influencing the policy agendas of Members of Congress and provide broader infrastructure for furthering legislative progress on progressive policies.

b) Enable the CPC to become a powerful voting bloc and agenda setter

Following the 2020 election results, progressive Members received significant backlash due to the loss of House Democratic seats. The CPC PAC (the caucus's campaign arm) had invested heavily in Democratic congressional candidates who campaigned strictly on progressive priorities; eight won their campaigns. Furthermore, no CPC Member or Medicare for All co-sponsor lost their general election, even in swing districts. However, many moderate Members felt that progressive ideas, such as "Medicare for All" and "Defund the Police[53]," had been weaponized by the Republican Party and caused the loss of eight frontline New Democrats.

With a reduced Democratic majority in the House, the CPC only needs five Members to vote consistently in line with its priorities to influence a floor vote. Therefore, the CPC has the potential to become a powerful voting bloc within the House of Representatives. However, the CPC co-

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[53] "Defund the Police" is not a legislative policy but instead a campaign that highlights the disinvestment in Black communities and police violence, by demanding the shift of spending on police into social services. The Congressional Progressive Caucus has not formally endorsed it.

chairs have already expressed that they do not want to become the "Freedom Caucus of the Left", especially in confrontation with already tense in-party dynamics due to the election results. Therefore, the CPC will need to be judicious about which legislative efforts it will prioritize and put forth sufficient resources for when it does decide to deploy a voting bloc strategy. Doing so will allow the CPC to harness its ability to become an agenda-setter for Medicare for All should the politics stream shift towards an Administration with a progressive platform in the future.

4. Shape Public Support of Medicare for All

a) Understand the factors that positively or negatively impact public opinion on Medicare for All

Some political experts believe the most difficult element to influence in the politics stream is the 'national mood'. Kingdon categorically asserts that it does not refer solely to public opinion, but rather to the perceived climate of opinion by elites and other politicos. Dr. Mollyann Brodie, Executive Director of Public Opinion and Survey Research at the Kaiser Family Foundation, noted:

> There has been an established pattern and correlation between the success and ultimate failure of each past attempt at health reform legislation and the rise and fall of support from the American public. At the beginning of every policy debate, most Americans tend to support the general idea of reform. As the specifics of policy proposals are debated, and as opponents strike fears about potential downsides and changes to the status quo, Americans begin to turn on the idea of reform. By the end of the debate, inaction is "just fine. (Upadhyay & Dinh, 2018)

Medicare for All was heavily debated and subjected to oppositional campaigns from candidates and interest groups throughout the 2020 Democratic Presidential Primary Election. Throughout my project, I collected and examined every poll that was conducted on Medicare for All to keep track of public opinion. This section utilizes a series of comprehensive polls, conducted by the Kaiser Family Foundation (KFF) from March 2019 to May 2020, to illustrate the complexity of public opinion and how it is impacted by the debate on Medicare for All.

Figure 20 depicts monthly polls performed by KFF throughout the 2020 Democratic Presidential Primary election to assess the state of public opinion for Medicare for All. They consistently found that Medicare for All had support from a majority of the public, even as the topic was being heavily debated and opposed by most Presidential candidates. However, this poll alone does not provide an in-depth understanding of public perception and understanding of Medicare for All.

Figure 19. Public Opinion on National Health Plan 2015 to 2020
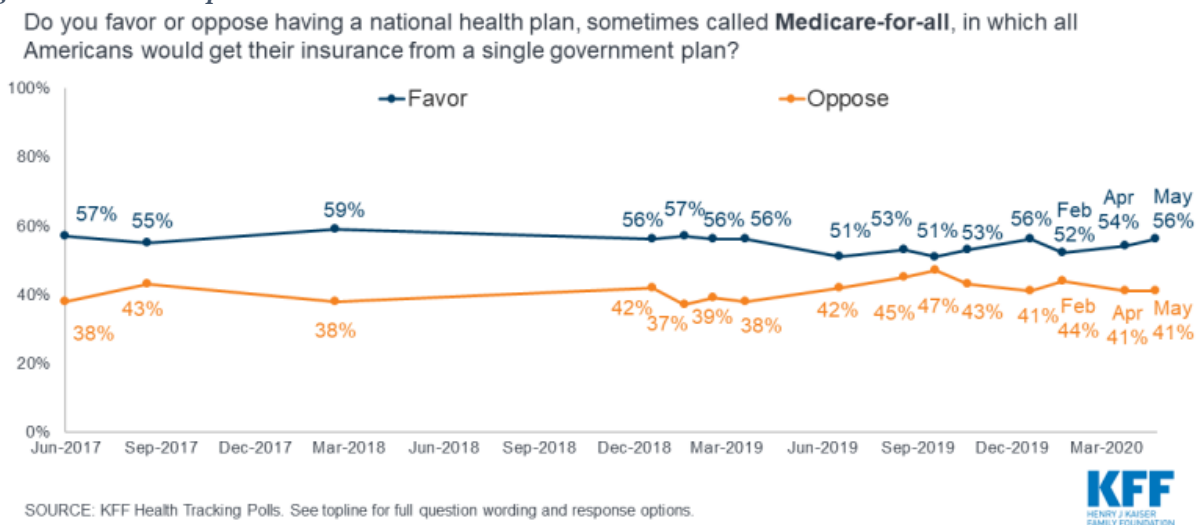
Source: Adapted from (KFF, 2019)

For example, KFF performed a poll that indicated why 'Medicare for All' was used to brand single-payer policy (refer to Annex 3). According to KFF, the term "universal health coverage" (UHC) has the most positive and least negative reaction. While Medicare for All would provide UHC, the terms are not interchangeable; yet, both terms garnered the same percentage of positive reaction. There is a significant reduction in positive reaction with the term "single-payer health insurance system" and "socialized medicine." Single-payer is a difficult concept where many believe that they, as an individual, are the "single-payer." "Socialized medicine" has been politicized and associated with negative connotations for almost a century. However, both terms still garnered positive reactions from nearly half of the respondents, indicating that the term may not be as harmful as it was in the past.

