FEDERALIZE MEDICAID TO FIX THE AFFORDABLE CARE ACT
For Efficiency, Equity, and Social Justice

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ABSTRACT

Federalizing Medicaid (thereby eliminating state program variation) is a bold and affordable alternative to Medicare for all (M4A) and proposed ACA public options. Making Medicaid an entirely federal program using Congress’ budget reconciliation process will reverse the U.S. Supreme Court ruling that enabled states to reject Medicaid expansion. Such legislation achieves Congress’ original intention to create universal entitlements for low-income persons who lack health coverage and concentrate new federal health spending on them (unlike M4A).

Arguments for federalizing Medicaid involve state budget relief, efficiency, social justice and the history that created national industries from local and state-based health systems. Theory suggests that liberal democracies are generally more successful when path dependent, building incrementally on existing policies instead of plunging into new, untested innovations no matter how rational. In addition to realizing the congressional intent of the ACA, federalizing Medicaid can be a cost-effective, incremental path to single-payer health coverage.

Key Words: Medicaid, Medicare, Medicare for all, single-payer, Affordable Care Act (ACA), public option, Medicare buy-in, federalize, federal government, states, intergovernmental relations, Centers for Medicare and Medicaid Services (CMS), budget, budget reconciliation, cost, efficiency, social justice, equity, path dependence, implementation, Supplemental Security Income, Martha Derthick, presidential campaign, Democratic Party, progressives, centrists, Congress, long-term care, Bernie Sanders, Elizabeth Warren, Joe Biden
In the current political climate, progressives demand bold ideas involving deep structural change. Replacing employment-sponsored health insurance and most other government programs with Medicare for all is a clarion call that sometimes seems to serve as the defining characteristic of the truly progressive Democrat. Centrists respond that a single government payer for all health care is too big a gulp to force down the American gullet all at once. Instead, they suggest that the Affordable Care Act (ACA), achieved after 100 years of struggle for government-supported access to health care, should be improved by the addition of Medicare as an option in the health insurance exchanges (AKA the health insurance marketplaces) established in every state by that Act. One former candidate, recognizing that many beneficiaries of private insurance either like their coverage or fear replacing it with a new, untested government alternative, has called this approach "Medicare for those who want it." Over time, these centrists suggest, the demand for this public option and its competitive advantages will drive private insurers out of the ACA exchanges. The centrists also challenge progressives by emphasizing the gigantic costs added to the federal budget by Medicare for all. Progressives respond that exorbitant health care spending is already taking the necessary resources from the system’s many private pockets and that it is time for centrists to advocate bold ideas for fundamental structural change that Americans are demanding.

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* Use of the labels “progressive” or “left” and “centrist” reflects the discourse of the primaries in 2019 and 2020. Support or opposition to Medicare for all was the principal policy used by candidates and commentators to determine who is progressive or centrist. Centrists focused on improving the ACA; many also want to add a public option and a Medicare buy-in to improve it. Of course, other issues were discussed (e.g., higher or new taxes to pay for Medicare for all and promote economic equality, federal support for students’ college tuition, explicit endorsement of an expansive, visionary “Green New Deal,” and making unauthorized immigration a civil rather than criminal offense). Positions on these other issues tended to track with candidates’ views on health coverage reform. Although party nominee Joe Biden now has wide support from all factions, informed commentators continue to distinguish these ideological positions.
In health care, as in other policy domains, the Democratic left makes bold and expensive proposals, when many observers believe that practicality and victory in the general election dictate proposing only manageable increases in the federal budget. Prudence also suggests that ambitious new commitments build upon the very real successes of the ACA. At least one bold idea satisfies the policy constraints of no excessive federal costs and fulfilling the promise of the ACA: Making Medicaid entirely a federal program.

Medicaid, which provides medical care to many low-income Americans who lack other coverage, is currently a federal-state partnership with Washington paying the lion’s share of the costs and the states responsible for running the programs within federal guidelines. Congress designed the ACA to create a national uniform Medicaid floor covering anyone lacking access to other coverage in families with income below 138% of the federal poverty level (FPL). However, the landmark Supreme Court decision in Federation of Independent Business et al. v. Sibelius (2012) surprised Congress and most legal experts by making the highly subsidized expansion of Medicaid optional. Consequently, restoring Medicaid as the uniform national entitlement envisioned by the Affordable Care Act (ACA) is the easiest way to improve the ACA by restoring the 138% floor throughout the U.S. and concentrating resources already committed in that Act on those most in need. In the current political climate, the proposal to federalize Medicaid surely satisfies progressives’ criteria for bold ideas while improving the ACA as centrists implore. Moreover, it can be accomplished without excessive incremental costs (in contrast to the higher price tag of Medicare for all). Another attractive feature is that it overcomes the great variation in programs when states are in charge. However, with our current heightened concern about inequality, the most compelling reason to federalize Medicaid is that it will concentrate all the new resources for health care to help those most in need.
When the U.S. Supreme Court allowed states to refuse Medicaid expansion to all those below 138% FPL, it exacerbated the principal problem of Medicaid—the fact that it is really 51 different state programs (including D.C.). Old Medicaid only requires states to serve specific categories of “deserving” poor (such as pregnant women, children and disabled persons), but states can add coverage for other populations and services (defined by the state) and determine provider reimbursement rates. Consequently, Medicaid is a hodgepodge.

