Costs versus Coverage, Then and Now

Joseph White
Case Western University

Abstract To expand coverage to those without it, Democrats in 2010 sacrificed cost control methods that might have helped those already insured. The law therefore did not offer most Americans what they wanted most. President Obama and those who thought like him convinced themselves the legislation would control costs by reforming how health care is organized, but any such effects have been both weak and unpopular. Now many commentators are accusing Democratic candidates of making the same mistake by prioritizing an ideological vision of "Medicare for All" over voters' worries about out-of-pocket costs. Yet Medicare for All, unlike less "radical" approaches, addresses those concerns directly. Unfortunately, neither elites (outside the industry!) nor voters seem to understand that, and it is politically risky because of the same fears about change, industry opposition, and distrust of government that inhibited more effective action a decade before.

Keywords Medicare for All, costs, lessons, health care industry, public opinion

Politicians in crafting laws and scholars in analyzing them make judgments about both policy and politics. Like many other participants in this issue, I have offered such analyses about the Affordable Care Act (ACA) before,[1] both in a similar effort nine years ago (White 2011) and in other longer works (e.g., White 2013a, 2013b, 2018). So in this piece I must apologize for repeating myself, but I hope to be useful in two ways. I offer a quick version of some of my previous analysis, but further emphasize what that perspective on the ACA might tell us about the situation as Democrats fight

1. I will use this conventional shorthand for the combination of two laws, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, passed in 2010.

Journal of Health Politics, Policy and Law, Vol. 45, No. 5, October 2020
DOI 10.1215/03616878-8543286

among themselves about what health care policy to promote in the 2020 election and beyond.

Political Premises

Strategies to pass health reform in 2009 were shaped by "lessons" believed at that time.[2] These included, for example, that the Clinton administration's drafting of a complex proposal in-house was a mistake, and that the Clinton effort failed in part because even though the "problem" and "politics" streams were flowing in favor of reform, the "policy" stream had not generated an approach ready for action after Clinton's election (McDonough 2000). The 2009 effort therefore was preceded by years of efforts to build consensus among Democrats on the broad outlines of a policy approach (Kirsch 2011; McDonough 2011), that then could be drafted within Congress rather than the White House (Armstrong and Wayne 2009).

For our purposes, however, three other premises are more important. The first was that Clinton failed partly because people with remotely decent insurance were risk-averse and easily scared. Support for reform to "fix the system" would evaporate if individuals worried about negative effects on them personally (e.g., Nather 2009). Therefore any reform had to be presented as changing as little as possible: a judgment reflected in the many statements from reform advocates, especially President Obama, of versions of, "if you like your health plan, you can keep it" (Gore 2013).

The second was that beneficiaries of health insurance expansion were neither numerous nor mobilized enough to drive reform. Instead, reform had to be sold as protecting those who were already insured, but worried about erosion of either the availability or quality of their insurance. To put this another way, controlling costs was a more politically popular goal than expanding coverage for the uninsured—particularly among Republicans and self-identified independents (KFF 2009; Nather 2009; Saad 2009).

Third, reform could be blocked by powerful special interests working to protect their incomes and, therefore, against cost control. As Larry Brown (2011: 423, 426) wrote, "simultaneously expanding coverage and containing costs is the political equivalent of squaring a circle. . . . Reform passed in part because Obama and the congressional Democrats figured out how to talk about costs without sending affronted special interests and an alarmed general public to the exits." But this meant, he added, that "nothing

2. A typical list is provided by Oberlander (2010).

in the new law is likely to slow [costs'] near-term growth"—a judgment echoed by other authors in the collection (Oberlander 2011; Gusmano 2011; Rodwin 2011).

Cost Control and Coverage Expansion in the ACA

Legislating the ACA was guided by these premises, but readers may have noted a problem: the last three premises were contradictory. If a popular reform had to control costs for the worried-but-insured, and reform could not be passed if it actually controlled costs, then it should not have been possible to pass a popular reform. The Obama administration, its expert advisers, and its political allies decided there was a way to square the circle: through promoting an approach summarized by Mark V. Pauly (2011: 593) as, "that direct change can be made in the methods, costs, and effectiveness of delivery of medical services by changing its *organizational form*: the medical home model, accountable care organizations, or the 'high-power' or 'evidence-driven' health care system of the future embody this approach." This approach was supposed to avoid the twin perils of angering voters by raising cost sharing or the industry by regulating prices.[3]

