THE HAMILTON PROJECT

Advancing Opportunity, Prosperity and Growth

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HEALTH CARE RECONSIDERED

Options For Change

One of four approaches to achieving universal coverage released by The Hamilton Project

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Achieving Universal Coverage Through Medicare Part E(veryone)

The Brookings Institution

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Achieving Universal Coverage Through Medicare Part E(veryone)

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This discussion paper is a proposal from the authors. As emphasized in The Hamilton Project's original strategy paper, the Project is designed in part to provide a forum for leading thinkers from across the nation to put forward innovative and potentially important economic policy ideas that share the Project's broad goals of promoting economic growth, broad-based participation in growth, and economic security. The authors are invited to express their own ideas in discussion papers, whether or not the Project's staff or advisory council agree with the specific proposals. This discussion paper is offered in that spirit.

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Abstract

Several principles govern the creation of our Medicare Part E(veryone) proposal. First, universal health insurance coverage is necessary. Second, there should be no gaps in coverage. Third, coverage should be provided at the lowest possible cost to individuals and society. Fourth, the private sector should be involved when it can add value. Fifth, the program should be easy to explain and built on the existing infrastructure so that it can be implemented quickly. Finally, although additional reforms to the health care system—including cost containment initiatives—are desirable, they should not be a prerequisite to universal coverage.

This proposal adopts Medicare rules and payment systems to provide the same benefits to the enrollees in Medicare Part E(veryone) as current Medicare beneficiaries receive today. Private health plans could participate through Medicare Parts C and D, offer Medigap coverage, and continue to offer private health insurance coverage. Firms could buy into the Medicare Part E program for all of their employees, and they would contribute at least as much to the premium as their employees do. Those without employer-based coverage could enroll individually. The Part E premium, which would be the same for every enrollee, would be determined using Medicare actuaries to "break even" over each year. The federal government would use a sliding scale to subsidize the premium for individuals whose income is below 400 percent of the federal poverty level. This proposal estimates that Medicare Part E would initially enroll 121.3 million beneficiaries for a total net cost to the government of about $94.4 billion. Coverage would be universal, continuous, and affordable.

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1. Introduction

Our starting premise is that any proposal to provide universal health coverage should be simple to explain, so the public can assess how the changes would affect them. Medicare Part E(veryone) is designed to be easy for the public to understand: it builds on the existing Medicare infrastructure and makes minimal changes to the rest of the health care system. Although we developed Part E as a self-contained program, policymakers could choose to combine it with a more ambitious restructuring of the health care system.

Our proposal to add a Medicare Part E is simple: make the benefits that current Medicare beneficiaries receive available to everyone. This expansion achieves universal coverage using the existing Medicare rules and payment systems. Under our proposal, all individuals will be required to have health insurance. Those with existing insurance coverage will not have to change to Medicare Part E unless they or their employers want to change, as long as their public or private health insurance coverage meets certain minimum criteria. Firms will be able to buy into the Medicare Part E program, and individuals without employer-based coverage will be able to enroll on their own. In the case of firms participating in Part E, the employer will pay at least as much of the premium as each employee, all of whom are required to enroll.

Part E is financed through a standard premium; everyone is charged the same amount. The federal government, however, provides a sliding-scale subsidy to help cover the cost of the premium for households whose income is below 400 percent of the federal poverty level (FPL). The level of the subsidy is based on the wage income of the household, where income is determined by how much the household pays in Medicare payroll tax. Premiums will be set so that the program breaks even, net of the subsidy.

Motivation for the Proposal

The structure of our Medicare Part E proposal is motivated by the Institute of Medicine's (IOM) recommended five guiding criteria when considering health insurance expansion options. The IOM's five criteria are universality, continuity, affordability for individuals and families, affordability and sustainability for society, and enhancement of the population's health status (IOM 2004). We believe, first, that universal health insurance coverage is necessary to improve the health status of Americans who are not currently covered or who have inadequate health insurance coverage. Several IOM studies have documented the benefits of insurance coverage (IOM 2001, 2002a, 2002b, 2003a, 2003b, 2004). Second, there should be no gaps in coverage when people change jobs, move, or fail to sign up for coverage. Third, the option providing coverage at the least cost to individuals and to society should be chosen. Fourth, the private sector should be involved when it can add value. Fifth, the method for covering the uninsured should be easy to explain and should be built on the existing infrastructure so that it can be implemented quickly. Finally, although additional reforms to the health care system—including cost containment initiatives—are desirable, this should not be a prerequisite to universal coverage. Medicare Part E pursues these goals in the following ways:

Universality and Continuity. Individuals are mandated to purchase health insurance, employers are mandated to offer health insurance, and federal government subsidies are designed to make health insurance affordable to low-income individuals. By offering an accessible option outside the employer-based health care system, Part E would reduce the medical and financial uncertainty that currently results from lapses in coverage when workers switch jobs or working arrangements.

Affordability. In implementing universal health care reform, it is important to ensure that the new option is affordable on both the societal and individual levels. We believe that the least expensive option on both counts is to offer Medicare to the uninsured. Part E will have significantly lower administrative costs than an expansion of private insurance, and it is more appropriate than Medicaid for a variety of logistical and economic reasons outlined in §5.8. Part E would keep down the cost for individuals and firms who would be required to purchase coverage, as well as for taxpayers who would be required to subsidize the coverage of low-income individuals. We predict that Part E would be cheaper on an individual level, with premiums for a family of four dropping to $10,000 from the current average family premium of $11,480.

Added Value from the Private Sector. The private sector will be encouraged to participate when it has the ability to provide a better product at a lower or similar cost. Under our proposal, private insurance can be sold to individuals and employers, and these private health plans must meet only minimal requirements in order to qualify. In addition, private health plans are able to participate under Medicare Parts C and D, and are able to sell Medigap coverage.

Simplicity and Feasibility. Our plan adds a new option but, unlike many other universal coverage proposals, does not require changes to any of the existing options, including the employer-sponsored health insurance system, Medicaid, the State Children's Health Insurance Program (SCHIP), and Medicare for current beneficiaries. To this end, we maintain the existing tax exclusion for employer contributions to health insurance, both for private insurance plans and for employer contributions to the new Medicare Part E plans. By establishing universal coverage through the current system rather than in place of it, our proposal should be much more politically feasible than other reforms that affect many different constituencies.

Why Medicare?

The Medicare benefit package offers sufficient coverage for the uninsured without imposing excessive costs. However, we recognize that there are limitations to the Medicare benefit package, such as high levels of cost sharing, inadequate long-term-care coverage, lack of transportation to medical services, and insufficient coverage for some chronic conditions. When the Medicare program was constructed in 1965, it was designed primarily for acute care, and now most of the utilization is for chronic care. We believe there are provisions in the Medicare program that should be changed. However, the Medicare program represents more than forty years of political compromises and has benefited from countless analytical studies. As a result, we have chosen not to modify the Medicare program.

We also recognize that some of the Medicare benefits may not be perfect for children, pregnant women, and younger adults. However, 15 percent of Medicare enrollees are disabled individuals who are under age 65, and the benefit package covers their needs. For example, although Medicare's benefits may not be ideal for pregnant women, the current system already provides support when disabled women become pregnant. We anticipate that the Medicare program will continue to evolve and improve. Medicare Part E may actually accelerate this transformation because it will give Medicare additional market power.

We acknowledge that the Medicaid benefit package is more comprehensive and may be more appropriate for low-income individuals. If long-term care and other standard Medicaid benefits are included, then Medicaid is also more expensive than many other purely health insurance packages. Though there are studies that demonstrate that Medicaid is actually less expensive than private insurance on a comparable per person basis (Hadley and Holahan 2003/2004, Miller, Banthin, and Moeller 2004), Medicaid's lesser expense stems primarily from lower payments to health care providers than

those that private insurance (or Medicare) pays. As such, Medicaid is likely to be unpopular with providers and may be unable to attract a sufficient number of providers for a universal health plan. Additionally, because the Medicaid benefit package is more comprehensive than either Medicare or most private insurance benefit packages, an expansion of Medicaid is likely to be opposed by Medicare beneficiaries and people with private insurance wondering why they do not receive such a comprehensive benefit package. For these reasons, we have chosen not to offer the Medicaid benefit package. We assume no changes in the current Medicaid program.

Who is Covered?

In developing the model and the cost estimates, we make several assumptions to calculate the number of people who would enroll in a new Part E. We assume that the number of uninsured adults in the United States will continue to increase at current rates in the absence of reform. Approximately 1 million adults are added to the ranks of the uninsured every year (Kaiser Family Foundation 2006a). Currently, it is estimated that 8 million children do not have health insurance coverage (Holahan, Cook, and Dubay 2007). We assume that SCHIP will cover all of the low-income children it currently does; Part E will cover the 6.5 million children currently eligible for SCHIP but not enrolled. According to studies, only 4 percent of children above 300 percent of the FPL are uninsured (Dubay, Holahan, and Cook 2007). Nonetheless, we assume most families in this income range would seek to keep their children under the same policy as the adults, and we adjust take-up rates accordingly.