Very few voices have championed Medicaid as an alternative platform to Medicare for fostering greater access to health care coverage. In 2017, a flurry of opinion pieces did examine Medicaid as an alternative to Medicare, but no one proposed federalizing Medicaid in order to provide a truly national program and bypass the many difficulties faced by state officials who wish to regulate as much health coverage as they can legally oversee. This discussion was inaugurated by Michael Sparer of Columbia University’s Mailman School of Public Health in a *New York Times* op-ed column. In the *Times* and in a subsequent longer piece in *Vox* he argued that states should allow individuals or employers to buy into Medicaid, emphasizing that such a Medicaid buy-in option will strengthen the ACA health insurance marketplaces, which at the time seemed to be faltering. (Fortunately, as insurers gained experience with these subsidized populations most of the individual insurance marketplaces have stabilized and premiums are no longer rising as rapidly.) Sparer regards state variation as a strength of Medicaid, which makes it immune from the supposedly pejorative “label [as] a monolithic national program.” Because both Medicaid and ACA marketplaces (generally with sub-state premium rating areas) are organized by state, this approach fails to address the inequality in benefits and beneficiaries depending on state of residence. In addition to this general discussion, one law review article proposed Medicaid as a path for achieving single-payer coverage within one state. In a recent journal symposium, Sparer explains the barriers
faced by individual states pursuing single-payer proposals, but repeats his favorable view of state efforts to permit individuals who are not eligible for Medicaid to buy into its coverage. Thus, the relevant literature would leave states as the decision-units for Medicaid, suggesting that state innovation allow Medicaid buy-in by those not automatically eligible for Medicaid or build single-payer state health care on a Medicaid base. None suggests supplanting state-based Medicaid in favor of reinventing Medicaid as a purely federal program.

The first section of this paper fleshes out the proposal and potential pitfalls more fully, explains why it is politically feasible, shows that the costs will not be exorbitant, and suggests how federalized Medicaid could become an alternative incremental path to single-payerdom. The contrast with Medicare for all is found throughout the paper, but the second section examines proposals for Medicare for all in more detail. The concluding discussion outlines the principal justifications for a federal takeover of Medicaid.

**Federalizing Medicaid**

The key to reimagining Medicaid is for Washington to relieve states of any responsibility for Medicaid. The most effective legislative response to the Supreme Court’s surprising denial of Congress’ clear intent to force all states to expand Medicaid is for Congress to exercise its constitutional powers to make Medicaid (Title XIX) an entirely federal program, just as its 1965 sibling Medicare (Title XVIII) is. Formally, both are amendments (P.L. 89-97) to the Social Security Act of 1935, which is firmly grounded on the national government’s power to tax and spend to improve the general welfare. This structural change (to use the progressive term) will make the ACA’s 138% of poverty an income floor that insures coverage for the neediest without requiring them to have children in the home or a job. Concentrating responsibility and the necessary resources in the Centers for Medicare and Medicaid Services (CMS) in the U.S.
Department of Health and Human Services will task the agency that already manages the entire Medicare program to overhaul its Medicaid division by incorporating state program operations that CMS managers already oversee. Thus, in terms of intergovernmental relations, the bureaucratic federal and state cogwheels already intermesh in ways that should facilitate federalization.

The takeover must involve rebranding Medicaid to remove any residual stigma. Marketeers should be enlisted to research a new name, perhaps something such as “FullHealth,” which emphasizes how the new program contrasts with fragmented and incomplete Medicare. (This paper will use this moniker to avoid saying “federalized Medicaid” too often.) Medicaid may still seem degrading to some Americans, due to its origins as an adjunct to cash welfare. Fortunately, stigma surrounding Medicaid has lessened in recent years as the program’s coverage has been extended to many qualifying low-income populations who receive no income support. Beginning in the early 1980s with sympathetic support from state governments, Medicaid expanded to cover pregnant women and infants without requiring them to qualify for welfare payments. During the same period elderly and disabled middle-class Americans and their families increasingly came to rely upon Medicaid for institutional care, i.e., nursing homes or intermediate care facilities. The Welfare Reform Act of 1996 (P.L. 104-193) and the Children’s Health Insurance Program, part of the Balanced Budget Act of 1997 (P.L. 105-33), completed the emancipation of Medicaid from the yoke of cash welfare. In 2017, 43% of all U.S. births were covered by Medicaid, according to the U.S. Centers for Disease Control and Prevention. Adults benefit from programs for nursing home residents and the chronically ill who are eligible as a Qualified Medicare Beneficiary are described as “dual eligible,” because they receive Medicaid to cover what Medicare does not cover or covers
incompletely (its premiums, copays, deductibles, drugs). Personal familiarity with someone who receives Medicaid often softens the stigma associated with large bureaucratic programs for the poor. The topsy-turvy experience generated by efforts to curb Covid-19 can only advance this humanization of Medicaid recipients.

Of course, much of the public may still disdain Medicaid because it is associated with poverty and government. There is considerable truth in the common saying that poor people’s programs are poor programs. Over the years many states have found it difficult to recruit sufficient numbers of physicians practicing high-quality medicine to serve their Medicaid recipients. In order to simplify the program and insure adequate numbers and quality of health providers, federalized Medicaid should phase in Medicare rates and reimbursement systems (prospective payment system for hospitals and resource-based relative value scale for physicians). Except for pediatricians, a large proportion of primary care physicians cooperate fully with Medicare, which constitutes the major source of demand for their services. The combination of higher average reimbursement and the application of Medicare provider participation rules to Medicaid should go a long way toward ensuring adequate availability of services.