President Obama emphasized cost control in making his case for reform. In his first State of the Union address for example, he proclaimed that "we must also address the crushing cost of health care":

> This is a cost that now causes a bankruptcy in America every 30 seconds. By the end of the year it could cause 1.5 million Americans to lose their homes. In the last eight years, premiums have grown four times faster than wages. And in each of these years, 1 million more Americans have lost their health insurance. It is one of the major reasons why small businesses close their doors and corporations ship jobs overseas. And it is one of the largest and fastest-growing parts of our budget. Given these facts, we can no longer afford to put health care reform on hold. We can't afford to do it. (*New York Times* 2009)

Unfortunately, the organizational reform approach did not win over either most of the public or more hard-nosed analysts.

Republicans and the conservative media machine sold fake news (an accurate term in this case) about "death panels" and the like (Gitterman and

3. Although the two other approaches were included, the first through the "Cadillac tax" and the second to earn creditable budgetary savings within Medicare, far more emphasis was placed on the potential "transformative" effects of the organizational reforms, as explained at more length in White 2018.

Scott, 2011). But the inconvenient truth was that most voters were skeptical of the presumptions behind the reform agenda. As one report concluded, "many consumers' values, beliefs and behaviors remain rooted in traditional beliefs about the doctor-patient relationship and the medical care system." They commonly believed, "that medical guidelines represent an inflexible, bargain-basement approach to treating unique individuals," or might even "discriminate against doctors who give you better care," and were skeptical of claims that more care meant worse care (Carman et al. 2010: 1401, 1402). In principle, majorities might approve of insurance coverage for treatments depending on those having been shown to be "more effective than existing, less expensive, treatments." But when told that, "in some cases, treatments for drugs recommended by a person's own doctor wouldn't be covered by their health insurance," responses switched to 63–32 percent opposition (Bernstein 2009: 6–7).

The reform agenda inherently assumed that someone other than a person's own physician would be shaping care options. This is clear for direct approaches like evidence-based guidelines, but it lurks in more indirect approaches. "Paying for Performance" means someone judges your physician's performance. "Accountable Care Organizations" presumes someone other than your doctor is accountable—somewhere in that big bureaucracy, somebody, somehow. The problem is that nobody—whether an insurer, government, or employer—could elicit comparable trust. We trust our doctors to touch us in otherwise inappropriate ways, advise us to ingest mysterious chemicals, make us unconscious and do things to us, and stick sharp objects in us. Trusting your doctor is not optional, and what analysts may see as irrational trust in personal physicians is the only way to avoid debilitating cognitive dissonance. Yet the reform agenda begins from the premise that doctors often don't know best. Under these circumstances, Republican distortions could tap into a powerful vein of preexisting distrust, and President Obama's defenses of the approach were futile.[4] It is not an accident that the Democrats did not embark on a big campaign boasting about all the organizational reform cost controls in the ACA—that could have been more risky than not talking about them at all.

Moreover, analysts who were not committed to the dominant worldviews within the health policy community—particularly the Congressional Budget

4. For example, he argued that if evidence showed the red pill cost twice as much as the blue pill and was no more effective, then promoting the blue pill was "not rationing. That's being sensible" (Nather 2009). But that begged the question of how strongly evidence would be promoted. Note also that if the government required the lower price for both pills, this would not be an issue.

Office staff who tend to look for reliable data—also didn't believe that the ACA would generate meaningful savings within the private insurance system (CBO 2009, 2011). As a result, media coverage of the ACA also expressed skepticism that the law would meaningfully reduce health care costs for the average voter (for one good example, see Roberson 2011). The major measure that CBO would credit as reducing the costs of typical health insurance plans was the "Cadillac Tax," which was most likely to reduce the cost of plans by reducing their value through increasing cost sharing. Higher costs when they needed care was not the average voter's definition of making care more "affordable" (Altman 2014).

As the editor of this journal and I argued at the time, public opinion suggested then, and had for many years, that price regulation was more popular than other cost-control approaches (Oberlander and White 2009, 2010). Yet the only effort to lower prices for most peoples' care, the "public option," was abandoned to neutralize interest groups (Oberlander 2010). In Jacob Hacker's (2010: 865) words, "the Obama administration" (which did make many of the key calls in spite of its allegedly "hands-off" approach),

> consistently acted as if the crucial swing votes in Congress depended not on wavering citizens, but on organized interests with the greatest ability to shape the positions of congressional moderates within the Democratic Party . . . these up-front concessions . . . limited the law's ability to deliver tangible benefits to the middle class and largely took off the table tools of cost control used in other nations, such as provider rate-setting and government negotiations for lower drug prices.