Additionally, our proposed Medicare Part E would cover undocumented immigrants who pay Medicare payroll taxes. Any undocumented immigrants who do not pay their taxes would not be covered under our plan and would need to continue to receive care from public clinics and private sources.

2. Medicare Part E

Flat premiums would be the primary financing mechanism for Medicare Part E. The value of the premium will reflect the actuarial value of the coverage, as calculated by Medicare actuaries. The premium will be split among employers, employees, and the federal government. Higher-income beneficiaries—those with incomes above 400 percent of the FPL,[1] or about $80,000 for a family of four in 2006—would share a premium reflecting the full cost of the insurance with their employers, while lower-income beneficiaries would receive a sliding-scale subsidy paid through government general revenues. In addition, workers and employers would continue to pay the 2.9 percent payroll tax that funds the current Medicare Part A program, and individuals who qualify for Medicare under current law would continue to pay premiums under current rules. This financing mechanism is designed to be both sustainable and fair. The value of the premium is adjusted every year to reflect changes in the cost of the program.

Household income as a percentage of the FPL will be determined through the income tax system. We use this measure of income because the FPL takes into account the size and earnings of the entire household. We acknowledge, however, that it may be administratively difficult to communicate to employers each employee's FPL on a timely basis, which is important because it affects what both the employer and employee pay. Should the administrative problems prove too difficult, alternatives could be considered, such as a flat tax rate based solely on wage income during the pay period.

A review of the existing proposals to cover the uninsured shows that most proposals base the subsidy on the FPL, and 400 percent of the FPL is the most common threshold. In Medicare Part E, persons whose Medicare income is above 400 percent of the FPL would not receive a federal subsidy. The formula for calculating the share of the Medicare Part E premium to be contributed by government (the subsidy) is 1-(%FPL/400). The continuous formula prevents discontinuities in coverage by income. The formula for calculating the share of the Part E contribution to be contributed by the employer (if any) and the individual is (%FPL/400). If there is no employer, then the employer's share would be covered by the individual, as under current Medicare law. Under this proposal, each person would be expected to contribute something to her insurance coverage and to the coverage of any dependents that do not qualify to receive other government-sponsored health insurance (e.g., SCHIP). People would be expected to purchase individual coverage in Medicare Part E.

Table 1 illustrates the percentage of the Part E premium that will be paid by the government, the amount that will be paid by the individual, and the amount that will be paid by the employer at various levels of the FPL. Although this payment structure explains the theory behind Part E funding, actual payment distributions may differ somewhat from what is listed here (see §4.2.6).

As is true in the current Medicare program, the premium would be nationally rated (not risk adjusted), and there would be no geographic adjustments for the cost of medical care in the area where each individual lives. As stated above, the premium will be calculated based on the actuarial value of the package, adjusted by Medicare actuaries based on the previous year's experience. Because of its open enrollment and flat premium, and because the implementation of Medicare Part E will be accompanied by an insurance mandate,

1. The FPL is commonly used for federal means-tested programs. In 2007, the poverty threshold cited by the Department of Health and Human Services for a family of four living in the forty-eight contiguous states and Washington, DC is $20,650.

TABLE 1

Employer, Individual, and Government Contributions to Medicare Part E Premiums

Percent of Federal Poverty Level	Employer Contribution (percent)	Individual Contribution (percent)	Government Contribution (percent)
0	0	0	100
50	6.25	6.25	87.5
100	12.5	12.5	75
200	25	25	50
300	37.5	37.5	25
400+	50	50	0

it is quite likely that the program will experience adverse risk selection in the sense that relatively unhealthy individuals will join it and relatively healthy individuals will seek lower-cost insurance options in the private sector.

To counteract this adverse selection and to ensure the fiscal solvency of Medicare Part E, the proposal could be adapted so that the federal government provides a subsidy to the program equivalent to the actuarial value of the risk adjustment each year—in other words, the financial value of the difference between the average actuarial value of the benefits package for the full under-sixty-five U.S. population and the actuarial value of the same package when offered to the Medicare Part E population. This adaptation could ensure that the share of the premium paid by firms and individuals would remain affordable. This is a policy that would by itself discourage, to some extent, the adverse selection that the program is likely to encounter. However, since the extent of adverse selection and its effect on Part E premiums is impossible to predict and would need to be monitored on an annual basis, we leave government subsidies of risk selection to the Medicare actuaries to monitor.

The objective in setting the premium rate is to make the Medicare Part E program financially self-sustaining, after taking account of the income-related subsidies that will be financed from general government revenues. Of course, there will be year-to-year fluctuations because of problems with actuarial projections and unexpected circumstances. As a result, the Part E program will have a small surplus in some years to be offset by small deficits in other years. No long-term deficits or surpluses are permitted.

The payment system under Part E would be the same as the Medicare program and would be updated as the Medicare program changes. The advantage of this approach is the clearly specified payment rules under the current Medicare program. All Medicare provisions would apply to Medicare Part E. The additional bureaucracy necessary to administer the program would be minimal because the current Medicare rules and regulations would apply. The Medicare collection mechanisms are already in place.

It is usually difficult to anticipate all the responses when new programs are implemented. It would be relatively easy to predict the responses of the various actors under Medicare Part E since the Medicare program has existed for more than forty years and is continuously monitored.

2.1. Benefits Included in Medicare Part E

The benefit package remains the same as under the Medicare program. Part E participants would have access to Parts A, B, C, and D since the Medicare Part E program would use the existing Medicare rules and regulations. Medicare Part E enrollees would also be permitted to purchase Medigap coverage under the same rules as current Medicare beneficiaries. Medigap premiums would not have income-related subsidies.

We expect that Medicare Parts A to D will continue to evolve and foster the adoption of quality-of-care initiatives (such as coordinated care for patients with chronic conditions) and to provide incentives to providers to adopt new technologies (such as health information technology). Also, we anticipate that Medicare will adopt cost-containment strategies to resolve sustainability issues of Parts A to D. Assessment of clinical effectiveness is an important component of Medicare modernization. Since enrollees under Medicare Part E have access to Parts A to D, enrollees are assumed to reap all the benefits of any changes made to the Medicare program.

2.2. Opting Out of Medicare Part E

Public or private coverage would need to meet only minimal standards in order to be deemed acceptable and to exempt the person from mandatory Part E enrollment. The only criterion is that the health plan or the insured person would be expected to pay the medical bill. Under Part E, if 98 percent of the medical bills for hospital and doctor services were paid by either the insurer or the patient, then the health plan would be considered acceptable. This rule allows the private sector maximum flexibility. If less than 98 percent of hospital and doctor bills were paid by either the patient or the insurer, the health plan would lose its accreditation status. Initially all health plans would qualify. Public insurance programs would qualify (e.g., Medicaid), whereas public programs that simply provided services (Community Health Centers, Veterans Health Administration, and so on) would not. People unable to pay their medical bills would be automatically enrolled in Medicare Part E for a five-year period unless they qualify for public insurance.

2.3. Allowing Individuals and Firms to Buy into Medicare Part E

In addition to the uninsured, everyone would be eligible to enroll in Medicare Part E. For individuals, small firms, larger firms with high-risk individuals, and larger firms with an older workforce, the Medicare Part E premium would probably be less expensive than the premium being offered in the marketplace. One reason for that cost difference is that plans offered through Medicare would have lower administrative costs, including marketing. Moreover, a majority of the population would be eligible for subsidies if they purchase insurance through Medicare Part E (Bureau of Labor Statistics and the Census Bureau 2006a). This would create a major incentive for employers to switch to coverage through Medicare Part E.

If firms choose to enroll in Medicare Part E, they would be required to enroll all employees. Firms would not be permitted to enroll only high-risk individuals or only low-wage individuals. Calculations of the amounts to be paid by the individual, the employer, and the federal government would be based on the individual's income. As a result, firms with a high proportion of low-wage workers would get a larger subsidy from the federal government than would firms with higher-wage workers.

As an example, consider an individual making 100 percent of the FPL. She and her employer would each pay 12.5 percent of the premium (the amount expected at 100 percent FPL). The federal government would cover the remaining 75 percent. Firms that voluntarily decided to use the Medicare Part E program for health insurance coverage would need to remain in the Part E program for a minimum of two years. Firms with a high proportion of unhealthy workers may find Part E attractive, given the lower premiums than in the private sector. The federal government could also contribute a general revenue subsidy to account for possible adverse risk selection (see §2).

3. Rationale for Expanding Medicare

Why Public Provision Is Less Expensive than Private Provision of Health Insurance

Since the federal government will be providing the subsidy for low-income workers, the federal government should choose the least expensive option to cover the uninsured. Public insurance programs are less expensive than private insurance in terms of administrative costs. Also called the loss ratio, this figure measures the amount that insurance companies retain and do not pay out in benefits. Administrative costs for a private health insurance beneficiary are more than three times the costs for a Medicare beneficiary (Table 2). In addition, administrative costs are growing twice as fast among private insurers compared to the Medicare program. Between 1986 and 2003, administrative costs rose 400 percent for private insurers and 200 percent for Medicare. (Centers for Medicare and Medicaid Services [CMS] 2003, CMS n.d.).