**Implementation.** While some hesitancy about ending this long familiar, if often troubled and inefficient, federal-state partnership is natural, fortunately reassuring guidance from an important precedent is available. In the Social Security Amendments of 1972 (P.L. 92-603), Washington assumed full responsibility for a cooperative program providing income to impoverished aged, blind and disabled individuals and renamed it Supplemental Security Income (SSI). As the late Martha Derthick pointed out, the reputation of the highly regarded

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1 Medicaid paid for 64% of expenditures for nursing homes and other non-hospital institutional care, which exceeded spending for home- and community-based services. However, annual increases in the latter were greater, according to a Kaiser Family Foundation 2015 report celebrating Medicaid’s 50th anniversary.
Social Security Administration (SSA) suffered from its problems in implementing SSI. All corporate sector acquisitions seem to suffer some glitches in transition, so it is no surprise that the effort to graft the very different SSI program onto the Social Security Administration experienced some initial difficulties. However, that federal program has functioned well in the decades since the takeover. Many of the problems encountered by SSA in the early 1970s should be avoidable in the 2020s, especially if public administrators learn from these past efforts. One major problem stemmed from the need to bring together incompatible state information systems. Some 50 years on, in the era of large-scale data science and data analytics, the deployment of adequate federal information technology resources and sufficient time should forestall difficulties in merging state data sets.

To reduce the complexity of this transformation, a two-step handover seems advisable. In the first bite of the transition, CMS should assume responsibility for health care finance and delivery, making provider reimbursement systems as uniform as possible in guiding evolution from very different state-managed care systems to a more uniform federal structure. Although Medicaid care networks and individual fee-for-service reimbursement are currently managed at the state level, CMS’ responsibility for Medicare has given it considerable experience handling these aspects of the delivery system. In principle, federal assumption of responsibility for financial control of the delivery system, physician recruitment, and responsibility to assure quality of care should be no more difficult than the problems and glitches experienced when one large corporation acquires another in the private sector.

The second stage—eligibility determination and enrollment—poses many more problems, because it requires DHHS to undertake activities that are largely new to it. States currently have street-level bureaucrats in local social service agencies who make the complex determination of Medicaid eligibility. The complex criteria for Medicaid eligibility vary widely
among the states and there is no common database. Federal assumption, however, greatly simplifies Medicaid, because the ACA makes anyone eligible for Medicaid who is part of family with an annual income at or below 138% of FPL and ineligible for other affordable coverage.\textsuperscript{1} It will likely require several years to establish local offices, train personnel to follow new uniform national guidelines, develop and test relevant databases necessary to enroll new Medicaid clients, and renew those already receiving benefits, among other tasks. Fortunately, Social Security and Medicare have a large number of local offices that can be expanded to deal with the quite different problem of Medicaid enrollment and re-enrollment. (As long ago as FY2008 SSA had about 1,300 field offices to process claims for Disability Insurance under Social Security and SSI.\textsuperscript{19, 20})

Although this paper makes the assumption that Congress will only enact federalized Medicaid with the less expensive 138% FPL of the 2010 budget resolution, implementation would be simpler if the legislation made the ceiling 200% FPL. At 138% of poverty, CMS will have to continue to recognize the specific categories of special needs or merit (”deservingness”) in traditional Medicaid, because some categories allow enrollees to be in families with incomes up to 180%. If the ceiling were raised from 138% FPL to $\leq$ 200% FPL, the FullHealth benefit would become a uniform income-based entitlement with no need to maintain any categorical eligibility. Two hundred percent (or more) is preferable, because 200% is the federal subsidy ceiling for children in the Child Health Insurance Program (which is distinct from Medicaid but is incorporated operationally into Medicaid in many states). Consolidating, simplifying, and making uniform all of the federal health programs for low-income Americans in one national program will constitute a bold, but quite achievable improvement of the U.S. social welfare

\textsuperscript{1} Additional rules may restrict immigrants within the first five years of receiving legal status.
States wishing to provide benefits for those in families with incomes beyond the federal FullHealth income ceiling will be free to establish and fund those programs.

One complexity is what to do with Medicaid recipients receiving institutional long-term care (LTC). In the past, federally supported long-term care largely occurred in institutional settings of various sorts (especially skilled nursing and intermediate care facilities). However, nowadays the emphasis in Medicaid is on home-and-community-based services, although as recently as 2015 the majority of LTC dollars still went to individuals living in institutional settings (excluding hospitals, rehabilitation centers, and post-acute hospitals). More analysis must be given to the sticky question of whether to make institutional Medicaid LTC—or at least skilled nursing facilities—a federal responsibility. Because many of the issues surrounding institutional LTC are non-medical, it may be best to leave them to the states. States will realize great savings if all Medicaid except institutional LTC becomes a federal responsibility; those savings can fund institutional LTC programs that states wish to maintain. (Experts favor the expansion of home- and community-based services, which will be fully funded by federalized Medicaid.)

Cost. The costs of FullHealth are manageable, because the number of new beneficiaries is limited. Washington already pays 50% to 77% of traditional Medicaid costs and 90% or more of expanded Medicaid. In 2018 the federal budget provided $370,892 billion (62%) of total Medicaid costs. Given the current federal burden from covering the eligible population up to 138% in most states, the total implementation and start-up costs should not exceed twice the current 2018 combined federal and state Medicaid costs of 597,387 billion dollars (trended forward to cover inflation). Thus, an entirely federal program will cost less than 1.2 trillion dollars per year without factoring in any savings, because adding the new

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§ In federal fiscal year 2020, the largest federal match is Mississippi’s 76.98% of that state’s total Medicaid medical benefit expenditure. (Administrative reimbursement is typically only 50%.)
Medicaid enrollees in the 14 states that had not expanded Medicaid by 2018 will not double its enrollment.**22, 23 This conservative estimate allows some leeway for what experts call the “woodwork” effect (eligible individuals who become aware of their entitlement due to the publicity generated by FullHealth). Federalized Medicaid, then, will cost far less than Medicare-for-all even before counting administrative savings achieved by unifying 51 complex administrative structures into one national purchaser of health services.