While this explains how the ACA was crafted, however, it doesn't explain why anyone would have thought the legislation would accomplish its key political goal: support from voters worried about the insurance they had. Apparently the key policy makers in the Obama administration and their allies (mostly in the Senate) believed (in spite of the evidence) that the various organizational reforms would save money in a popular way—thereby satisfying both voters and the interest groups. As time passed, they continually asserted that the delivery system reforms had saved money, in spite of both weak evidence for that proposition and continued or intensifying public concern about costs.[5]

The political failure of the approach is evident enough: Democrats were unable to sell the law in a way that would protect them against electoral

5. A good example is Obama (2016). I do not have space to address the evidence here; please see White (2018) for more.

backlash (especially in 2010), and polling showed more unfavorable than favorable attitudes towards the law for nearly the entire period from 2011 through 2016. It became more popular after the prospect of repeal became more real with the 2016 election,[6] and that appears to have directed more attention to the real though limited benefits that would be put at risk. The legislation would have been blasted from the Right regardless of what it included. Yet the absence of cost controls that could have been used to win any support has to be part of why support was weak.

The legislation's policy failure—the trend in personal health care costs after it passed—became part of the context for the current reform effort.

Cost Control and Coverage Expansion in the 2020 Election and Beyond

Slow forward (it has been protracted and painful) to December of 2019. As Democratic candidates fought about "Medicare for All" versus a "Medicare option" or "building on the ACA," numerous experts argued they were fighting about the wrong thing: about coverage expansion across the population rather than how even existing coverage exposes people to unaffordable costs.

In April of 2019, for example, Kaiser Family Foundation president Drew Altman (2019d) argued that both parties' rhetoric about making health care a right (Democrats) or socialism (Republicans) were missing the point: "it's the candidates who can connect their plans and messages to voters' worries about out of pocket costs who will reach beyond the activists in their base. And the candidates aren't speaking to that much." In June, Robert Blendon, the best-known researcher about public opinion on health care, joined colleagues in emphasizing the breadth and depth of public worries about costs: not total national health spending (about which a miniscule proportion of voters care) but "the belief that health care services are unreasonably priced and that what people pay for care harms their household financial situation" (Blendon, Benson, and McMurtry 2019: 2487).

The *Washington Post* (Goldstein 2019) reported that, "Voters have big health-care worries, but not the ones Democrats are talking about." While candidates were trumpeting "bold ideas to achieve the party's long-held dream of ushering in health coverage for every American," the problem was "that many voters are not focused on such lofty goals. They want

6. See the Kaiser data summarized at www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable—Unfavorable&aRange=all.

something simpler—to pay less for their own health care." In one illustration Celinda Lake, a leading Democratic pollster, said that focusing on Medicare for All might appeal to voters in the nomination contests, but that prescription drug prices were a big issue for both primary and general election voters, adding that, "in my opinion, we're not talking enough about it." A review of polling data emphasized that in 2008 worries about cost had been a bit stronger than desires to expand health insurance coverage for the uninsured, but, "since the implementation of the ACA, health care costs now occupy a tier of their own on the public's list of pressing health care issues" (Kirzinger et al. 2019).[7]

In this case public opinion tracked empirical reality. People should have worried less about coverage, because uninsurance declined (Altman 2019d; Galewitz 2019).[8] Meanwhile, since 2010 costs had become much more burdensome. By 2018, "health care coverage for a family covered by a large employer cost, on average, $22,885: equivalent to buying a new car each year" (Altman 2019b). Per capita spending for private insurance and out-of-pocket spending for those with private insurance both rose substantially, relative to personal incomes, over the preceding decade. Employer-based coverage had become even less affordable for low-wage workers who were offered it; "surprise bills" became a publicized problem; and a wide range of data showed substantial portions of voters with employer-sponsored insurance having trouble paying medical bills, foregoing care because of expense, or worried about being unable to pay for an emergency (Altman 2019a, 2019b, 2019c; KFF 2019a; Kirzinger et al. 2019). In short, the problem got worse, which is evidence enough of the ACA's failings.

