Medicare Plus: Increasing Health Coverage by Expanding Medicare

by Jacob S. Hacker

Overview

Universal health insurance has been the great unfulfilled hope of American health care reformers, a siren call luring countless victims to the shoals of political defeat. One reason for this has been the inherent difficulty of outlining a compelling series of self-reinforcing policy changes that would simultaneously move the nation toward universal coverage and build political support and administrative capacity for further steps in that direction. Instead, the political constraints that American reformers inevitably confront have repeatedly pushed advocates to embrace highly categorical and complex programs that have proved durably resistant to expansion beyond their target populations.

To suggest a way out of this persistent trap, this proposal outlines a sequential approach to universal coverage—or near-universal coverage, depending on how many of the steps are taken. It takes an established program, Medicare, and shows how it might be expanded through a series of measures designed to minimize short-term disruptions to existing coverage while creating strong incentives for the formation of an inclusive social insurance program. Although constructed on familiar foundations,this proposal combines elements usually viewed as distinct: a "single-payer" plan that pools risks broadly, an "individual mandate" on Americans to obtain coverage,and a modified "play-or-pay" requirement waiving a modest levy on employers if they provide coverage. Together, these elements would encourage, rather than compel, working Americans to obtain their insurance through a common framework—a strategy that might foster a gradual movement away from employment-based insurance.

Motive and Rationale

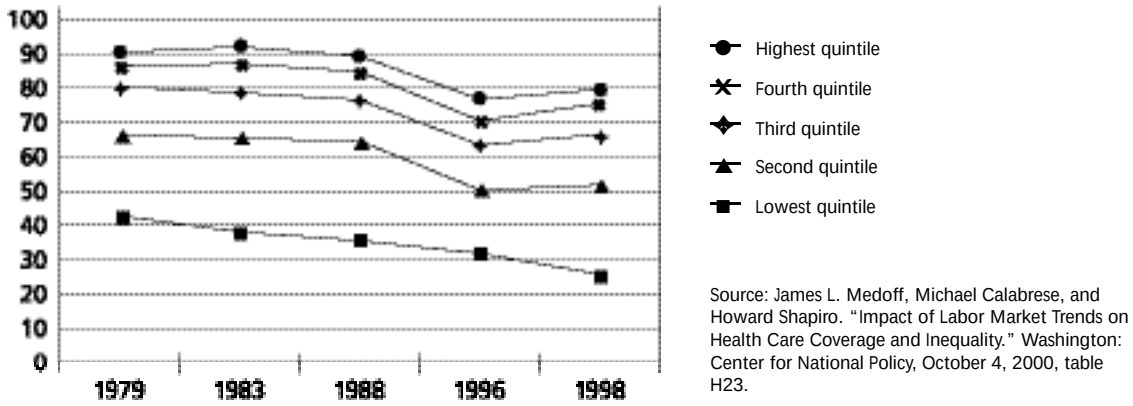
Asked to design an ideal, or even broadly acceptable, health financing structure, few would pick the patchwork of private coverage and public residual programs that exists in the United States today. Unlike citizens of other affluent democracies, most Americans rely for their health security on voluntary employer plans, with public programs only partially filling the gaps left behind. Although the tax code encourages firms to offer insurance,a substantial share of smaller and lower-wage firms do not. Even when employers sponsor health benefits, an increasing number of workers decline coverage because the expense is too great. Equally important, economists generally agree that Americans who are covered pay for workplace insurance in the form of lower wages, and this forgone income represents a growing hardship. Over the past two decades, real premiums have nearly tripled, even as most workers' real wages have risen only modestly.

These voluntary arrangements leave more than 40 million Americans without insurance, almost 85 percent of them in families headed by workers. These arrangements leave 20 to 30 million more Americans insufficiently protected against medical costs and a third of Americans without insurance at some point during a two-year period.[1] These arrangements saddle Americans with persistent uncertainty about how they will obtain protection if they change jobs or if their employer reduces cover-

[1] Stuart H. Altman, Uwe E. Reinhardt, and Alexandra E. Shields. *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?* Chicago: Health Administration Press, 1998; The Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book,* Menlo Park: Henry J. Kaiser Family Foundation, 2000.

FIGURE 1

Share of Employees* with Health Insurance from Their Own Employers, by Wage Quintile, 1979-1998



Source: James L. Medoff, Michael Calabrese, and Howard Shapiro. "Impact of Labor Market Trends on Health Care Coverage and Inequality." Washington: Center for National Policy, October 4, 2000, table H23.

*Private, nonagricultural wage and salary workers age 21–64.

age. These arrangements channel the largest tax breaks to affluent workers with generous insurance while placing the greatest burdens on lower-income workers and people in poor health. And during a period of notable prosperity, these arrangements are eroding. Ten million more Americans were without insurance in 1998 than in 1988, with the most precipitous decline occurring among low-wage workers (see figure 1). Over the past two decades, Americans have been required to pay more for their coverage and to join plans that restrict their choice of provider or limit their benefits. The insurance market continues to fragment while the financial "slack" that underwrites America's tattered medical safety net grows tighter. If no action is taken, the situation will only grow worse.

America's public insurance programs, valuable as they are for many, do not represent an effective response to the weaknesses of workplace coverage. Although Medicare reaches virtually all elderly and disabled Americans through an inclusive national program, public programs for people under the age of 65 are scattered, incomplete,and often stigmatizing. Aimed at the indigent and the especially vulnerable, these state-based programs offer meager assistance to working-poor parents and childless adults,and virtually none to workers who have coverage but risk losing it or who can barely afford the cost. Eligibility requirements and the availability of care differ dramatically across states,and millions of uninsured Americans who are *eligible* for public help do not obtain it, including hundreds of thousands of lower-income families who have lost insurance in the transition from welfare to work. Despite the push to enroll children in Medicaid and programs set up under the State Children's Health Insurance Program (S-CHIP), public coverage of children has actually dropped. Indeed, as late as September 2000, almost half of the federal money allotted for S-CHIP had gone unspent.[2]

For all the shortcomings of the American approach to the uninsured, however, the political barriers to reform are a direct outgrowth of the incomplete financing system that has arisen in the United States. As the Clinton administration learned to its misfortune,any plan that can be portrayed as a direct threat to the private protections that many Americans enjoy faces a steep uphill journey. At the same time, the existing melange of *public* programs

[2] Robert Pear. "40 States Forfeit Health Care Funds for Poor Children." *New York Times* (September 24, 2000), A1.

also vastly complicates the challenge of reform. Because programs for the non-elderly are meant to fill gaps in private coverage, there is constant reluctance to streamline enrollment or extend public insurance up the income ladder, lest public programs displace private insurance. Moreover, because these programs often provide generous coverage to recipients (at least on paper), reformers legitimately worry that replacing them with a more extensive and uniform plan will deprive some current enrollees of the benefits they now receive. Little wonder then that the road to reform has proved so rocky and the proposals put forward so maddeningly complex.

And yet most Americans believe that the current financing system fails to live up to the nation's ideals.[3] Most also deplore the significant financial burden and insecurity that this system imposes on lower-income families, the ill, and those without insurance. The proposal outlined in the following pages presents a long-term policy approach to these fundamental problems based on three principles:

1. Affordable, guaranteed coverage offering a defined package of benefits should be available to all Americans, regardless of whether their employers sponsor it.

2. Such coverage should be designed to uphold social insurance precepts, spreading risks broadly through an inclusive plan that is available to all and within the financial reach of the less wealthy and the less healthy.

3. Basic insurance coverage should be expected of all Americans as long as all have access to an affordable plan.

These principles are goals, not methods—guideposts, not prescriptions. They must be tempered by judgments about the political and administrative constraints that a successful proposal must overcome. Five such judgments guide this proposal:

1. Universal health insurance will most likely be achieved through a series of large-scale but nonetheless partial steps that will need to be calibrated over time to the responses of other actors and institutions with influence over the breadth and depth of health coverage.

2. Any proposal that is perceived as taking away or significantly raising the cost of existing private coverage, imposing huge new costs on employers or individuals, or significantly reducing the benefits of public programs, is unlikely to be enacted.

3. A successful plan must be seen as beneficial and potentially available to all Americans, not as a form of organized charity through which the many aid the few.

4. Targeting coverage narrowly on the uninsured will likely be self-defeating, reinforcing the current confused welter of programs and leaving unprotected many Americans who are uninsured, insufficiently insured, at risk of becoming uninsured, or under serious financial pressure because of the cost of coverage.

5. Any plan should be simple to understand and to enroll in, based on popularly understood and time-tested institutions, relatively straightforward to finance and administer, and subject to democratic control.

These principles and judgments underlie the proposal that follows. It envisions the sequential replacement of most state-federal public insurance programs with a nationwide program modeled after Medicare that all Americans without private coverage could enter by paying an income-related premium. The first part of the exposition lays out the fundamental features of the proposal as they would operate once fully implemented. The second part usefully complicates this neat picture by considering how the proposal might be phased in over time, and how it might attract the necessary political support to become robust legislation.

[3] To be sure, Americans' views are complex and multi-faceted. Nonetheless, a wealth of opinion research indicates that while quite satisfied with the quality (if not the cost) of personal health care, the public is quite dissatisfied with the overall structure of American health financing. See, in particular, Rosita M. Thomas. *Health Care in America: An Analysis of Public Opinion.* CRS Report for Congress 92-769 GOV, Washington: Congressional Research Service, 1992; Lawrence R. Jacobs and Robert Y. Shapiro. *Politicians Don't Pander: Political Manipulation and the Loss of Democratic Responsiveness.* Chicago: University of Chicago Press, 2000, 232–60; "A Survey of American Attitudes on Health Care Reform," conducted by the Program on Public Opinion and Health Care and Marttila & Kiley, Inc., for The Robert Wood Johnson Foundation; Altman, Reinhardt, and Shields, 1998, 27–28; Robert J. Blendon et al. "Who Has the Best Health Care System? A Second Look." *Health Affairs 14* (4): 220–30; Robert J. Blendon et al. "Satisfaction with Health Systems in Ten Nations." *Health Affairs 9* (2): 185–92; and Karen R. Donelan et al. "All Payer, Single Payer, Managed Care, No Payer: Patients' Perspectives in Three Nations" *Health Affairs 15* (2): 254–65.

The Proposal in Brief

In broadest outline, the proposal has three central components:

1. All Americans not covered by Medicare or employer-sponsored insurance would buy into an expanded Medicare program, called "Medicare Plus," by paying an income-related premium. Most would be enrolled automatically, either at their place of work or by state outreach efforts. Existing public insurance programs for the non-elderly poor and near-poor would be phased out.