As with Medicare for all,**24, 25 efforts to project future FullHealth costs depend on many decisions that must be made when serious detailed consideration begins. Back-of-the-envelope calculations suggest that federal assumption of the current state programs (including Medicaid expansion to 138% FPL) could be accomplished for less than twice current total costs before savings are calculated, but the actual program choices will determine federal expenditures. For example, if legislators decide to leave institutional long-term care as a state responsibility, including its financing, federal costs will be reduced considerably.**25, 26, 27 On the other hand, the decision to move to Medicare rates and the timeframe for achieving them will drive up costs. A generous Congress committed to achieving a uniform entitlement and ending the categorical nature of Medicaid will make 200% FPL the ceiling for Medicaid eligibility, but that decision to prioritize simplicity and expand access will also drive up costs.

**Political feasibility.** The congressional politics is not impossible if Democrats obtain slim majorities. A relatively simple bill making the Centers for Medicare and Medicaid Services entirely responsible for financing FullHealth services can become law through the budget reconciliation process laid out in the Congressional Budget and Impoundment Control Act of

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** Over 10 years, even that cost (12 trillion) is well below the 52 trillion Elizabeth Warren advertises for her single-payer plan. Warren’s plan is touted as costing less than Bernie Sander’s Medicare-for-all.

** The Congressional Budget Office recently produced a lengthy detailed briefing outlining the immense number of design decisions that will have to be settled in any Medicare-for-all legislation. Perusing the CBO document makes one appreciate the great complexity involved in designing a single-payer plan from scratch.
The advantage of budget reconciliation is that it only requires a simple majority in both the House and the Senate and cannot be filibustered. Amendments during consideration are also limited. Significantly, the final enactment of the Affordable Care Act was achieved through the budget reconciliation process (allowing for House changes after the House adopted the Senate bill).28, 29

Several factors may mute opposition. Hospital associations in many states have pushed for Medicaid expansion, which their members see as a source of relief from the burden of uncompensated care. The era when the AMA bitterly fought Medicare as “socialized Medicine” has long passed; it supported the ACA.30 In many states, Medical societies also favor expanding Medicaid, which will generate patient revenues for patients who had no source of medical services except hospital emergency rooms or public clinics. Primary care providers, especially those practicing in rural and underserved areas, will benefit.

Insurance companies present a more complex story. They began by working with the Obama administration to ensure that any health care reform that emerged from Congress would be to their liking. They managed to eliminate the public option and supported the bill until the Senate weakened the penalties that enforced the individual mandate to purchase insurance.29 Medicaid recipients are not good prospects as subsidized consumers on insurance markets, especially markets with largely flat community-rated premiums, because their incomes are too low to participate meaningfully in subsidized premiums and large numbers suffer from chronic conditions. Consequently, America’s Health Insurance Plans (the important trade association) joined in the consensus supporting expansion of Medicaid as part of what became the ACA.28 If insurers are involved in claims processing and provider reimbursement under contract with FullHealth as they are in Medicare, they can hope to maintain the revenues that they now receive from state contracts to serve as Medicaid paymasters and HMOs.
The fact that almost three-quarters of the states have already expanded Medicaid suggests that widespread support for it already exists. These states will presumably be happy to accept the federal gift of ending all requirements for state matching funds. The state governments that have refused to expand Medicaid and condemned the ACA may at least refrain from active opposition to a federal takeover of a program that has roiled state legislative agendas for almost a decade. The funds formerly devoted to Medicaid can make significant contributions in advancing important state agendas in education, infrastructure, or tax cuts. Finally, it should be emphasized that Medicaid currently constitutes an ever-increasing on-going state commitment that they find hard to control; therefore, its termination eliminates a source of rising expenditures and constitutes recurring funding rather than a one-time windfall.

**Potential Incremental Single-Payer?** After FullHealth is running smoothly, coverage should be extended to 200% above poverty (if that step was not taken in the legislation enacting the takeover). In time, raising the level to 400% would open FullHealth to all those without alternative coverage who qualify for federally subsidized premiums on ACA exchanges. In order not to be seen as weakening the individual exchanges, FullHealth enrollees should be able to leave that plan to purchase coverage on the ACA insurance marketplaces and receive any premium and patient cost-sharing subsidies for which they qualify. This incremental strategy combined with an optional buy-in by those at even higher income levels can approach single-payer coverage. Of course, high-quality care and low cost must be the hallmarks of FullHealth, if it is to attract people previously covered by employers. If FullHealth income eligibility is raised over the years, when mature it could resemble Germany’s mandated coverage, which permits the very affluent to choose other coverage or self-insurance. The public health insurance system covers about 90% of German citizens, but higher-income residents are not required to participate: Seven to 9% choose to purchase private health
insurance and fewer than 1% self-insuring.\cite{31, 32, 33} If FullHealth does manage to best all competitors and become a near monopoly insurer of those not on Medicare, is it possible that a private insurance option will be introduced into this nearly pure social insurance plan? If FullHealth evolves in this manner, it might come to resemble Part C Medicare with its increasingly popular plans that provide an alternative to traditional Medicare.

**Medicare Proposals**

Progressive politics have careened sharply left since the Democrats scored a number of Congressional victories in the 2018 midterm elections by stoutly defending the ACA, especially the prohibition on preexisting conditions exclusions and waiting periods and the requirement that family coverage be extended to children up to age 26.\cite{34} By 2019 Medicare for all (M4A) had become a shibboleth demanded from any serious presidential candidate. Progressives’ success in enforcing homage to M4A constituted a remarkable reversal of fortune, because advocates of M4A had little input into the ACA; indeed, they were the only major interested party that House committees writing the bills in 2009 refused to hear.\cite{29}

Joe Biden, widely understood to be the centrist candidate who defended the Obama health legacy, became the Democratic presidential nominee at the party’s virtual convention, where all of his major rivals for the nomination pledged their support and urged party unity. Yet, as Representative Ro Khanna (D-CA) pointed out, “the key issues for progressives are ‘Medicare for all,’ a wealth tax, a commitment to free college tuition…The best way to win over progressives is to take bold positions on policy.”\cite{35} These policy positions will matter if the Democrats are victorious in November. The major health policy positions outlined during the primary campaign are the clearest and most systematic statements of the views of the current
Democratic leaders. Therefore, this section relies heavily on the platforms espoused in the primaries.