TABLE 2

Administrative Costs of Medicare and Private Health Insurance in 2003

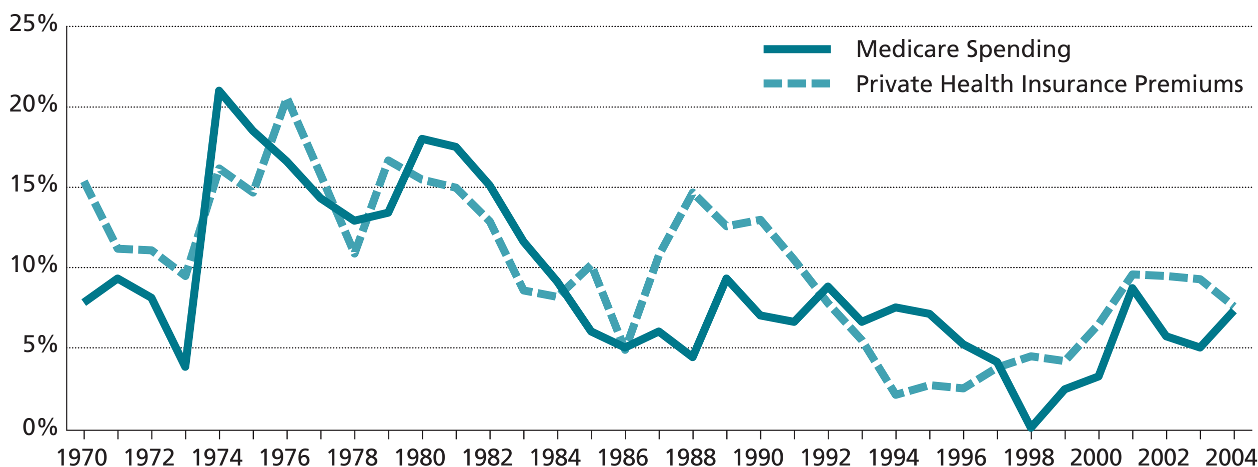
Program	Administrative Costs per Beneficiary
Medicare Program	$137
Private Health Insurance	$421

Note: The Medicare administrative costs are an upper bound amount assuming that administrative costs are 2 percent of Medicare costs. However, the source estimates that administrative costs were less than 2 percent of the total Medicare costs.
Source: Kaiser Family Foundation 2005b, Exhibit 6.11, Hoffman et al. 2004.

Administrative costs, however, might tell only a portion of the story: it is possible that higher administrative costs will actually lower total health care spending if they are identifying ways both to eliminate fraud and abuse and to improve the efficiency of the delivery system. To examine this point, Figure 1 compares the rates of increase in health care spending per capita in the Medicare and private health insurance programs from 1970 to 2004. In some years, the private sector is able to control health spending per capita more effectively

FIGURE 1

Per Enrollee Growth in Medicare Spending and Private Health Insurance Premiums (for Common Benefits), 1970-2004



Source: CMS 2003, Table 13.

than does the public sector, while in other years the reverse is true. Between 1970 and 2004, the annual rates of increase of spending per capita in the Medicare program were lower than in the private sector—9.0 percent in the Medicare program compared to 10.1 percent in the private sector. This suggests that over the long run the Medicare program has been more successful than the private insurance sector in controlling health care spending, in spite of the higher and growing administrative spending by private insurers.

Some have argued that managed care is clearly preferable to fee-for-service care. The Medicare program is predominately fee-for-service while the private sector is predominately managed care. Miller and Luft periodically evaluate the literature on the performance of fee-for-service and managed care. At each review, the results suggest that the managed care plans were only marginally more successful than the fee-for-service plans at controlling aggregate spending (Miller and Luft 1994, 1997, 2002). These literature reviews were published during the pinnacle of managed care in the mid- to late 1990s and early 2000s.

Since the last study published by Miller and Luft in 2002, the ability of managed care to control spending has diminished considerably, primarily because most consumers do not want to be presented with a restricted set of providers. As a result, the bargaining power of the managed care plans with doctors and hospitals has deteriorated (Blendon et al. 2006). Data suggest that private sector insurance rates increased rapidly once consumers stopped accepting restrictions in their delivery network (Claxton et al. 2006). Between 2000 and 2005, health insurance premiums increased an average of 11 percent per year. During this same time period, Medicare spending increased an average of 8.8 percent per year.

A recent comparison of the cost to the Medicare program between beneficiaries enrolled in fee-for-service Medicare and managed care Medicare suggests that the higher administrative cost in the private sector may not provide additional benefits in terms of lower health care spending, and that beneficiaries enrolled in Medicare Part C may actually be more expensive for Medicare (Biles et al. 2006). In our proposal, any additional subsidies to health plans in Medicare Part C would be eliminated.

Risk Selection in Private Insurance Interferes with Universality

A key objective of enrolling the uninsured is to achieve universality. Private health insurers have historically engaged in a variety of methods to achieve favorable selection. It is well known that a small proportion of the population accounts for a large portion of health care spending. This creates strong financial incentives for private insurers to engage in risk selection unless the payment system adjusts for the higher expected costs in these individuals. These are disproportionately individuals with chronic conditions. Therefore, it is likely that some private insurers will make it more difficult for uninsured persons with chronic conditions to obtain and retain health insurance coverage.

While it is possible to create legislation and regulations that prohibit certain actions by private health plans and to mandate provisions such as open enrollment and guaranteed renewal, the cost variations will still be a powerful incentive for private health plans to devise strategies that are one or two steps ahead of the rules and regulations. In contrast, the public sector does not have the profit motive and does not engage in competitive behavior. Therefore, risk selection is less likely to occur in the public sector. As a result, Medicare Part E will have fewer risk selection problems because of its reliance on community rating and guaranteed issue.

Medicare Part E Will Maintain Private Sector Involvement

There will be numerous opportunities for the private sector to participate in Medicare Part E. Medicare Part E will be able to take advantage of the

private sector's innovations under Medicare Parts C and D. Medicare beneficiaries are currently able to enroll in managed care options under Medicare Part C. The most innovative private sector options are able to attract Medicare beneficiaries under Medicare Part C. Many private insurers participate in Medicare Part D. Private insurers will also be able to provide Medigap coverage under Part E. We expect that the uninsured and individuals opting into Medicare Part E will be more likely to choose these options. In addition, health plans will still be able to provide private health insurance coverage as long as the plans meet minimal requirements.

4. Cost Estimates for Medicare Part E

4.1. Data Sources

In order to model the cost of Medicare Part E, we conducted a review of the literature concerning participation rates, crowd-out rates, the effects of premiums and copays on use, and the costs of coverage. We also reviewed the costs related to not having insurance. In addition to results from the literature, we use two principal data sources: The first is the March 2006 Current Population Survey (CPS) to measure current population insurance status and population characteristics (Bureau of Labor Statistics and the Census Bureau 2006b). The second is the medical expenditure panel survey (MEPS) for health expenditures for individuals with different self-perceived health status, by insurance status, income, and employment status (U. S. Department of Health and Human Services 2004).

4.2. Steps in the Modeling Process

4.2.1. Take-Up for Those Previously Uninsured (Participation)

We use the CPS 2006 and the MEPS 2004 to establish baseline estimates of the numbers of full-year uninsured individuals in the United States (Tables 3 and 4). We calculate the number of individuals between the ages of eighteen and sixty-four in Table 3 and children below the age of eighteen in Table 4. We also summarize certain characteristics such as employment status, health status, and income level. We assume that individuals older than sixty-four are already covered by the Medicare insurance system.

Take-up rates refer to the percentage of individuals who will accept a new insurance coverage offer when it is presented to them. In the literature,

TABLE 3

Number of Uninsured Adults Ages 18-64 by Income Level, Health Status, and Employment Status

Employment and Self-Perceived Health Status	Percent Federal Poverty Level				
	<100%	100–199%	200–399%	400+%	Totals
Employed					
Excellent or Good Health	3,520,848	6,510,891	7,400,706	4,286,921	21,719,367
Poor or Fair Health	519,199	735,051	862,531	422,819	2,539,599
Unemployed					
Excellent or Good Health	609,280	578,593	650,707	298,915	2,137,495
Poor or Fair Health	250,588	173,563	112,553	50,416	587,120
Not in Labor Force					
Excellent or Good Health	2,915,381	2,102,708	1,658,991	797,928	7,475,008
Poor or Fair Health	1,582,174	1,141,138	900,332	433,035	4,056,679
Total Uninsured Adults	**9,397,470**	**11,241,944**	**11,585,820**	**6,290,034**	**38,515,268**
Excellent or Good Health	7,045,509	9,192,193	9,710,403	5,383,765	31,331,870
Poor or Fair Health	2,351,961	2,049,751	1,875,417	906,269	7,183,398

Note: Numbers may not sum to totals due to rounding.
Source: Authors' calculations based on the March 2006 Current Population Survey.