2. Employers could choose to sponsor coverage at least as generous as that available under Medicare Plus or pay a modest payroll-based contribution to help fund public coverage. Workers whose employers paid the contribution would be enrolled in Medicare Plus automatically, although they could use their employers' contributions (minus a penalty) to purchase private coverage that met the same standards as workplace plans. With the exception of extremely lavish plans, employer-sponsored insurance would retain its favored tax status.

3. All Americans would eventually be asked to show proof of coverage. This could be largely done at existing decision points rather than through a separate process—when employers demonstrated that they covered their workers, when citizens were automatically enrolled in Medicare Plus, or when those automatically enrolled in Medicare Plus asked to opt out.

Before reviewing these three core elements in more depth, it is worth noting some features that the plan does *not* contain. The proposal does not mandate that employers provide comprehensive coverage. It imposes no massive payroll tax on employers that do not sponsor insurance. It does not require any employer to enroll its workers in a public plan or compel any individual to take public coverage. It does not place vast new requirements on employer-sponsored plans and,indeed, would mean higher costs for few employers that currently offer coverage. It does not eliminate the favorable tax treatment of health benefits. It does not impose major new regulations on private insurance. It has no new insurance pools, no complicated new tax subsidies, no complex new system of contracting or risk adjustment. It does not restrict the growth of private health spending. Indeed, it forswears essentially all new direct interventions in the private insurance sector.

This is not to deny that this proposal would bring a sea change in U.S.health financing—and for the better. All Americans currently eligible for public coverage would join an inclusive insurance pool that would allow them to obtain services from nearly all providers in their region (or to enroll in a qualified private health plan that contracted with Medicare Plus, much as private plans contract with Medicare today). Most smaller and lower-wage employers would likely decide that they would rather pay a modest payroll assessment than sponsor coverage,allowing their workers to receive subsidized coverage through Medicare Plus. Employers that still provided coverage would have to meet minimum standards, and any American without workplace coverage, even those turned down by private insurers, could buy into Medicare Plus. The plan's simple structure would make it easy to understand, efficient to administer, and a visible target for enrollment efforts. As a very large payer using Medicare's basic instruments, Medicare Plus would also have the capacity to ensure that expenditures were controlled and that enrollees always had the option of maintaining free choice of provider. In short, the nation's fragmented strategy for plugging holes in coverage would be replaced with a simple, inclusive,and familiar public plan through which all Americans without workplace insurance could buy coverage at affordable rates.

Of course, this brief sketch leaves out many thorny details that must be tackled by any reform plan. Accordingly, the following sections take up a series of critical topics: benefits, coverage, contributions and premiums, employer and state duties, administration, financing, and horizontal equity. After examining these crucial features of the proposal, I then suggest how they might be put into place through a process of "large-scale incrementalism" that reinforces, rather than retards, political support for further steps toward full implementation. Finally, I consider the reasons why—and the

conditions under which—this long-awaited journey to universal insurance coverage could become a possibility.

Benefits

The Medicare Plus benefits package would be similar to the current Medicare package. It would, however, be expected to include several benefits now fully or partially excluded from Medicare coverage — most critically, outpatient prescription drugs, preventive services, mental health services, and maternal and child health. In addition, Medicare Plus would not emulate Medicare in two respects. It would substitute a single deductible and coinsurance rate for Medicare's extremely high cost-sharing requirements for inpatient hospital care, and it would include a maximum cap on out-of-pocket spending. Finally, wraparound programs (either state or federal) would continue coverage for additional services now provided by state Medicaid programs to low-income families and children and to the working disabled. The proposal would not disturb current Medicaid arrangements for the nonworking disabled and the elderly.

Taken as a whole,therefore, Medicare Plus's benefits would be relatively modest compared with large employers' health plans, mainly because of higher cost sharing. Yet, unlike most private plans today, Medicare Plus would provide free choice of provider and place no limit on maximum benefits. And it would still be considerably more expansive than the current Medicare program. Although it would be desirable if these "extra" benefits were also gradually incorporated into Medicare, this proposal does not call for any specific changes in the Medicare benefit package. It seems likely, however, that the most important of these extra benefits—prescription drug coverage—will be incorporated into Medicare in some form within the next decade. Over time, moreover, political pressure from Medicare beneficiaries would likely push toward convergence of benefit levels across Medicare and Medicare Plus,creating the opportunity for an eventual merger. The proposal would also create a new Medicare Benefits Advisory Committee (MedBAC), an expert advisory body that would assist in designing the initial Medicare Plus benefit package, and would review the Medicare Plus and Medicare packages annually thereafter. Harmonizing the two benefit packages would be one of MedBAC's goals.

Whatever the exact benefit package chosen, it must balance competing objectives. Because Medicare Plus would be expected to enroll a large—and, most likely, growing—share of the population, the benefits that it provides need to be generous enough that enrolled Americans would enjoy adequate coverage for the services they need. If the benefits package were too minimal, moreover, all but the poorest and sickest Americans would be reluctant to enroll in the program, turning it into a potentially stigmatizing insurer of last resort. Weighing in the other direction, however, is the need to minimize both the new revenues necessary to establish the plan and the new burdens on employers that sponsor insurance. Since firms that wished to sponsor tax-favored insurance would need to provide benefits at least as good as Medicare Plus's, the benefits package should not be so generous as to require a major upgrade of most employers' health plans.

Coverage

All legal U.S. residents without qualified private coverage would be automatically entitled to Medicare Plus.[4] Enrollment would occur through three principal channels:

1. *Workplace enrollment.* The bulk of Medicare Plus beneficiaries would be enrolled automatically at their place of work when employers elected to make the payroll-based contribution instead of sponsoring tax-favored coverage. Similarly, self-employed workers would be required to show proof

[4] Arguably, undocumented workers should be treated in the same fashion as other workers, with their employers either providing coverage directly or contributing to Medicare Plus. Yet, it is difficult to conceive of a way in which to levy payroll contributions without relying on Social Security numbers, and this would seem to preclude allowing undocumented workers into Medicare Plus. Nonetheless, undocumented residents would continue to be able to use emergency and other services provided for under current law, and a portion of disproportionate share hospital payments would be preserved to compensate medical institutions that serve large numbers of undocumented patients.

All workers and their families would be enrolled automatically in either Medicare Plus or employer-sponsored plans, so the individual mandate would have true significance only for those without ties to the workforce.

of coverage or make the payroll-based contribution themselves.

2. State enrollment. State outreach and enrollment efforts to sign up non-workers (particularly those eligible for Medicaid and other state programs) would be the second major way in which Americans joined Medicare Plus.

3. Individual buy-in. For those Americans outside the workforce who were not signed up by the states, an individual buy-in option would be available, with premiums scaled to income (but not to health risk).

Because all Americans would be eligible for Medicare Plus, the availability (in contrast to the cost) of coverage would not hinge on income or assets. Premiums would be based on income reported for tax purposes and conducted by Medicare Plus's enrollment division in coordination with the Internal Revenue Service (IRS). Thus, states would no longer have a reason to impose cumbersome and stigmatizing means tests on potential enrollees.

Coverage of an individual under Medicare Plus would be continuous unless one of two events occurred: the individual was hired by a firm that sponsored qualified coverage, or the individual chose to opt out of Medicare Plus to purchase private coverage individually. In the latter case, the individual would be asked to present an annual insurance contract that met the same minimum standards as those required of workplace coverage. Opting out would be allowed only at the time of initial enrollment in Medicare Plus and during an annual enrollment period, and exemptions would have to be renewed. If the individual worked, the mandatory employer contributions made on his or her behalf, minus 20 percent to compensate for the cost of healthy people disproportionately opting out, would be forwarded directly to the qualified plan. The individual would be expected to pay the difference with after-tax dollars. In the unlikely event that the employer payments exceeded the private premium, private plans would be allowed to rebate the difference.

All Americans would eventually be required to show proof of public or private coverage, which could be done by attaching to a federal tax return a standard form supplied by Medicare Plus and qualified private plans. All workers and their families would be enrolled automatically in either Medicare Plus or employer-sponsored plans,so the individual mandate would have true significance only for those without ties to the workforce. To reach the many in this population who do not file tax returns, states would be given powerful incentives to enroll non-workers in Medicare Plus. States would also be encouraged to subsidize Medicare Plus coverage for the temporarily unemployed, and to establish mechanisms for enrolling the uninsured in Medicare Plus when they sought care.

Contributions and Premiums

Most enrollees in Medicare Plus would be workers whose employers elected to make the payroll-based contribution rather than provide qualified coverage. This contribution would equal a percentage of wages, tips, and salaries up to the Social Security wage base (roughly $80,000 in 2001). The level of the contribution would be dictated by three considerations.First, the payroll-based contribution should be low enough that it does not impose an undue burden on low-wage firms, which are least likely to sponsor coverage. Second, the level of the contribution should ensure that Medicare Plus has substantial enrollment, with the majority of enrollees not previously enrolled in public programs. Medicare Plus would not be a public assistance program, but rather the primary source of coverage for working

Americans who now struggle to obtain or afford insurance. Finally, the employer contribution rate should be not be so high that it would impose a large new cost (in the form of lower cash wages) on poorer citizens who previously enjoyed public protections or on wealthier citizens who previously enjoyed heavily tax-subsidized coverage. These considerations all point to a contribution rate that is substantially below the average amount that employers now spend for health benefits.

The payroll-based contribution suggested here—for esthetic as well policy reasons—is 5 percent. This would be the maximum share of taxable payroll that any firm would be required to pay for health insurance. As described more fully in the section on employers, firms insuring their workers for the first time,and with very low average wages, would be eligible for steep reductions in their initial contribution rate.

For those who wish to recall the bitter debates of the early 1990s, 5 percent will seem an extremely modest levy, well below the 7 percent to 9 percent that was common in proposals then. It should be noted that these earlier rates were usually divided between employer and worker, meaning that the portion paid directly by employers was lower. Moreover, the share of wages and salaries that employers spend on health benefits has actually fallen by about a percentage point since the early 1990s. Still, a 5 percent contribution rate is significantly lower than the average share of payroll that employers now pay for health benefits.[5] This is intentional: A play-or-pay requirement with a modest contribution rate is an entirely different policy approach from the same requirement with a higher rate.A low contribution rate would protect against many of the risks and problems correctly identified with the play-or-pay design (though, of course, it does raise other concerns), and it would create powerful self-reinforcing effects that would serve to bolster the position of Medicare Plus. Nonetheless, the contribution rate should be thought of as a variable rather than an exact value. What is crucial is that the rate chosen is consistent with the goals of the proposal and with the considerations just discussed.