All the major Democratic candidates during the 2020 primary season acknowledged the desirability of M4A as the ultimate goal for American health care, but the centrists campaigned on improving the ACA to avoid threatening moderate middle-class voters with the loss of employment-based health insurance. Consequently, two forms of M4A have emerged: Immediate legislation to enact M4A at the beginning of a Democratic administration in 2020 and "M4A-lite" or M4Some, which involves introducing a government-run public option to compete in the ACA’s health insurance marketplaces. Individuals choosing this public option would receive the same income-related subsidies to pay for premiums and patient cost-sharing that purchasers of commercial insurance on the exchanges receive. Pete Buttigieg, who provided considerable detail for his "Medicare for All Who Want It" proposal, was explicit in subscribing to the progressives’ goal: "This plan will create a natural glide-path to Medicare for all." To justify this positive slippery slope, he explains that the government-run insurer competing on a level playing field will drive commercial insurers out of the ACA marketplace. Joe Biden and Amy Klobuchar also proposed a public option. M4A in all its variants is one form of the generic notion of structuring health care finance so there is only a single payer. It is premised on the power of monopsony (market dominance achieved by concentrating purchasing power in a single buyer) to control health care costs and, ideally, to achieve optimum efficiency and quality. The cardinal insight underlying advocacy for single-payer in the U.S. is that quite enough money is already spent on health care to provide quality health care for all Americans: What is needed is to re-engineer how that money is spent. U.S. health care costs more than twice as much as that of almost every other country and yet its clinical outcomes are mediocre in comparison with those of other developed
democracies. Undoubtedly, the widespread satisfaction with Medicare reported by its beneficiaries, their familiarity with it, and its relatively good record for efficiency make M4A the most persuasive flag for American single-payer advocates to rally around.

**Problems with M4A and M4Some.** The intuitive appeal of M4A is based on the belief that the money necessary to support high-quality health care for every American is already in the system. However, skeptics challenge advocates of M4A on two fronts. The first set of issues questions the political wisdom of proposing an untried, abstract blueprint to replace a complex health care system that most individuals and families have learned to navigate. Because over 90% of Americans have some third-party help in paying health care bills, progressives must convince a majority that a massive wholesale reordering of current medical and payer relationships will give them an experience superior to their current reality. Conservatives, fresh from rereading their copies of Hayek’s *Road to Serfdom*, will again tar Democrats with the charge of social engineering as they have periodically done in the past. At the beginning of a campaign, bold, attention-getting ideas and promises of radical change can galvanize the public, but by the time November elections arrive, voters may well become more risk averse. Although single-payer advocates may think that experience with Covid-19 will fuel the revolutionary movement (as Sanders likes to call it), uncertainty and fear often lead the general public to cling to familiar services and institutions that currently serve them despite their unsatisfactory performance.

The attraction of conservatives’ free market objection is somewhat diminished when applied to Democratic centrists’ proposal for government-run health insurance to compete

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*In 2018 per capita American total health spending (excluding investment) was U.S. $10,586; only the U.S., Switzerland ($7,371) and petroleum-rich Norway ($6,187) exceeded $6,000; another seven of the developed countries spent between $5,000 and $6,000. U.S. national health expenditures have ranged between 17-18% of gross domestic product (GDP) during the 2012-2018 period of consistent growth in the GDP denominator. Yet the U.S. Census Bureau reported that 8.5% of U.S. residents lacked any third-party coverage during the entire year in 2018.*
head-to-head with commercial insurers and Blue Cross/Blue Shield. Based on strong evidence of popular support for the ACA, many voters are likely to respond favorably to calls to restore the ACA after years of Republican efforts to dismantle it. Furthermore, a recent survey of almost 200 U.S. health economists resulted in overwhelming support for the ACA. During the primary competition Democratic presidential candidates focused on the role of the public option to quell demands for M4A on the left; less attention was placed on the more important and far-reaching issues of improving the ACA as the vehicle most likely in the long term to expand access to health care. Consequently, centrists’ ideas may seem pedestrian and limited in comparison to the bold visions of full-throated M4A advocates. For example, M4Some proposals were restricted to offering the ACA’s essential benefits with no costly extras, because the public option must compete on price with private insurers that offer the same benefits. In contrast, both Bernie Sanders and Elizabeth Warren promised Americans “dental, hearing, vision, and home- and community-based long-term care, in-patient and out-patient services, mental health and substance abuse treatment, reproductive and maternity care, prescription drugs and more.” Warren’s list for fully-achieved M4A included those items, but she also mentioned prevention services, emergency and transportation services, and physical therapy.

The second major complex of issues involve how to pay for M4A and its expansive benefits that are cost-free at point of service. Many observers do agree in theory that the sums currently spent on U.S. health care are sufficient to provide quality health care for the uninsured and underinsured if better allocated and used efficiently. If only there were a giant front hoe excavator that could dip into all non-governmental pockets to scoop up just their contribution to health care and deposit those resources in the appropriate government accounts. Sadly, such precise financial machinery does not exist. Sanders did not quail at honestly declaring that taxes on individuals and corporations would have to increase to pay for
M4A. Sanders told voters that employers, who regard wages and benefits (including health coverage) as part of total remuneration, will pay workers higher wages as employers' benefit costs decline. The upshot is that higher wages and salaries will more than offset any necessary increase in individual taxes. In reality, the economics literature on the subject is very mixed: Whether employers raise wages or use the freed-up funds for other purposes appears to depend in part on the characteristics of the particular labor market.45

To her credit, Warren, a strong supporter of M4A, rethought her plan after being challenged to explain how to pay for it in an early debate. Her revised plan also responded to voter hesitancy to commit to an untried visionary plan. She subsequently proposed to establish a public option within the ACA insurance marketplaces in the early days of her administration and to seek legislation making M4A the single payer by the third year of her first administration.44 This compromise allowed her to avoid the risk of an immediate transition to M4A, while preserving the purity of her commitment to establish it without depending on competition-driven evolution.