Figure 20. Reasons for Opinions on Medicare for All March 2019
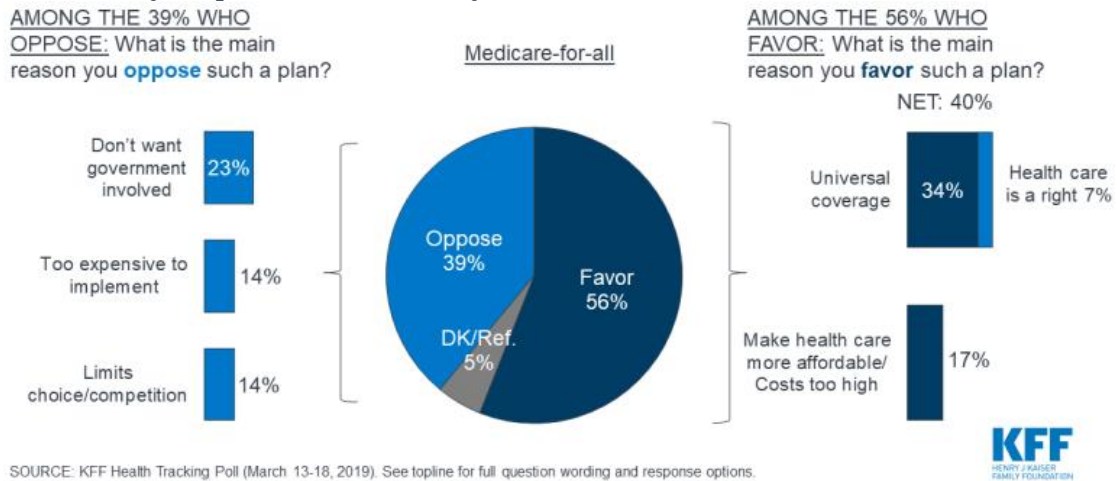
Source: Adapted from (KFF, 2019)

Beyond the label used, it is essential to understand what particular aspects of Medicare for All provokes opposition or support. Figure 21 illustrates that for almost 60% of those who oppose Medicare for All, the main reason is that they "don't want government involved." This reasoning

indicates the persistent resistance to policies that are perceived as "government control."

Additionally, one-third of those who oppose Medicare for All selected cost as the main reason, and another one-third indicated because it "limits choice."

As shown in Figure 22, universal coverage and simplifying the system were identified as the most important features of Me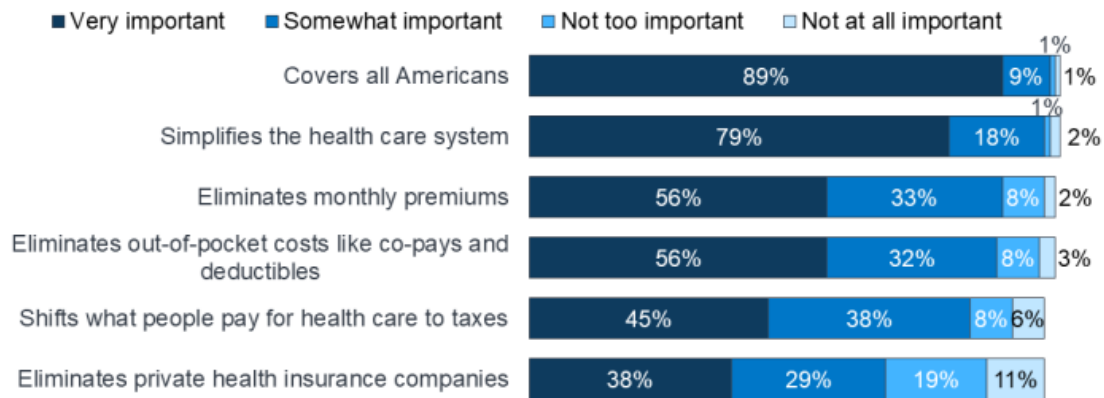dicare for All. The concept of shifting what people pay for health care to taxes and "eliminating" private health insurance are also important facets of the policy for Medicare for All supporters, with 83% and 67% indicating it is "somewhat important" to "very important", respectively.

Figure 21. Medicare for All Features Important to Supporters March 2019

How **important** is it that a national health plan...?

■ Very important ■ Somewhat important ■ Not too important □ Not at all important

	Very important	Somewhat important	Not too important	Not at all important
Covers all Americans	89%	9%	1%	1%
Simplifies the health care system	79%	18%	1%	2%
Eliminates monthly premiums	56%	33%	8%	2%
Eliminates out-of-pocket costs like co-pays and deductibles	56%	32%	8%	3%
Shifts what people pay for health care to taxes	45%	38%	8%	6%
Eliminates private health insurance companies	38%	29%	19%	11%

NOTE: Among those who favor a national health plan.
SOURCE: KFF Health Tracking Poll (March 13-18, 2019). See topline for full question wording and response options.

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Source: Adapted from (KFF, 2019)

While support is strong overall for Medicare for All, this doesn't necessarily indicate that understanding what Medicare for All entails is clear for voters. For example, Figure 23 shows that a significant number, 78%, expect that taxes for most people would increase under Medicare for All. Yet, 61% believe that individuals and employers would continue to pay health insurance premiums and that people would be able to keep their current plans. This represents that for more

than half of voters, the Medicare for All's policy details are still unclear. Therefore, much of the public still does not have a clear understanding of what Medicare for All entails, particularly its impact on current private health plans.

It is possible misunderstandings were exacerbated by the 2020 Democratic Presidential Primary election, in which "Medicare for All" became the title for multiple candidate's plans that were not single-payer national health insurance proposals. For example, Senator Kamala Harris introduced her "Medicare for All" plan that kept a large role for private insurance while Mayor Pete Buttigieg used "Medicare for All Who Want it" to describe a plan that provides a public option and maintains the employer-sponsored insurance system. However, Figure 23 shows that accurate understandings of Medicare for All rose five to 11 points for almost each description of the policy over the course of six months, signifying an improvement in understanding.

Figure 22. Expectations for Medicare for All January 2020 vs June 2019
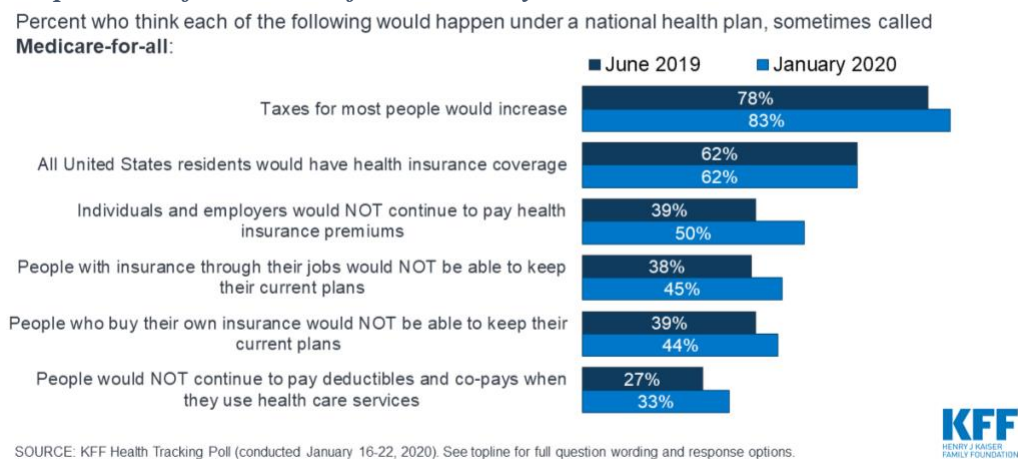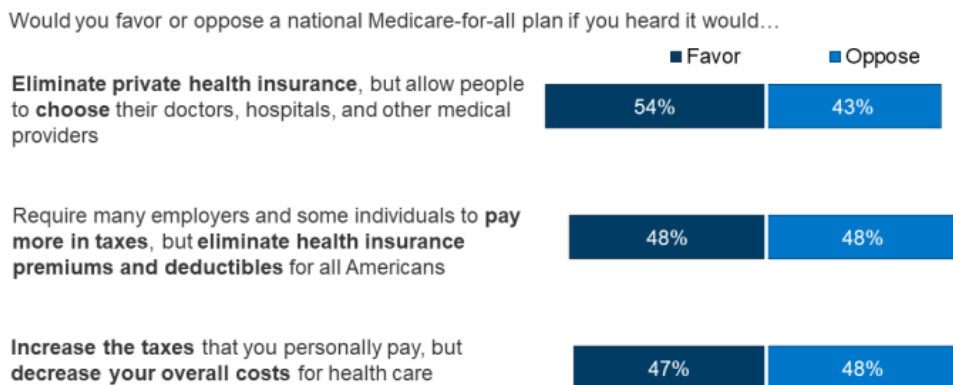

