Between the Waves: Building Power for a Public Option

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Abstract Given the close division of power in Washington, DC, how might health reformers pursue their bolder aims? In particular, how might they pursue the robust public option that was a centerpiece of Joe Biden's health plan during the campaign? This new iteration of the public option—far more ambitious than anything seriously considered during the debate over the ACA—is not in the cards right now. But instead of giving up on it, advocates should recast it in an inspiring vision that can structure immediate initiatives designed to make its achievement more feasible. This strategy, which might be called "building power through policy," would involve using the openings for policy change that are likely to exist in the near term to reshape the political landscape for the long term. Three interim steps in particular could advance the public option's prospects: (1) pursuing immediate improvements in the ACA that are tangible and traceable yet do not work against the eventual creation of a public option, (2) building the necessary foundations for a public option within Medicare while encouraging progressive states to experiment with state public plan models, and (3) seeding and strengthening movements to press for more fundamental reform.

Keywords public option, health care reform, Medicare

The close division of power after election 2020 has left many reform advocates despairing. While Democrats hold the presidency, the House, and the Senate, their congressional majorities are razor thin (indeed, their Senate majority rests of the tie-breaking vote of incoming Vice President Kamala Harris). Meanwhile, they face a radicalized Republican opposition that has the power of the filibuster in the Senate and that dominates all three elected branches in almost half (24) of US states. Given these realities,

Journal of Health Politics, Policy and Law, Vol. 46, No. 4, August 2021
DOI 10.1215/03616878-8970739

many ambitious reform ideas that looked possible when the polls suggested a big Democratic win now look quixotic.

Among these ideas is a goal that has loomed increasingly large within center-left reform circles: the public option. Almost two decades ago I argued for giving all Americans the choice of enrolling in an affordable government insurance plan built on Medicare's infrastructure (Hacker 2001). When I first set out this blueprint for what would come to be called the public option, it was seen as a huge reach—cautious only in comparison with the pipe dream of Medicare for All. Indeed, Democrats were unable to pass a scaled-back version of the public option even when they had a filibuster-proof Senate majority in 2009–10. Today, however, the public option is not just a mainstream Democratic idea; the version Joe Biden supported during his campaign is more robust than anything considered during the debate over the Affordable Care Act (ACA). Indeed, I have argued it should really be called the Public Option 2.0.

The narrow opening that will exist in 2021, however, puts advocates of the Public Option 2.0 in a familiar position: seeking reforms that cannot be passed in the near term. This is hardly a new situation for health reformers. Unfortunately, it is also one they have often handled poorly. First, advocates tend to refight the last war—which, in the current context, would mean focusing only on shoring up the ACA—rather than getting themselves in the best position to fight the next one. Second, they are tempted to jump from one reform enthusiasm to another, rather than building the policy grounds and political case for an inspiring but realistic goal around which a large coalition can rally. Third, they tend to pay far too little attention to the *political* consequences of the policies they pursue, or what political scientists call *policy feedback effects* (Hacker and Pierson 2019; Pierson 1993). That is, they ask whether policies are effective at broadening coverage or restraining costs, but not whether they are effective at building power for their cause.

In this commentary, I argue for bringing that last question front and center. Rather than refight the last war or swoon for something new, now is the time to refine the basic vision of the public option and pursue interim steps that can help build the necessary power to pass it. To make this argument, I first briefly explain just how far reaching the current mainstream vision of the public option is, and why it has political as well as policy virtues. Then, I describe a self-reinforcing path to the public option that involves what I call *building power through policy*—using the openings that are likely to exist in the near term to reshape the political landscape for the long term. This path has three key steps: (1) pursuing immediate

improvements in the ACA that are tangible and traceable yet do not work against the eventual creation of a public option; (2) building the necessary policy foundations for a public option, while encouraging progressive states to experiment with state public plan models; and (3) seeding and strengthening movements to press for more fundamental reform.

The Public Option 2.0

During the 2020 primaries, Joe Biden clashed over health care with his main progressive rival, Senator Bernie Sanders. The eventual nominee supported a plan to build on the ACA with a Medicare-like public option. Sanders, of course, demanded Medicare for All with no cost sharing. The fight left many with the impression that Biden's health plan was modest. That was not true even before Biden won the nomination: Biden said he would give all Americans the choice of a public health insurance plan, including those with employment-based health insurance who would be better protected by it (thus, breaking the "firewall" in the ACA, which makes workers offered qualified coverage ineligible for premium tax credits [PTCs]). After securing the nomination, Biden's plan became even more ambitious. To use the phrase that Biden famously uttered at the signing of the ACA, Biden's public option became a "BFD."