Warren provides considerable detail about how she would pay for M4A. These financing proposals enabled her to assert that M4A will not involve any tax increases for middle-class families, a politically important claim. She explained that she would redirect funds currently being spent for health care and health insurance by state and local governments and by employers. Consequently, she argued, her single-payer plan could be implemented for 20.5 trillion in new federal spending (i.e., dollars not recovered from current and projected future spending), instead of the 52 trillion dollars in total health care spending projected over the next 10 years if nothing is done to reform the system. Instead of turning to middle-class taxpayers to make M4A budget neutral, her plan would give American families an 11 trillion-dollar
bonanza over the 10 years by ending premiums paid by individuals and patient cost-sharing (copays, coinsurance, and deductibles).23

Her figures seem convincing as far as they go, but policy analysts can question the political feasibility of trying to legislate radical changes in the U.S. health care system and asking Congress at the same time to pass several separate tax increases that have no connection to health care or its financing. Specifically, she proposed “targeted taxes on the financial sector, large corporations, and the top 1% of individuals [as well as] better enforcement of our existing tax laws.”23 [p. 20] The conventional wisdom is that a new presidential administration has a limited “window of opportunity” to enact its signature legislation. If it misses that window or if it overwhelms the Congressional pipeline with too many high-priority items, securing passage of bold new legislation becomes nearly impossible.29 Thus, analysts should be skeptical about the chances that a president could both convince Congress to fundamentally transform the U.S. health care system and enact a second legislative package that raises taxes on powerful corporate interests and rich families that are used to getting their way with Congress.

M4A, M4Some, and federalized Medicaid. The simplicity of federalized Medicaid in contrast to the grand vision of M4A is a distinct advantage of FullHealth. The compelling precedent, creation of Supplemental Security Income, is a persuasive political argument for preferring FullHealth: The proposal is not an untried, gauzy vision. Yet it is a bold proposal in comparison with the government-run public option that constitutes the health policy of Democratic centrists. Moreover, federalizing Medicaid is the simplest, most effective way to reverse the Supreme Court’s unexpected ruling that made expanding Medicaid a state option.

The primary reason for preferring federalized Medicaid over M4A and M4Some, however, rests on its singular focus on those with the lowest incomes and the greatest need for
government-supplied health services. At a time when both progressives and centrists decry the increasing inequality in American society, both Medicare approaches chiefly respond to the dissatisfactions of those who have some coverage but are unhappy with the behavior of their insurers or employers and/or the increasing cost of premiums and out-of-pocket costs. Of course, Medicare expansion does envision enrolling those without coverage, but the major emphasis of Medicare expansion is on middle- and lower-middle class families where, not coincidentally, the median voter is found.

Although middle-class coverage does need improvement, the pressing reality is that the ACA’s critical capacity to advance uniform coverage of the poorest Americans was gravely impaired when Medicaid expansion was held to be a state option. Restoring and improving the ACA, as some centrists promise, ought to start with Medicaid. Many of the poorest Americans lack the cultural knowledge, experience with insurance, and sometimes the intellectual resources (e.g., literacy) necessary to take advantage of ACA insurance marketplaces by making informed consumer decisions about insurance plans. A recent national poll of 4,400 Americans across income levels for “The Upshot” showed the difficulty experienced by low-income individuals “to get and stay enrolled…[in] the American social safety net” as administrative burdens increase. Moreover, their incomes are typically so low that premiums and patient cost-sharing will require federal subsidies approaching 100% of the cost. To force this population into a health insurance market as Some would do will require laborious on-line enrollment processes for the beneficiaries and involve their health providers in largely phony insurance administrative billing processes when in fact the federal government is bearing the risk. The simplicity of federally run Medicaid, administered like Medicare, is much more desirable administratively and is both more humane and realistic in
terms of the needs, desires, and capacities of populations that are largely outside of the mainstream (which does have considerable experience with insurance of all types).

**Discussion: Justification for Federalizing Medicaid**

State management of Medicaid is a legacy compromise that has long exhausted its utility. It is neither efficient nor just. In *National Federation of Independent Business, et al. v Sibelius* (2012) the Supreme Court used the long-standing state involvement in Medicaid to give States a veto over those provisions of the Affordable Care Act designed for the first time to provide universal access to health care in all states for individuals living at or below 138% of the federal poverty level. In the 21st century, convenience is the chief justification for devolving responsibility for federally financed health care to the states. That convenience ends when federal courts leverage it to frustrate national legislative purpose.

If CMS ran Medicaid using Medicare provider reimbursement protocols, the administrative expenses should approach the efficiency of Medicare (~ 98% of expenditures paid for medical benefits; 2% for administration). Only 12 states continue to reject ACA Medicaid, but they include four of the 10 most populous states (Texas, Florida, Georgia, and North Carolina, all with large low-income populations). Even if all states accepted expanded Medicaid, from a national perspective this hodgepodge is an inefficient anachronism that denies citizens living in different jurisdictions equal rights to health care under a national program.