In addition to the 5 percent employer contribution,many workers enrolled in Medicare Plus would also be assessed a premium that would vary with income and family size. With regard to all but the poorest Americans,the level of this premium would be set so as to keep the nominal division of employer and worker responsibilities relatively similar to what it is today within firms that sponsor coverage. Economists are surely correct that, in general and over the long term, workers will end up paying much of the "employer share" through lower cash wages. Yet this impeccable economic logic runs up against the reality that most workers today do *not* recognize the extent to which they pay for health insurance through forgone wages, and most also seem to treat the distinction between employer and employee contributions as meaningful. If preserving the largely fictitious notion of employer contributions is the price that must be paid for significantly expanded coverage, it seems a small price indeed.

Medicare Plus would offer four types of coverage: *single* (individual), *couple* (individual and spouse), *single-parent family* (individual and children),and *family* (individual, spouse, and children). The amount of the premium for each type of coverage would vary with income and mechanism of enrollment and would be deducted directly from a worker's paycheck. Although there are several possible premium structures,table 1 describes a simple framework that meshes closely with the proposal's goals.

These premiums are higher than the average monthly amount that insured workers pay today for single coverage ($28, down from $37 in 1996). But they are close to the average employee payment for family coverage and to the $43.80 monthly premium that Medicare enrollees pay for Part B coverage. And many, if not most, workers enrolled in Medicare Plus would be eligible for subsidies and thus not pay the full premium.

For individuals enrolled in Medicare Plus

[5] According to the Bureau of Labor Statistics, the average private employer's health spending represents between 7 percent and 8 percent of wages and salaries. Among firms with more than 500 employees, virtually all of which sponsor coverage, the cost is closer to 9 percent of payroll. U.S. Census Bureau. *Statistical Abstract of the United States.* Washington: U.S. GPO, 1999, 331.

TABLE 1

A Possible Framework for Monthly Premiums, by Income and Coverage Type*

Income Relative to FPL**	Single	Couple	Single-Parent Family	Family
Less than 100%	No premium; cost sharing limited			
Less than 150%	No premium; cost-sharing subsidies gradually phased out			
Less than 200%	No premium			
Less than 300%	$0–50	$0–100	$0–90	$0–140
300% or more	$50	$100	$90	$140

*As with employee payments to private health plans, Medicare Plus premiums would generally not receive favorable tax treatment.The main exceptions would be cases in which premiums plus other health expenses exceeded 7.5 percent of adjusted gross income (under the income-tax deduction for extraordinary medical expenses) or in which premiums were paid with funds from a qualified "flexible spending account" set up by an employer.

** In 2000, the federal poverty level (FPL) was roughly $8,500 for an individual and $17,000 for a family of four.

through the workplace, determining premium levels would be relatively simple, because payroll-based contributions would be based on wages and thus could be used as a proxy for income. This would also be true, of course, of single-parent families enrolled through the workplace. The situation would be somewhat more complicated for *couple* and *family* coverage. If both members of the couple were enrolled in Medicare Plus through the workplace, determining eligibility would be straightforward. A married individual enrolled in Medicare Plus would simply indicate that his or her spouse was also covered, and the program would bill them as a unit for the *couple* or *family* premium, basing subsidies on combined income.[6] If, by contrast, one member of the couple worked for an employer with private insurance while the other was enrolled in Medicare Plus, estimates of joint income would be based on a combination of the employer's wage and tax filings and on self-reported income, with a reconciliation process at the time of annual tax filing. Families in this situation could elect to receive family coverage through the private employer, in which case the payroll-based contributions made would be rebated directly to the employer. Or they could elect to buy into Medicare Plus, in which case the firm with private coverage would contribute 5 percent of payroll to defray the cost of coverage under Medicare Plus.

In all cases,there would be an annual reconciliation process based on tax information to ensure that Medicare Plus enrollees had paid the appropriate premium in the previous year. Workers who overpaid would be refunded the difference, while workers who had underpaid would be charged the additional amount, which could be taken directly out of a tax refund, if applicable. In the case of major underpayments, a penalty would apply. Premiums would be based solely on income, so there would be no requirement to demonstrate limited assets to justify subsidized premiums or cost sharing.

For those without ties to the workforce, both the method for determining income and the level of premiums would necessarily differ. All non-workers, including the unemployed and recipients of public assistance, would receive subsidized coverage if their income fell below 300 percent of the federal poverty level (FPL). As with working Americans, limits on out-of-pocket spending would apply to

[6] It should be noted that the net cost would be the same if, instead of obtaining *couple* coverage, the couple paid for two *single* policies. And it would also be the same if, instead of purchasing family coverage as a unit, one member of the couple signed up for *single-parent family* coverage, and the other paid for *single* coverage.

TABLE 2

Employer Contributions, Monthly Premiums, and Rebates in Four Examples

Enrollee(s)	Income (relative to FPL)	Payroll-Based Contribution*	Monthly Premium	Rebate for Private Coverage	Cost Sharing Limited?
Single worker	$20,000 (230%)	$1,000	$15 ($180/yr)	$800	No
Family of four	$20,000 (120%)	$1,000	$0	$800	Yes
Family of four	$60,000 (350%)	$3,000	$140 ($1,680)	$2,400	No
Non-worker	$20,000 (230%)	$0	$119** ($1,430)	$0	No

* If the employing firm paid the maximum 5 percent contribution.

** Assuming the average actuarial cost of single coverage was $2,200.

non-workers with incomes up to 150 percent of the FPL, phasing out between 100 percent and 150 percent. For non-workers with incomes above 150 percent of the FPL, premiums would rise on a sliding scale from zero for non-workers at 100 percent of the FPL to the average actuarial cost of coverage at 300 percent. As described later, states would be given incentives to establish assistance programs for the temporarily unemployed. Non-workers could amend their self-reported income at any point during the year if their circumstances changed, and the same end-of-year reconciliation process would apply to non-workers as to workers.

The four simple examples in table 2 clarify these guidelines.

The Role of Employers

Although employers would be asked to take on new responsibilities, their obligations under this proposal would be inherently limited.[7] Indeed, this proposal should actually reduce costs for many large and high-wage employers by obligating all firms to pay a share of the expense of covering working spouses and by reducing cost shifting from uninsured to insured patients. As for smaller and lower-wage employers, Medicare Plus would offer an inexpensive and simple option for insuring their workers, guaranteeing that no firm would have to pay more than 5 percent of covered payroll for insurance.

Many firms, however, would pay much less. This is because lower-wage firms and firms that had not previously offered insurance would be eligible for significant reductions in their contribution rate. For lower-wage firms, the payroll-based contribution would be just 3.5 percent if average annual wages were below $15,000, 4 percent if average wages were between $15,001 and $20,000, 4.5 percent if average wages were between $20,001 and $25,000, and the full 5 percent if average wages were $25,001 or more. Firms that had not offered insurance before would also be eligible for additional rate reductions during the transition period. These transitional reductions would equal 1.5 percentage points and would be on top of the discounts for low-wage firms. Thus a low-wage firm that had not offered insurance in the past could pay as little as 2 percent of payroll for Medicare Plus coverage. To be eligible for this transitional reduction, firms would have to be in existence at the time the legislation was passed and not have sponsored insurance in any of the prior five years. This reduction would phase out over 10 years, falling from 1.5 percent in year one to 1.35 percent in year two and so on.

Besides the level of the payroll-based contributions, the potential burdens on business depend

[7] I assume that public employers would be treated in the same way as private ones, but they could simply be required to sponsor coverage meeting minimum standards, since essentially all do now.

upon three key aspects of the proposal: (1) the nature of the minimum requirements on coverage; (2) the complexity of administration and compliance; and (3) the rules for coverage of part-time workers, employees' dependents, and departing workers. In each area, this proposal offers the maximum possible flexibility consistent with the goal of ensuring that all workers and their dependents receive health insurance.

Minimum Requirements on Coverage

The relatively modest Medicare Plus benefits package would become the benchmark against which employer-provided health plans were judged. Firms that did not offer coverage that was at least equivalent to Medicare Plus's protections would be required to make payroll-based contributions to Medicare Plus. Such coverage would not receive special tax treatment.

"At least equivalent" does not mean "identical." Indeed, most employer-sponsored health plans are already more generous than Medicare Plus would be and are likely to remain so. Rather, employer-sponsored plans would have to meet criteria similar to those that currently apply to private health plans contracting with Medicare: Private plans would be required to include all Medicare Plus covered services, but could include additional benefits. Compliance would be assessed by the Department of Labor and the IRS, using congressionally approved guidelines. These enforcement procedures would build to a certain extent on current law. Federal regulations already require that plans furnish a description of benefits to the Secretary of Labor, and that plans with more than 100 participants file a detailed annual return with the IRS (Form 5500).

Administrative and Compliance Requirements

To the fullest extent possible, this proposal would rely on existing administrative and enforcement mechanisms rather than new ones. In particular, the choice of payroll-based contributions as a major financing mechanism builds on the well-developed system for collecting Federal Insurance Contributions Act (FICA) taxes for old-age and survivors' insurance, disability insurance, and Medicare. On top of the 6.65 percent FICA tax that employers already pay, firms that did not sponsor private coverage would contribute an additional 2 percent to 5 percent of covered wages. Somewhat more complicated, they would also have to deduct the Medicare Plus premium from paychecks and report these withheld contributions on tax statements. Because premiums would be based on income, formulas for estimating premiums based on current wages and self-reported income would be straightforward to develop. For instance, a new line could be added to worksheets for calculating workers' automatic tax withholding (W-4 forms) to determine if workers had additional income that might change their premium.

Existing mechanisms would also be expanded to assess whether employers were exempt from the payroll-based contributions. The IRS is already charged with determining whether employer-provided health benefits qualify for favorable tax treatment. Under this proposal, the IRS's role would expand in three main directions. First, the IRS would assess whether employers actually sponsored insurance for their workers and dependents. Second, the IRS (in concert with the Department of Labor) would judge whether this coverage met the minimum standards necessary to allow the employer to be exempt from payroll-based contributions for the following tax year. Third, the IRS would become the conduit between enrolled workers and Medicare Plus, collecting payroll-based contributions and premiums while recording plan exit and entry. Accordingly, firms would be required to notify the IRS when workers entered or left their employ. All these duties would be compatible with existing IRS procedures and could be carried out using the normal tax calendar and reporting mechanisms.