One reason for the increased boldness, of course, was COVID-19. As part of his proposed emergency response, Biden said he would create—and automatically enroll lower-income Americans in—a public option with no deductible at the ACA's "platinum" level (meaning it would cover at least 90% of patients' costs, on average). This generous public plan would also become the default for those losing their job-based coverage whose COBRA benefits ran out.

Yet the pressure of the pandemic was not the only reason Biden embraced a bigger plan; he also faced the pressure of progressives. The major upgrades in Biden's plan were all contained in the so-called Unity Task Force Recommendations, which emerged out of negotiations between the Biden and Sanders camps (Biden for President 2020). These recommendations included a commitment to providing a no-deductible public option that would cover all primary care without cost sharing. The Task Force Recommendations also make clear that the public option would be run directly by the federal government, pay prices negotiated by Medicare, and include a drug benefit that also bargained for lower prices. In other words, it would resemble the public insurance side of Medicare, as opposed to regulated private plans of the sort provided through Medicare

Advantage. All these changes brought Biden's plan much closer to his progressive campaign rivals'.

In 2009, the public option was tacked onto a proposal drawn largely from the Massachusetts experience. Today, it is at the center of an integrated vision that would fundamentally transform not just the ACA but American health insurance. Three features of this Public Option 2.0 are particularly important. First, the public option would be a part of Medicare, using its provider network and basing its reimbursements on its payment rates. Second, it would be available through the ACA marketplaces nationwide to all those not eligible for other public coverage, including workers with employer-sponsored insurance, with PTCs provided on the same terms as to private plans. Third, at least some Americans would be automatically enrolled in the public option, and there would be a much tighter connection between employers and the public option, with the possibility that employers could—or, if they did not offer qualified coverage, even be required to—pay the federal government to enroll their workers in it.

The Public Option 2.0 would not be Medicare for All, but it could evolve into something close to it. Essentially, a fully evolved public option would be a system in which all Americans who lacked qualified coverage from another source were automatically enrolled in a Medicare-like public plan. For workers, the primary site of enrollment would be the workplace, with employers at a minimum required to report when they failed to provide qualified coverage to their workers and ideally required to sign up and make modest contributions based on payroll on behalf of those workers. Other Americans would sign up through the ACA marketplaces. The public plan would be government insurance, not private plans regulated by Medicare (currently known as Medicare Advantage plans). However, private plans would continue to be available alongside the public option through the marketplaces.

Critics of this vision who support Medicare for All have argued that a Sanders-type plan would be more likely to cover everyone and restrain costs. The problem is that such a plan is far less likely to pass. First, it envisions displacing workplace insurance, through which half of Americans receive coverage. Second, it involves enormous up-front federal spending and thus enormous new revenues. To be sure, these new taxes may be lower in the aggregate than existing private payments and will certainly be more progressive, leaving most households better off. But they will also be much more visible than today's hidden sources of financing, such as the reduced take-home pay of workers who receive employment-based benefits. As a result, many insured Americans are likely to perceive

that they are being made worse off, especially after the stakeholders whose interests will be threatened demonize the plan.

Moreover, Medicare for All is not a readily scalable proposal—you enact it or you don't. Interest groups that see Medicare for All as an existential threat are not going to be mollified by gambits such as the one proposed by Senator Kamala Harris before she went from Biden's campaign rival to his VP pick: a ten-year "phase in" of Medicare for All. If legislation envisions getting rid of all employment-based insurance and deep-sixing private insurance, it will face an onslaught of lobbying no matter how long the reckoning is delayed. The Public Option 2.0 will also face intense opposition, of course, but because it does not envision universalizing public coverage (or public payment rates), it will pose comparatively less of a threat to many key interests.

More to the point, a Medicare for All plan that was scaled down and passed in pieces would look a lot like the Public Option 2.0. Revealingly, Sanders' Medicare for All plan contained a set of interim steps that involved a public option. Similarly, Senator Elizabeth Warren responded to criticisms that her Medicare for All proposal could not be achieved in one fell swoop by embracing a robust public option. These examples suggest not just that the most realistic path toward Medicare for All involves building a robust public option, but also that progressives in power will be supportive of that approach.