**Fiscal prudence.** In addition to efficiency and justice, intergovernmental fiscal prudence also constitutes a compelling case for federalizing Medicaid in the midst of unprecedented chaos caused by a global pandemic. Federal assumption of ongoing state Medicaid expenditures will provide major relief to annual state budgets that have been buffeted by the impact of COVID-19. State sales and gas taxes have cratered as a result of economic
lockdowns to control the spread of the epidemic; reduced hours and rising unemployment have decreased income tax revenues. At the same time, states and local governments face increasing demand for services by citizens faced with unexpected hardships. Unlike the federal government, almost all states are prohibited from borrowing money to finance operating budgets. This constraint makes it very difficult for states to engage in counter-cyclical spending to battle economic downturns by increasing government spending. State savings from the federal assumption of Medicaid can be used for sorely needed investments in education, transportation and other infrastructure, or to shore up shaky state pension funds. Of course, some states may choose to reward citizens with further tax cuts. Providing this greater budget flexibility to governments closer to individuals and communities reflects America’s long tradition of favoring government levels closest to the people.

Although the federal government could respond to the immediate state revenue problems with a one-time infusion of federal cash, the reality in mid-2020 is that Congress is deadlocked on the issue of providing further support to state and local governments. In any case, such emergency one-time support will not address the underlying problems facing state finances. In contrast, federalizing Medicaid provides an alternative way to secure state fiscal stability for the long term, because it permanently relieves state budgets of the need to fund one of the largest and fastest growing social services that states currently provide. This fiscal sweetener for the states is important in making such a bold policy innovation more attractive to interests that often oppose federal expansion.

**Efficiency.** Efficiency suffers when 51 governments (the District of Columbia has its own Medicaid program) determine what they will cover, how much they will pay, and who qualifies for care (so long as federal regulations are followed). States with small populations will face difficulty in securing large volume-based discounts. The increasing state practice of
delegating delivery of health care to competing at-risk health maintenance organizations (AKA managed care plans) further fragments potential purchasing power. Although Medicaid can boast low per capita cost, that record is largely due to fact that many of its insureds are relatively young and healthy and Medicaid commonly reimburses hospitals and doctors at very low rates. In contrast, Medicare, which mainly covers older Americans and the disabled, has very low administrative cost, with about 98% of expenditures going for medical care of beneficiaries.

**Justice.** The often-heard claim that “health care is a right” may be a useful rhetorical slogan in political arguments, but there is no legal “right” to health care in the U.S., except for the very limited duty of hospital emergency rooms to treat emergent patients who enter the ER until they are stabilized (established by the Emergency Medical Treatment and Labor Act of 1985 [EMTALA]). Some states that fully exploit the many federal funding opportunities and generously spend state tax revenues have managed to drive the uninsured rate down to about 5%; in other states, residents may have zero income and be homeless but have no legal right to health care unless they enter an ER. It is manifestly unjust that what health care one is entitled to depends upon where one lives or seeks health care. Eligibility for Medicaid, in particular, varies widely from one state to another. Federal taxpayers also pay widely varying proportions of state expenditures for traditional Medicaid: from 50% in many states such as New York and California to 76.98% in Mississippi in fiscal year 2020. This unequal Medicaid burden among states was supposed to change for the new Medicaid expansion established pursuant to the ACA. The law provided for the federal government to pay all of the cost of expansion in the initial year and then phase down to 90%. However, many states exercised the option given them by the Supreme Court to decline the federally funded expansion of Medicaid, thereby perpetrating and compounding the injustices that existed before ACA enactment.
Federalizing Medicaid effectively focuses its dollars on populations most in need of coverage, because those with the lowest incomes suffer from the highest incidence of uninsurance and underinsurance. Those with somewhat higher incomes who need health coverage can purchase individual coverage in the ACA insurance marketplaces with federal income-related subsidies for both premiums and out-of-pocket costs.

**National scope of 21st century health care.** Federalizing Medicaid reflects the new reality that health care has become a national industry. Medicaid was established in 1965 as separate state programs with federal dollars and guidelines when health care was largely a local concern like education. At that time solo fee-for-service practice, often characterized as "cottage industry" without pejorative intent, was still often held to be the model medical practice; nationally few multispecialty group practices as envisioned in the 1930s by the Committee on the Costs of Medical Care existed. In the 1960s, for-profit hospitals were typically small doctor-owned institutions treating local patients; except for the VA, no giant national hospital chains existed. Consolidation and the growth of for-profit chains generated by new revenue streams from Medicare rapidly reconfigured the national hospital profile. Medicaid fueled the growth of nursing homes, which also started as local institutions but grew into regional and national chains. Blue Cross/Blue Shield plans merged and consolidated; some became multistate for-profit corporations. Commercial health insurance, initially merely another product line of large life or property insurers, evolved into national Fortune 500 companies concentrating entirely on health care.

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57 At least in the U.S. many in the health care field in the 1960s were unaware of the status of cottage industry as an archaic from of production in Marxist analysis.