TABLE 4

Number of Uninsured Ages 0–17 by Income Level

Children Under Age 18	Percent Federal Poverty Level		
	<300%	300%+	Totals
Currently Insured	35,349,205	30,041,256	65,390,461
Currently Uninsured	6,527,233	1,367,413	7,894,647
Totals	**41,876,439**	**31,408,669**	**73,285,108**

Note: Numbers may not sum to totals due to rounding.
Source: Authors' calculations based on the March 2006 Current Population Survey.

predicted take-up rates for public insurance programs increase with individuals' age, educational status, and income. The rate for public insurance take-up most commonly used in studies for population groups below 150 percent of the FPL is 55 percent to 60 percent (Glied, Remler, and Zivin 2002). Because the implementation of Medicare Part E involves a mandate for coverage, we assume these take-up rates are higher than previous estimates.

We assume unemployed individuals will join at a 100 percent rate, since they will be unable to obtain insurance coverage through an employer and will find Medicare Part E considerably less expensive than private insurance options in the individual market. Conversely, higher-income individuals are predicted to participate at lower rates because they will be more likely to obtain insurance through an employer or in the individual market (Table 5). To partly account for adverse selection and actions by private insurers, take-up rates are estimated to be higher for adults who have fair or poor self-reported health status.

Applying these percentages to the baseline numbers for uninsured adults from Table 3 yields the total numbers of previously uninsured individuals who are predicted to join Medicare Part E (Table 6).

4.2.2. Take-Up for Those with Previous Private Insurance (Crowd-out)

Crowd-out refers to take-up into a public program by those who are already insured by another insurance plan. The crowd-out rate is typically defined as the percentage of individuals with private insurance who are eligible for a public program and who actually switch to the public program. For the purposes of Medicare Part E, we define crowd-out as the enrollment of individuals with any type of previous insurance—public or private—in Medicare Part E. We assume individuals that switch decide that Part E is the better and more affordable option. Table 7 shows the numbers of individuals aged eighteen to

TABLE 5

Take-up Rates for Uninsured Adults Ages 18-64 by Income Level, Health Status, and Employment Status

Employment and Self-Perceived Health Status	Percent Federal Poverty Level			
	<100%	100–199%	200–399%	400+%
Employed				
Excellent or Good Health	60%	55%	40%	25%
Poor or Fair Health	85%	80%	65%	50%
Unemployed				
Excellent or Good Health	100%	100%	100%	100%
Poor or Fair Health	100%	100%	100%	100%
Not in Labor Force				
Excellent or Good Health	100%	100%	100%	100%
Poor or Fair Health	100%	100%	100%	100%

Source: Authors' estimations based on relevant literature.

TABLE 6

Total Take-up for Previously Uninsured Adults Ages 18-64 (Participation)

Employment and Self-Perceived Health Status	Percent Federal Poverty Level				
	<100%	100–199%	200–399%	400+%	Totals
Employed					
Excellent or Good Health	2,112,509	3,580,990	2,960,282	1,071,730	9,725,512
Poor or Fair Health	441,319	588,040	560,645	211,409	1,801,414
Unemployed					
Excellent or Good Health	609,280	578,593	650,707	298,915	2,137,495
Poor or Fair Health	250,588	173,563	112,553	50,416	587,120
Not in Labor Force					
Excellent or Good Health	2,915,381	2,102,708	1,658,991	797,928	7,475,008
Poor or Fair Health	1,582,174	1,141,138	900,332	433,035	4,056,679
Total	**7,911,251**	**8,165,033**	**6,843,511**	**2,863,434**	**25,783,228**
Excellent or Good Health	5,637,170	6,262,292	5,269,980	2,168,574	19,338,015
Poor or Fair Health	2,274,081	1,902,741	1,573,531	694,860	6,445,213

Note: Numbers may not sum to totals due to rounding.
Source: Authors' calculations based on Tables 3 and 5.

TABLE 7

Number of Insured Adults Ages 18-64 by Income Level, Health Status, and Employment Status

Employment and Self-Perceived Health Status	Percent Federal Poverty Level				
	<100%	100–199%	200–399%	400+%	Totals
Employed					
Excellent or Good Health	4,266,858	11,988,811	37,384,101	58,395,899	112,035,669
Poor or Fair Health	767,720	1,662,764	2,941,755	3,310,782	8,683,021
Unemployed					
Excellent or Good Health	4,360,641	3,207,886	5,563,340	6,915,970	20,047,837
Poor or Fair Health	2,969,509	1,854,218	1,778,550	1,239,885	7,842,162
Not in Labor Force					
Excellent or Good Health	21,765	23,055	121,232	121,203	287,255
Poor or Fair Health	4,013	5,061	21,477	6,990	37,541
Total Insured Adults	**12,390,506**	**18,741,795**	**47,810,455**	**69,990,729**	**148,933,485**
Excellent or Good Health	8,649,264	15,219,752	43,068,673	65,433,072	132,370,761
Poor or Fair Health	3,741,242	3,522,043	4,741,782	4,557,657	16,562,724

Source: Authors' calculations based on the March 2006 Current Population Survey and the 2004 Medical Expenditure Panel Survey.

sixty-four in the United States who currently have insurance broken down by income level, health status, and employment status.

As crowd-out rates increase, the efficiency of public insurance—comparing costs to the net increase in coverage—decreases. Estimates from the literature suggest that for the privately insured, the short-run elasticity (responsiveness) of take-up to a new program offer is approximately 30 percent as high as the elasticity of take-up among the uninsured (Glied, Remler, and Zivin 2002). Medicare Part E is likely to see higher crowd-out rates given the subsidization of the premium provided by the federal government. The subsidies will be particularly attractive for individuals with low to moderate levels of income. Firms would need to decide to opt in completely to Medicare Part E or to stay out of it completely: they cannot choose to place only some of their employees in the program. As a result, we predict the short-term effects of crowd-out into Medicare Part E to be as shown in Tables 8 and 9. We expect crowd-out rates will increase over time as individuals and firms realize the value of Part E.

TABLE 8

Take-up Rates for Previously Insured Adults Ages 18-64 (Crowd-out)

	Percent Federal Poverty Level			
	<100%	100–199%	200–399%	400+%
Employed	65%	60%	55%	50%
Unemployed	30%	25%	22%	20%
Not in Labor Force	30%	25%	22%	20%

Source: Authors' estimations based on relevant literature.

4.2.3. Total Enrollment in Medicare Part E

Total adult enrollment (Table 10) is a combination of participation (Table 6) and crowd-out (Table 9).

Additionally, we predict that 24.3 million children below age eighteen would enroll in Part E from the following groups: approximately 6.5 million currently uninsured children that live in families below 300 percent of the FPL, and 17.8 million currently insured children from families above 300 percent

TABLE 9

Total Enrollment for Previously Insured Adults Ages 18-64 (Crowd-out)

Employment and Self-Perceived Health Status	Percent Federal Poverty Level				
	<100%	100–199%	200–399%	400+%	Totals
Employed					
Excellent or Good Health	2,773,458	7,193,287	20,561,256	29,197,950	59,725,949
Poor or Fair Health	499,018	997,658	1,617,965	1,655,391	4,770,033
Unemployed					
Excellent or Good Health	1,308,192	801,972	1,223,935	1,383,194	4,717,293
Poor or Fair Health	890,853	463,555	391,281	247,977	1,993,665
Not in Labor Force					
Excellent or Good Health	6,530	5,764	26,671	24,241	63,205
Poor or Fair Health	1,204	1,265	4,725	1,398	8,592
Total	**5,479,254**	**9,463,500**	**23,825,833**	**32,510,150**	**71,278,737**
Excellent or Good Health	4,088,180	8,001,022	21,811,861	30,605,384	64,506,447
Poor or Fair Health	1,391,075	1,462,478	2,013,971	1,904,766	6,772,290

Note: Numbers may not sum to totals due to rounding.
Source: Authors' calculations based on Tables 7 and 8.

TABLE 10

Total Adult Ages 18-64 Enrollees in Medicare Part E

Employment and Self-Perceived Health Status	Percent Federal Poverty Level				
	<100%	100–199%	200–399%	400+%	Totals
Employed					
Excellent or Good Health	4,885,966	10,774,277	23,521,538	30,269,680	69,451,461
Poor or Fair Health	940,337	1,585,699	2,178,610	1,866,800	6,571,447
Unemployed					
Excellent or Good Health	1,917,472	1,380,565	1,874,642	1,682,109	6,854,788
Poor or Fair Health	1,141,441	637,117	503,834	298,393	2,580,785
Not in Labor Force					
Excellent or Good Health	2,921,910	2,108,472	1,685,662	822,169	7,538,213
Poor or Fair Health	1,583,378	1,142,403	905,057	434,433	4,065,271
Total Adult Enrollees	**13,390,505**	**17,628,533**	**30,669,343**	**35,373,584**	**97,061,965**
Excellent or Good Health	9,725,349	14,263,314	27,081,841	32,773,958	83,844,462
Poor or Fair Health	3,665,156	3,365,219	3,587,502	2,599,626	13,217,503

Note: Numbers may not sum to totals due to rounding.
Source: Authors' calculations based on the March 2006 Current Population Survey.

of the FPL. This latter category is calculated based on crowd-out rates of 55 to 60 percent of the 30 million children above 300 percent of the FPL. We base this calculation on the assumption that most families in this income range would seek to keep their children under the same policy as the adults, whether that policy is private insurance or Medicare Part E.

