Medicare Part E (for "Everyone")

Jacob S. Hacker, Yale University
November 14, 2017

Medicare Part E is a new proposal for building on the Affordable Care Act (ACA).[1] It does not merely upgrade the ACA; it guarantees health care as a right through an improved Medicare program—or through improved Medicaid or a quality workplace plan.

Part E means **E**veryone: Every American should be enrolled in Medicare, automatically, without complicated eligibility processes or payment hassles, regardless of health status or preexisting conditions, unless they have another source of comparable, qualified insurance.

In addition to guaranteeing health care as a right, Medicare Part E moves us toward the international model of effective cost control. A large public plan with low administrative costs and no need to earn profits or pay high executive salaries will have greatly enhanced capacity to bargain for lower drug and medical prices. Moreover, it will create new pressures—and opportunities—for private plans to lower *their* prices, just as has occurred with Medicare Advantage plans that operate alongside traditional Medicare.

Medicare Part E encompasses three simple elements:

1. *Shared Risk*. All Americans will be automatically enrolled in improved Medicare—or, if eligible, improved Medicaid or qualified employer plans. Coverage through these sources will be continuous and seamless.

2. *Shared Responsibility.* All employers that don't provide insurance will be asked to contribute to the cost of their workers' coverage, with the payments nominal to nonexistent for smaller, lower-wage firms.

3. *Shared Progress*. Standards for insurance benefits and affordability will be improved for everyone, whether coverage is through Medicare, employer coverage, or Medicaid. These improvements will include lowering and placing a cap on Medicare's out-of-pocket costs and strengthening the ACA's standards for non-group and employment-based insurance to limit out-of-pocket expenditures and individuals' premiums. They will also include broadening and better integrating services within Medicare and establishing a Medicare drug benefit that will be able to negotiate lower drug prices. At the same time, Medi*caid* payments should be upgraded to Medicare levels over time, ensuring high levels of provider participation and access to care for Medicaid as well as Medicare beneficiaries.

The ACA made crucial progress. Now it is time to achieve the full promise of reform and fulfill the original vision of Medicare as a stepping-stone to universal insurance. We are on the cusp of a great debate: between the successful approach of Medicare and the discredited approach of expensive, incomplete, and insecure coverage grounded in a distorted private market. Medicare for **E**veryone is within our grasp—if we appreciate not only Medicare's promise, but also the challenges that proposals for expanding Medicare must overcome.

Why Medicare Part Everyone?

The Affordable Care Act (ACA) has produced tremendous achievements, including reducing the uninsured rate to the lowest level on record while contributing to a historic slowdown in medical inflation. Nonetheless, the United States' $3.2-trillion-a-year medical complex still fails to achieve what the vast majority of Americans say they want: guaranteed health care that is affordable, comprehensive, and high-quality.

This is not an unrealistic expectation. We spend far more on health care per person than any other nation. Yet because our prices are so much higher and our system so much less efficient, tens of millions continue to lack secure coverage that limits their direct costs.

We know we can do better not just because other nations do better, but also because our most successful insurance program, Medicare, does better. Medicare provides valuable and valued coverage for much less than the private sector would charge for the same protections. It works because it guarantees health care through a simple enrollment and financing system. Coverage isn't contingent on whether someone has the wherewithal or means to navigate a complex eligibility gauntlet; all eligible Americans are enrolled more or less automatically. This is what other countries do as well—for everyone.

What's more, the prices that Medicare pays providers are lower and more consistent across services, regions, and providers, and they have risen more slowly over time. This, too, dovetails with international experience: Given the need for insurance, the only proven way to restrain costs is to create "countervailing power" to push back against suppliers of medical goods (including prescription drugs) and services so they have consistent incentives to deliver affordable quality care. Indeed, commercial insurers have generally emulated Medicare's payment approaches, and Medicare Advantage (MA) plans (which enroll roughly a third of Medicare beneficiaries) are attractive and effective only because they "shadow price" the larger and more efficient traditional Medicare program.