Source: Adapted from (KFF, 2020)

According to Figure 24, the overall level of support can shift depending on how "negative" aspects of Medicare for All are phrased (KFF, 2020). Similarly, to the Morning Consult poll described in Section 3.7.2, if the phrase "eliminate private health insurance" is followed by "but allow people

to choose their doctors," then support actually increases than being asked if they support Medicare for All without additional framing. Additionally, support declines to 47% when told that some may pay more in taxes, but they would no longer pay premiums or deductibles (refer to Annex 3).

The cost of Medicare for All was a constant question during the Democratic Presidential Primary debate. However, it was not an economic question as much as it was a political one—how does one respond without inciting the fear around taxes? This prompted Senator Warren to put forth her financing plan without "middle-class tax hikes", while Senator Sanders framed it as "premiums" that would cost less than what the average American family is paying now. Yet, the KFF polls indicate that even when describing Medicare for All with "tax hikes" and "elimination of private insurance," a near majority of the public supported Medicare for All, including 78% of Democrats and 61% of Independents (KFF, 2020). While there is no doubt that taxes are a vulnerability for Medicare for All, it may not be as fatal to building support for single-payer as critics have expressed. These concerns may also be further managed as Medicare for All policy entrepreneurs refine their ability to positively frame the more "politically contentious" aspects of the bill.

Figure 23. Shifts in Support for Medicare for All Based on Description of Plan November 2019

Would you favor or oppose a national Medicare-for-all plan if you heard it would...

	Favor	Oppose
Eliminate private health insurance, but allow people to **choose** their doctors, hospitals, and other medical providers	54%	43%
Require many employers and some individuals to **pay more in taxes**, but **eliminate health insurance premiums and deductibles** for all Americans	48%	48%
Increase the taxes that you personally pay, but **decrease your overall costs** for health care	47%	48%

SOURCE: KFF Health Tracking Poll (conducted November 7-12, 2019). See topline for full question wording and response options.

KFF
HENRY J KAISER
FAMILY FOUNDATION

Therefore, the policy entrepreneurs should recognize that while the current national mood is favorable towards Medicare for All, public opinion must continue to solidify. Politically contentious aspects of Medicare for All, such as taxes, should not be underestimated, but also not written off as deal-breakers. Improved public understanding of Medicare for All's policy impacts will be critical to create more resilient support in face of oppositional messaging. Otherwise, there may be unintended backlash if the policy suddenly moves up the agenda and opposing groups attempt to influence the narrative.

b) Fund a mass education campaign to influence national mood and combat oppositional efforts

There are organized political forces in support and opposition of Medicare for All. The opposition is considerably more organized, resourced, and experienced. Dr. William Hsiao, Professor of Economics at the Harvard School of Public Health, stated:

> You haven't even seen the insurance industry and pharmaceutical industry come out yet with really well-organized campaigns against it. They only have to use one-thousandth of one percent of their revenue to fight [Medicare for All]. They can elect the key decision-makers in Congress, the Senate and the House of Representatives because they can mobilize literally a billion dollars. And those powerful, wealthy, well-organized, vested interest groups have not come out openly yet. That's the reality of American money, politics. (Reynolds, 2019)

As of now, Medicare for All is unable to move through both chambers of Congress, so the threat of a policy window is not as prominent for the opposition. Public opinion may shift when the bill gathers more momentum, and the opposition expands their efforts. Chapter Four noted that competing against oppositional campaigns was a major challenge the Medicare for All Coalition faces. Currently, the Medicare for All Coalition and political champions have mostly been defensive and focused on addressing the misconceptions laid out by oppositional interest groups and politicians.

Significant resources will be needed to produce a mass education campaign that engages and effectively informs the public on the key tenets of Medicare for All, based on the messaging determined by the coalition, instead of the opposition. For example, Figure 23 noted that only 33% of the public know that Medicare for All eliminates deductibles and co-pays. This policy point should be emphasized as a benefit, not just as a counterpoint to potential tax increases. Therefore, the Medicare for All Coalition must prioritize managing the narrative and pool finances to fund a mass media campaign that can set the terms on how Medicare for All will be described and perceived by the public.

5. Enhance and Expand Interest Group Advocacy

a) Improve coordination of efforts within the Medicare for All Coalition and with political champions

The survey results in Chapter Four indicated challenges the Medicare for All Coalition faces, such as the need for improved coalition structure and coordination, and their limited influence inside Congress. In terms of coalition structure and coordination of efforts, currently, leadership is

consolidated under the National Nurses United. Similarly, the Congressional strategy is mostly funneled through the Office of Congresswoman Jayapal. Leadership should be distributed amongst coalition groups and congressional offices so that efforts are not limited or reliant on the resources or capacity of a single entity. Therefore, groups must directly engage with other Members as spokespersons for Medicare for All, without direct coordination through Rep. Jayapal's office, to establish a broader active constituency within Congress. These Members should include the Medicare for All Congressional Caucus Vice Chairs[54] who could further employ their resources extensively to promote support of the policy, as well as the incoming Members who campaigned on Medicare for All.

b) Expand the Medicare for All Coalition to include a broader range of stakeholders

There is some hesitation from certain Medicare for All groups who feel that bringing different stakeholders to the table may compromise ideology or policy. However, according to the stakeholder survey, several groups identified "expanding the coalition of interest groups" as vital towards achieving more progress for Medicare for All. Therefore, the next section will provide a stakeholder commitment matrix to identify various groups that could be brought into the Medicare for All Coalition.