Finally, the public option is much more palatable to voters. In polling, the public option is consistently viewed more favorably than Medicare for All. The basic reason is that most voters who support Medicare for All also support the public option, while a significant minority of those who favor the public option do not support Medicare for All—with the promise of choice provided by the public option the most often cited reason for the preference (KFF 2020). In fact, more than half of voters supporting Medicare for All in a recent poll believed it would allow them to keep their own plans obtained through work or purchased individually under a Medicare for All plan (Oberlander 2019), another strong sign that an expansion of Medicare of the sort envisioned by the Public Option 2.0 is more consistent with where Americans are on the issue, despite their highly favorable views of the Medicare program.

Moreover, recent polling indicates that voters not only support a generic public option by overwhelming bipartisan margins but also support automatically enrolling every uninsured person into a generous public option and, in fact, support having this coverage be paid for through taxes rather than individual or family premiums (Hacker and Winter 2020). Nor does

this polling indicate that Americans are particularly fearful of the public option evolving into Medicare for All. To the contrary, the biggest plurality of voters think it *should* be a stepping stone to universal Medicare or something similar. Another large bloc thinks a system in which the public option competes with private plans would be a good outcome. Together, these two groups vastly outnumber those who do not support a public option, even among Republicans. One reason for the appeal of the public option, then, is that it offers the promise of continued progress toward universal public insurance, while not sparking as much resistance from voters inclined toward a public-private system.

Analysts should be cautious about reading too much into even well-designed polls; they can provide a general picture of voters' views in the absence of concerted counter-framing by opponents, including a rough view of the relative support for different policy options, understood in broad terms. What seems clear is that voters are quite favorable toward the public option and somewhat more favorable toward it than toward Medicare for All. Moreover, a case can be made that, in comparison with Medicare for All, affected interests will have less incentive and capacity to move voters from favor to fear. Nonetheless, the Public Option 2.0 is still a very big political lift. The challenge, then, is identifying steps forward that would lessen public and interest-group resistance while building allies, enthusiasm, and infrastructure for the cause.

Political Landscaping

Given the close division of power in Washington, a robust public option is not presently in the cards. Elements of it could be passed through the budget process, which is not subject to a filibuster in the Senate, but it is very hard to see these elements gaining the support of the most conservative Senate Democrats, such as Joe Manchin of West Virginia. And unlike some other health policy measures, it cannot be put in place through executive action.

Still, those who favor the Public Option 2.0 should not simply throw up their hands. They should use the cards they have to strengthen their position for the next round. Advocates of health reform focus a lot on how to use policy to expand coverage; they focus too little on how to use policy to expand power. Recently, Jerry Taylor—the cofounder of the libertarian CATO Institute who now heads the moderate Niskanen Center—marveled at the difference between his old and new allies:

> When I was on the right discussing policy with allies, the politics occupied most of our time, and the policy design (to my frequent frustration) occupied a meager remainder. . . . Regardless of what the campaign that brought them into office was about, conservatives invariably attend to policy initiatives designed to cripple Democratic power. . . . Democrats, however, take the political landscape as a given and do little to change it. They build political strategies upon sand, while conservatives build political strategies premised on shaping that sand to suit their needs, and then mixing it into semi-concrete (Taylor 2020).

Advocates of the public option need to shape "the sand to suit their needs"—to use the openings that are likely to exist in the near term to transform the landscape for the long term. These openings will center on four potential fast tracks: the pressures of the COVID-19 emergency, the unilateral powers of the presidency, the Senate budget process (with its proscription of filibusters), and progress in states controlled by Democrats. Each of these tracks has distinctive qualities, but all provide scope for building power through policy. Drawing on the literature on policy feedback, I lay out three basic strategies: (1) doing popular, traceable things; (2) laying the foundations for the public option; and (3) augmenting movements for fundamental reform.

