

Achieving Universal Coverage through Medicare Part E(veryone)

HEALTH CARE RECONSIDERED

Options For Change

This proposal is one of four alternative approaches to achieving universal coverage that will be released by The Hamilton Project

WHILE INNOVATION has led to an expanded choice of technologies, drugs, and services in the American health care marketplace, it has come with a price. Those fortunate enough to have health insurance can receive very good health care, but those excluded from that system often find even adequate health care beyond their reach. About 45 million Americans were uninsured in 2005, including over 8 million children, and the numbers grow by about 1 million adults every year. Even those with insurance pay high and rising premiums and often risk disrupting or losing coverage when they change their work situations.

In a discussion paper released by The Hamilton Project, Gerard Anderson and Hugh Waters present a proposal that would give all Americans access to affordable health care coverage. Instead of requiring fundamentally new ways of operating, however, the Anderson and Waters proposal is guided by the principle that a practical and feasible reform for universal coverage should minimize disruptions and costs. Therefore, their proposal would allow individuals to keep their current employer-sponsored coverage, and it offers an affordable insurance option to all Americans through the familiar and popular model of Medicare. Their proposal achieves universal coverage by requiring individuals to acquire health insurance (with federal subsidies for low-income households) and requiring firms to provide it. By building on the history and experience of Medicare, Anderson and Waters aim to present a feasible plan that provides affordable, continuous, and efficient health care coverage to everyone.

THE CHALLENGE

Health care spending in the United States is increasing rapidly. Although U.S. health spending per capita is almost two and a half times that of the median for other industrialized countries, in 2003 the United States had fewer physicians, nurses, and hospital beds per capita than the median OECD country had. It is also tied for second to last among industrial nations in infant mortality.

Unlike nearly all industrial nations, the United States does not provide health care coverage to all of its citizens. Health insurance in the United States is provided by a complex mix of employers, private insurers, and government programs that leave many Americans without any coverage or without adequate coverage.

The employer-centric model has been the foundation of the American health care system since World War II. This foundation has weakened as workers have become more mobile, and rising health spending has driven up premiums. Just 62 percent of non-elderly Americans were covered by employer-sponsored health insurance in 2005, down from more than 70 percent in 1987. The private insurance market is therefore the only option for a growing share of America's workers, but it is a poor option for two reasons. First, individuals seeking private insurance policies often find that they are extremely expensive, exclude preexisting conditions, or deny coverage altogether. This situation occurs because the individual market does not have large risk pools.

As a result, private insurers, wary of their bottom lines, invest serious effort and resources into avoiding costly clients. Second, whereas employer-sponsored insurance receives a tax subsidy, there are no subsidies for purchasing insurance in the individual market. Meanwhile, uninsured Americans impose heavy costs on the U.S. health care system when they receive uncompensated care at the expense of taxpayers, health care providers, and ultimately individuals who must pay higher premiums to offset the unrecovered costs.

The public sector currently provides health insurance to about 30 percent of Americans, notably through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). The public sector generally has lower administrative costs than the private sector. In addition, the public sector has been able to negotiate lower prices for medical services, given its sizeable market and regulatory power. Per capita spending by public insurers has also increased at a slower rate than that of private insurers since 1970. In spite of these financial advantages, however, the U.S. government provides an inadequate safety net for many of the groups that are marginalized by the current system.

These problems are becoming more prominent on the policy agenda. Several states have taken the lead in implementing widespread insurance coverage plans, and the policy space has become crowded with myriad reform plans advanced from every imaginable direction. Even amid this political energy, however, many still consider universal coverage an unattainable goal. Anderson and Waters argue that most universal coverage plans have so many moving parts and affect so many different constituencies that it is difficult for the general public to understand them. As a result, they encounter considerable political opposition. The massive and often unavoidable uncertainties surrounding the details of how such plans will play out also may fuel political resistance, dim-

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ming the prospects for fixing a system that many agree is exclusionary, fragmented, inequitable, and overly costly.

