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Assessing the Medicare Crisis Proposal



**Supporting Unemployed Workers and Traditional
Medicare Enrollees Through the Pandemic and Recession**

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Introduction and Overall Findings

The COVID-19 pandemic has produced a severe economic downturn in the United States at breakneck speed. Between March 15 and May 2, 30.5 million people have filed for initial unemployment claims.¹ This equals 16.2 percent of the U.S. workforce as of this past February. During the 2007–09 Great Recession, the monthly unemployment rate peaked at 10.0 percent in January 2009, a full year after the onset of the recession. The only unemployment experience comparable in severity to the present situation is the 1930s Great Depression. Over the full decade of the 1930s, unemployment averaged 18.2 percent. The current unemployment rate could easily reach or surpass the 1930s average figure if present trends continue for only a few more weeks.

Representatives Pramila Jayapal and Joe Kennedy have recently proposed the Medicare Crisis Program, as a measure that would be critical in providing support to families over the course of the pandemic and severe economic downturn. The Medicare Crisis program would enable anyone who has filed for unemployment insurance due to the COVID-19 crisis to receive traditional Medicare support for themselves and their families. This will include any testing or treatments related to COVID-19 itself. In addition, under Medicare Crisis, the federal government also will absorb all cost-sharing for unemployed workers and their families, including premiums, deductibles, co-payments and any additional out-of-pocket expenses. These costs are normally paid by Medicare enrollees themselves.

Further, under the Medicare Crisis program, all ongoing traditional Medicare enrollees—whether or not they have become unemployed due to the pandemic and economic downturn—will receive additional health insurance benefits. This will include COVID-19 testing and treatment at no costs, no premiums, as well as a cap on cost sharing for all other treatments at 5 percent of income.

In this note, we estimate the costs of the Medicare Crisis program. We also compare this measure with a bill introduced on April 14 by Democratic Congressman Bobby Scott—the Worker Health Care Protection Act. This proposal would subsidize the existing COBRA program that is now available to workers who lose their employer-sponsored health insurance.² At present, the COBRA program allows workers and their families to keep their job-based health insurance plan for a limited period of time, but the workers themselves are responsible for covering the full costs of their employer-based insurance. Under the proposed subsidized COBRA measure, the federal government will assume the full costs of health insurance premiums within the existing COBRA program. But the unemployed workers will still be responsible themselves for covering all out-of-pocket costs, including deductibles and co-payments.³

Our overall results include the following:

The Medicare Crisis program provides significantly more extensive coverage at much lower costs per covered worker than the subsidized COBRA approach. Medicare Crisis covers all workers who have become unemployed due to the COVID-19 crisis as well as these workers' family members. Medicare Crisis also provides support during the crisis for traditional Medicare enrollees with respect both to COVID-19 treatments and their out-of-pocket costs for non-COVID care. The COBRA subsidy program covers only workers who had previously carried employer-provided health insurance. In terms of specific figures, if we assume unemployment averages 30 million workers between April 1 and June 30, then

Medicare Crisis will provide coverage for 19.2 million workers and their families during these three months, while subsidized COBRA will cover 12.9 million—50 percent fewer than Medicare Crisis.⁴

In terms of the direct comparison between Medicare Crisis and subsidized COBRA—i.e. in their respective costs of covering premiums and individual cost-sharing for the unemployed workers who had been carrying employer-based insurance—we estimate that the costs of Medicare Crisis will be nearly 50 percent lower than subsidized COBRA. More specifically, assuming an average unemployment level between April 1–June 30 of 30 million people, we estimate the costs of covering this particular cohort of unemployed workers for 3 months to be \$47.5 billion under Medicare Crisis and \$93.1 billion under subsidized COBRA. If we assume an average of 40 million unemployed people between April 1–June 30, the relative costs of coverage for this population cohort rise proportionally, with Medicare Crisis at \$63.3 billion, in comparison with subsidized COBRA at \$93.1 billion.

Main Features of Medicare Crisis and Subsidized COBRA Programs

With the number of people filing initial unemployment insurance claims in the U.S. rising by nearly 31 million between March 15 and May 2 (i.e. the weeks ending March 21–May 2), it follows that millions of people who carried health insurance through their employers will have lost their coverage along with their jobs. It also follows that people who purchased individual market health insurance plans will face greater difficulties in covering their insurance premium bills after having become unemployed. Finally, given the severe economic downturn combined with the pandemic, it is also likely that a high proportion of people covered through traditional Medicare are also facing major economic difficulties.

In response to this crisis of health insurance coverage, Representatives Jayapal and Kennedy have introduced the COVID-19 Medicare Crisis Program. The basic concept behind the proposal is straightforward, as stated in the program's 4/20/20 "Proposal" document:

- **Eligibility.** Any uninsured person and the household of a person who is found eligible for unemployment insurance due to COVID-19 qualifies for the Medicare Crisis Program.