4.2.4. Expenditures

We base the estimates of expenditures under Medicare Part E on the 2004 MEPS—calculating current health expenditures for different health status groups by insurance status, income, and employment status (Table 11). Based on these estimates, the total annual expenditures for adults in Medicare Part E will be $459.3 billion, adjusting for health status (Table 12).

In addition, Medicare Part E will insure an estimated 24.3 million children under the age of eighteen, as calculated above. We estimate average annual expenditures for this age group of $1,200 per person, based on current Medicaid expenditures for this age group. As a result, Medicare Part E will have $29.1 billion in expenditures for children under age eighteen, for an overall total of $488.4 billion in expenditures. Of this amount, an estimated $60.2 billion will be paid through patient cost-sharing—deductibles and copayments—for a net health care cost of $428.2 billion.

TABLE 11

Predicted Expenditures per Adult Enrollee

	Percent Federal Poverty Level			
	<100%	100–199%	200–399%	400+%
Excellent or Good Health	$4,413	$4,483	$4,574	$4,458
Poor or Fair Health	$6,468	$6,273	$6,192	$5,937
Weighted Average	**$4,975**	**$4,825**	**$4,763**	**$4,567**

Source: Authors' calculations based on the 2004 Medical Expenditure Panel Survey.

4.2.5. Administrative Costs

In addition to these expenditures, Medicare Part E will have administrative costs. Medicare's administrative costs are currently among the lowest of any

TABLE 12

Total Predicted Expenditures for Adult Enrollees (billions U.S. $)

Employment and Self-Perceived Health Status	Percent Federal Poverty Level				
	<100%	100–199%	200–399%	400+%	Totals
Employed					
Excellent or Good Health	21.6	48.3	107.6	135.0	312.4
Poor or Fair Health	6.1	9.9	13.5	11.1	40.6
Unemployed					
Excellent or Good Health	8.5	6.2	8.6	7.5	30.7
Poor or Fair Health	7.4	4.0	3.1	1.8	16.3
Not in Labor Force					
Excellent or Good Health	12.9	9.5	7.7	3.7	33.7
Poor or Fair Health	10.2	7.2	5.6	2.6	25.6
Total					
Excellent or Good Health	42.9	63.9	123.9	146.1	376.8
Poor or Fair Health	23.7	21.1	22.2	15.4	82.5
Total Predicted Expenditures ($ billion)					**459.3**

Note: Numbers may not sum to totals due to rounding.
Source: Authors' calculations based on the March 2006 Current Population Survey and the 2004 Medical Expenditure Panel Survey.

insurer—public or private—in the United States. Average administrative costs per capita for Medicare are estimated to be $137, compared to $421 for private insurance (CMS 2005). Medicare Part E will insure a total of 121.4 million beneficiaries—97.1 million adults and 24.3 million children. The resulting administrative costs will be $16.6 billion, or $137 per beneficiary, which is exactly in line with the current Medicare program.

As a result, the combined annual health care costs and administrative costs for Medicare Part E are $444.8 billion. This is on the higher end of program cost ranges compared to other proposals (Collins, Davis, and Kriss 2007, Sheils and Haught 2003). However, all of the uninsured population will be covered under our proposal, and high-risk individuals will be subsidized.

4.2.6. Calculation of the Premium

A guiding principle of Medicare Part E is that premiums are nationally rated; the same premium is charged to every adult enrollee (with subsidies based on income). In calculating the premium, we take into account the current Medicare cost-sharing arrangements—including a deductible for hospitalization, 20 percent copayments under Part B, and the existing cost-sharing structure for the pharmaceutical benefit. As a result, we calculate a total premium of $3,900 for adults and $1,100 for children—so a family of four would have an annual premium of $10,000 under Medicare Part E. In comparison, the average annual family premium was $11,480 and the individual premium was $4,242 in 2006.

The government's share of the Medicare Part E premium equals 1-(%FPL)/400; therefore, the share of the Part E premium to be contributed by the individual and employer (if any) is (%FPL)/400. We start with the objective of splitting this part of the premium equally between employees and employers, with the federal government subsidizing each low-income worker. However, it is infeasible for the government to calculate separately the percent of the FPL for each employee in a firm. Therefore, our proposal would base government subsidies to each firm on the average wage at that firm. As a

TABLE 13

Estimated Premium Revenues for Adults Ages 18-64

Employment and Self-Perceived Health Status	Percent Federal Poverty Level				
	<100%	100–199%	200–399%	400+%	Totals
Average percentage contribution from:					
Employer	12.0%	32.5%	34.5%	52.5%	
Individual	6.25%	12.5%	34.5%	47.5%	
Government General Revenue	81.8%	55.0%	31.0%	0.0%	
Total contribution from: ($ billions)					
Employer	8.3	28.6	52.2	87.8	176.8
Individual	4.3	11.0	52.2	79.4	146.9
Government General Revenue	56.4	48.4	46.9	0.0	151.7
Total Revenues ($ billions)	**68.9**	**88.0**	**151.2**	**167.2**	**475.4**

Note: Numbers may not sum to totals due to rounding.

result, firms with a large proportion of high-income workers will receive a lower federal subsidy, since their average wage will be higher.

Workers above 400 percent of the FPL will still pay half of their premiums, and their employers will pay the other half. Workers below 400 percent of the FPL will pay a share of the premium equal to ½(%FPL)/400, and their employers will pay the remainder. Thus employers will pay as much as their workers in all cases and more than their workers in some cases, because the firm will pick up the remainder, regardless of the subsidies it qualifies for based on its average wage. Table 13 reflects our calculations of how the differences in employee and employer shares affect total contribution levels. We estimate that employers would contribute $176.8 billion, individuals $146.9 billion, and the federal government $151.7 billion.

Under Medicare Part E, the premium for a family earning $40,000 per year, after government and employer contributions, would amount to approximately 11 percent of its pretax income for health insurance for two adults with children. We apply our premium calculation in Table 13 to estimate total revenues for the program, but note that precise calculation would take into account the fact that firms are expected to cross-subsidize their lowest wage workers. In addition, premium revenues for children under age eighteen will be equivalent to $26.7 billion, for total premium revenues of $502.1 billion. The federal government will pay $151.7 billion of this amount (Table 13).

4.2.7. Cost Offsets and Compensating Factors

We have not included a potentially significant source of savings that comes from the reduction in the rate of individuals being uninsured. An IOM study (2003a) estimates that the economic value of a lack of insurance coverage ranges from $1,645 to $3,280 per year—between $65 billion and $130 billion aggregated for the United States (Miller, Vigdor, and Manning 2004). The IOM study also estimates the cost of increased financial risk to families without insurance—calculating that this increased risk poses an aggregate economic cost of $1.6 to $3.2 billion for uninsured Americans (IOM 2003a). A more detailed study conducted in the state of Maryland found that expenditures by and for the uninsured in that state in 2003 totaled $1.47 billion dollars—equivalent to $2,371 per full-year uninsured person in the state (Waters et al. 2007). Additionally, providers would see an increase in income as services previously provided on an uncompensated basis to the uninsured become reimbursable. The Lewin Group estimates that universal cover-

age would result in an increase in provider income of approximately $15.2 billion (Sheils and Haught 2003, Appendix E [Hacker 2001]).

4.3. What Is Not Included in the Cost Estimates

For the sake of clarity, these simulations employ several simplifications. First, medical inflation is not included. All cost estimates use 2006 dollars. Second, we do not account for pent-up demand—the expansion of insurance that leads to initial levels of utilization that are higher than normal because previously uninsured individuals use services that they wanted or needed earlier but could not afford. Third, as explained in §2, any potential federal subsidies to compensate for the effects of risk selection are not included.

5. Possible Concerns about Medicare Part E

The Medicare Part E proposal creates several analytical and political issues. Some of the analytical issues involve concerns over mandates that everyone must have health insurance coverage (§5.1), the impact of tax increases on labor market participation (§5.2), the potential crowd-out of private health insurance (§5.3), the effect of Medicare Part E on the existing Medicare program (§5.4), Medicare Part E's potential adverse impact on providers (§5.5), the ability of Medicare cost sharing to control spending (§5.6), the coverage of undocumented immigrants (§5.7), concerns about Medicaid (§5.8), the Federal Employees Health Benefit program (§5.9), state initiatives (§5.10), other Medicare expansion proposals (§5.11), and similar proposals to Medicare Part E (§5.12) In this section, we attempt to address these concerns.

5.1. Are Mandates Necessary?

Some have argued that mandates interfere with the marketplace and can have adverse employment effects. There is public concern over whether the benefits of universal coverage outweigh the costs of mandates, particularly on small employers (Bright 2007). Critics of the Medicare Part E proposal will raise the concern that any mandate—employer or individual—will interfere with the marketplace and could lower employment, especially for low-wage workers. They might also argue that low-income individuals have more pressing needs than health insurance coverage, so low-wage workers cannot afford to pay anything for health insurance coverage.