*5.4 Strategies for Generating Stakeholder Commitment*

Beyond building political power within Congress, Medicare for All's policy entrepreneurs must invest significantly in expanding stakeholder support. The array of interest groups supporting

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[54] The Medicare for All Congressional Caucus Vice Chairs include: Representatives Yvette Clarke (NY), Steve Cohen (TN), Joseph Neguse (CO), and Ilhan Omar (MN).

Medicare for All is diverse and includes faith organizations, labor unions, progressive advocacy organizations, racial justice organizations, think tanks, and grassroots organizers. Nevertheless, there are other stakeholders across health policy-making who need to be more actively engaged. There are also several stakeholder groups who have not been engaged but could be persuaded not to oppose Medicare for All. The stakeholder commitment matrix (Figure 25) displays key stakeholders' current level of commitment and what level they need to be at for Medicare for All's success. The matrix shows some stakeholders with multiple current and desired levels of commitment to set apart the engagement of various subgroups within that constituency. This section will identify each stakeholder, their current level(s) of commitment, and strategies to get them to a level of commitment that advances Medicare for All towards a policy window.

Figure 24. Stakeholder Commitment Matrix
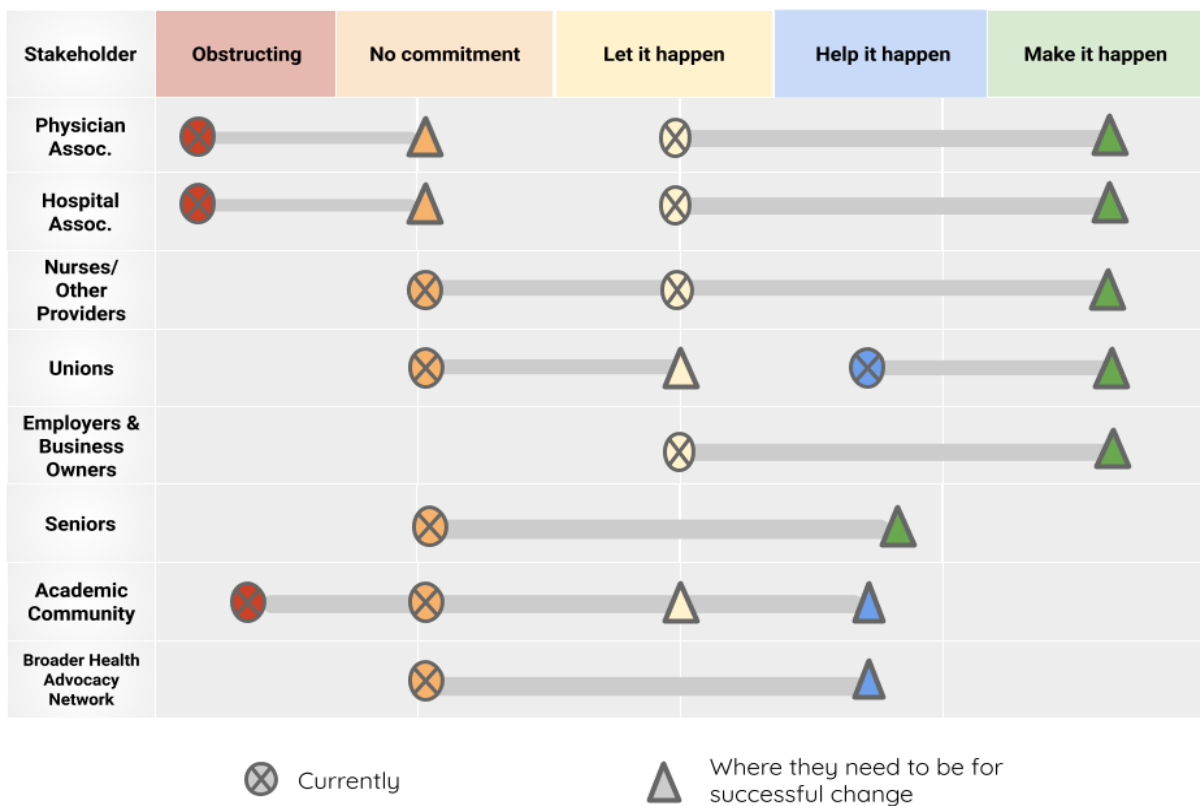
According to Figure 25, physician associations are in two general groups— those who strongly oppose Medicare for All and those who would "let it happen." While PNHP, a physician advocacy organization described in Section 4.2, is in full support of Medicare for All, their 20,000 members represent a fraction of the physician community. The AMA, which has 240,000 members, remains an effective and powerful stakeholder in opposing health reform, as evidenced by the surprise billing legislation's halting. They are the third-largest U.S. lobbying organization behind the National Realtors Association and the U.S. Chamber of Commerce (Dickson, 2017) . The AMA opposes Medicare for All for the same reason they oppose surprise billing— payment reduction. However, only 12% of physicians are members of the AMA. Also, a 2018 poll indicated that 66% of physicians support the U.S. moving to single-payer healthcare (Ault, 2018). Therefore, the AMA should not be considered the only voice representing physicians on single-payer.

For example, the American College of Physicians (ACP), the second-largest physician group after the AMA with 163,000 members, and the Society of General Internal Medicine (SGIM) support single-payer. However, their endorsements included support for both Medicare for All and public option proposals. Also, the ACP and SGIM are not an actively contributing member of the Medicare for All Coalition. If the ACP and the SGIM become more active champions of Medicare for All, this could help neutralize the AMA opposition or move the AMA closer to removing explicit single-payer opposition from their doctrine. Furthermore, both physician groups should be brought to the table for the next iteration of the bill drafting of the Medicare for All legislation. Doing so could create an opportunity to gain more buy-in from the association and respond to any hesitations or concerns they have that could be addressed in the Medicare for All bill text.

Also, the American Medical Student Association (AMSA), a student-led national organization with 30,000 members, is an avid supporter of Medicare for All. In the 1960s, AMSA split away from the AMA due to differing philosophies and their desire to focus on more socio-medical issues, such as civil rights and universal health care (AMSA, 2015). In 2019, AMSA launched the "Healthcare for All Campaign" that endorsed Rep. Jayapal and Senator Sanders's bills and launched a series of actions and organizing trainings for its members to support Medicare for All. However, AMSA is not an active collaborator within the Medicare for All Coalition. Building a stronger relationship with AMSA will be critical to shifting the narrative around provider support for Medicare for All, especially as the AMA demographics shift towards a younger and more diverse generation.