The favorable tax treatment of health insurance would be largely preserved under this proposal, with two important exceptions.First, supplemental plans provided by employers whose workers enrolled in Medicare Plus would not be tax-exempt. This not only would protect against large revenue losses, but also would discourage employers from economizing by dropping insurance and providing wraparound benefits to bring coverage back up to previous levels. Second, the tax exclusion for health benefits

would be capped at a level twice that of the imputed Medicare Plus premium. (A more complicated alternative, which would account for regional premium variations, would be to cap the level at twice the average amount paid by Medicare Plus to contracting private plans in a given geographic area. Given how high the cap is, this seems unnecessarily complex.) All other benefits currently receiving favorable tax treatment—or slated to receive it, as with the deductibility of premiums for the self-employed—would continue to do so.

Coverage Rules

Employers that did not make payroll-based contributions to Medicare Plus would be required to offer comparable insurance coverage to all of their employees as well as their employees' spouses and non-working children under the age of 23. They would also be required to automatically enroll all of their workers in one or more qualified health plans, allowing individuals to opt out only if they had alternative coverage. In practice, this would mean that employers could only exclude from coverage a worker who had a family policy through Medicare Plus (in which case the firm would contribute 5 percent of the worker's payroll to Medicare Plus) or through another employer (in which case the worker would show proof of private coverage under another employer's plan, and the two firms would be free to arrange transfer payments, if they desired). Again, if an employer covered a spouse working for a firm that did *not* sponsor private insurance,the non-sponsoring firm's 5 percent contribution would be transferred to the other employer. Similar rules would apply to workers with more than one job. For example, if one employer of a worker with two jobs provided private coverage and the other did not, the latter employer would contribute 5 percent of covered payroll to pay for the private policy.[8]

The minimum share of private premiums that employers would be required to contribute would vary with the type of coverage and the number of hours an employee worked.[9] For employees who worked more than half-time, the minimum share would be three-quarters of the premium for single coverage and two-thirds for family coverage.[10] (If an employer offered multiple qualified plans, the contribution floor would apply to the lowest-cost plan.) For employees who worked between one and 20 hours a week, the minimum share would be lower, though exactly how much lower is hard to say, because the requirement would need to be sensitive to estimated effects on employer and worker spending. One possible approach would be to have the share fall by a percentage point for each hour fewer than 20 worked per week. An employee who worked 10 hours a week, for example, could be asked to pay as much as 35 percent of the premium for single coverage and 43 percent for family coverage. This would lower the expense of part-time workers without creating incentives for firms to increase reliance on such workers to evade coverage requirements. A weakness of many past plans that relied on an employer mandate or play-or-pay requirement is that they would have drastically reduced the cost of insuring part-time workers, encouraging firms to hire part-time workers or limit existing workers' hours.

This proposal would maintain the Consolidated Omnibus Budget Reconciliation Act (COBRA) con-

[8] These rules are less complex than they may appear at first. Recall that a worker whose employer did not offer coverage would be automatically enrolled in Medicare Plus. If that worker had coverage from another employer, he or she would simply notify Medicare Plus and show proof of coverage, and Medicare Plus would transfer the payroll contribution made by the first employer to the second. The same is true in the case of spousal coverage. A worker enrolled in Medicare Plus who had alternative coverage through a spouse would ask to decline Medicare Plus coverage and show proof of private coverage, and Medicare Plus would transfer the worker's contribution to the sponsor of the spouse's plan. To be sure, this approach carries the risk that some workers will not report alternative coverage and simply remain in Medicare Plus (or take coverage from both sources). At least among those who are paying a premium to Medicare Plus, however, this would seem a relatively unattractive option.

[9] Independent contractors would be treated as self-employed workers, while temporary and contract workers would have to be insured by the firm judged to be their primary employer—either the firm to which they provided services or the firm that arranged their employment.

[10] Across all employers sponsoring plans in 2000, the average share of the premium paid was 86 percent for single coverage and 73 percent for family coverage, although the average shares have been as low as 79 percent and 68 percent, respectively, over the past decade. Jon Gabel et al. "Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows." *Health Affairs 19* (5): 147–48. Under the Federal Employees Health Benefits Program, government premium contributions average just over 70 percent.

TABLE 3

Costs and Benefits of Employers' New Role

	Firms that Do Not Sponsor Insurance	Firms that Sponsor Insurance
New Costs	At least 2 percent of covered payroll for health benefits	New requirements governing level and breadth of coverage
	Reporting and compliance expenses	Cap on tax exclusion
		Reporting and compliance expenses
New Benefits	Access to low-cost coverage for workers through Medicare Plus	New payments to cover working spouses
	Ten-year transitional reductions in Medicare Plus contribution rate	Opportunity to limit cost of health benefits by paying into Medicare Plus
	Reduced cost of COBRA requirement makes coverage more affordable	Reduced cost of COBRA requirement makes coverage more affordable
	Reduction in unpaid medical bills makes coverage more affordable	Reduction in unpaid medical bills makes coverage more affordable

tinuation requirement, but would slash its costs. Although displaced workers could obtain COBRA coverage, most undoubtedly would choose subsidized insurance under Medicare Plus, especially if state unemployment insurance programs helped with the premiums. For this reason, employers would have markedly greater reason to inform departing workers of their statutory rights than they do now, because many employees who might have taken up COBRA coverage in the past would choose Medicare Plus instead. As under COBRA, employers would be required to provide standard information describing departing workers' options.

The new costs and benefits for employers are summed up in table 3. On the cost side, employers that do not sponsor health insurance now will have to pay at least 2 percent of covered payroll for health benefits. Employers that do sponsor health insurance will have to bear new costs if their coverage fails to meet the minimum standards and they choose to upgrade it, or in the rarer event that they provide health coverage so expensive that it runs afoul of the new cap on the tax exclusion. All firms will have to comply with the proposal's modest new administrative and compliance requirements. On the benefit side, firms that do not now provide coverage will be able to purchase low-cost coverage for their workers through Medicare Plus and will be eligible for transitional reductions in the Medicare Plus payroll contribution. Many firms that provide coverage for working dependents of their employees will receive a new transfer payment to offset the cost. Some firms that now provide coverage may also benefit from the option of enrolling their workers in Medicare Plus, which would effectively cap their direct obligations. The cost of COBRA continuation coverage will also be dramatically reduced, and all firms will benefit from the reduction in unpaid medical bills incurred by the uninsured.

The Role of the States

This proposal would end Medicaid and S-CHIP as we know them. Those now eligible for Medicaid and S-CHIP with ties to the workforce would be covered by Medicare Plus or employer-sponsored plans. For

eligible non-workers, the role of the states would largely be transformed from a provider of insurance into a portal for coverage under Medicare Plus. Nonetheless, states would still retain a substantial role. This role would, in important respects, be financial.States would be required to make "maintenance-of-effort" payments to Medicare Plus equal to their existing and projected spending on Medicaid and S-CHIP benefits for children, non-elderly adults, and the working disabled. Yet states would also serve vital administrative and enrollment functions. Not only would they be expected to continue to finance long-term care for eligible populations, they also would be responsible for (1) enrollment of non-workers, (2) provision of wraparound coverage, and (3) subsidization of Medicare Plus premiums for the unemployed.

Enrollment of Non-Workers

Although many Americans eligible for Medicaid and S-CHIP would be automatically enrolled in Medicare Plus through their place of work, states would be given strong incentives to enroll the remaining uninsured in the program. These incentives would come in the form of reductions in the state's maintenance-of-effort requirement. For each uninsured person previously eligible for Medicaid or S-CHIP that a state enrolled in Medicare Plus,the state's maintenance-of-effort payments would be reduced by an amount proportional to previous state per capita spending. This credit, in effect, would give states that had expanded coverage in earlier years comparatively greater scope to reduce their financial responsibilities. In addition, of course, states would directly reduce their spending on Medicaid or S-CHIP by shifting beneficiaries into Medicare Plus. For non-workers not previously eligible for Medicaid or S-CHIP, a smaller credit would be awarded. A portion of prior Medicaid spending would also be earmarked for ongoing outreach efforts, with costs shared between the federal government and the states,as under current law.

Provision of Wraparound Coverage

An important principle of this proposal is that current recipients of public coverage should not receive less generous benefits than they do now—although, of course, some would be paying a portion of the cost of coverage that they currently receive free or virtually free. It is important, therefore, that wraparound coverage be available to provide those eligible for Medicaid with benefits that are not included in Medicare Plus or are not commonly covered by employer-sponsored health plans. This wraparound coverage would be provided to former recipients who continued to meet their state's income eligibility criteria. It would also be provided to all those automatically eligible for Medicaid coverage under federal law.[11] Employers of workers likely to fall into either category would be informed that no-cost supplemental policies were available.

In providing wraparound coverage, the states would have two options. They could continue to operate state programs to provide these benefits, with the state share of spending credited against maintenance-of-effort payments. Alternatively, they could agree to have these populations enrolled in a set of standardized federal supplements to Medicare Plus. States would be encouraged to choose the second option by generous terms: For each enrollee, the state's contribution would be equal to the (regionally adjusted) average cost of the supplemental package multiplied by 80 percent of the state's previous matching share of Medicaid spending. Thus, if a state previously paid 50 percent of expenditures, it would pay 40 percent of the cost of the supplemental package.[12] Both the state's contribution and the 20 percent savings would be credited against maintenance-of-effort payments.

Subsidization of Coverage for the Unemployed

The temporarily unemployed represent a distinct population that states could do much to help. Although workers between jobs may be eligible for COBRA coverage, they must finance the entire cost at a time when they are often under financial strain. Moreover, such workers may end up having non-

[11] Over the long term, it would be desirable if the eligibility requirements for wraparound coverage were standardized and federalized to ensure equal treatment of citizens across states.

[12] This formula is similar to the enhanced federal matching rate under S-CHIP.

trivial incomes for the year and thus be reluctant to participate in Medicare Plus out of fear that they will be asked to repay subsidies or incur a penalty. (This concern would be largely unfounded because workers could amend their expected income during the year.) Those who are between jobs and uninsured are, in short, precisely the sort of group for which a social insurance system requiring small sums to be put aside for future contingencies would be well suited. Currently, however, no such system exists.

As a response to this problem, states would be encouraged to develop a framework of subsidies for the temporarily unemployed. This system could operate in conjunction with unemployment insurance and be financed by a small surcharge on state unemployment taxes. Alternatively, states could operate federally backed low-interest loan programs paying the Medicare Plus premiums of the unemployed, with full or partial forgiveness offered to workers whose income after regaining employment fell below a specified level. At a minimum, states would be required to provide enrollment information to all recipients of jobless benefits. States that operated such programs, which would be largely self-financing, would receive a reduction in their contribution requirement proportional to the number of unemployed residents assisted.