But what are the lessons? At one level, 2020 looks like "déjà vu all over again." As in 2009 there is a clear gap between prospective voters' views of the system as a whole (quite pessimistic) and of their own coverage (better). Advocates for Medicare for All (hereafter M4A), especially, are warned that they may scare risk-averse voters (e.g, Klein 2019, Thomson-Deveaux 2019). As M4A became an object of controversy, like virtually any specific proposal including the 2009 proposals, its popularity declined.[9] Responses

7. For further information about the priority of costs see figure 1 in Kirzinger, Kearney, and Brodie 2019, which reports 70% calling lowering prescription drug costs a top priority, as opposed to 30% giving implementing a national Medicare-for-All plan the same importance.

8. The main census survey found that "8.5% of the U.S. population went without medical insurance for all of 2018," compared to 13.3 in 2013). The rate had fallen to 7.9% before rising in 2018, likely due to Trump administration policies in regard to immigration and Medicaid (Galewitz 2019).

9. Trends can be tracked in sources already cited, or by searching the collection of responses at www.pollingreport.com/health.htm.

to opinion surveys have been based more on broad political leanings and loyalties than on knowledge about the questions (Holahan and Karpman 2019; Levitz 2019; KFF 2019b). Public "opposition to allowing experts to make decisions based on cost-effectiveness" was almost identical in 2019 to that in 2012 (Blendon, Benson, and McMurtry 2019: 2490–91).

Yet while all these dynamics persist, the charge that advocates for M4A are prioritizing coverage (which the public doesn't care about so much) over cost control (which is more popular) is simply false. Yes, coverage expansion is a much more useful platform while chasing the Democratic nomination than for the general election. Yet the candidates pushing M4A have made costs the leading argument for their approach.[10] Their plans would essentially *eliminate* out-of-pocket costs.

Both Sanders and Warren emphasize the statistics about people going without care and financial risks. Warren (2019a) explains her position as grounded in her research into the causes of bankruptcy—including that, "three quarters of those who declared bankruptcy after an illness were people who already had health insurance." She emphasizes under-insurance, describing it as "like a car with the engine missing. It looks fine sitting in the garage, but is inadequate if they actually need to use it." She describes her approach as, "the best way to cover every person in America at the lowest possible cost because it eliminates profiteering from our health care and leverages the power of the federal government to rein in spending" (Warren 2019b). Sanders's (2019) summary of the case for his Medicare for All Act proclaims that the US has the "most expensive, inefficient and bureaucratic health care system in the world," with much higher per capita costs in the United States than in other countries. He argues that "Medicare for All is the most cost-effective health care plan" because of huge savings in administrative costs from not having to deal with multiple insurers. In contrast, the official description of former Vice President Biden's plan endorsed price regulation for pharmaceuticals, but declared other prices could be reduced by tackling "market concentration" with antitrust authority. It did not address the potential administrative savings from standardized insurance whether of M4A or some other form.

In short, in the debate as of late 2019, it was precisely the more "radical" candidates who were making the most evidence-based case for policies that would do what most people want: reducing costs. To them, the key lessons of the ACA are that trying to appeal to peoples' risk-aversion failed both politically (as shown by the law's weak support and fervent opponents) and

10. I refer below to statements downloaded on December 21, 2019.

as policy (as shown by the cost crisis). They believe, rightly or wrongly, that a better approach is to try to beat the medical industry by demonizing it—especially its least popular parts, pharmaceutical companies and insurers.

They are partially right about the substance. M4A isn't needed to achieve the administrative efficiencies, lower prices, and therefore much lower costs achieved in other countries. That is normally managed, instead, through "all-payer" regulations of plans and payments (White 2013b). But they are far more right than the critics who accuse them of pursuing the wrong goal.

Unfortunately, they appear to be wrong in assuming that ordinary voters know *why* they should support M4A. The problem is not simply that many voters don't know what M4A entails—after all, that's pretty logical given that Medicare for All as proposed is extremely different from *Medicare as It Is*. The real problem is nicely illustrated by an ordinary voter quoted by Goldstein (2019) that, "Medicare-for-all would be great if we could do the other side of the coin—get the cost down."