Hospital Associations

The American Hospital Association (AHA) has publicly noted that they not only oppose the Medicare for All bill, but they reject any proposal that includes a public plan option, a buy-in Medicare or Medicaid option, or lowers the Medicare enrollment age. The AHA referred to each of these proposals as "government-run" policies that would do "more harm than good to patient care." Therefore, other hospital associations will need to be brought in to counter the AHA narrative, similarly to the approach described for physician groups.

For example, America's Essential Hospitals Association (AEHA) has a vast network of 300 public hospital systems, and the National Rural Health Association (NRHA) represents more than 21,000 rural health organizations and hospitals. Both have neither explicitly endorsed nor opposed Medicare for All. In my conversations with these organizations, both expressed support for the policy in theory. Each indicated that several of their board members were enthusiastic supporters

of Medicare for All but that as an organization, they were not ready to take a stance until Medicare for All was further down the legislative process.

Both safety net and rural hospitals, which tend to operate on thin or negative operating margins, face unstable economic situations. Twenty-one percent of rural hospitals are at risk of closing due to financial unviability, and a number of safety net hospitals also have shuttered or merged with larger health systems. Meanwhile, a few rural health systems in Maryland and Pennsylvania have already piloted global budgets as a successful financial model endorsed by the AHA (LaPointe, 2019). Potentially, significant buy-in could be garnered by rural and safety-net hospitals through Medicare for All's global budget model. Separately, hospitals that mostly care for poor and uninsured patients could see higher, more stable revenues through a system that reimbursed for every patient at Medicare rates (Section 3.7.2 notes the Medicare for All bill does not yet specify the exact rate). Therefore, AEHA and NRHA members may have much to gain from a Medicare for All system that would pay them prospectively and guarantee them virtually no incidence of uncompensated care.

Other Clinicians, Providers, and Health Care Workforce

Since Medicare for All covers dental, vision, hearing, mental health, long-term care, and more, nurses, dentists, physical therapists, physician assistants, and others across the health care workforce will all be impacted by a Medicare for All system. Therefore, to varying extents, representatives from each type of health provider should be further engaged and their support promoted.

The American Nursing Association (ANA) has endorsed single-payer in the past but has a contentious history with National Nurses United, the Medicare for All coalition leader. The ANA was not involved with drafting the Medicare for All bill, which may have caused them to not endorse the bill during the 2020 Democratic Presidential Primary. The ANA was a key player in lobbying efforts for the ACA and in stopping the Republican attempt to repeal it. Involving the ANA in the next drafting process of the Medicare for All could help recover their support and identify their policy priorities that could be incorporated into the proposal.

The American Dental Association (ADA) strongly opposes Medicare for All for reasons similar to the AMA and AHA. However, the American Student Dental Association (ASDA) has not taken a position or publicly stated any opposition towards single-payer. Therefore, there is an opportunity to engage with the ASDA to gauge their openness to the policy and either broaden the physician advocacy organizations to include dental students and other clinical providers, or neutralize opposition from the ADA. Similar efforts should be applied to other providers, such as physician assistants and licensed therapists.

Unions

Senator Sanders received more union endorsements than any other 2020 Democratic Presidential candidate. Over 20 national unions endorsed H.R. 1384. Labor support for single-payer is largely based on the substantial collective bargaining efforts spent towards negotiating health plan benefits. Many unions believe that untethering health care from employment would allow their negotiations to secure other benefits or wage increases. While there is broad labor support for single-payer,

there is some resistance from certain unions[55] who are concerned about the impact of Medicare for All on their already negotiated plans.

Furthermore, there is divided support for Medicare for All amongst the labor community. Several unions, such as the American Federation of Teachers (AFT) and Service Employees International Union (SEIU), support both Medicare for All and public option proposals. Other more conservative unions, such as the International Association of Fire Fighters, completely oppose single-payer. The AFL-CIO has shown significant influence in health reform in the past and endorsed Medicare for All in 2017. However, throughout the 2020 Democratic Presidential Primary, AFL-CIO President Richard Trumka noted, "There's no question that ultimately we need to establish a single-payer system, but there has to be a role for those hard, hard-fought-for, high-quality plans that we've negotiated."

Lastly, some unions have also highlighted the concern about the reduction of jobs in the health care industry due to the reduced need for administrative staff in a single-payer system. The Medicare for All bills include a just transition provision to provide benefits to affected workers for up to five years. Additionally, a recent economic analysis concluded that a Medicare for All system would actually result in a net increase in jobs (Bivens, 2020). However, political champions for Medicare for All will need to address this concern more directly before it is exacerbated significantly by the opposition and results in further divided labor support.

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[55] The Culinary Workers Union Local 226, one of Nevada's most powerful political forces, released a flyer that stated Senator Sanders would "End Culinary Healthcare". However, several members disagreed with union leadership and noted that while their insurance was high-quality, losing their health care if they became unemployed was a major concern. Consequently, members broke off from leadership, and Senator Sanders won majority support from Culinary Union caucusgoers by a large margin (Collins, 2020).

These concerns could be addressed by including certain labor-specific provisions in the next iteration of the Medicare for All text. Such provisions could allow the renegotiation of benefits into other means of compensation during the transition to single-payer, sunset labor health plans within a certain number of years or require employers to convert the difference in premiums towards wages. The just transition provision could also include more robust benefits and support to affected workers. Garnering strong and consistent labor support will be critical for Medicare for All's progress towards a policy window. Therefore, substantial technical expertise and input from labor unions into the text of the next Medicare for All bill will be vital towards alleviating union concerns and minimizing political backlash.

<u>Employers & Business Owners</u>

Employers will be critical for the passage of Medicare for All, as much of the financing for a Medicare for All system will rely on employer contributions. Already, there has been established support from small and mid-sized businesses. The 30.7 million small and mid-sized businesses in the U.S. (businesses with fewer than 500 employees) represent 60 million workers, a significant portion of the population. They also represent more than 99% of employers. The rising cost of employee health insurance remains a particular challenge facing small businesses. A 2018 study from the Bureau of Labor Statistics found that only 57% of workers at firms with 100 employees or less had employer-sponsored healthcare. The cost of providing health coverage to employees is a more difficult challenge for smaller businesses, but this issue impacts businesses regardless of size (Enterprise Bank & Trust, 2019).

Furthermore, according to the 2019 Commonwealth Fund Small Business report, the cost of health insurance extends to recruiting and retaining talent. For small businesses to compete with larger employers, they are pressured to "offer benefits like health insurance, even as the benefit takes up a larger share of the bottom line". This report also stated, "Though business owners tend to be a conservative group, we did see an unexpected and almost apolitical frame on the issue of health care." The report determined that 58% of small business owners support Medicare for All, even when described as a single government plan that would not allow coverage from private insurers (Buttle et al., 2019). Therefore, there is significant opportunity to garner broader support by small business owners.