This last point is crucial: Medicare's critics frequently argue that Medicare Advantage shows MA plans could substitute for traditional Medicare. But it is only because MA plans are small compared with Medicare that they perform generally well. When treating Medicare beneficiaries, providers are mostly paid Medicare rates. MA plans can thus pay similar rates without much risk providers will balk. If, however, private plans were the norm, providers would demand rates closer to those they receive for privately insured patients younger than 65. In other words, Medicare's ability to set prices is what makes Medicare Advantage's "market" work.

For historical reasons, however, Medicare serves this vital countervailing role only for America's elderly and disabled. Medicaid does much the same for low-income workers and their families. Meanwhile, employer-provided health insurance provides valuable benefits to approximately half of Americans. Still, far too many Americans fall through the cracks, and Medicaid can be excessively difficult to enroll in and its payments too low to attract broad provider participation. Partly as a result, our ability to use government's bargaining power to control costs—the cost-containment approach taken in all other rich nations and key to Medicare's success—is far too limited.

Why Not "Single Payer"?

In short, Medicare hits the trifecta: It is popular, familiar, and effective. Expanding Medicare is thus the natural next step toward affordable quality care for all.

The question is how. Some advocates are calling for a "single payer," in which everyone would be covered through an improved Medicare program. For all its virtues, however, this approach faces two major challenges.

First, single payer envisions displacing employer-provided insurance, through which half of Americans now receive coverage. Past debates have repeatedly demonstrated that those with coverage from their employers can be frightened by the argument—certain to be loudly and forcefully made—that their coverage will be taken away from them and replaced by government insurance that decreases the quality and increases the costs of their care. (A recent poll by the Kaiser Family Foundation found, for example, that just under half of those surveyed—47 percent, including 44 percent of those with employer coverage—incorrectly believe they would be able to keep their current coverage under single payer.)[2]

Second, because it replaces employer coverage, single payer involves enormous up-front spending and thus requires enormous new revenues. These revenues will necessarily have to involve major new taxes on the middle class. To be sure, these taxes are likely to be lower in the aggregate than existing private payments, leaving most households better off. But they will also be much more visible than today's hidden sources of financing, such as lower cash wages that offset employer premium payments and the forgone revenue due to tax breaks for employer-provided benefits. Many of those asked to pay new taxes will perceive they are being made worse off—especially after the deep-pocketed stakeholders whose interests will be gravely threatened by single payer demonize the plan.

Recognizing the role of employer-sponsored insurance and the risks of displacing it does not require ignoring its many shortcomings. Out-of-pocket costs for those with employment-based plans continue to rise despite the ACA, with almost a quarter of those covered facing more than $1,000 in such costs in 2015—up 7 points since 2005. Moreover, this out-of-pocket tally does not include workers' share of the premium, which is now close to $6,000 a year for family coverage.[3] Thirty-six percent of people aged 18-64 who *have* workplace health plans say they "feel vulnerable to high medical bills" (compared with 45 percent of those in non-group plans).[4] It is vital, therefore, to raise the standards for employment-based health insurance at the same time as employers are asked to contribute to Medicare Part E if they don't offer good coverage.

The stakes could not be higher—and they make it essential to think through both the structure of new policies and the arguments for them. Any plan to expand Medicare will be caricatured as a "government takeover." But there is a real risk that single payer could be portrayed as imposing large new tax increases while threatening the coverage of well-insured Americans. It is hard to imagine a thornier position for candidates to defend in a general election, or a better way to provoke political backlash against an otherwise popular Medicare expansion.

How Medicare Part E Solves the Puzzle

In response to these concerns, some advocates have called for a partial expansion of Medicare—say, to those between the ages of 55 and 65. If the expansion is smaller, the price tag will be lower. But so too will the extent of new coverage. More important, there is no guarantee that Medicare's expansion will not stop with the newly eligible group, as it did after its extension to the disabled in 1972—the only major categorical expansion in its history.

Furthermore, a limited expansion does not get around the problem of displacing employment-based insurance: workers would still be concerned, and policymakers would still have to figure out how to integrate workplace plans and Medicare.

Medicare Part E takes a very different route. It is designed to create a process for expanding Medicare that minimizes the costs and dislocations, while achieving much of the promise, of a one-shot transition to a universal Medicare program.

The centerpiece of Medicare Part E is the same as that of single payer: a guarantee that Medicare is there for everyone. Unlike single payer, however, Medicare Part E seeks improve employers' role rather than replace it. It does so by establishing new standards for employment-based plans and requiring that all employers contribute to Medicare if they do not provide insurance directly to their employees.