We argue that mandates are necessary if everyone is going to obtain health insurance coverage and the federal government is not going to provide the coverage directly. Previous attempts to provide financial inducements to employers or individuals to purchase health insurance have estimated that a considerable percentage of the uninsured would remain uninsured (Davis 2007, Glied 2001). One study showed that nine out of ten individuals who tried to get coverage through the individual market never bought a plan because of lack of affordable coverage or because they were turned down (Collins et al. 2006). According to estimates, providing a $7,500 tax deduction for individuals and a $15,000 tax deduction for families as proposed by President Bush may induce only a small proportion of the uninsured to obtain health insurance coverage (Collins, Davis, and Kriss 2007).

The Medicare Part E proposal attempts to minimize the impact of the mandates on low-income individuals. The amount an individual must pay is directly related to her income. While everyone with an income (as calculated by how much each person pays in Medicare taxes) will pay something, the percentage of the total premium is minimal for individuals with very low incomes. Only when the person's income reaches 400 percent of the FPL is the person paying the full premium.

Medicare Part E also attempts to minimize the impact of the mandate on small businesses. They will receive considerable federal subsidies to help allay the cost of mandated health care, especially since they tend to hire a relatively high proportion of low-income workers. Part E also places workers in small businesses in a much larger insurance pool, reducing the risk selection problems that often lead private insurers to charge small businesses premiums that are not affordable.

5.2. The Impact of the Proposal on Labor Market Participation

This proposal has the potential to affect the labor market in three ways. First, taxes will need to be increased to fund the annual subsidy. Second, the phase-out of the premium subsidies is equivalent to raising the marginal tax rate for a family of four

below 400 percent of the FPL by 12.5 percentage points. Finally, the employer mandate could affect employment if employers are not able to pass the cost of the mandate on to employees in the form of lower wages.[2] A caveat to the wage decreases and job loss due to insurance mandates is the potential benefit of providing health insurance to improve the health of employees. Better health translates to increased earnings of the employee, which could offset any wage loss due to the mandate (Hadley 2003). Although this is a less researched area, evidence suggests that improving the health of employees increases productivity, reduces employee turnover, and decreases absenteeism for the firm (IOM 2003a).

5.3. Will Medicare Part E Crowd Out Private Health Insurance?

Private insurers are currently not marketing to the uninsured and would not choose to market to them in the absence of public dollars. Since the first Blue Cross plans were founded in 1929, the private sector has not found a viable way to insure the millions of Americans who do not have health insurance coverage.

Under Medicare Part E, private insurers could benefit and collect on previously uncompensated care costs that are currently absorbed through donated time, forgone profits, and philanthropy—an estimated $7.5 to $9.8 billion annually (Dobson, DaVanzo, and Sen 2006, Hadley and Holahan 2003, Walker 2005, MedPAC 2003). By recovering these costs, private insurers could lower their prices and attract additional subscribers.

A criticism of the Medicare Part E proposal is the crowd-out of private insurers if many individuals and firms choose to obtain Medicare Part E coverage. This will be a concern primarily of insurers that write policies to individuals and small firms. Unlike some other proposals that provide a new role for the private insurers, the Medicare Part E proposal does not automatically guarantee private insurers any additional roles. Several proposals have private insurers playing a major role, including the Massachusetts and California health care reform plans, America's Health Insurance Plans, the Federation of American Hospitals, and the Health Coverage Coalition for the Uninsured (America's Health Insurance Plans 2004; Emanuel and Fuchs 2005; Federation of American Hospitals 2007; Gruber 2001; Health Coverage Coalition for the Uninsured 2007; Holahan, Nichols, and Blumberg 2001; Kaiser Family Foundation 2006b; Kendall, Lemieux, and Levine 2002; Miller 2001; Schwarzenegger 2007; Singer, Garger, and Enthoven 2001).

Under Medicare Part E, the challenge for the private sector will be to develop innovative products in order to compete with Medicare for lower prices and better quality. If the private sector is able to create a better product than Medicare Part E, then it will be able to maintain its market share. If, as alleged, the Medicare fee-for-service benefit plan and payment system is outmoded, then it should be easy for the private sector to compete effectively with Medicare Part E.

Medicare Part E would not guarantee private insurers a new role in covering the uninsured. The major arguments against guaranteeing a new role for the private insurers are that they have higher administrative costs, have not demonstrated any greater efficiency in controlling spending increases, and are more likely to engage in risk selection. For these reasons, public funds should not be used to subsidize private insurers.

However, our proposal maintains three important roles for private insurers—Medigap, Part C, and Part D. The first is supplemental coverage. Currently, there are ten Medigap plans that are available to all Medicare beneficiaries. These Medigap

2. Other common responses to mandates, like shifting work to temporary or part-time workers, would be precluded because our proposal requires all workers to be covered regardless of work status (Sinaiko 2004).

plans would also be available to the Part E beneficiaries; it is likely that some Part E beneficiaries would choose to purchase them.

The second way that health plans could participate is through the Part C program. If Medicare Part E were enacted, it would more than double the size of the Medicare program. This would allow more opportunities for health plans to participate in Medicare. The uninsured could be more likely than current Medicare beneficiaries to participate in Part C. The current Medicare beneficiaries are older, have more chronic conditions, have established relationships with doctors and other health providers, and may be more risk averse. The Medicare Part E beneficiaries will be younger, healthier, lack established relationships with most providers and may find that the managed care options are a better match to their needs. As a result, a higher percentage of the currently uninsured could choose Part C. Currently, most individuals in small firms have a limited choice of health plans; under Part E, employees would have more options and would choose Part C options (Kaiser Family Foundation and Health Research Educational Trust 2005).

Medicare beneficiaries in Part E could also enroll in prescription drug plans under Medicare Part D. Under our proposal, almost 65 million new beneficiaries would purchase drug coverage under Part D, and the private sector would be able to compete for new business.

Our proposal does not require the private sector to provide as generous a benefit package as Medicare, so a potential concern is that some health plans would have to enrich their benefit packages (Newhouse and Reischauer 2004). Hopefully, health plans will be able to find ways to offer less expensive plans than Medicare Part E with equally good or better benefit packages.

In this proposal, the minimum benefit package that private insurers would have to offer in order to qualify is not very restrictive. High deductible health plans, for example, would qualify. Firms that have employees that find this type of health insurance coverage acceptable would meet the requirement, and private insurers could continue to offer this option.

Many other proposals for universal health care have endorsed expanding programs that involve more generous benefit packages, such as Medicaid. However, we do not see an argument for why the uninsured should get better benefits than Medicare beneficiaries or many privately insured individuals.

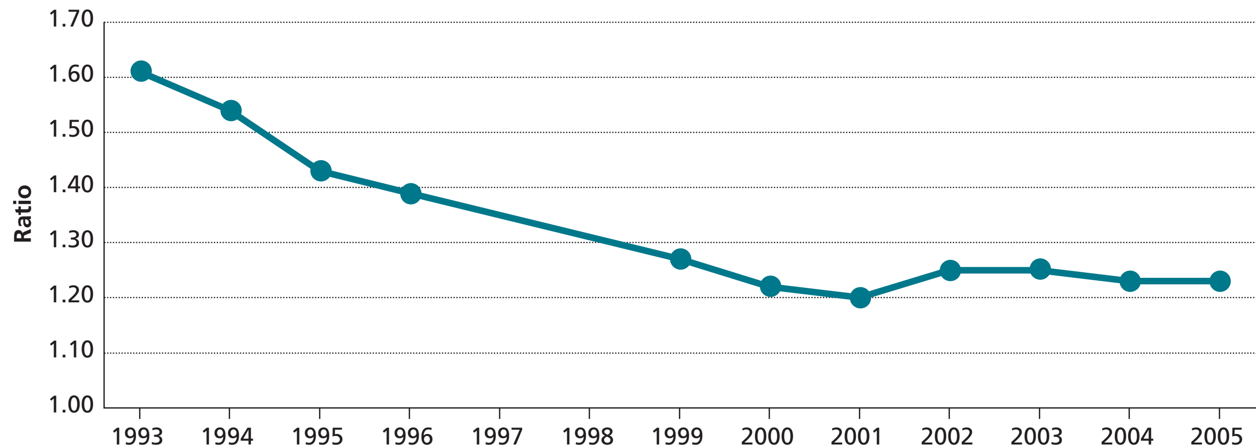
5.4. Will Medicare Part E Adversely Affect the Existing Medicare Program?

We agree that the Medicare program needs modernization. The Medicare Modernization Act of 2003 (U.S. Congress 2003) was an important first step. It began the much needed transformation of the Medicare program to one that is oriented to the needs of people with chronic conditions (Anderson 2005, Anderson and Chu 2007). We anticipate that additional changes will be forthcoming. Some of these changes are outlined in other Hamilton discussion papers (Furman 2007, Lambrew 2007).

A possible concern is that Medicare Part E would have an adverse impact on the Medicare program. On the contrary, Part E should strengthen the Medicare program. Medicare Part E is self-sustaining and is not permitted to run a deficit net of the income subsidies. Firms with large shares of unhealthy and low-wage workers, or individuals who are unhealthy or earn low wages, may be early adopters of Part E. Subsidies are built in for low-wage employees, and general revenues will be used for subsidization of firms with a large low-income population. Premiums may start high, but as more firms and individuals find Part E to be an affordable option compared to the private sector, premium growth will slow with the healthier and wealthier mix of beneficiaries in Part E.