Additionally, there is shifting support for large employers. With the growth of the gig economy, more and more individuals are being hired as contractors without benefits, such as health insurance. Multiple large gig economy companies have approached the Office noting their support for Medicare for All as a means to help retain their workers. Additionally, even massive companies, such as Amazon, JPMorgan, and Berkshire Hathaway, have recognized the unsustainability of rising health premiums and are trying to create their own health care company to control costs. Therefore, there is ample opportunity for the business coalition for Medicare for All to be substantially scaled to include employers from varying political leanings and enterprises.

Seniors

The case must be made to seniors that they could significantly benefit from a Medicare for All system. Currently, traditional Medicare does not cover key benefits like dental, vision, hearing, and prescription drugs and can incur high out-of-pocket costs. Therefore, 81% of seniors purchase

supplemental insurance (Cubanski et al., 2018). Additionally, there are currently minimal options for long-term care coverage, which is very costly to pay for out-of-pocket. Therefore, Medicare for All's coverage of long-term care could be key to gaining buy-in from seniors. Professor Robert Blendon stated, "The long-term care piece is unbelievably significant. It surely will help [progressives] with older voters" (Luthra, 2019). Additionally, the case could be made that seniors will prefer having a single, easier to navigate, insurance plan that provides significantly more benefits without out-of-pocket costs or premiums.

Also, there are significant concerns about the financial viability of Medicare as it provides insurance for seniors and people with disabilities, the populations with the highest overall health care costs. It is possible to argue that expanding Medicare to include a younger, healthier risk pool would significantly improve Medicare's financial sustainability. Including "lower-cost" beneficiaries into the Medicare system would require less per-capita financial output and more retention of contributions. However, this explanation must be delivered carefully as seniors may strongly oppose any program that could seemingly risk or depreciate Medicare.

Another significant political barrier is the elimination of Medicare Advantage plans under Medicare for All. Over a third of seniors have Medicare Advantage, as these plans offer more benefits and lower out-of-pocket costs than traditional Medicare. However, Medicare for All offers significantly more benefits than the most generous Medicare Advantage plan, at no out-of-pocket costs, and broader physician networks. Seniors are bound to have an adverse reaction to "losing their private plan," thus, significant work will be needed to allay these concerns. Seniors were a critical grassroots supporter in the passage of Medicare. However, as Medicare for All would completely transform the current Medicare program, seniors' fears and concerns will need to be

effectively managed and addressed. Neutralizing opposition, or, more ideally, mobilizing support from seniors would provide significant advocacy for Medicare for All.

<u>Academic Community</u>

The need for more reputable academic advocates[56] was particularly evident when we needed to identify established experts to testify in the four congressional hearings on Medicare for All. One of the strongest academic allies was Dr. Donald Berwick, former Administrator of the Centers for Medicare and Medicaid, and a supporter of single-payer. During his opening remarks in the Ways & Means hearing on Medicare for All, he stated:

> Medicare for All is not an end in itself. It is a means to achieve what we care about: better care, better health, lower cost, and leaving no one out. I am open to considering any proposal that moves our nation fast and well toward those goals. Compared with Medicare for All, I see none better.

However, the overall available academic expertise is very thin, as very few professors and research institutions have a focus on the implementation of single-payer systems, especially in the U.S. context. While the idea of single-payer is not new, the area as a research subject is as the research landscape in the U.S. is largely dictated by funding and evaluating more "immediate problems." The academic community must be significantly expanded beyond just academic advocates to also include neutral brokers who can publish rigorous analysis of Medicare for All. As policy details for Medicare for All are delineated, a more robust understanding of a single-payer system's trade-offs and benefits will be necessary.

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[56] "Academic advocates" refers to academics who provide evidence to recommend a specific policy option.

As Medicare for All garners more traction, there may be more funding directed to the topic. In the meantime, significant investment is needed to produce the level of analysis and evidence to address many of the political and technical concerns surrounding implementation. Therefore, the Medicare for All Coalition and political champions should consider engaging with large foundations, such as The Commonwealth Fund, to determine interest in publishing a series of studies (such as the analyses suggested in Section 5.3.1) and further develop relationships with academics to encourage more regular output on the design and benefits of a Medicare for All single-payer system.

<u>The Broader Health Advocacy Network</u>

The demand for health reform is juxtaposed by high public mistrust in the government's ability to handle it. Therefore, the public needs to directly experience concrete improvements in the health care system as a result of federal legislation. Legislative wins and resounding proof of a positive impact from government intervention on health care could potentially alleviate some of the mistrust and concern that exists for many regarding government involvement in health care.

Surprise billing and drug-pricing are two ways for the public to experience real relief from certain health problems. Passing surprise billing legislation with benchmarking could also lessen the argument against political infeasibility for bills that are opposed by the AMA. Also, significant drug-pricing legislation, like H.R. 3, would provide considerable relief from exorbitant prescription costs for the vast majority of the U.S. population. These types of legislative wins could help set the political stage for Medicare for All and promote trust that the federal government can handle health reform.

Additionally, this could provide an opportunity to consolidate advocacy across health organizations. As noted from the Medicare for All Coalition analysis, a few organizations shifted their priorities towards Medicare for All after being involved in the protection of the ACA. Relationships with other health advocacy organizations, such as FamiliesUSA, could be developed due to their substantial involvement in lobbying both drug-pricing and surprise billing. FamilesUSA has been a substantially influential organization through several health policy battles, including in the passage of the ACA (McGinley, 2016). In my conversations with their leadership, they expressed interest in supporting efforts around Medicare for All. Eventually, their buy-in could be established by supporting their efforts for other health policy issues and continuing to encourage their organization to endorse Medicare for All.

Summary

For many of the stakeholders, there is ample opportunity to involve their constituencies into the policy process and garner more buy-in. However, each stakeholder's feedback will need to be assessed thoroughly for policy and political implications. A balance between preserving the core values of the bill and incorporating feedback to promote engagement will need to be maintained. Bringing in these stakeholders and neutralizing opposition will need to be a well-executed coordinated strategy across Medicare for All's policy entrepreneurs.

Policy windows are quick and can come unexpectedly. The policy entrepreneurs must put into place a comprehensive strategy, infrastructure, and a well-developed Medicare for All proposal for when a political change makes it the right time for a policy window.

5.6 CODA: COVID-19

"Crises are moments of opportunity for policy change, but it's not a sure thing, it's not going to happen automatically. It does require leadership at the end of the day."