Price regulation remains, as it was in 2009, far more popular with the voters than the delivery reform agenda, even if it is not as popular with the health policy community (Oberlander and White 2009; Blendon, Benson, and McMurtry 2019). But we appear to be years away from enough voters believing not only that prices are a big problem but also that Medicare is much better at controlling them. This may be blindingly obvious to the health care industry, but its leaders likely see government as more capable than most voters do. Yes, we can't expect voters to know much about much of anything. We also know that it has to be easier to attack drug companies and insurance companies than hospital and specialty physician group managers.[11] But until the cure is linked clearly to the diagnosis—government power and simplification as curing administrative costs and abusive prices—it will be too difficult to pass M4A, or even a less transformative all-payer reform.[12]

It is certainly possible that a frontal attack on the providers would fail. If voters tend to trust their physicians and other providers, then perhaps the latter will always be able to sell arguments that serious price regulation threatens to damage care and create rationing. Yet the evidence is so strong, and the supply of narratives of decline and abuse so large, that there should be a good chance of delegitimizing provider opposition—especially since

11. Even though, as the surprise billing evidence shows, many emergency physician and anesthesiology groups richly deserve to be attacked.

12. All-payer is less transformative because it can leave room for a private insurance industry, on a public utility model.

public opinion has tended to support price regulation in principle. Compared to providing less care, paying lower prices is a much more common sense approach to reducing costs—from patients' perspective, a form of seemingly "painless" cost control. The case has to be made with both evidence about current costs, such as the fact that even Medicare Advantage plans depend largely on government price-setting,[13] and lots of talk about the scandalous behavior that should reduce faith in hospitals, especially, as authorities on health policy.

In short, no approach to reform is a clear political winner. Yet even M4A advocates might consider the possibility that setting the stage, by highlighting the diagnosis that individuals' cost problems are due to high prices and overhead costs, is a necessary step toward their policy goal. Republicans simply cannot speak as frankly on this topic, and contrasts on issues like drug prices would be easy to draw.

Ironically, then, the critics are right—even though their own refusal to see the cost-control aspects of M4A is part of the problem. It would make more sense, right now, to focus on costs and specific cost controls than on expanding coverage. That could begin with prescription drugs and the services that largely generate "surprise bills." The first task now is to show ordinary voters that government is better at controlling costs. Democrats could be building toward either M4A or some sort of heavily regulated all-payer system. What they have in common—effective measures to make care more affordable within insurance plans—is far more important than their differences.

■ ■ ■

Joseph White earned his PhD in political science with research that focused on US federal budgeting. His work on health care politics and policy began with interests in both its budgetary consequences and the differences between the United States and other countries. He joined Case Western Reserve University after appointments with the Tulane School of Public Health and Tropical Medicine and the Brookings Institution. His most recent work focuses on how ideas within policy communities influence health care politics and how ideas that are very popular with experts, such as performance measurement, tend to have disappointing results.
jxw87@case.edu

13. In essence, plans with few exceptions pay the Medicare rates or something very similar for all services that are covered under prospective payment systems in fee-for-service Medicare. See Berenson et al. 2015 for an overview; the key language is in *Federal Register* 75, no. 73, April 15, 2011, page 21492. www.govinfo.gov/content/pkg/FR-2011-04-15/pdf/2011-8274.pdf.

Acknowledgments

I would like to thank Jon Oberlander for trenchant comments on this piece and for sharing his learning over the years, and I also want to thank many colleagues in the political science health policy community for speaking truth to power—though normally to deaf ears.

References

Altman, Drew. 2014. "Health Care Cost Growth Is Down, or Not. It Depends Who You Ask." Kaiser Family Foundation, March 5. www.kff.org/health-costs/perspective/health-cost-growth-is-down-or-not-it-depends-who-you-ask/.

Altman, Drew. 2019a. "Employer-Based Coverage Is Unaffordable for Low-Wage Workers." *Axios*, September 26. www.axios.com/employer-based-coverage-is-unaffordable-for-low-wage-workers-f6855a5e-83ed-452e-825a-7ed966dd0f3b.html.

Altman, Drew. 2019b. "Health Care Costs as Much as a New Car." *Axios*, August 23. www.axios.com/health-care-costs-insurance-premiums-deductibles-car-580fa6c8-0dd2-427b-8dda-c898d568e51e.html.

Altman, Drew. 2019c. "Surprise Bills Often Hit in Emergencies." *Axios*, December 9. www.axios.com/surprise-hospital-bills-emergency-heart-attack-6cd3a8cd-6466-4a73-89a3-973c48ee3093.html.