The replacement of state insurance programs with alternative arrangements poses unavoidable challenges. This is as true of many tax credit proposals as it is of the Medicare expansion outlined here. Replacing Medicaid and S-CHIP with a refundable tax credit, for example, could easily cause some former beneficiaries to lose benefits, face higher costs, or fail to obtain coverage. By comparison, the transition process envisioned under this proposal contains only minor risks. All current Medicaid and S-CHIP beneficiaries with ties to the workforce would be automatically guaranteed coverage, and most would be eligible for generous subsidies. Virtually all of the remaining beneficiaries would be members of populations that states are required by federal law to cover—most notably, individuals who meet eligibility criteria for the former Aid to Families with Dependent Children program, pregnant women, and very poor children. At the same time, states would have overwhelming financial incentives to move these recipients into Medicare Plus. Finally, all former Medicaid beneficiaries would be guaranteed supplemental benefits through state or federal wraparound programs.

Administration

A crucial virtue of this proposal—or crucial vice, for those who harbor deep-seated animus toward the Health Care Financing Administration (HCFA)—is that it builds on well-established and time-tested institutions of administration and finance. This choice is not incidental: Medicare is a familiar and overwhelmingly popular program, Americans' famed distrust of government notwithstanding.[13] Judged across many dimensions, moreover, it succeeds admirably in covering a high-needs population that private insurers shunned almost entirely before its implementation. It has a well-developed, if not well-funded, administrative infrastructure; an established system of private administrative intermediaries; a sophisticated hospital and physician payment schedule;an improving procedure for contracting with private health plans; and,above all, an accepted and longstanding place in American medical finance. Any health policy analyst could no doubt dream up health financing systems that work far better than Medicare does. But existing and necessarily imperfect institutions—whether public programs or private benefits—should first be judged,not against rosy visions of ideal reforms, but against concrete alternatives. Expanding Medicare is the best route to inclusive and nationally comparable coverage that reaches all Americans not insured through employment.

That said, the new responsibilities inherent in this proposal will require improvements in Medi-

[13] Ninety-five percent of Americans believe it is "important" or "very important" that Medicare be preserved, putting it alongside Social Security as the cherished core of American social insurance. And among Americans within 15 years of entering the program, Medicare is more trusted as a provider of high-quality and easily accessible care than either employer-sponsored insurance or privately purchased individual coverage. Cathy Schoen et al. *Counting on Medicare: Perspectives and Concerns of Americans Age 50 to 70.* New York: The Commonwealth Fund, 1999.

Expanding Medicare is the best route to inclusive and nationally comparable coverage that reaches all Americans not insured through employment.

care's occasionally creaky administrative machinery, if only because this proposal envisions a major expansion of the program. Because Medicare's administrative costs are already quite low (less than 2 percent of total program expenditures), administrative spending could be boosted without bringing expenditures anywhere close to the administrative costs of private health plans.

Under this proposal,HCFA would have primary responsibility for Medicare Plus, as it does now for Medicare. The Social Security Administration and Treasury and Labor departments would see the expansion of their historical roles as managers of the FICA tax system and regulators of the operation and tax treatment of private health plans. As already discussed, states would also have important administrative duties related to the enrollment of non-workers in Medicare Plus and, if they so chose, the provision of wraparound coverage. With few exceptions, then, Medicare Plus would expand existing administrative institutions rather than create new ones.

Like Medicare, Medicare Plus would consist of a default fee-for-service program coupled with a system of contracts with private health plans. Medicare Plus would use existing Medicare rates, adjusted when necessary for the lower costs of the non-elderly. In service areas where Medicare coverage does not now extend, new rate schedules would be developed based on existing methodologies. Medicare Plus would contract with private health plans using procedures similar to those now used or under development by HCFA. Because enrollees in Medicare Plus are more likely to be familiar with health maintenance organizations and other private plans, and less likely to have chronic conditions, they will probably be more interested in private plans than are elderly Medicare beneficiaries. On the other hand, because Medicare Plus will cover a more comprehensive range of benefits than Medicare, Medicare Plus enrollees may have less incentive than Medicare beneficiaries to join private plans offering benefits not covered under the fee-for-service program.

Financing

Neither the payroll-based contributions nor the premiums are designed to cover the full cost of providing Medicare Plus benefits. The chief reasons for this are fivefold:

• The opposition of businesses that do not provide insurance would likely be overwhelming if the payroll-based contributions were raised to a level closer to full funding. Under this proposal, all employers would make some contribution to the cost of insurance, but none is forced to assume a large new burden.

• A higher tax, even when proportional to income, also places a significant burden on low-wage workers, who are not only least capable of paying any new levy, but also most likely to have earnings at or near the minimum wage. For these workers, new labor costs cannot be fully offset by wage cuts and may increase unemployment.

• The premiums and payroll-based contributions are set so that virtually all working and non-working participants in Medicare Plus would purchase coverage at highly subsidized rates, with lower-income participants receiving a large subsidy. This cannot be done without tapping into other funding sources.

• Relying on multiple sources of financing guards against the disruptions that might occur if any one source failed to produce the expected revenue.

• Most important from a political standpoint, multiple-source financing is essential if legislators are to minimize the visible new costs that Americans

will face. Current financing arrangements fundamentally obscure the real costs to Americans of health insurance. Any transition away from this system will require careful policy choices designed to avoid imposing large, visible, and immediate losses, and this entails sacrificing some degree of clarity in the interest of political feasibility.

The magnitude of the funding shortfall depends on three principal factors: (1) the generosity of Medicare Plus coverage, (2) the number of workers whose employers choose to make payroll-based contributions rather than to sponsor qualified coverage, and (3) the income and health characteristics of those who enroll in the program, which would influence both revenues and costs. Since the benefit package has already been discussed, the brief analysis that follows examines the second and third of these three crucial factors.

How Many Americans Will Be Enrolled in Medicare Plus?

This proposal requires firms to provide basic health coverage, but allows them to limit their financial obligations by enrolling workers in Medicare Plus. It thus incorporates the core element of the (now much-maligned) play-or-pay plans of the early 1990s, which were subject to a number of separate estimations.[14] Although this proposal differs markedly from these earlier plans, the various analyses conducted nonetheless provide some guidance as to its likely effects.

The key variable in estimating the number of working Americans who will be covered under a play-or-pay proposal is the "pay" requirement—that is, the share of payroll that employers are required to contribute to the public plan if they choose not to insure their workers. A lower contribution requirement will result in more workers enrolling in the public plan.[15] Typically, analysts have assumed that employers (and, by implication, workers) do not care whether coverage is public or private, and will choose the option that minimizes costs. This assumption seems persuasive with regard to firms that do not sponsor insurance but somewhat more questionable with regard to firms that do. After all, these latter firms sponsor insurance in the absence of any coverage requirement, presumably because of labor competition and tax policy. If workers in this firm's labor pool continued to desire private coverage, and if tax policy remained essentially the same, these employers might continue to sponsor private insurance despite being able to obtain public protections for a lower cost. Because of the significant uncertainty surrounding employer responses, forecasts based on the assumption that employers minimize costs should be considered upper-bound estimates of public plan enrollment.

Previous estimates suggest that at a 7 percent to 9 percent contribution rate, between 30 percent and 50 percent of the non-elderly population would be covered by public insurance, compared with approximately 13 percent today. It is important to recognize, however, that most of this increase is due to the movement of Americans who are uninsured or have non-group insurance into public coverage, not the transfer of workers out of employment-based health plans. Indeed, earlier estimates suggest that even at contribution rates as low as 8 percent, the share of Americans enrolled in employment-based plans would most likely increase as the uninsured and non-group insured moved into both public coverage and workplace plans.

This would certainly not be the case if the payroll contribution rate were 5 percent or lower. Still, the shift from private group coverage to Medicare Plus might not be as large as earlier estimates suggest. In

[14] For example, The Pepper Commission. *A Call for Action.* Washington: U.S. GPO, 1990; Jack A. Meyer and Sharon Silow-Carroll (eds.,). *Building Blocks for Change: How Health Care Reform Affects Our Future.* Reston, VA: ESRI, 1993; John Holahan, Marilyn Moon, W. Pete Welch, and Stephen Zuckerman. *Balancing Access, Costs, and Politics: The American Context for Health System Reform.* Washington: Urban Institute, 1991; Sheila R. Zedlewski, Gregory P. Acs, and Colin W. Winterbottom. "Play-Or-Pay Employer Mandates: Potential Effects." *Health Affairs 11* (1)(2000): 61–83.

[15] Many of these earlier estimates further assume that employers minimize their direct contributions under each option (rather than total premiums, including the share paid by workers). Yet it is not clear why the respective shares of the premium paid by employers and workers should make a difference for firm decisions (as long, of course, as both receive favorable tax treatment). Rather, employers would be expected to compare the total cost required to provide coverage via private insurance to the total cost of providing insurance under public auspices.

the first place, since the early 1990s, employers have kept health costs in check during a period of impressive wage growth. As already noted, employer health spending is lower as a share of wages now than it was a decade ago. Moreover, the recent upswing in the incidence of employment-based coverage masks a long-term decline in rates of plan sponsorship and coverage among low-wage employers. Given that the employers most likely to take advantage of the "pay" option increasingly do not provide health benefits, the expected shift from public to private coverage may well be less significant today than it was a decade ago. Finally, 5 percent represents only the mandatory employer contribution, not the total cost of Medicare Plus coverage. Workers with incomes above 200 percent of the federal poverty line would have to pay additional premiums, so the effective contribution could exceed 7 percent for workers obtaining single coverage and 8 percent for workers obtaining family coverage.[16]

Although reliable forecasts will require microsimulation modeling, a very rough high-end estimate based on earlier studies and current data is that approximately 50 percent to 70 percent of the non-elderly population would be enrolled in Medicare Plus when the program was fully implemented.[17] Put more simply, the plan would be very large—certainly larger than was contemplated (at least openly) by any of the sponsors of play-or-pay proposals in the past, when critics loudly charged that a public plan with a third of the non-elderly population was an abandonment of the American way.[18] These critics will resurface whatever the size of the public plan. But this is an area where an intuitive and widely held notion—that displacement of employment-based coverage should be avoided at all costs—is fundamentally at odds with good public policy. A large public plan should be embraced, not avoided. It is, in fact, key to fulfilling the goals of this proposal.

The virtues of a large public plan are multiple and compelling. First, a large plan enrolling a significant share of the population ensures that a diverse cross-section of Americans will be within a common insurance pool, which is essential both for the political strength of the program and to guard against the prospect that the public plan will be saddled with the highest-risk groups. Second, a large public plan facilitates cost control by simultaneously increasing the bargaining power of the public plan and the share of health costs paid by it. Third, and perhaps most often overlooked, a large public plan ensures that subsidies for coverage are available, not just to the very poor and the previously uninsured, but to near-poor and lower-middle-class workers, who are burdened the most by high premiums and at the greatest risk of losing coverage. Because the premiums of employment-based plans essentially constitute a regressive head tax, a low contribution rate and large public plan inevitably produce a more progressive distribution of the costs of health coverage than a higher contribution rate and smaller public plan.