Robert Griffin, Research Director, Democracy Fund Voter Study Group (2020)

Chapter Two determined that the problem stream was already primed for action. The lack of health coverage and health security in the U.S. was perceived as a societal issue that needed to be addressed. Now, in 2020, the COVID-19[57] pandemic has served as the ultimate 'focusing event' for this problem. Kingdon refers to focusing events as crises or disasters that direct attention to a problem. In the U.S., as of December 31, 2020, COVID-19 has resulted in over 341,000 deaths and almost 20 million cases, while 12 million have lost their health insurance due to job loss and remain uninsured (Bivens & Zipperer, 2020; CDC, 2020). While the U.S health care system offers a variety of health insurance plans, millions of the recently unemployed have fallen into the coverage gap as they are unable to afford COBRA[58], ACA marketplace plans, or qualify for Medicaid. Simultaneously, Congress and HHS implemented rules to require private insurers to cover COVID-19 testing and treatment, yet people have continued to receive expensive medical bills with unexpected fees and been denied claims related to coronavirus tests and treatment (Kliff, 2020). Additionally, COVID-19 has exacerbated the racial inequities in the U.S. health care system. Before the pandemic, Black and Latino communities were already disproportionately uninsured

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[57] COVID-19 is caused by a coronavirus called SARS-CoV-2. As of October 2020, there have been 42 million cases and 1.14 million deaths caused by COVID-19 (CDC, 2020).

[58] According to the U.S. Department of Labor, "The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the opportunity to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost to the plan" (U.S. Department of Labor, n.d.).

and had lower life expectancy than their white counterparts. Now Black and Latino people are nearly three times more likely than white Americans to be hospitalized with COVID-19 and twice as likely to die from the disease (Oppel Jr. et al., 2020).[59]

However, focusing events alone are rarely able to carry a policy towards a policy window. Furthermore, not only is there a global pandemic, but there is massive economic downturn, large-scale social unrest, and a hyper-polarized political landscape that threatens the very nature of democracy in the U.S. Therefore, under these critical conditions, Medicare for All policy entrepreneurs have begun to rally an effort on how "COVID-19 makes the case for Medicare for All," while recognizing that there is not sufficient political will in the face of these many crises. Normally, Administrative turnover to a President who opposes single-payer could have shifted the politics stream completely away from Medicare for All. However, the impacts of COVID-19 reinforce the preexisting perception of the "health care" problem and can serve as a warning for the consequences of a health care system that bases coverage for the majority of people on employment. Consequently, polls have shown that as COVID-19 continues, support for Medicare for All is rising. The March 2020 Morning Consult poll showed a nine-point increase in support among Democrats and Independents, and a seven-point increase among Republicans (Murad, 2020). The latest Hill-HarrisX poll found the highest level of public support for Medicare for All since before the 2020 Presidential Primary election, including 88% of Democrats, 68% of Independents, and 46% of Republicans.

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[59] This thesis does not claim that Medicare for All would not resolve racial inequities in our health care system, but providing equitable and comprehensive protection for everyone is a fundamental step towards health justice (Benfer, 2015).

CHAPTER 6: CONCLUSION

"In the confrontation between the stream and the rock, the stream always wins; not through strength, but through perseverance."

H. Jackson Brown, Jr.

Medicare for All is an incredibly ambitious, politically contentious, justice-oriented policy that seeks to transform the U.S. health care system. Concurrently, it is paired with an energetic national movement led by a diverse array of advocacy organizations and political champions. Their combined efforts culminated with the most successful legislative year for single-payer policy, with an unprecedented number of congressional hearings and Member support. At the beginning of 2020, the prospects of Medicare for All felt closer than ever as Democratic Primary election exit polls showed majority public support and Senator Bernie Sanders was in the top two of a crowded field of candidates.

Ultimately, none of the candidates who supported Medicare for All became the Democratic Presidential nominee. However, in the midst of the COVID-19 pandemic, the movement has found a different source of energy. Due to multiple concurrent crises, COVID-19 is not the 'game-changing' factor a pandemic could hypothetically be in directing political will towards health reform. Still, as COVID-19 draws focused attention to the deficiencies of the U.S. health care system and the lack of social protections available overall, certain political arguments against Medicare for All have weakened, and the case and public support for single-payer have become stronger.

Throughout my time in the U.S. House of Representatives, I encountered countless staff, policy experts, industry leaders, and Congressmembers who told me that Medicare for All is politically or technically infeasible. Undoubtedly, the history of health reform in the U.S. has shown that it is a long and arduous road with the rare opportunity of return or reward. Yet, according to my analysis, past health reform attempts, in particular for single-payer, were never paired with the level of grassroots momentum and movement-powered agency that currently exists for Medicare for All. Furthermore, Medicare for All's political champions have the "sheer persistence" that Kingdon believes is so important to successful policy reforms, and the ranks of support is expanding with each incoming Congress. Therefore, the conditions for this health reform attempt are unique and the prospects for Medicare for All in the future should not be underestimated.

Nevertheless, single-payer faces long political odds— as it has for almost a century. Efforts can seem futile in a political system that has so far rendered the passage of a single-payer approach as impossible. Representative Jayapal often referred to the Office's tactics like "water on rock." Eventually, even a small drop can break through if it is steady, focused, and "persistent". This thesis cannot predict when or exactly how Medicare for All will reach a policy window. However, history has shown that even if "Medicare for All" doesn't happen, single-payer will rise and be offered again as long as the health care system continues to lack universal coverage and equitable protection for all. Therefore, this thesis concludes that a policy window for single-payer health care is a not a question of if, but *when*.

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Annex 1. RedCap Medicare for All Coalition Stakeholder Survey

Questions
What is your organization's type? 501(c)(3) 501(c)(4) 501(c)(3) & 501(c)(4) Political action committee Private foundation Private, for-profit Academic institution Think tank Union
How many full-time employees are within your organization? 1-10 10-25 25-50 50+
What is your organization's annual operating budget? <$50,000 $50,000 - $99,999 $100,000 - $499,999 $500,000 - $999,999 $1,000,000 - $4,999,999 $5,000,0000 - $9,999,999 $10,000,000 - $19,999,999 $20,000,000 - $49,000,000 >$50,000,000
Approximately what percentage of your budget/resources are spent on Medicare for All efforts? 1-10 11-20 21-30 31-40 41-50 51-60 61-70 >70

How would you rank Medicare for All as your organization's priority
Our only issue area
One of our top priorities
Part of our broad portfolio but not the utmost priority

How long has your organization been advocating for Medicare for All and/or single-payer health care?
Less than 6 months
Between 6 months and 1 year
1-2 years
2 -4 years
5-9 years
10+ years

How was it decided that Medicare for All/single payer would be a priority for your organization?
The org was started to directly support Medicare for All/single-payer
The org, since inception, has had M4A/single-payer as a priority
The org decided to include M4A/single-payer as a priority after org had formed

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What TOP THREE aspects of the Medicare for All policy are particularly important for your organization?
Women and reproductive health
Long-term care/disability
Access to care
Affordability
Racial Justice
Drug Pricing
Health Equity
Other (Immigrant access to care; business case;)