Credible Credit Claiming

Recent writings on policy feedback highlight the fundamental difficulty of convincing voters that government policies are helping them in a hyperpolarized era (Mettler 2019). Although the concrete benefits of the Affordable Care Act do seem to have swayed some Americans, the process has been painfully slow and incomplete. To build power for a public option, Democrats will have to learn what no less of an authority than Barack Obama (2020) confessed that he only realized after leaving office—that if you wanted to get credit for benefits you provided, "you had to sell your program, reward supporters, punch back against opponents, and amplify the facts that helped your cause while fudging the details that didn't."

This is not just about messaging. Some policies are simply very hard to "sell" because they are neither highly visible nor clearly associated with their backers. Much of the current agenda for shoring up the ACA, alas, has this problem. It is good policy, but not likely to change politics. The central problem is that the ACA marketplaces reach a very small share of

Americans. Improving premium credits or fixing various glitches in the law will improve the ACA but will not provide big opportunities for credit claiming.

What will? The biggest opportunities center on the COVID-19 response. Millions of Americans have lost employment-based coverage in the crisis, and many will not regain it. The central focus of reformers, therefore, must be putting in place a high-profile process for getting the uninsured covered, tied to the ACA marketplaces but not limited to it. Fortunately, both federal emergency powers and recent relief bills give the incoming Biden administration unprecedented scope to broaden coverage using the ACA marketplaces, COBRA, and existing programs, including Medicaid. Already, there is ample scope in existing law for an incoming Biden administration to massively streamline enrollment and offer substantial assistance to the unemployed as well as provide support for states to expand Medicaid. Additional measures were contained in the massive 2021 relief law signed by President Biden in early March, though these are mostly temporary. As discussed shortly, publication and enrollment of these coverage expansions by a new federally authorized Public Health Jobs Corps would make it much more likely that Americans recognize and avail themselves of those benefits, and reward Biden and his allies for them.

These efforts should have one central aim: to provide broad benefits that are highly visible and closely associated with the president. In turn, such benefits will increase the chance that Democrats hold the House and gain in the Senate in 2022. The "midterm curse" is a regularity, not a law of physics. With the economy and COVID crisis both improving, 2022 might well be an election that resembles that of 1934, when FDR, buoyed by the post-1932 slackening of the Depression, picked up seats in the House and obtained a Senate supermajority. For health reformers, what is most crucial is that the Democratic Party enter the midterm associated with a popular visible program of expanded coverage amid the crisis. Equally crucial, that program needs to include key political and policy prerequisites for a public option.

Foundations First

The most effective attack on universal health care is that it will help "them" (lower-income Americans who lack coverage) at the expense of "us" (higher-income Americans who have it). Thus, a central imperative of those seeking to create the public option—perhaps the central imperative—is to foster communities of shared interest. Medicare has to be seen as a

high-quality source of health security for those covered by it. At the same time, both Medicare beneficiaries and those who remain in employment-based health plans have to see a direct link between reformers' vision for a public option and better benefits for themselves.

This imperative has at least four implications. First, Medicare has to be improved for older and disabled Americans if it is to be expanded to the rest of Americans. If the fight over the ACA carries any lesson, it is that Medicare beneficiaries need assurances that their benefits are secure and improving. It should not take two or three elections for them to find out that Medicare benefits are better and "death panels" are a conservative bogeyman.

Fortunately, good politics is also good policy. For all its popularity and success, Medicare has significant gaps—most notably, the lack of a cap on out-of-pocket costs and a Medicare drug benefit integrated into the traditional public program. Moreover, Medicare Advantage requires reform: Recent changes and the stagnation of traditional Medicare's benefits threaten to effectively privatize Medicare. Simply improving traditional Medicare's benefits and creating a public Medicare drug plan will reduce the inherent bias of current policy toward Medicare Advantage plans (which can offer broader benefits, including integrated drug coverage). In addition, excess payments to private plans should be reduced through better risk adjustment, increased policing of plan efforts to game the system (such as "upcoding" to make patients appear sicker than they are), and more discerning use of quality bonuses, which are now received by plans covering the vast majority of beneficiaries (apparently, all Medicare Advantage plans are above average). Addressing these shortcomings through both executive and legislative action will be popular in itself. It will also create a stronger foundation for a public option built on Medicare. Indeed, even when particular upgrades prove impossible, fighting the good fight for them will likely redound to reformers favor.