Although anathema to the philosophy of some on the left, the notion that the public sector should cover lower- and middle-income Americans while leaving the more affluent in private arrangements is not really so exotic or threatening. Social Security's benefit formula, after all, provides income replacement rates that are far lower for high-income workers than for low-income workers, and few are surprised or dismayed that, as a result, most upper-

[16] The highest effective rate would be paid by a worker at exactly 300 percent of the federal poverty level—roughly, $25,500 for an individual and $51,000 for a family of four. With the full Medicare Plus premium set at $600 per year for an individual and $1,680 for a family, the effective rates would go up by 2.3 percentage points (600 divided by 25,500) and 3.3 percentage points (1,680 divided by 51,000), respectively.

[17] This would include all or virtually all former recipients of Medicaid and other public insurance programs (approximately 9 percent to 10 percent of the non-elderly population); nearly all of the previously uninsured (15 percent to 18 percent of the non-elderly population); 80 percent to 100 percent of Americans with non-group insurance (4 percent to 5 percent of the non-elderly population); and a third to three-fifths of Americans who are currently covered by employment-based coverage (22 percent to 39 percent of the non-elderly population). These expected enrollment rates use the high-end estimates of Zedlewski, Acs, and Winterbottom, 2000, as the low end of the range of possible effects. Data on the current distribution of coverage among the non-elderly come from the Current Population Survey tabulations of John Holahan and Johnny Kim. "Why Does the Number of Uninsured Americans Continue to Grow?" *Health Affairs 19* (4): 189.

[18] Confusingly, a chorus of criticism also raised the concern that the public plan would be too *small*—an unpopular, stigmatizing, residual plan enrolling only those on the periphery of the economy or dependent upon public assistance.

income workers obtain private supplements. In the Netherlands, about a third of citizens are allowed to remain outside the statutory health program, with no dire effects. Similar rules apply in Germany. In contrast, the traditional American approach has been to target new coverage at the bottom third of the income scale while trying not to disturb coverage among the top two-thirds. But the better approach, on both political and distributive grounds, is quite the opposite: Provide good, affordable coverage to the bottom two-thirds of Americans, and let the top one-third essentially do what they please.

Of course, critics will decry this approach as an unstoppable expansion of government's purview. But they will also argue for a minimal tax on struggling small and low-wage firms,and a lower tax will mean a larger public program. Moreover, the initial enrollment in the public plan will not be etched in stone. If the private sector keeps insurance costs down,then an increasing number of workers will be shifted back into employment-based plans. Nothing in this plan prevents employers from providing qualified coverage on their own. In contending that the scope of the public plan will inexorably grow, opponents must essentially concede that employers cannot be counted on to provide insurance or restrain the growth of private premiums.

What Will Be the Characteristics of Medicare Plus Enrollees?

In addition to the virtues just enumerated, a large public plan also addresses the second major criticism of past play-or-pay proposals: that the public plan will be subject to a devastating influx of the unhealthy. Such adverse selection is always a potential problem, but much less so when half or more of Americans under age 65 are enrolled in the public plan.

To begin with, those most likely to be moved into public coverage are probably *not* much more costly than average.[19] Although some of the uninsured are in poor health (in part because they lack insurance), many are young and inexpensive to insure. The same is true of lower-wage workers. Past estimates suggest that the overall costs of uninsured Americans should be about equal to the rest of the population once they are covered. If Medicare Plus simply enrolled all citizens up to a given wage level — say, three times the poverty level—there would be little reason to expect significant adverse selection.

But, of course, that is not what Medicare Plus would do. Employers that can obtain lower rates in the private market are free to opt out of the program, and individuals and families can elect to get back 80 percent of employer payroll contributions to purchase coverage on their own. As a result, employers with high-risk workforces would have a stronger financial incentive to pay the fixed payroll contribution than similarly situated employers with low-risk workforces, and high-risk individuals and families would be less likely to opt out of Medicare Plus than low-risk individuals and families. These responses would raise the average risk of enrollees in Medicare Plus.

For several reasons, the probable effect appears manageable. With regard to employers' behavior, the overriding determinant of the choice between public and private coverage would be average wages rather than the health characteristics of workers, because the cost of coverage is so heavily subsidized at lower wage levels. In addition, nearly all smaller firms would probably enroll their workers in Medicare Plus to avoid the large administrative and loading costs of private insurance in the small-group market. Thus, most firms that opted out would be larger groups, which would be expected to have more heterogeneous risk profiles. Moreover, to the extent that there was moderate adverse selection against Medicare Plus because high-risk groups opted in, this could be defended as the equivalent of a federal high-risk pool, protecting the private group market from the destabilizing effects of an extremely skewed distribution of risks.

[19] The only possible exception is the 12 million Americans with non-group insurance, who do appear to be above-average risks. Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks,* Washington: AEI, 1999, ch. 6; Alice M. Rivlin, David M. Cutler, and Len M. Nichols. "Cost Estimates: Authors Respond." *Health Affairs* Supplement (Spring 1994): 55; P. Anthony Hammond. "Actuarial Memorandum: Premiums in Regional Health Alliances under the Clinton Administration's Proposed Health Security Act." *Health Insurance Market Reform,* Hearing before the Committee on Finance, United States Senate, 103rd Congress, 2nd Session, February 1, 1994, Washington: U.S. GPO, 1994, pp. 102–4.

If adverse selection were more severe, several possible remedies could be adopted. An obvious solution would be to impose community rating and other reforms on the private insurance sector. But this would inspire considerable political opposition and interfere with the practices of self-insured health plans. Instead, an attractive halfway measure would be to make it more difficult for employers to shift between public and private coverage. For example, exemptions from the payroll-based contributions could be renewed on a five- or 10-year basis rather than annually, forcing employers to stay in or out of Medicare Plus for a long, continuous period. Employers could also be penalized for opting into the plan in proportion to the number of years they had stayed outside it, discouraging opportunistic switching as workforces age.

Similar remedies could be used to reduce adverse selection caused by the individual opt-out provision, but fewer problems should arise here for at least four reasons. First, those who opt out of Medicare Plus receive back only the amount that their employer contributed to the program,minus a 20 percent penalty designed to reduce adverse selection. In other words, no income-related subsidies are available for the purchase of non-group coverage. Second, private non-group coverage is, in most cases, not eligible for special tax treatment.[20] For all but very-high-income buyers,this means that a fairly substantial portion of private premiums will have to be paid with after-tax dollars. Third, opting out of Medicare Plus will require an affirmative decision and a potentially costly search. Evidence on private benefit plans suggests that, even with minimal switching costs, levels of participant inertia are very high.[21] Fourth, and finally, non-group premiums are comparatively expensive and, absent insurance reform, undoubtedly will remain so.

For political reasons, it seems prudent to allow people to leave Medicare Plus if they have qualified private coverage. Some affluent Americans will surely seize this expensive exit option,as do affluent citizens in other social insurance systems that allow it. But in practice very few Americans will find the rebate attractive.

Additional Financing

Despite the advantages of a lower contribution rate, it does have the disadvantage that it brings in less revenue per enrollee, even as it increases the size of the public plan. The amount of revenue forgone at lower contribution rates, however, is not proportional to the reduction in the rate. This is because a significant proportion of enrollees in Medicare Plus — public assistance recipients, non-workers, very-low-wage workers—would pay little or nothing toward the cost of coverage at any tax rate. Furthermore, as the tax rate goes up, fewer employers contribute to the plan, and they contribute less on average. Finally, as already discussed, adverse selection is likely to be a greater problem at higher contribution rates than at lower ones.

The contribution rate and premiums envisioned in this proposal clearly imply a significant net government cost.[22] How significant a cost is the big question. It bears noting that several features of the proposal help to keep net expenditures in check. First, all workers enrolled in Medicare Plus have a share of their wages automatically devoted to health insurance. Although this proportion is relatively modest and will cover only a small fraction of the cost of coverage at the lowest wage levels, some workers who previously received public coverage for free will now make a contribution, while some with higher earnings will pay all or most of the cost of their coverage. This differentiates this proposal from plans relying on refundable tax credits or expansions of low-income programs, because these plans typi-

[20] The exceptions are when it is purchased by the self-employed, or when premiums plus health costs exceed 7.5 percent of income, under the deduction for extraordinary medical expenses. If the opt-out provision were destabilizing Medicare Plus, however, the extraordinary expense deduction could be amended to exclude private non-group insurance premiums.

[21] Brigitte C. Madrian and Dennis F. Shea. "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior." National Bureau of Economic Research Working Paper No. W7682, Cambridge: NBER, May 2000.

[22] This is to be distinguished from a net cost to the economy as a whole. In the short term, new spending on the uninsured would raise economy-wide costs, but if Medicare Plus effectively slowed the rate of increase in health expenditures, these costs would be outweighed by savings quickly.

TABLE 4

Other Potential Sources of Revenue, with CBO Estimates

Source	Revenue, 2001-2010	Rationale
Expand Medicare to include uncovered public employees	$11.3 billion	Most excluded workers qualify for coverage on the basis of another job or their spouse's employment.
One to 10 percent "health tax" on private insurance payments or provider revenues from private sources	No CBO estimates available	Would compensate for adverse selection against Medicare Plus and ensure that high-income workers made some contribution to the program. Would also reduce externality costs of rising private health costs
Increase the cigarette tax up to 50 cents/pack	Up to $68 billion	Increasing excise taxes would reduce the health costs of smoking.
Increase the federal alcohol tax up to $16 per proof gallon	Up to $49 billion	Increasing excise taxes would reduce the health costs of alcohol consumption.
Three percent excise tax on non-retirement fringe benefits	$50–60 billion	Would reduce the subsidy for benefits without requiring the valuation of each employee's benefits.

Sources: Congressional Budget Office. *Budget Options.* Washington: Author, March 2000; Sherry Glied. *Chronic Condition: Why Health Reform Fails.* Cambridge: Harvard University Press, 1997, ch. 8.; Sheldon D. Pollack. "It's Alive." *American Prospect 11* (17) (July 31, 2000).

cally raise little or nothing directly from recipients.

Second, this proposal limits new subsidies for coverage to those insured by Medicare Plus. Although the rationale for this feature is discussed in the next section, the important point to note is that it further reduces the budgetary costs of the plan.