58 In a 1971 forward to the reprint of his 1931 study for the CCMC, Rorem reports that an American Medical Association survey in 1965 found about 1,500 multispecialty clinics in the U.S. involving about 17,000 physicians; his 1930 research had discovered 150 multispecialty group practices with some 1,800 doctors. With the addition of prepayment, the multispecialty group practice became the health delivery and financing model for health maintenance organizations in the 1970s.
Perhaps the most compelling argument for insisting on a truly national health care program, whether federalized Medicaid, Medicare-for-All, or the VA system, is that the organization, delivery and financing of health care is now more national than state or local. The same logic that impelled the movement of regulatory authority over railroads and subsequently other forms of transportation from state governments to the federal arena in the late 19th century and federal responsibility for pharmaceuticals, health research and public health with the Food and Drug Administration, the National Institutes of Health, and the Centers for Communicable Disease and Prevention in the 20th century suggests the need in the 21st century for more comprehensive national policy addressing the problems of national industries involved in the delivery and financing of health care. The McCarran-Ferguson Act of 1945 (P. L. 79-15) that exempted the business of insurance from federal regulation was enacted before commercial health insurance was widely available and is a pernicious anachronism when applied to health insurance.55 [pp. 138-140, p. 146]

If insurers, regulators, hospitals, nursing homes, pharmaceutical companies, and others are all national, progressives looking for bold ideas should bring Medicaid into the 21st century by transforming and rebranding it as a truly nationwide universal entitlement for all low-income Americans. Consolidating its 51 different programs into a single funder of care for beneficiaries will promote both economic efficiency and social justice, achieve the ACA's goal of universal coverage of low-income Americans, and open an alternative, incremental path to single-payer health care.

**Theoretical underpinnings.** The observation that the health care industry and its regulation resemble other national industries that have become national in scope over time introduces a theoretical dimension to the difference between building on what already exists and replacing the current health care financing root-and-branch66 with a rational but untried
plan. Liberal democracies have much more positive experience with the former approach to change; social scientists have noted that fact and generalized evolutionary change as "path dependence." Thus, federalizing Medicaid, which builds on the experience gained in creating SSI, is one path dependent response to the Supreme Court's 2012 *Sibelius* decision and other vicissitudes in implementing the ACA over the objections of recalcitrant states. In contrast, sometimes more authoritarian regimes exhibit greater capacity to put into practice policies that embody the logic of their ideas without much reference to pre-existing policy or social practices. Notable examples include the one-child family in post-cultural-revolution China and India's precipitous demonetization of the 500 and 1000 rupee notes, constituting 85% of all Indian banknotes. Government nationalization of industries is also often done suddenly without many preparatory steps. When unprecedented large-scale departures are launched in liberal democracy—"big-bang" legislation—the new policy commonly develops a constituency that constrains the degrees of freedom to make subsequent radical changes. If the policy proves successful, this constituency can be expected to come to its defense when threatened. "Policies make politics," as the saying goes. Growing support for the ACA and popular support for Medicaid expansion constitute strong arguments for making the federalization of Medicaid the next big health care policy.

Attentive readers will note that this paper contains both empirical and normative arguments. It reflects what Frank Fischer and Herbert Gottweis have called "the argumentative turn," building on the work of Giandomenico Majone, one of the pioneers of policy analysis in the 1950s and 1960s. Maggione points out,

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The creation of the British National Health Service, however, nationalized health care but left in place the private practices of general practitioners, the bulk of the physician workforce. In the memorable but perhaps apocryphal words of Anaren Beven, he "stuffed the doctors' mouths with gold." The hospitals were largely non-profits that already depended on government subsidies (through insurance).
Modelling, mathematical programming, simulation, cost-benefit analysis, and decision analysis will always remain important tools. However, if the purpose of policy analysis is not simply to find out what is a good or satisfactory policy but to ensure that the policy will actually be chosen and implemented, the traditional skills are not sufficient. The analyst must also learn rhetorical and dialectic skills—the ability to define a problem according to various points of view, to draw an argument from many different sources, to adapt the argument to the audience, and to educate public opinion.  

The early efforts to construct a hard dichotomy between quantitative, technical policy analysis with its roots in systems analysis—"positivism"—and interpretative or deliberative approaches ("postpositivism") to policy issues have failed. This political commentary tends toward the interpretive, because meaningful quantitative analysis is not relevant before the outlines of a policy alternative become clear. It has been devoted to developing the basic insight into something which can provide parameters that can be measured and evaluated when adopted. The intention is to contribute to the stream of policies by providing an alternative to M4A and M4Some in the effort to ameliorate the multi-faceted problems of organizing and financing U.S. health care. Kingdon's research led him to discern three somewhat distinct "streams" in the policymaking process: problem, policy, and politics. This paper, then, is positioned in the stream of policy proposals and deliberation, which is not directly involved in the political hurly-burly. However, relevant policy proposals must address current or (near) future public policy problems as they flow down the ever-changing problem channels.

**Conclusion.** This paper responds to the widely felt political need to put forth genuinely new, bold ideas that constitute "fundamental structural reform" (as Warren puts it), but with ideas that will not add unduly to the growing federal deficit. Re-envisioning, rebranding, and
renaming Medicaid as an entirely federal program run by the Centers for Medicare and Medicaid Services is well within its administrative capacity and reasonably inexpensive for a targeted expansion of medical services to large numbers of underserved individuals. At least one useful precedent of the federalization of a cooperative federal-state partnership—the creation of Supplemental Security Income—provides useful lessons for the 21st century administrator.

The reasons for undertaking such major structural reform are many:

- Federalizing Medicaid will concentrate the new resources on those most in need of health coverage;
- Ending state responsibility to finance Medicaid will relieve state budgets that are squeezed by falling revenues and rising costs for other needed state services;
- Program consolidation of its finance and regulation at the national level will adjust Medicaid to the organizational realities of the contemporary health care system;
- New funding needed to federalize Medicaid will approximate the least expensive Medicare for some (adding a public option to the existing ACA) costs and be much cheaper than Medicare for all;
- Elimination of 51 state administrations and other cost-savings (e.g., volume purchasing discounts) will greatly enhance efficiency;
- Some scale-economies from the consolidation of Medicaid and Medicare operations are also likely;
- The end of state differences in eligibility of beneficiaries, benefits, and provider reimbursement will advance social justice;
- Addressing the fundamental health and health care inequalities of those who constitute the principal target population of Medicaid, instead of yielding to the political temptation to diffuse benefits among those who are likely voters, also fosters social justice.
Notes

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