Second, and by the same token, reformers must focus on linking a future public option to tangible benefits for workers whose employers continue to provide insurance. Any proposal that envisions a good chunk of Americans remaining in employment-based coverage has to make workplace plans work better for the tens of millions of Americans who remain vulnerable to high medical bills and unexpected insurance gaps. The ACA's standards are simply not high enough, a reflection of the narrow political window through which they had to pass and Obama's determination not to displace employment-based insurance. These standards need to be upgraded in ways that are visible, impactful, and rhetorically tied to the improvement of Medicare.

Third, public-option advocates should encourage states and localities to provide public coverage to the uninsured through innovative new strategies, including public plans available to those not currently eligible for Medicaid. These efforts could be facilitated through executive waivers and the COVID-19 emergency response. Here, the goal is less to build the foundation for a public option—something very hard to do at the state level—than to keep the idea alive in progressive circles and encourage innovative uses of Medicaid and the ACA to broaden coverage.

Finally, reformers should resist interim steps that would undercut the political and policy foundations for the Public Option 2.0. Among the riskier steps: accepting the notion that the public option could be a private plan regulated by the government, whether modeled on Medicare Advantage or on state "public options" that were actually managed by insurers; or redefining the public option as something more like Medicaid, varying from state to state and delinked from Medicare. These steps would carry the triple risk of confusing voters, undercutting the Medicare model, and alienating reform movements dedicated to a Medicare-like plan (whether the Public Option 2.0 or Medicare for All). How to augment those movements is the final topic.

Power to the People

Support coalitions must be built. More important, they must be *organized*. Broad public opinion—positive or negative—matters much less than organized citizen voice. In health care, the biggest civic barrier to self-reinforcing reforms is the political weakness of those most in need of action, especially when compared with those most invested in maintaining the status quo.

Thus, reformers must work not only to ensure that those who benefit from expanded coverage recognize that benefit but also to focus on measures that spark civic mobilization and foster and strengthen organized allies. At the same time, they need to pursue changes that weaken the capacity or incentive of opponents to stand in the way of such changes.

Increasingly, I have come to believe that the best opportunity for such power building is a Public Health Jobs Corps, which Biden says he supports. The rationale for this new effort should include addressing the serious racial inequities in health care brought to light by COVID-19 and central to the protests of 2020. Indeed, it would be a way of harnessing some of the movement energy already on the ground and focusing it on expanded public coverage.

As with the Peace Corps, the Public Health Jobs Corps could potentially be established with an executive order, using existing funds for insurance enrollment and public health efforts. A Biden administration could also name a charismatic head (the Sergeant Shriver of public health), and initial volunteers could likely begin work immediately. Ultimately, however, the Corps will need to have permanent authority and funding to operate on the scale envisioned.

In the immediate term, the Public Health Jobs Corps will be able to perform vital health roles, such contract tracing, care coordination, and enrollment in coverage. The Corps itself will also diversify and bolster the health care workforce as well as backstop and expand safety net providers who are currently under severe strain. And since it will be providing direct service jobs, it will also contribute to expanded employment.

But while the Public Health Jobs Corps will have key policy aims, its overarching goal will be to develop a network of young health advocates spread across the nation, with ties to local advocacy and labor organizations. Over time, the Corps will expand the scope of organized actors involved in health policy, create a set of grassroots activists fighting for and drawing attention to broadened coverage, and provide avenues for labor organizing and mobilization by organizations active in disadvantaged and minority communities. In short, this large-scale effort would not just be about meeting immediate needs and bolstering public coverage, but also building power for further expansion of that coverage—in time, through a robust public option.

Making New Policies to Make a New Politics

The struggle over health care has always been about politics as much as policy. The challenge is not coming up with proposals that would be far better than the policy dumpster fire that is the status quo. The challenge is figuring out how to overcome the political barriers to pursuing those proposals—not only to get them passed but also to ensure that they foster the political conditions for continuing improvement.

Without the capacity to overcome a Senate filibuster, Democrats will not be able to pursue their boldest visions in 2021. But they can do much more than undo what Trump has wrought, or make modest improvements to the ACA. They can build power for the ambitious vision of the public option that Biden ran on in 2020.

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Acknowledgments

I would like to thank Jed Cohen for his able oversight of the submission process and Diane Archer, Abbe Gluck, Alexander Hertel-Fernandez, Jamila Michener, and Jonathan Oberlander for astute comments that greatly improved the final product.

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