Third, the proposal eliminates federal spending for S-CHIP and for some portions of the Medicaid program, while recapturing a large share of previous state spending for these purposes (as well as unspent S-CHIP funds). By vastly reducing the strain on providers that serve low-income communities, it would also allow for a significant reduction in federal and state spending on disproportionate share hospital payments.

Fourth, the proposal will naturally create three positive revenue effects: a reduction in tax subsidies for workers who shift from tax-favored private coverage into Medicare Plus, a reduction in tax subsidies now realized by people who purchase very expensive health coverage, and a long-term increase in payroll and income tax receipts caused by the substitution of wages for health benefits among firms that pay less for insurance than they would have without reform.

Nonetheless, additional financing will be needed. A significant share could come from the 10-year budget surplus, roughly $1 trillion of which is due to the recent slowdown in the growth of Medicare and Medicaid.[23] Table 4 lists a handful of additional sources of revenue that could potentially be tapped. (The list is illustrative, not exhaustive.) All receipts

[23] Karen Davis, Cathy Schoen, and Stephen C. Schoenbaum. "A 2020 Vision for American Health Care." *Annals of Internal Medicine 160* (22) (2000).

would be transferred directly into a dedicated Medicare Plus trust fund that would have access to permanent budget authority, allowing budget resources to be spent without new legislation.[24]

Fiscal Sustainability

Programs need to do more than get up and running; they must also be fiscally sustainable over time. Given that medical cost escalation has fairly consistently outpaced wage growth, is there any reason to expect that a public program covering a defined set of benefits would be able to continue into the future, absent huge tax increases? And what assurances are there that the surplus that now makes general revenues look attractive won't evaporate in the future, forcing a Darwinian struggle among a rash of underfunded programs? The second question has an easy answer: There is no assurance that any program, even one financed solely by earmarked contributions and possessing entitlement status, will not confront future fiscal pressures. The suggestion that general revenues should finance a portion of Medicare Plus reflects twin policy judgments: first, that the surplus is due in substantial part to reductions in Medicare and Medicaid spending; and, second,that the program should not be financed solely by payroll levies, which would impose excessive costs on lower-wage workers and the firms that employ them. It also reflects a political judgment that Medicare Plus will be large and popular enough to weather potential fiscal storms.

The broader concern about fiscal sustainability is more serious. Here too, however, important features of Medicare Plus promise to keep its costs manageable over time. In the first place, affected businesses will put heavy political pressure on Congress to minimize the payroll-based contributions. Although these contributions are not the only financing source, keeping them at modest levels will act as an effective restraint on program growth. It will also ensure that Medicare Plus enrolls a significant share of the workforce, maximizing the program's ability to use its concentrated purchasing power to keep medical expenditures in check.

Indeed, if sustainability is a concern, it applies equally well to private-sector spending. Medical costs that rise consistently faster than the economy as a whole translate into a growing share of national income devoted to health care, whether those costs are financed by public or private sources. There is no compelling reason to expect that Medicare Plus would be more profligate than the private sector. To the contrary, if Medicare's experience since the early 1980s is any guide, Medicare Plus should be at least as capable of controlling costs as private health plans—indeed, based on the past few years of essentially zero growth, significantly more capable. But if employers did hold down costs more effectively, then private insurance would become increasingly attractive compared with Medicare Plus. And if, by contrast, private health premiums were not kept in line,an increasing share of employers would enroll their workers in Medicare Plus. In short, the structure of the proposal ensures that the sector most capable of controlling costs gains a larger share of the population. It does so, moreover, in a context in which minimum standards for coverage and strong protections for lower-wage workers would ensure that cost containment did not simply equal cost shifting.

Horizontal Equity

The financial architecture of this proposal raises the important issue of "horizontal equity," the notion that similarly situated Americans should be treated similarly. Under this proposal, Americans with incomes below 300 percent of the poverty level would receive highly subsidized coverage if their employer elected to make payroll-based contributions to Medicare Plus, but only existing federal tax subsidies if they did not. Thus, a low-income worker whose employer sponsors coverage would receive significantly less in federal subsidies than a similarly situated worker enrolled in Medicare Plus.

This problem could be rectified by providing

[24] Some may find it strange to create a trust fund when full funding for Medicare Plus would not come from earmarked payroll taxes. But this is quite consistent with the financing of many existing trust funds, including Medicare's Part B trust fund, which is financed principally by general revenues. See Eric M. Patashnik. *Putting Trust in the U.S. Budget: Federal Trust Funds and the Politics of Commitment.* New York: Cambridge University Press, 2000.

In practice, nearly all smaller and lower-wage employers would likely choose to contribute to Medicare Plus rather than provide coverage on their own.

additional subsidies for health coverage to low-income workers who receive coverage from their employer—or, if desired, who purchase coverage on their own. But providing income-related subsidies to all workers would be complicated (would subsidy amounts vary by region, for example, or with the health characteristics of workers?),and it could raise costs dramatically. It would also, of course, discourage employers with low-wage workers from enrolling in Medicare Plus by reducing the expense of providing employment-based coverage. This, in turn, would reduce the ability of Medicare Plus to pool risk and provide common protection to low-wage workers. In addition, there would be no guarantee that subsidies would cover a reasonable portion of the costs of coverage, as there would be under Medicare Plus. Thus, if the problem were judged sufficiently pressing, a better solution might be to further lower the contribution rate for employers insuring their workers for the first time and perhaps also for employers with very small groups or very-low-wage workforces.

In practice, nearly all smaller and lower-wage employers would likely choose to contribute to Medicare Plus rather than provide coverage on their own. For firms that had low average wages or faced very high private premiums, the potential savings offered by Medicare Plus's fixed contribution rate would be overwhelming. Low-wage workers who obtained private coverage from their employers would therefore be principally concentrated in high-wage sectors in which the payroll-based contributions were larger and employers saw advantages in providing insurance. Available evidence suggests that low-wage workers in such industries are already treated comparatively well; their rates of coverage are higher and their average contributions lower than other low-wage employees.[25]

It also should be noted that those covered by private employment-based plans would continue to receive federal tax subsidies. These subsidies are worth little to workers who face low marginal tax rates, but they are quite valuable for the higher-income workers who are most likely to remain in private workplace plans under this proposal. The break-even point at which existing federal tax subsidies would be greater than federal subsidies for Medicare Plus coverage is probably around $20,000 to $30,000 in annual income for a single worker and $50,000 to $70,000 for a family of four. (By way of comparison, the median household income in the United States is about $40,000.) In effect, then, this proposal would replace the regressive tax subsidy in current law with a subsidy structure whose benefits were distributed more equally across the income ladder, even without creating a complex new system of tax credits.

Implementation

Because this proposal builds on existing institutions, it could be implemented swiftly. Certainly the task would be no more daunting than the original establishment of Medicare, which, in the pre-digital era, went from passage to the payment of benefits in a single year. It is more realistic to expect, however, that implementation would be extended over several years and broken down into a series of discrete steps. In that context, the key issue would be whether each step increases the chance of future progress toward full implementation or, to the contrary, blunts political interest in further movement or even allows opponents to scuttle progress altogether.[26]

[25] Jon Gabel et al. "Class and Benefits at the Workplace." *Health Affairs 18* (3) (1999): 144–50.

[26] Alan Weil. "Increments Toward What?" *Health Affairs 20* (1) (2001): 68–82.

The typical American approach is to extend coverage by population group: first, the elderly; then, poor children; then, the near-elderly; then, the parents of poor children; and so on. The advantage of this approach is that it fixes political attention and public sympathy on specific vulnerable groups that, as a rule,are not expected to be able to obtain coverage on their own. But the advantages of this approach are counterbalanced by a principal disadvantage: The divide-and-cover strategy does not lend itself to ready movement beyond the target population. When public assistance for a residual group is defended as a special exception, everyone else is presumed to be well served by the status quo. At the same time, addressing the plight of the most sympathetic groups further reduces interest in a general solution. Thus, while Medicare Plus could well begin by covering a specific population, such as children, there would be no assurance that this initial step would be followed by others, and, in fact, some reason to think it would not.

A more promising route would be to phase in the components of the proposal on an extended timetable. This could be done by, for example, softening the initial requirements for employers, subsidizing firms being asked to provide coverage for the first time, exempting certain employers at the outset, or gradually moving non-workers and low-wage workers from state programs into Medicare Plus. Two features of the proposal, in particular, could be delayed or softened substantially without sacrificing its fundamental goals. The first is the limit on tax-free employer-sponsored health benefits, which would affect few existing plans but could be made even less threatening without crippling the proposal. The second is the individual mandate. Because all workers would be enrolled in private plans or Medicare Plus, while many non-workers would be former recipients of state programs who would be automatically enrolled as well, the remaining pool of the uninsured would consist principally of people who are between jobs and higher-income citizens who have chosen to forgo insurance. Covering Americans who continue to go without insurance even after being informed of the highly subsidized protections available under Medicare Plus would naturally be a lower priority than guaranteeing basic health security for low-wage workers who now lack it.

The approach I have just outlined is best termed "large-scale incrementalism," and it is similar to the strategy pursued by Medicare's original architects, who saw public coverage for the elderly as merely the first step toward universal health insurance.[27] Without adopting the highly categorical route that Medicare's architects took, it is possible to outline a comparable step-by-step agenda for full realization of this proposal that would play out over five or 10 or even 20 years following initial legislative enactment.

Step 1: Laying the Foundation. In the initial year after enactment, employers and individuals would be allowed to buy into Medicare Plus, with employers that enrolled their workers in the program making payroll-based contributions. Transitional rate reductions for employers newly insuring their workers would be made available and widely publicized. Because their value would phase out over 10 years, there would be strong incentives for employers to take advantage of these reductions immediately. States would begin the process of moving Medicaid and S-CHIP beneficiaries into Medicare Plus.

Step 2: Requiring Employer Sponsorship. In the second phase of implementation, employers that did not enroll their workers in Medicare Plus would be required to offer, but not contribute to the cost of, at least one private health plan for their workers that would have to meet very minimal standards to receive favorable tax treatment.

Step 3: Requiring Employer Contributions. In the third phase, employers that did not contribute at least half of the cost of private coverage for full-time workers would be required to do so. Over a period of years, the contribution requirement would be raised to the full cost. Simultaneously, the minimum standards for private coverage would be upgraded gradually to ensure that private plans were at least as generous as Medicare Plus.

Step 4: Closing Gaps. If a nontrivial proportion

[27] For a fuller explanation of the strategy behind Medicare and its only partial success, see Theodore R. Marmor. *The Politics of Medicare,* 2d ed. Hawthorne, NY: Aldine de Gruyter, 2000.

of Americans remained uninsured, the individual mandate would go into effect. The final two pieces of the proposal, the cap on tax-free health benefits and the tax on supplementary coverage, would also be put in place; yet these elements could be postponed indefinitely if circumstances required it.