A NEW APPROACH

Taking these challenges into account, Anderson and Waters propose a reform that leverages the public sector's strengths to ensure that everyone has access to affordable health care coverage. In short, it expands an existing and familiar program—Medicare—to serve as a cost-effective option for those not covered by other private or public insurance. The Anderson and Waters Medicare Part E(veryone) proposal achieves universal coverage by requiring all individuals to acquire health insurance (with subsidies for low-income individuals) and requiring all employers to purchase or provide it. Individuals and firms would be free to retain their current private insurance, but they would have the option of buying into Medicare Part E, thereby guaranteeing access to health insurance that is more cost-effective than almost anything offered on the private market. Under this proposal, half the population would initially be covered either by the current Medicare or by Part E. The authors predict that, over time, more and more people will choose to shift to the more efficient, cost-effective Medicare Part E.

Anderson and Waters acknowledge that further reforms are necessary to fix the many ills of the American health care system, from managing its accelerating spending to improving its overall effectiveness. Nevertheless, they argue that their proposal's goal is to provide continuous and affordable universal health care coverage to all Americans—especially those who are currently uninsured—in a feasible way. They maintain that other reform components, though much needed, should not stall progress toward a universal coverage plan, just as their plan should not preclude other concurrent reforms to further improve the system.

Medicare Part E(veryone)

Medicare Part E would provide the same benefits as current Medicare beneficiaries receive, and it would be available to the uninsured as well as to firms and individuals who want to switch into it. While Anderson and Waters acknowledge the shortfalls of the Medicare benefits package—such as high levels of cost sharing and benefits that may not be perfect for younger populations—it is their chosen basis because it provides coverage at relatively low cost and would simplify the process of switching to a new system. Over time, they envision that Medicare would evolve to serve its new population.

Medicare Part E would adopt Medicare rules and payment systems. Under the Anderson and Waters proposal, everyone would be required to buy into the Medicare program unless they had other public or private health insurance coverage. Private health plans would be eligible to provide coverage if they met minimum criteria. Firms could either buy into the Medicare Part E program—in which case all their employees would be enrolled—or could provide private health insurance to employees. Anderson and Waters note that the federal subsidies and lower administrative costs should make Medicare Part E an especially attractive option for employers (especially small businesses) and for self-employed individuals. Employees would have to participate in Part E if their employer participated in it, and individuals without employer-based coverage could enroll in Medicare Part E separately.

Every adult enrollee would be charged the same premium, regardless of health status or age, though the federal government would use general revenues to subsidize premiums on a sliding scale for individuals whose income falls below 400 percent of the federal poverty level. Working individuals would share the cost of premiums with their employers. The premium would be set to fully pay for Part E on

Key Highlights

The Proposal

The Anderson and Waters proposal extends Medicare to all Americans who do not have other public or private insurance. Features include the following:

- **Plan benefits.** Medicare Part E benefits would be the same as those offered in the standard Medicare package.
- **Mandates.** All individuals would be required to have health insurance, and firms would be required to provide it, through either Medicare Part E or private insurers.
- **Subsidies.** Individuals with incomes of less than 400 percent of the poverty level (about \$80,000 for a family of four) would receive an income-related subsidy for the Medicare Part E premium.
- **Employers' role.** Firms would decide whether all of their employees would be in Medicare Part E. Employers in Medicare Part E would split the premium cost with workers.

Benefits

- **Universal coverage.** Everyone would have access to affordable and continuous health care coverage. Universal coverage would also reduce inefficient risk selection by insurers and uncompensated care costs.
- **Lower costs.** Because of administrative savings, the premium for Medicare Part E would be lower than average premiums today (about \$10,000 versus \$11,480 for families).
- **Feasibility.** Medicare Part E would build on the extensive Medicare infrastructure and experience and would not require changes to the current health care system.

an annual basis (not counting the premium subsidies for low-income households that would be funded by general revenue).

Anderson and Waters anticipate that the Part E premium would be less expensive than the premium offered in the private marketplace because of Medicare's lower administrative costs and the lower prices negotiated with providers. Taking into account Medicare's cost-sharing arrangements, Anderson and Waters predict that the premium would be \$3,900 for adults and \$1,100 for children, giving a family of four an annual premium of \$10,000. In comparison, they report that the average annual premium for American families in 2006 was \$11,480, and for individuals was \$4,242.