FIGURE 2

Ratio of Private Insurer Physician Fees to Medicare Payment Rates, 1993–2005



Note: Data are not available for 1997 and 1998.
Source: MedPAC 2007, Exhibit 2B-2.

In addition, Medicare Part E could actually strengthen the existing Medicare program by giving the Medicare program additional market power with providers. Data collected by the Medicare Payment Advisory Commission (MedPAC) suggest that private insurers are paying substantially higher rates than does the Medicare program for physician services (Figure 2) (MedPAC 2007). At the present time, the Medicare program cannot lower its prices too far below the rates paid by private insurers without jeopardizing access to care for Medicare beneficiaries. A larger share of the marketplace would allow the Medicare program greater ability to constrain the rates that the Medicare program pays to providers.

5.5. Will Medicare Part E Have an Adverse Impact on Providers?

Providers continually complain about the low rates paid by the Medicare program. As shown in Figure 2, Medicare rates are lower than the private sector. As a result, most providers would prefer options that involve the private sector.

Three arguments may persuade providers. The strongest argument is that providers, including hospitals, currently receive only a small portion of their bills from uninsured patients (Dobson, DaVanzo, and Sen 2006). Under this plan, providers would receive Medicare payment rates for individuals that previously paid very little. This will substantially improve the bottom-line for many providers.

Second, Medicare rates are designed to provide the efficient provider a small profit (MedPAC 2003). Third, some providers also argue that the Medicare program forces them to incur greater administrative expenses than they incur with the private sector. However, the providers are already incurring these administrative expenses if they participate in the Medicare program. Once the providers have established the administrative apparatus to respond to Medicare rules and regulations, the marginal cost of treating additional Medicare beneficiaries will be relatively low.

5.6. Can the Medicare Program Control Spending?

The problems encountered by the Medicare program are well known. Spending is increasing at levels that cannot be sustained without significant changes in benefits, dramatic reductions in payments to providers, or tax increases (Fuchs and

Emanuel 2005). Others have suggested that Medicare is not a reasonable option for covering the uninsured because of long-standing problems with the Medicare program.

First, private insurers have been less successful at controlling health spending than the Medicare program over the past thirty-five years. Second, under Medicare Part E, the actuaries would be required to set rates that ensure that the Medicare Part E program is self-sustaining over each year.

Another concern is that the Medicare program relies heavily on regulation and stifles the marketplace. One problem with this argument is that international experience suggests that the marketplace is not effective at controlling health spending. Switzerland and the United States have two of the most expensive health care systems in the world; both countries rely heavily on private markets (Anderson et al. 2006, Herzlinger and Parsa-Parsi 2004, Reinhardt 2004). If the health insurance market was able to obtain less-expensive alternatives, then health expenditures would be lower in these two countries. At the same time, while prices paid to providers in the United States are higher, there is no evidence that clinical outcomes are better or that satisfaction is higher in countries where the health care system is more market oriented (Anderson et al. 2003, Hussey et al. 2004, Reinhardt, Hussey, and Anderson 2004, Schoen et al. 2004, World Health Organization 2000). International comparisons seem to suggest that the health care market is ineffective at controlling costs and providing quality care.

The market has failed to develop any solutions to cover the uninsured. As noted earlier, there is also evidence that the private sector pays more than Medicare for identical services in the United States (MedPAC 2003). It is also shown that the United States pays much higher prices for most goods and services used in health care (Anderson et al. 2003, Anderson et al. 2004). The U.S. private market pays higher prices for drugs and other services than the public sector pays in other countries.

Finally, the Medicare Part E option has important opportunities for the private sector. Part E will more than double the number of individuals participating in the Medicare program, thus doubling the number of individuals that might choose one of the Part C or Part D alternatives. An effective private health plan should be able to compete with the Medicare fee-for-service program and not incur the marketing expense.

5.7. What about Undocumented Immigrants?

Undocumented immigrants will not be automatically covered under this proposal. Medicare Part E would be available to anyone who pays the Medicare tax. This would provide health insurance coverage for many undocumented immigrants because they are currently paying into the Medicare program.

Certain classes of nonresident foreign nationals on temporary visas in the United States who are currently exempt from social security and Medicare taxes will continue to be exempt.[3] They may use the U.S. system, but payment is arranged as under current law. However, as current law specifies, spouses and dependents of nonresident aliens are subject to taxes if they are employed. According to the last census, there were an estimated 9.6 to 9.8 million undocumented immigrants in the United States, or approximately 25 percent of the uninsured (Camarota 2005). However, another estimate is that as few as 6 to 7 percent of nonelderly uninsured are undocumented immigrants, given that 21 percent of the nonelderly uninsured are noncitizens and 30 percent of 36 million immigrants in the United States are undocumented.[4]

3. Nonresident aliens include nonimmigrant students, scholars, teachers, researchers, trainees, physicians, au pairs, summer camp workers, and other nonimmigrants who are in the United States temporarily under F-1, J-1, M-1, Q-1, or Q-2 visas.
4. Estimate provided by Kaiser Family Foundation based on data found at www.pewhispanic.org.

The current safety net would continue to operate. Those undocumented immigrants that contribute to Medicare would get health insurance coverage and the remaining undocumented immigrants would not be any worse off. If migrant workers are granted guest worker status as a result of immigration reform and they pay Medicare taxes, then they could fall under any new individual or employer mandates.

5.8. Why Not Medicaid?

The United States has a number of publicly funded health care financing and delivery systems. For this paper, they will be divided into two main categories: financing systems and delivery systems. We will quickly dismiss the delivery systems as a viable alternative because they do not actually provide health insurance coverage. Individuals covered under these systems would still need to be enrolled in Medicare Part E or to be covered by the private sector.

Service delivery programs such as those provided by the Veterans Health Administration or the Health Services and Resources Administration (e.g., community health centers) are important programs that provide care to the insured and uninsured populations. They will need to be maintained to provide care for individuals with special health care needs and for undocumented immigrants. Under this proposal, the workload from undocumented immigrants will likely diminish because the uninsured will obtain health insurance coverage and obtain better access to medical care. However, since Medicare Part E would only be available to individuals paying taxes for the Medicare program, there will remain a need for free or low-cost providers for undocumented immigrants and nonresident aliens.

Turning now to the financing options, there are three publicly financed models available: Medicare, Medicaid, and state-only options. Each option has been proposed as a mechanism to cover the uninsured. In this section, the advantages and disadvantages of each option are compared, and the reasons why we prefer the Medicare option are explained.
Expanding the Medicaid program is often suggested as a method for covering the uninsured (America's Health Insurance Plans 2004, Feder et al. 2001, Federation of American Hospitals 2007, Health Coverage Coalition for the Uninsured 2007, Pauly 2001). Some of the reasons are historical—local provision of care to the poor is traditional in English law, and states were chosen as the embodiment of local provision in Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act. Another reason is that the Medicaid program is oriented to the provision of care for the poor.

However, there are several compelling reasons for not choosing Medicaid as the primary method for covering the uninsured. First, the Medicaid program has a very generous benefit package—much more generous than Medicare and most private sector insurers. While choosing a generous benefit package has many desirable benefits for the recipients, and while there are clear gaps in the Medicare benefit package, choosing the Medicaid benefit package would be considerably more expensive and raise the total cost of covering the uninsured. The added expense of Medicaid would partly be due to the inclusion of long-term-care coverage and limited cost sharing. As discussed earlier, we find this unappealing in part because expanding Medicaid would likely require raising provider payments. Additionally, it would be politically difficult to give the uninsured a better benefits package than are given to Medicare beneficiaries and to most privately insured people. It would increase pressure on the Medicare program and on the private sector to expand the benefit package, thereby increasing total health care spending. These changes would be necessary to make an expanded Medicaid sustainable, but they would also increase the cost considerably.

A second problem is that each state has a different Medicaid benefit package. This would mean that the benefits that the uninsured would receive would vary from state to state. If the state was financially supporting the coverage of the uninsured, then using the Medicaid program as the vehicle for cover-

ing the uninsured is understandable. However, under Medicare Part E, the state does not contribute its own funds.

A third problem with using the Medicaid program as the primary vehicle providing insurance to the currently uninsured is the low rates that many Medicaid programs pay to providers. These low rates are extremely unpopular with doctors, hospitals, and other providers. For this reason, a universal Medicaid option would be a less popular choice with providers.

A fourth problem is that Medicaid is a federal-state partnership with both the states and the federal government contributing to the program. Under most proposals to cover the uninsured (including Medicare Part E), the state government is not actually contributing to the cost of covering the uninsured. Funding comes from the federal government; states are not expected to contribute their own resources. When the federal government is providing all the funds, it is unclear why the states necessarily need to be involved.