Altman, Drew. 2019d. "The Winning Health Care Message Will Be about Out of Pocket Costs." *Axios*, April 1. www.axios.com/winning-2020-health-care-out-of-pocket-costs-d5708e35-b308-4c91-a636-121e45f82032.html.

Armstrong, Drew, and Alex Wayne. 2009. "A Second Opinion." *CQ Weekly*, April 6, 768–76.

Berenson, Robert A., Jonathan H. Sunshine, David Helms, and Emily Lazarus. 2015. "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices." *Health Affairs* 34, no. 8: 1289–95.

Bernstein, Jill. 2009. "Public Perspectives on Health Delivery System Reforms." Robert Wood Johnson Foundation, June 1. www.rwjf.org/en/library/research/2009/01/public-perspectives-on-health-delivery-system-reforms.html.

Blendon, Robert J., John M. Benson, and Caitlin L. McMurtry. 2019. "The Upcoming US Health Care Cost Debate—The Public's Views." *New England Journal of Medicine* 380, no. 26: 2487–92.

Brown, Lawrence D. 2011. "The Elements of Surprise: How Health Reform Happened." *Journal of Health Politics, Policy and Law* 36, no. 3: 419–27.

Carman, Kristin L., Maureen Maurer, Uill Mathews Yegian, Pamela Dardess, Jeanne McGee, Mark Evers, and Karen O. Marlo. 2010. "Evidence That Consumers Are Skeptical about Evidence-Based Health Care." *Health Affairs* 29, no. 7: 1400–06.

CBO (Congressional Budget Office). 2009. "An Analysis of Insurance Premiums under the Patient Protection and Affordable Care Act." Letter to the Honorable Evan Bayh, November 30. www.cbo.gov/publication/41792.

CBO (Congressional Budget Office). 2011. "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010." Testimony of Director Douglas W. Elmendorf before the Subcommittee on Health, Committee on Energy and Commerce, US House of Representatives, March 30. www.cbo.gov/publication/22077.

Galewitz, Phil. 2019. "Breaking A Ten-Year Streak, the Number of Uninsured Americans Rises." *Kaiser Health News*, September 10. khn.org/news/number-of-americans-without-insurance-rises-in-2018/.

Gitterman, Daniel P., and John C. Scott. 2011. "'Obama Lies, Grandma Dies': The Uncertain Politics of Medicare and the Patient Protection and Affordable Care Act." *Journal of Health Politics, Policy and Law* 36, no. 3: 555–63.

Goldstein, Amy. 2019. "Voters Have Big Health-Care Worries, but Not the Ones Democrats Are Talking About." *Washington Post*, June 21. www.washingtonpost.com/health/voters-have-big-health-care-worries-but-not-the-ones-democrats-are-talking-about/2019/06/21/5c4a353e-8d22-11e9-adf3-f70f78c156e8_story.html.

Gore, D'Angelo. 2013. "Fact Check: If You Like Your Health Plan, You Can Keep It." *USA Today*, November 11. www.usatoday.com/story/news/politics/2013/11/11/fact-check-keeping-your-health-plan/3500187/.

Gusmano, Michael. 2011. "Do We Really Want to Control Health Care Spending?" *Journal of Health Politics, Policy and Law* 36, no. 3: 495–500.

Hacker, Jacob. 2010. "The Road to Somewhere: Why Health Reform Finally Passed." *Perspectives on Politics* 8, no. 3: 861–76.

Holahan, John, and Michael Karpman. 2019. "What Explains Support for or Opposition to Medicare for All?" Health Reform Monitoring Survey, Urban Institute, August 7. www.urban.org/research/publication/what-explains-support-or-opposition-medicare-all.

KFF (Kaiser Family Foundation). 2009. "Kaiser Health Tracking Poll—November 2009." November 1. www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2009/.

KFF (Kaiser Family Foundation). 2019a. *Employer Health Benefits: 2019 Annual Survey*. files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019 (accessed May 27, 2020).

KFF (Kaiser Family Foundation). 2019b. "Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage." January 30. www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/.

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

Kirzinger, Ashley, Audrey Kearney, and Mollyann Brodie. 2019. "KFF Health Tracking Poll—September 2019: Health Care Policy in Congress and on the Campaign Trail." Kaiser Family Foundation, September 12. www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-september-2019/.