Because the Anderson and Waters proposal is crafted to minimize disruptions to the current system, it does not require any changes to Medicaid, Medicare, SCHIP, the current employer-sponsored health insurance system, or the tax exclusion for employer contributions to health insurance plans. Invoking the aims of simplicity and feasibility, Anderson and Waters design Medicare Part E to be the least-invasive approach that achieves the basic goal of universal coverage.

Benefits of Medicare Part E

Anderson and Waters anticipate a variety of benefits resulting from implementation of Medicare Part E.

Universal Insurance. The coverage requirements under the Medicare Part E proposal would ensure universal coverage, which is important for several reasons. First, there is a philosophical argument that everyone should have access to basic health care, just as everyone has access to basic public education. But there are also strong economic rationales. For instance, universality should lead to more stable and lower average insurance premiums because risks would be pooled more broadly. Next, because every-

one would have insurance, people would have better access to preventive care, potentially reducing the use of more costly emergency services.

Finally, universality would mitigate risk selection problems. Currently, private insurers devote substantial resources to avoiding high-cost patients: if they do not, they risk entering an “adverse selection” cycle wherein the sickest, most costly individuals enroll in health insurance, causing costs and premiums to rise. This, in turn, leads the healthiest individuals in the insurance pool to exit, causing costs and premiums to rise again and continuing the cycle. Universal coverage alleviates these effects by bringing everyone into the system, healthy and sick. Though the private sector would still have some incentives to risk select (because they would not be serving the full pool), Anderson and Waters maintain that the public sector does not face the same profit imperatives and would have no motivation to risk select, thereby eliminating the associated inefficiencies and guaranteeing coverage to high-cost and high-risk individuals, such as those with chronic conditions.

Affordability. Finding an affordable and efficient means of providing health insurance coverage to Americans is of paramount importance in an era when health care spending is skyrocketing out of control. Anderson and Waters choose Medicare as their model for expanding coverage because they find it to be a relatively cost-effective option. Most of these savings occur in administration. The administrative costs of private insurance per beneficiary are more than three times those of Medicare (\$421 versus \$137). In addition, Medicare has done a better job of controlling health care spending on average in the past few decades than has the private sector. From 1970 to 2004, the annual rate of increase of spending per capita in Medicare was 9.0 percent, compared to 10.1 percent in the private sector. International experience also reveals that private markets are not necessarily effective at controlling health spending: two of the most expensive

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health care systems in the world are also two of the most privatized—those in Switzerland and the United States.

But the plan presented by Anderson and Waters continues to draw on private sector competition to boost the efficiency of the system. Private health insurance in both the employer and individual markets would need to meet only minimal standards to continue to exist. Medicare Part E participants could enroll in privately-run managed care options under Medicare Part C, and private insurers would continue to offer Medigap coverage and to participate in the provision of prescription drugs through Medicare Part D. Finally, the authors believe that Medicare Part E could encourage the private sector to hone its competitive edge, whether through innovative products or quality improvements, to make it competitive with Medicare’s administrative cost advantage.

Feasibility. Despite the philosophical and economic appeal of universal coverage, and the widespread adoption of universal coverage across the industrial world, prior attempts to advance universal health care in the United States have met with stiff political resistance. Anderson and Waters argue that their proposal would be feasible. First, expanding Medicare should be simple to explain to the American public, given Medicare’s high level of public recog-

Medicare Part E premiums would be set such that no long-term deficits or surpluses would be permitted.

dition. Second, the proposal requires no changes to the current system and allows people to keep their current health care coverage unless they, or their employers, choose to change it. Finally, the proposal could be implemented relatively quickly because it would use Medicare's existing infrastructure, including the same administrative bureaucracy, rules, and collection mechanisms.

Implementing Medicare Part E

Financing Medicare Part E. The primary financing mechanism for Medicare Part E is premiums. Beneficiaries with incomes above 400 percent of the federal poverty level (or about \$80,000 for a family of four in 2006) would pay a premium that reflects the full cost of insurance. In other words, Medicare Part E would break even for these participants. No long-term deficits or surpluses would be permitted. Workers would split the cost of the premiums with their employers. Lower-income beneficiaries would receive a continuous, sliding-scale subsidy paid for 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.