A fifth problem with a Medicaid expansion that retains a federal-state partnership is that states have different percentages of uninsured. Table 14 shows the eight states with the highest percentage of uninsured (where two states are tied for second place and four states tied for fifth place) and the five states with the lowest percentage of uninsured in 2005 (Kaiser Family Foundation 2005a). If the differences in the percentage of uninsured were solely due to differences in state policies and spending, it might be acceptable for states to bear different cost burdens under a federal mandate for universal coverage. Nevertheless, many factors contribute to differences in the percentage of uninsured, not the least of which is the difference in the characteristics of residents among states. As such, there is little justification for why some states should pay a higher burden than other states to cover the uninsured.

Finally, some have proposed moving all low-income, nonelderly, and nondisabled individuals to Medicare, but our goal is to make the least number of changes while achieving the greatest amount of coverage. Moving this population to Medicare would require a payroll opt-out that is hard to implement. Tracking who is insured by what firm in a dual-worker family would also be difficult. This would require compliance reporting above and beyond what Medicare already does, which would add to the cost of the proposal. Also, moving current Medicaid beneficiaries to Medicare would make some individuals worse off.

TABLE 14

Distribution of Uninsured, 2005

State	Uninsured Rate (percent)
National	15
Top Eight	
Texas	24
Florida	20
New Mexico	20
Oklahoma	19
Arizona	18
California	18
Georgia	18
Nevada	18
Bottom Five	
Pennsylvania	10
Wisconsin	10
Hawaii	9
Iowa	9
Minnesota	8

Source: Kaiser Family Foundation 2005b.

5.9. Why Not the Federal Employees Health Benefit Program?

Another option is the Federal Employees Health Benefit (FEHB) plan. This plan is used to cover government workers, including members of Congress. The FEHB plan is often used as a model for covering the uninsured (Collins, Davis, and Kriss 2007). There are, however, several problems with using FEHB to cover the uninsured. First, there is an unclear benefits package in FEHB. About half of beneficiaries are enrolled in a Blue Cross–Blue

Shield plan under FEHB, and about half are in a variety of other managed care plans. Each plan participating in FEHB has a different benefit structure and uses a different payment system to pay providers. Our second argument is similar to the earlier argument about adopting Medicaid. We do not see a convincing reason for providing the uninsured a more generous benefit than Medicare. The third argument is that using Blue Cross–Blue Shield as the blueprint for a benefits package and for payment structure gives one private insurer additional market power compared to other private insurers. Fourth, the payment rates paid under FEHB are typically higher than Medicare rates, leading to an increase in the cost of covering the uninsured. Finally, there is a private sector choice for individuals who want something other than fee-for-service Medicare—Medicare Part C.

5.10. Why Not State Initiatives?

Another alternative is to enroll the uninsured in state health insurance programs. These could be the plans that are offered to state government workers or other programs established by the states.

Hawaii has the longest-operating program to cover the uninsured; recently a number of states have either passed legislation or are considering legislation to cover the uninsured in their state. The primary advantage of this approach is that states are often a laboratory for federal government health care initiatives and programs.

There are many problems with relying on states to cover the uninsured. First, Employee Retirement Income Security Act (ERISA) rules generally prevent states from involving large employers that often have more resources than small employers. Since in most states more than half of the employed population works in firms covered by ERISA, this limits the state's ability to get the largest and often the most affluent employers to contribute to covering the uninsured. A second and related problem is that many firms are multistate. This means that they can move their office, plants, and facilities to whichever state does not mandate health insurance coverage. Perhaps the most compelling argument against state-specific solutions, however, is the uneven burden across the United States in the number of uninsured. Table 14 has already shown the variation in the percentage of uninsured across the states. As a result, some states have greater burdens than other states. Nevertheless, the problem of the uninsured is primarily national and not local.

5.11. Why Not Other Medicare Expansion Proposals?

There are a variety of proposals and federal legislation that have been proposed to cover everyone under Medicare (U.S. Congress 2006a, 2006b, 2007). The Medicare for All Act (U.S. Congress 2006b), for instance, would insure everyone in the United States through the Medicare program. This would be a fundamental change from how health care is delivered in the United States. Even some of the supporters of this option agree that it is more of a concept than a realistic alternative (Hacker 2006).

One problem with the Medicare for All Act is that the tax increases necessary to support the U.S. health care system primarily though public financing would be politically and economically unacceptable. The total health spending in the United States in 2010 is projected to be $2.8 trillion. The Congressional Budget Office (CBO 2007) projects total federal revenues in 2010 to be $2.9 trillion. If health expenditures were totally supported by the federal government, nearly all the federal tax revenues in 2010 would have to be allocated to health care—clearly an unacceptable option. In subsequent years, health spending would exceed all government revenues.

Perhaps more important is that the current system works reasonably well for the wealthy and the healthy. These individuals would sharply oppose any attempt to replace their current private health insurance with Medicare coverage, because many of them would pay higher taxes but receive a less generous benefit package.

5.12. Similar Proposals to Medicare Part E

In 1991, Karen Davis recommended the expansion of Medicare to cover the uninsured (Davis 1991). The benefit package of Davis's plan would have a reduced deductible and limits on cost sharing compared to the current Medicare program. Employers would contribute at least 6 percent of workers' wages to the expanded Medicare program or to a private health insurance plan with similar benefits. Employees and all other uninsured individuals would contribute 2 percent of their family income to health care coverage, which is unfavorable for high-income individuals and families. Under the Davis proposal, states would have the option to buy into Medicare for all of their Medicaid beneficiaries. Low-income individuals would be subsidized through an earned income tax credit. Financing Davis's plan would require restructuring the Medicare trust funds and changing the current Medicare Part B premium settings. Davis's plan would be funded through premium contributions and state Medicaid funds if states decide to buy into Medicare.

Medicare Plus developed by researcher Jacob Hacker is a variation of the Davis proposal, with a few key differences (Hacker 2001). The benefits include a single deductible and wraparound services for those that have moved from Medicaid and SCHIP. Medicare Plus limits the role of private health insurers by requiring the prescription drug benefit to be provided directly by the Medicare Plus program. Employers are required to provide benefits as generous as Medicare Plus or else pay an approximate 5 percent payroll tax to participate in Medicare Plus. However, employees instead may take the employer contribution minus a penalty and purchase a private health plan with similar coverage. The movement of low-income individuals combined with the option of employees to opt out of Medicare Plus sets up the program for serious adverse risk selection.

Congress has been debating an option similar to Medicare Part E in recent years. One proposal is the AmeriCare Health Care Act (U. S. Congress 2006a). AmeriCare expands the current Medicare program while maintaining a role for private health insurers. AmeriCare covers individuals not covered by employer-sponsored health insurance, and it covers all low-income adults and children not receiving long-term care under Medicaid. This effectively dismantles the Medicaid and SCHIP programs. AmeriCare is funded by premiums, state funds previously earmarked for Medicaid, and general revenues. AmeriCare provides a benefit package that is more generous than the Medicare program with lower deductibles and out-of-pocket caps. Children, individuals, and families below 200 percent of the FPL do not have cost sharing. AmeriCare provides a sliding-scale subsidy only up to 300 percent of the FPL. Employers must cover all of their employees with a benefit package equivalent to AmeriCare or else pay 80 percent of the premium cost for AmeriCare coverage for their employees.

Most of these proposed plans, while similar to Medicare Part E in building off a well-established Medicare program, make significant changes to the current Medicare program along with other public programs of Medicaid and SCHIP. The Medicare Part E program does not make these changes and focuses simply on covering the uninsured.

6. Conclusion

Medicare Part E(veryone) achieves universal coverage by offering the current Medicare benefits to everyone. Part E is simple to understand and easy to implement, since the plan builds on existing infrastructure. Employers can buy into the plan or keep their current private insurance. Families under 400 percent of the FPL receive subsidies —an aspect of the plan that also helps keep costs down for small businesses. Although there will still be room for improvement in the health care system, Medicare Part E provides a fiscally sensible way to achieve affordable, universal, and continuous health insurance coverage.

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Dr. Anderson is currently conducting research on chronic conditions, comparative insurance systems in developing countries, medical education, health care payment reform, and technology diffusion. He has directed reviews of health systems for the World Bank and USAID in multiple countries. He has authored two books on health care payment policy, published over 200 peer reviewed articles, and testified in Congress over 35 times as an individual witness. He also serves on multiple editorial committees.

Prior to his arrival at Johns Hopkins, Dr. Anderson held various positions in the Office of the Secretary, U.S. Department of Health and Human Services, where he helped to develop Medicare prospective payment legislation.

HUGH R. WATERS
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Dr. Hugh Waters is a Health Economist and Associate Professor at the Johns Hopkins Bloomberg School of Public Health. Dr. Waters' areas of expertise are: (1) health insurance and health financing reforms; (2) evaluation of the effects of health financing mechanisms on access, equity, and quality; and (3) economic evaluation of health care interventions. He has strong skills in statistical and econometric analysis and in modeling health care outcomes.

Dr. Waters has 19 years experience working with public health programs and has worked extensively as a consultant with the World Bank, World Health Organization, and other international organizations. He speaks French and Spanish fluently, and has worked in over 30 countries. He currently teaches a course on comparative health financing systems. Dr. Waters holds a Ph.D. in Public Health Economics from the Bloomberg School of Public Health and a M.S. in International Economics from Georgetown University.

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