Kirzinger, Ashley, Cailey Muñana, Bryan Wu, and Mollyann Brodie. 2019 "Data Note: Americans' Challenges with Health Care Costs." Kaiser Family Foundation, June 11. www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/.

Klein, Ezra. 2019. "Why Aren't Voters More Willing to Abandon a Health System That's Failing?" *Vox*, July 29. www.vox.com/policy-and-politics/2019/7/29/8910387/medicare-for-all-insurance-private-abolish-bruenig.

Levitz, Eric. 2019. "Polls: Voters Want Medicare for All—But Don't Know What It Is." *New York*, June 18. nymag.com/intelligencer/2019/06/medicare-for-all-polls-public-option-kaiser-popular-misunderstood.html.

McDonough, John E. 2000. *Experiencing Politics: A Legislator's Stories of Government and Health Care*. Berkeley: University of California Press.

McDonough, John E. 2011. *Inside National Health Reform*. Berkeley: University of California Press.

Nather, David. 2009. "Selling the Greater Good." *CQ Weekly*, July 6, 1576–82.

New York Times. 2009. "President Obama's Address to Congress." February 24. nytimes.com/2009/02/24/us/politics/24obama-text.html.

Obama, Barack. 2016. "United States Health Care Reform: Progress to Date and Next Steps." *JAMA* 316, no. 5: 525–32.

Oberlander, Jonathan. 2010. "Long Time Coming: Why Health Reform Finally Passed." *Health Affairs* 29, no. 6: 1112–16.

Oberlander, Jonathan. 2011. "Throwing Darts: Americans' Elusive Search for Health Care Cost Control." *Journal of Health Politics, Policy and Law* 36, no. 3: 477–84.

Oberlander, Jonathan, and Joseph White. 2009. "Public Attitudes toward Health Care Spending Aren't the Problem: Prices Are." *Health Affairs* 28, no. 5: 1285–93.

Oberlander, Jonathan, and Joseph White. 2010. "Systemwide Cost Control: The Missing Link in Health Care Reform." *New England Journal of Medicine* 361, no. 12: 1131–33.

Pauly, Mark V. 2011. "Patient Protection and Affordable Care Act Cost-Containment Approaches: The Case for Incentive-Based Approaches." *Journal of Health Politics, Policy and Law* 36, no. 3: 591–96.

Roberson, Lori. 2011. "Fact Checking Health Insurance Premiums." FactCheck.org, October 24. www.factcheck.org/2011/10/factchecking-health-insurance-premiums/.

Rodwin, Marc A. 2011. "Why We Need Health Care Reform Now." *Journal of Health Politics, Policy and Law* 36, no. 3: 597–601.

Saad, Lydia. 2009. "Cost Is Foremost Healthcare Issue for Americans." Gallup Poll, September 23. news.gallup.com/poll/123149/cost-is-foremost-healthcare-issue-for-americans.aspx.

Sanders, Bernie. 2019. "The Medicare for All Act of 2019." www.sanders.senate.gov/download/medicare-for-all-2019-summary?id=FA52728F-B57E-4E0D-96C2-F0C5D346A6E1&download=1&inline=file.

Thomson-Deveaux, Amelia. 2019. "Americans Want the Health Care System to Change. Just Not Their Own Health Care." *FiveThirtyEight*, December 19. fivethirtyeight.com/features/americans-want-the-health-care-system-to-change-just-not-their-own-health-care/.

Warren, Elizabeth. 2019a. "Ending the Stranglehold of Health Care Costs on American Families." Warren Democrats. elizabethwarren.com/plans/paying-for-m4a (accessed April 27, 2020).

Warren, Elizabeth. 2019b. "My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All." Warren Democrats. elizabethwarren .com/plans/m4a-transition (accessed April 27, 2020).

White, Joseph. 2011. "Muddling through the Muddled Middle." *Journal of Health Politics, Policy and Law* 36, no. 3: 443–48.

White, Joseph. 2013a. "Cost Control after the ACA." *Public Administration Review* 73, suppl. 1: 524–33.

White, Joseph. 2013b. "The 2010 US Health Care Reform: Approaching and Avoiding How Other Countries Finance Health Care." *Health Economics, Policy, and Law* 8, no. 3: 289–315.

White, Joseph. 2018. "Hypotheses and Hope: Policy Analysis and Cost Controls (or Not) in the Affordable Care Act." *Journal of Health Politics, Policy and Law* 43, no. 3: 455–82.