In this respect, Medicare Part E builds on the ACA's requirement that large employers provide coverage or pay a penalty. However, existing employer plans often leave workers bearing too much of the cost of care. Moreover, there is no guarantee that if a worker loses employment-based coverage, he or she will continue to be protected. By contrast, Medicare Part E upgrades the quality of workplace coverage and ensures that every worker—even those in small firms and the self-employed—is automatically enrolled in Medicare (or, if eligible, Medicaid) if they lack high-quality workplace coverage.

Medicare Part E also improves Medicare's benefits to make them more suitable for the non-elderly and more comparable to current private plans. Doing so not only addresses potential concerns among current Medicare beneficiaries that expansion of the program will adversely affect them; it also makes important overdue steps toward a better Medicare benefit package. When prescription drug coverage was added to Medicare, it should have been provided directly by the program, so that Medicare could bargain for lower drug prices as other countries and programs successfully do. Moreover, every serious analyst of Medicare believes it should include limits on out-of-pocket costs.

Similarly, Medicaid has long been in need of improvement. Medicaid's payment levels are generally inadequate. More recently, the decision by some "red states" to refuse to implement the Medicaid expansion in the ACA has left millions in limbo—ineligible for Medicaid yet too poor to qualify for subsidies for private coverage. While the Supreme Court's 2012 ruling says the federal government cannot make *all* Medicaid funding contingent on a state implementing the ACA expansion, many carrots and sticks remain to ensure every state broadens and improves its

program. The goal should be to harmonize Medicare and Medicaid, creating the potential for merging the two (with appropriate protections for low-income beneficiaries) in the future.

These changes will require new financing, of course. But because most Americans who receive employment-based insurance will continue to do so, the new costs are much more modest than those for single payer. Moreover, while retaining an important role for (affordable) workplace coverage, this proposal moves more Americans into a public plan that has low-administrative costs and no need to earn a profit or pay high CEO salaries. By extending the reach of Medicare's payment structure, and by permitting direct negotiation for prescription drug prices, it also greatly improves the overall ability of the federal government to restrain medical prices.

In 2007, a proposal with these basic elements was analyzed by the Lewin Group—an independent consulting firm with expertise in micro-simulation modeling of health care plans. Lewin estimated that 99.6 percent of Americans would be covered and that the proposal would lower national health spending and require modest new federal spending. Over time, it was projected to produce enormous savings for employers, households, states, and the federal government.[5]

How Medicare Part E Would Work

Under this proposal, everyone is assumed to be covered by Medicare. In the same way that everyone turning 65 knows they will be eligible for Medicare and can enroll through a simple enrollment process—for Part A, automatically upon receiving Social Security benefits—everyone under 65 know that they are eligible for Part E and can enroll easily and in many cases automatically.

In practice, many Americans automatically enrolled in Medicare Part E will have alternative sources of coverage, whether through Medicaid or their employer. Medicare Part E can easily determine this, and then facilitate enrollment in an alternative plan if a subscriber is eligible. For those whose employers opt to provide coverage at least as good as Medicare Part E's, Medicare will simply discontinue coverage for as long as the workers' employer indicates the worker (and his or her family, if relevant) has qualified coverage. For those who are eligible for Medicaid, Medicare Part E will transfer the insurance subscription to the relevant state agencies, resuming coverage if and when the state indicates the individual or family is no longer eligible.

Medicare Part E, and the standards set for employer coverage, will guarantee comprehensive benefits, including mental, maternal, and child health, and a prescription drug plan in which Medicare negotiates lower prices. It will also have low out-of-pocket costs as well as limits on patient out-of-pocket expenses, with special subsidies for low-income subscribers. Simultaneously, the benefit package for Medicare for the aged and disabled will be updated to directly cover prescription drugs and limit out-of-pocket costs at the same levels set for Medicare Part E, as well as cover essential health benefits that are not currently included. And, as just discussed, *Medicaid*'s payment levels will also be increased, with the federal government bearing all or most of the cost.