This step-by-step approach is not, of course, without risks. Perhaps the most threatening is that opponents of the proposal, beaten in the initial legislative round, will nonetheless rise anew to scuttle Medicare Plus later. This possibility, made vivid by the repeal of the Medicare Catastrophic Coverage Act, would be far less likely if initial enrollment in Medicare Plus were substantial and broad-based. Not only would significant initial enrollment create a large pool of beneficiaries ready to mobilize against backtracking; it would also create a new business constituency in favor of continued progress. Just as large employers have typically been more favorable toward employer mandates, employers who enrolled their workers in Medicare Plus would likely become more supportive of measures requiring their competitors to assume similar burdens.

In comparison, other risks seem more tractable. It is true, for instance, that adverse selection is likely to be significant with a voluntary buy-in option. Yet, if implementation proceeded as envisioned, this would be a temporary phenomenon. Initial unfavorable selection could be treated as a transition cost and financed through short-term transfers from general revenues. More troublesome perhaps is the possibility that some employers will drop coverage and encourage their workers to purchase Medicare Plus on their own. Some monitoring would probably be necessary to prevent flagrant abuses of this option,and some "crowd-out" is to be expected. But unless employers were already planning to eliminate coverage (in which case Medicare Plus would be cushioning an inevitable blow), it seems unlikely that they would wish to suddenly confront their workers with the fairly large direct costs of buying into Medicare Plus individually, especially because these firms would be forfeiting the goodwill that employer-sponsored coverage buys.

Political Robustness

This proposal runs against the grain of current political debate in a number of key respects. It presents an integrated approach to universal coverage in an era in which incremental steps have become the modus operandi of U.S. health policy. It shifts the primary locus of public insurance protections from the states to the federal government after more than two decades in which new coverage has been achieved under state auspices. Perhaps most politically challenging, it suggests a dramatic expansion of an established federal program at a time when America's political class firmly believes that the only route to broadened coverage is via modest expansions of state-based programs or a bevy of new tax subsidies for private health insurance. Surely this proposal defies all reasonable standards of political feasibility.

In the near term, this is undoubtedly true: The prospect that the current President and Congress will follow the map outlined here is nil, and,in fact, there is little prospect that either will take substantial steps toward universal coverage by any means. Some believe that a tax credit approach will attract widespread support, but the magnitude of credits required to reduce significantly the number of uninsured is unlikely to materialize anytime soon. Far more likely is a modest new package of credits and deductions that throws more money into the private insurance sector but achieves limited tangible results.

In the long term, however, the tides of American politics are more difficult to foretell. Just a decade ago, it is worth recalling, leading corporations, trade associations, and professional organizations were widely convinced that major reforms would be enacted, and many entered the debate favoring an approach bearing some similarity to the one described here. Historically, health reform has become a major issue about every 15 years, after a period of dormancy during which politicians and private leaders celebrated private market solutions. If the past is prelude to the future, the next big tide of health policy ferment is set to roll into Washington sometime near the end of this decade.

At the moment,this tide may seem unthinkable. Yet the same was thought in the early 1980s, when,as now, tax-based reform was the rage, and employers seemed sold on the "new" inventions of utilization review and managed care. It is instructive to recall what happened next. Faced with a significant recession, many large firms became alarmed about the cost of providing health insurance, and a significant number stridently argued that smaller firms (whose workers were often insured by large firms through family policies) should be required to provide coverage.State governments, too, faced hard times, feeling the pinch of an expanded Medicaid program at a time of fiscal distress. And as employers tried to control costs, Americans grew alarmed about the uncertainty and increasingly visible costs of health benefits that many had once taken for granted.[28]

Today's preferred policy options—inaction, symbolic gestures, or, at most, modest tax credits or small program expansions—are a reflection not just of the long shadow of the Clinton health plan's failure, but also of good economic times and the historically low rate of increase in private premiums that has come with them. If the economy continues to weaken, if the cost of private health insurance returns to the high growth rates of the past (as it has over the past few years), and if the states begin to face new fiscal pressures (as they already have started to), the interest of employers and the states in strict cost containment may revive once again. Yet it will do so after a decade during which both players have used nearly all the managerial and administrative tools at their disposal, in the process prompting a public backlash against some of the most restrictive of their practices. The alternatives left will be much less attractive: for the states,cutting Medicaid benefits for the very poor to retain or expand coverage for the near-poor; for employers, switching to so-called defined contribution arrangements in which workers are given a fixed amount for medical costs that is pegged to inflation or company revenues rather than health costs. Judged against these options, Medicare Plus may become not simply a viable alternative, but an attractive solution for many key stakeholders—not least the American public.

If it does, this proposal will have at least three important political advantages. First, it builds on positive aspects of broadly popular and widely understood institutions—namely, Medicare and employment-based health insurance. Group health plans work well for better-off workers in large firms. This proposal allows them to continue to do so, while at the same time using the workplace as a conduit for public coverage for the rest of the working population. Medicare Plus also immediately gains the legitimacy and familiarity of a well-liked program. No great leaps of faith are required to anticipate how it will operate. Nor are tales of sinister bureaucracies quite so fearsome when the bureaucracy in question already takes care of grandparents, parents, neighbors, and friends.[29]

Second, this proposal is designed to impose minimal new costs on employers that do not now provide insurance and to reduce costs for most employers that do sponsor coverage. At the same time, it provides new subsidies for lower-wage workers without imposing large, visible new costs on other Americans.

Third, this proposal promises to retain a substantial role for private health insurance and to spare insurers that choose not to contract with the program from extensive regulation of their business. Implicitly, it strikes a bargain: Insurers that can thrive in a market dominated by large employers and a public contracting regime will be free to operate as they have before. Those whose competitive advantage rests on cherry-picking healthy small groups will face harder times.

To be sure,the political challenges will be formi-

[28] Jacob S. Hacker. *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security.* Princeton: Princeton University Press, 1997, ch. 1.

[29] It is often noted that some do not recognize that Medicare *is* a government program. A frequently repeated story, for example, describes an elderly woman leaping up at a congressional town hall meeting to demand that her elected representatives "keep government's hands off my Medicare." Commentators quickly go on to conclude that Medicare is in woeful shape: Even its beneficiaries don't know that the federal government runs it. Yet, if anything, this seems another strong political count in the program's favor—and a strong reason to base an expanded public program on it.

dable. Yet this proposal holds a final advantage over other likely contenders—what might be termed "political robustness." Political robustness refers to the ability of a proposal to function successfully despite alternative specifications and to sustain itself politically over time. This proposal is politically robust in both senses. First, a number of its features could be altered (or new features could be added) without fundamentally compromising its effectiveness. For example, this proposal would be compatible with a system of refundable tax credits targeted at lower-wage workers, as long as the credits could be applied to Medicare Plus as well as to private insurance premiums, and the default option for workers without employer-sponsored insurance was Medicare Plus. Indeed, one possible first step in implementing this proposal would be to provide a refundable tax credit of a relatively low value (say, $1,000 per person), but make it fully convertible into coverage under Medicare Plus. (The same could be done, of course, if a refundable tax credit were already in place.) This would allow Americans to apply the credit to employer-sponsored or non-group insurance if they chose, but also would ensure that they could buy into a comprehensive program by paying a modest, income-related premium.

By comparison, refundable tax credit schemes are not so robust: It is difficult to guarantee, for instance, that a tax credit will purchase adequate benefits over time, and because take-up of private insurance is highly sensitive to the level of the subsidy, the effects of a tax credit program on coverage are dramatically different at alternative levels.

Second, and more important, the proposal creates several powerful self-reinforcing processes that are likely to facilitate its expansion over time. Of these, one that has already been mentioned is the level of the payroll-based contribution. There will be strong political pressure to keep the contribution rate low. Yet, paradoxically, a low contribution rate will bolster the size and bargaining power of Medicare Plus. Similarly, if private health premiums rise more quickly than the payroll-based contribution, then the share of the population enrolled in Medicare Plus will also rise over time.

Another source of political robustness is the structure of the premiums. As enrollment reaches up the income ladder, Medicare Plus will naturally bring in more revenue per enrollee. As the income of new enrollees reaches the break-even point, the subsidies required for new enrollees will be offset almost entirely by the savings in federal tax subsidies for private health coverage. Moreover, controlling Medicare Plus's spending will also automatically reduce the tab for existing tax subsidies by lowering the level of the tax cap on private workplace coverage.

A final source of political robustness is the character and source of the subsidies. By targeting new subsidies on workers enrolled in Medicare Plus, the proposal ensures that the bulk of new spending goes to the most vulnerable, and that these subsidies are spent on a defined-benefit package that spreads risk broadly across a large population. Not only does this mean substantial savings over more scattershot subsidy arrangements; it also means clear lines of political accountability that would generally be lacking in proposals that simply offered new tax credits for private health plans. And because these subsidies are financed almost entirely at the federal level, there would be no concern that states would be under competitive pressure to keep spending low, or that responsibility for the program would be lost in the interstices of state and federal duties.

In sum, this proposal offers medium-term promise of political success. More important, it holds out the hope that the next big step in American health politics will lead not to another political dead end but to the beginning of the difficult yet necessary journey toward universal health insurance in the United States.

Acknowledgements

For valuable advice, I thank all the participants in this project. Special thanks go to Judith Feder, who offered useful suggestions at the pre-writing stage, and to Elliot Wicks, who reviewed an early draft. Gina Kramer provided able research assistance, financed by the William Milton Fund of the Harvard Medical School. These individuals and institutions are, of course,absolved of responsibility for the argument and analysis contained herein. ■

Hacker Proposal

Key Elements

Jacob S. Hacker has proposed a plan to achieve universal coverage by building on the Medicare program. The proposal includes the following elements:

EMPLOYERS COULD CHOOSE either to offer and automatically enroll employees in a plan at least as generous as that available under an enhanced Medicare benefits package or to pay a modest payroll-based contribution to help fund enrollment of their employees in Medicare Plus.

WORKERS WHOSE EMPLOYERS PAID the contribution instead of providing their own plan would be enrolled automatically in Medicare Plus at their workplace, although they could use their employers' contributions (minus a penalty) to purchase other coverage that met the same standards as the workplace plans.

STATES WOULD HAVE STRONG FINANCIAL INCENTIVES to use outreach efforts to enroll non-workers in Medicare Plus, which would effectively replace Medicaid and the State Children's Health Insurance Program (S-CHIP).

INDIVIDUALS OUTSIDE THE WORKFORCE who are not enrolled by their state would have an individual buy-in option available, with the premium based on income.

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