Enrollment and Cost Estimates. Anderson and Waters model the cost of Medicare Part E using the March 2006 Current Population Survey (CPS), the 2004 Medical Expenditure Panel Survey (MEPS), and an extensive review of the literature. Taking into

account that those who are unemployed, in poorer health, and uninsured are more likely to enroll, they predict that Medicare Part E would initially enroll 121.3 million beneficiaries. They estimate that the net cost of the program to individuals, employers, and government, including the subsidies for low-income individuals and after \$60.2 billion in patient cost sharing (deductibles and copayments), would be \$444.8 billion.

Questions and Concerns

Are Mandates Necessary? Anderson and Waters argue that mandates for individuals to carry health insurance are necessary to achieve truly universal coverage. They point out that past attempts to encourage individuals to purchase health insurance without mandates have failed to significantly boost coverage. In that vein, estimates suggest that President Bush's recent plan, which would extend a \$7,500 tax deduction on health insurance for individuals and a \$15,000 tax deduction for families, would induce only a small proportion of the uninsured to purchase insurance.

Some argue that mandates have potential downsides: for example, firms may hire fewer low-wage workers, and low-income individuals may struggle to pay for health insurance. However, Anderson and Waters believe that the labor effects would be small, especially because employers would have access to larger and more stable insurance pools through Medicare Part E. More importantly, the subsidies are designed to minimize the financial burden of purchasing insurance for low-income individuals.

How Will Medicare Part E Affect Medicare?

Anderson and Waters believe that Medicare Part E would strengthen the Medicare program. First, Medicare Part E would be financially self-sustaining (aside from the subsidies for low-income individuals that would come out of general federal revenues).

Therefore, it would not have any effect on the current Medicare program's finances. Second, Medicare Part E could give Medicare more bargaining power with providers because it would more than double Medicare's participation numbers. Finally, Medicare Part E could encourage Medicare to improve and innovate in order to serve its much larger constituency.

CONCLUSION

The United States needs to take a bold step and join the rest of the industrial world in providing its citizens with health security. Universal coverage will not only help citizens on an individual level, but it will also improve the productivity and efficiency of the economy as workers take fewer days off work for illnesses, as risk selection inefficiencies abate, and as uncompensated emergency care costs are reduced. The Anderson and Waters Medicare Part E(veryone) proposal provides one means of achieving universal, continuous, and affordable health care coverage. By mandating individual coverage, guaranteeing access through Medicare, and subsidizing low-income individuals, Part E could cover the millions of uninsured Americans in a way that Anderson and Waters believe is both financially sustainable and practically feasible. The result would be a healthier and more productive American workforce that is better situated for the twenty-first century.

Learn More About This Proposal

This policy brief is based on The Hamilton Project discussion paper, *Achieving Universal Coverage through Medicare Part E(veryone)*, authored by:

GERARD ANDERSON

Professor, Johns Hopkins University

Anderson is currently conducting research on chronic conditions, insurance in developing countries, medical education, health care payment reform, and technology diffusion.

HUGH WATERS

Associate Professor, Johns Hopkins University

Waters' research interests are health insurance reforms, the effects of health financing mechanisms, and economic evaluation of health care interventions.

Alternative Approaches to Universal Coverage

This proposal is one of four alternative approaches to achieving universal coverage that will be released by The Hamilton Project

- **Gerard Anderson and Hugh Waters** propose extending Medicare to all firms and individuals wishing to buy into it. The reform, which includes individual and employer mandates and income-based subsidies, is designed to expand affordable coverage to everyone.
- **Stuart Butler** proposes creating state-chartered health insurance exchanges as alternatives to employment-based pooling, using employers to facilitate (rather than fully sponsor) health coverage, and reforming the tax treatment of health care.
- **Ezekiel Emanuel and Victor Fuchs** propose giving vouchers to every American for comprehensive health insurance. They argue the vouchers, funded by a value-added tax, would provide portability and promote cost effectiveness.
- **Forthcoming: Jonathan Gruber** examines the feasibility, costs, and benefits of extending nationwide the "Massachusetts model," which provides universal coverage through a combination of mandates, subsidies, and alternative insurance risk pools for purchasing insurance.

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and evidence, not ideology and doctrine—to introduce new, sometimes controversial, policy options into the national debate with the goal of improving our country's economic policy.

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THE BROOKINGS INSTITUTION

1775 Massachusetts Avenue NW, Washington, DC 20036
info@hamiltonproject.org ■ 202.797.6279

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