In addition to whatever contributions employers make, those enrolled in Medicare Part E will pay a modest premium, based on their income. This premium would range from zero for those with very low incomes to the full individual premium for those with high incomes. Based on an independent analysis of a similar 2007 version of this proposal (updated to reflect current cost levels), the full premium would be approximately $250-300 per month for family coverage.

Employers, for their part, will have a choice similar to the one they have under the ACA: They can provide qualified insurance to their worker, in line with the improved coverage standards for Medicare: insurance with low out-of-pocket costs and affordable premiums that covers all required services and has adequate provider networks. Or they can make a payment to the federal government. (If they do the latter, they also are free to supplement Medicare Part E with additional benefits.) As today, employers can distinguish between full-time (30 or more hours) and part-time workers—they can choose to cover just full-timers or both groups.

The only changes are that, first, payments made in lieu of providing coverage will be considered *contributions* rather than a penalty; and, second, firms that are making contributions will need to make them for part-time workers (on an hourly basis or percentage of payroll) if they choose to cover only their full-time employees. To ensure the federal government has an accurate record of all employment-based coverage, firms of all sizes will also be required to report to Medicare Part E if they do or do not cover their workers. However, smaller firms would not necessarily have to pay a contribution, and these contributions could be nominal to nonexistent for smaller, lower-wage firms (as was true, for example, under the House version of the ACA in 2009).

Questions and Options

As a process, rather than a fixed outcome, Medicare Part E can take several different routes, each involving important questions about how to accommodate longstanding features of American health insurance or build on more recent legacies of the ACA.

The first question is how to integrate Medicaid into the new framework. The approach advocated here is to improve the existing program. By guaranteeing universal insurance, however, this proposal will fundamentally transform Medicaid. First, all states would have to provide a benefit package at least as comprehensive as Medicare Part E's. Second, because Medicare Part E will coordinate with state Medicaid programs, everyone with a tie to the workforce will be automatically covered and transitions between the two programs will be seamless. Finally, raising Medicaid payments to providers will reduce the differences between the two programs, ensuring that Medicaid coverage on paper is coverage in fact. Alternatively, Medicaid could be folded into Medicare Part E, with state programs providing wraparound benefits, including the low out-of-pocket limits necessary to protect the health and finances of those with low incomes.

The second question is how to enroll independent contractors and the self-employed, as well as non-workers. The guarantee of secure coverage—once you are enrolled Medicare, you remain enrolled in Medicare absent proof of alternative coverage—will go a long way toward this goal. All firms should be required to report whether the people who work for them are covered, even when those workers are considered to be independent contractors. For those without ties to the

workforce, enrollment can also take place online and through public agencies and medical facilities.

Like workers, non-workers should be required to pay a premium based on income. The self-employed, for their part, should also make a contribution comparable to what employers pay on workers' behalf—again, with little or no contribution required of lower-income workers. This is similar to how the self-employed pay into Social Security.

The third question is how closely Medicare Part E should resemble the current Medicare program. In particular, should it require participation of providers who treat current Medicare beneficiaries and should it use the same payment rates? The correct answer to both questions is yes. Though providers may balk at the prospect of lower rates for some of their patients, they will receive higher reimbursements under Medicaid and the amount of uncompensated care will massively decline. Moreover, providers will see their billing processes become simpler as more of the care they provide is financed by Medicare.

There is also a strong argument for requiring that private plans that participate in Medicare Advantage offer coverage to those newly enrolled in Medicare Part E. Private plans can be a valuable alternative. But such plans should have to compete on a level playing field with public insurance; they should not be able to segment the Medicare risk pool by picking and choosing which parts of the population to insure. Nor should they be paid amounts greater than the cost of providing care to the same patients through public insurance. And they should not gain a competitive edge merely because they are the only source of comprehensive coverage for Medicare beneficiaries without supplemental insurance. Instead, all Medicare beneficiaries should receive broader benefits, including limits on out-of-pocket costs and an integrated drug benefit within Medicare.

To be sure, private plans have a poor record for cost control compared with Medicare's. Because Medicare Part E would be competing with private plans, however, these plans would have a strong new incentive to restrain their costs. They would also face greater competitive penalties for overly narrowing their networks, because they would have to compete with Medicare's enormous "network."