What types of activities are most common for your organization on Medicare for All?
Op-Eds/LOEs
Rallies/Barnstorms
Press conferences
Lobbying
Educational workshops
White papers/research analysis
Canvassing
Other

Which THREE organizations do you most collaborate with on Medicare for All?
Businesses for M4A
Center for Popular Democracy
Congressional Progressive Caucus Center
Labor for Single Payer
National Nurses United
Our Revolution

People's Action
Physicians for a National Health Program
Progressive Democrats of America
Public Citizen
Social Security Works
Other

In addition to the three you work most closely with, what are the next groups you most collaborate with on Medicare for All?
Businesses for M4A
Center for Popular Democracy
Congressional Progressive Caucus Center
Labor for Single Payer
National Nurses United
Our Revolution
People's Action
Physicians for a National Health Program
Progressive Democrats of America
Public Citizen
Social Security Works
Other

What do you find most challenging about influencing public opinion on Medicare for all?
Open Response

What do you find most challenging about influencing legislators on Medicare for All?
Open Response

What are your organization's key next steps/strategies/focus areas for Medicare for All?
Open Response

What does your organization and the greater M4A working table need to be more effective with advocating for M4A?
Open Response

Annex 2. Key Informant Interview Script

INTRODUCTION
- Everything you tell us will be confidential. To protect your privacy, we won't connect your name with anything that you say.
- At any time during our conversation, please feel free to let me know if you have any questions or if you would rather not answer any specific question. You can also stop the interview at any time for any reason.
- Please remember that we want to know what you think and feel and that there are no right or wrong answers.
- To ensure your message and thoughts are correctly registered Is it OK if I audiotape this interview today?

I'd like to begin by asking you some questions about your current job.
1. What is your position at [organization]? What are your major responsibilities in your current position?
2. How long have you been with [organization]?

Now I will ask you about the current health care system in the US
1. How well do you think the current US health system is functioning?
2. What does it do well? What are the most critical areas for improvement?
3. I'd like to get your opinions about the concept of affordability and access- what does it mean to you for people to be able to afford and access care in the US?
4. How do you think patients and families think about health care?
5. What is the primary non-political reason these gaps have not been addressed?

Now I will ask you about the policy perspective for health care in the US
1. If you could design a policy to reform our health system, what would its main components include?
2. Is there any particular country from where we can get some insights to improve our healthcare system?

Now I will ask you about the political perspective for health care in the US
1. What do you feel is your organization's experience and role in the next steps in health care improvement?
2. What do you feel is the greatest political barrier towards comprehensive health care reform in the US?
3. What is needed to get different participants to "buy in" to the health care reform

Medicare for All
1. On the spectrum of ACA shore-up, medicare expansion, public option, and Medicare for All, or none of the above where are you for the short-term and long-term of healthcare reform.
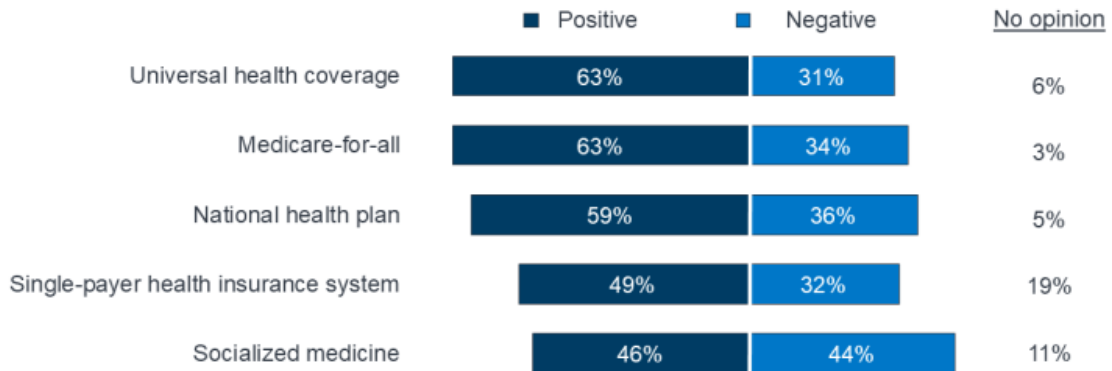2. How do you define "Medicare for All"?

Is there anything else that you would like to add about any of the topics that we've discussed or other areas that we didn't discuss but you think are important?

Figure 5

Terminology Affects Public Opinion On A National Health Plan

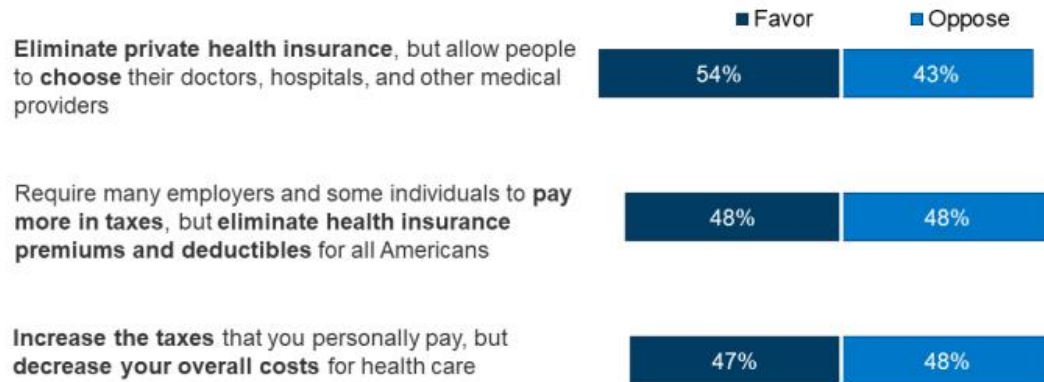Do you have a positive or negative reaction to each of the following terms?

	■ Positive	■ Negative	No opinion
Universal health coverage	63%	31%	6%
Medicare-for-all	63%	34%	3%
National health plan	59%	36%	5%
Single-payer health insurance system	49%	32%	19%
Socialized medicine	46%	44%	11%

SOURCE: KFF Health Tracking Poll (April 11-16, 2019). See topline for full question wording and response options.

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Figure 10

Some Moderate Shifts In Support For Medicare-for-all Depending On Description Of Plan

Would you favor or oppose a national Medicare-for-all plan if you heard it would...

	■ Favor	■ Oppose
Eliminate private health insurance, but allow people to **choose** their doctors, hospitals, and other medical providers	54%	43%
Require many employers and some individuals to **pay more in taxes**, but **eliminate health insurance premiums and deductibles** for all Americans	48%	48%
Increase the taxes that you personally pay, but **decrease your overall costs** for health care	47%	48%

SOURCE: KFF Health Tracking Poll (conducted November 7-12, 2019). See topline for full question wording and response options.

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Source (KFF, 2020)