Less obvious but no less important, Medicare Part E could give private plans greater leverage over providers in their cost-control efforts. As already noted, private plans that cover Medicare patients pay rates very close to Medicare's. If Medicare covered more Americans younger than 65, this dynamic could play out in the rest of the market, too. After all, even the most consolidated and costly provider systems accept Medicare rates for older patients. Once Medicare Part E entered the mix, these lower rates would be paid on behalf of many younger Americans, too. For providers, the alternative to private payments would increasingly be Medicare rates for younger as well as older patients. As result, private plans would be able to lower what they paid for nonelderly patients and still attract providers.

The final question is how to build on the ACA. On the one hand, many of the ACA's core features will transition easily into Medicare Part E. Indeed, the ACA has created the infrastructure for an employer coverage requirement of the sort envisioned in this proposal. On

the other hand, the ACA's exchanges are less than ideal as a means for regulating and enrolling people in private plans. Many of the exchanges feature limited enrollment and plan participation, and Medicare has done much better ensuring that private plans take the high road. Indeed, the exchanges would be mostly superfluous in a system in which Medicare Part E enrollees could choose private plans under Medicare Advantage. Thus, adding Medicare to the exchanges could make sense as an interim step (the so-called public option), and states could be allowed to retain exchanges as a source of non-group coverage or supplemental benefits. In the end, however, a guarantee of automatic coverage through Medicare requires a national enrollment process that piggybacks on other universal or near-universal national policies, such as Social Security, Medicare, and the federal tax code.

Looking Forward

Medicare Part E ensures that all Americans are guaranteed secure, continuous, affordable coverage that is familiar, popular, and effective. It uses the bargaining power of government to keep health care prices and administrative costs in check—the only proven method of cost control. Above all, it fixes what's wrong with American health care: a set of perverse incentives grounded in a fundamental mismatch between the economics of medical care and health insurance and medical-industry-friendly policies and practices that too often put the pursuit of profits ahead of the care of patients.

Advocates of universal, affordable, quality health care will continue to debate the best way forward. Our disagreements, however, should not blind us to our shared priorities—and how much they differ from the priorities that have animated congressional debates over the past year.

We have a near-consensus that Medicare should be the foundation for expanded coverage, a recent and vital development. We agree that affordable coverage should be guaranteed as a right—that even if multiple sources of coverage continue to exist, no one should fall through the cracks. We agree that the bargaining power of a democratically accountable government can and should be used to restrain costs.

The disagreements that remain are real, but they are rooted in strategic considerations, not value differences. Our hopes for the future are shared. Our assessments of what's politically and fiscally possible (at least in the medium term) are not. Single payer represents one way to achieve our shared goals. Medicare Part E is another. And it is one that ultimately has a greater chance of overcoming the barriers to affordable quality health care that stand in our path.

It will take all the persuasion, ambition, and leadership of the strongest champions to achieve a plan like that envisioned here—guaranteed Medicare coverage alongside improved Medicaid coverage, with the ability of employers to continue providing employment-based plans if those plans meet high standards. But it can and must be done.

Notes

[1] This plan has many precursors, of course, including two proposals of my own, "Medicare Plus" (2001) and "Health Care for America" (2007); see also Gerard Anderson and Hugh Walters,

[2] Ahley Kirzinger, et al., "Data Note: Public's Views of a National Health Plan," Kaiser Family Foundation, 25 October 2017, https://www.kff.org/health-reform/poll-finding/data-note-publics-views-of-a-national-health-plan/.

[3] Bradley Sawyer, Cynthia Cox, and Gary Claxton, "Who is most at risk for high out-of-pocket health spending?" Kaiser Family Foundation, 4 October 2017, https://www.healthsystemtracker.org/brief/who-is-most-at-risk-for-high-out-of-pocket-health-spending/#item-start; "2017 Health Benefits Survey," Kaiser Family Foundation, 19 September 2017, https://www.kff.org/report-section/ehbs-2017-summary-of-findings/

[4] Liz Hamel, et al, "Survey of Non-Group Health Insurance Enrollees, Wave 3," Kaiser Family Foundation, https://www.kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/

[5] The Lewin Group, "Cost Impact Analysis for the 'Health Care for America' Proposal," 15 February 2008, http://www.sharedprosperity.org/hcfa/lewin.pdf.