The Jayapal/Kennedy proposal also includes these features beyond the extension of traditional Medicare coverage to unemployed workers:

- **Cost-Sharing for COVID-19 Services.** Ensure coverage without cost-sharing for testing and specified COVID-19 treatments under traditional Medicare and Medicare Advantage. The federal government would absorb these costs for traditional Medicare enrollees while private insurers would bear the costs for Medicare Advantage enrollees.
- **Cost-Sharing for Non-Covid-19 Services.** For the duration of the COVID-19 crisis, Medicare Crisis and traditional enrollees will not pay premiums for Parts A (hospitalization) and B (outpatient) plans. Out-of-pocket costs for Medicare Crisis and traditional Medicare enrollees will be capped to 5 percent of their monthly income.

We estimate the costs to the federal government of all features of the Medicare Crisis proposal, including the absorption of the specified shares of out-of-pocket costs for both COVID-19 and Non-COVID-19 services.

We also estimate the costs of the proposed Worker Health Care Protection Act, i.e. the subsidized COBRA proposal, as an alternative to Medicare Crisis. Under subsidized COBRA, the federal government assumes the full costs of health insurance premiums under the existing COBRA program for workers who have lost their employer-sponsored health insurance due to unemployment. At present, the COBRA program allows workers and their families to keep their job-based health insurance plan for a limited period of time, but the workers themselves are responsible for covering the full costs of their employer-based insurance.

As we review in more detail below, there are large differences in both the extent of coverage and relative costs of the Medicare Crisis and subsidized COBRA proposals. These include:

1. The full Medicare Crisis program is both substantially more extensive and generous than subsidized COBRA in supporting unemployed people and their families during the COVID-19 crisis. It also provides significant support for traditional Medicare enrollees.⁵ Focusing on the unemployed, Medicare Crisis would cover nearly 50 percent more unemployed workers—19.2 million vs. 12.9 million people—assuming an average of 30 million unemployed for three months. Medicare Crisis would also absorb all cost-sharing for unemployed workers and their families for both COVID and non-COVID treatments, so that unemployed workers face no premiums, deductibles, co-pays, or other out-of-pocket expenses during the crisis.⁶
2. The Medicare Crisis program is significantly less expensive than subsidized COBRA, in terms of total costs to provide insurance for the same cohort of people. That is, in terms of their respective costs of covering premiums and all out-of-pocket expenses for unemployed workers who had been carrying employer-based insurance—the only population cohort covered by subsidized COBRA—we find that the costs of Medicare Crisis will be nearly 50 percent lower than subsidized COBRA.

There are two reasons for the much lower costs of the Medicare Crisis program relative to subsidized COBRA. The first is that the administrative and marketing costs as well as the profits of private health insurance companies are built into the cost structure of subsidized COBRA. The costs of administration, marketing and profits for private health insurance companies average 12 percent of their overall budgets while Medicare operates with an average of roughly two percent. In addition, Medicare operates with significantly lower reimbursement rates for physicians and other professional services than private health insurance. A relatively low-end estimate provided in the March 2020 MedPAC *Report to Congress* estimates the Medicare reimbursement rates as averaging about 35 percent less than private health insurance rates.⁷

Review of Main Findings

In Table 1, we provide estimates of the health insurance status of workers who will have experienced unemployment, based on two alternative scenarios: that the level of unemployment over the three-month period April 1–June 30 averages either a) 30 million or b) 40 million workers. Between March 15 and May 2, 30.5 million people filed initial unemployment insurance claims. Of course, it is impossible to predict how much higher this figure will reach or when the unemployment rate might start declining. This is especially the case since, as noted above, survey evidence suggests that roughly 50 percent of those eligible for unemployment insurance have not yet been registered in the system and are not receiving benefits.⁸

We derive our estimate of the distribution of the health insurance status of unemployed workers through examining the distribution of health insurance status of the U.S. workforce as of 2018, as well as the distribution of initial unemployment insurance claims between March 15 and April 25. We provide details of our estimating methodology and results in Appendix 1.

As the table shows, assuming a total of 30 million people experiencing unemployment between April 1 and June 30, we estimate that 12.9 million of the unemployed will have previously carried private health insurance through their employer. Another 2.3 million newly unemployed will be carrying private insurance that they purchased on the individual exchange. A total of 6.9 million of the unemployed would be covered by the private plans of another family member. In addition, 3.9 million of the newly unemployed will be carrying insurance through a public plan. Another 4.0 million will have been uninsured at the time they became unemployed. If the number of unemployed people instead averages 40 million between April 1 and June 30—a 33 percent increase relative to 30 million—we assume that the number of people in each of the various categories with respect to health insurance coverage will rise by the same proportional 33 percent.

In Table 2, we estimate the costs of the Medicare Crisis program for an average unemployed worker and her family if the worker had been carrying insurance through her employ-

TABLE 1
Health Insurance Status of Unemployed Workers Prior to Job Loss
Actual Initial Unemployment Insurance Claims, March 15 – May 2, 2020: 30.5 Million Workers

Health Insurance Status	Alternative Projected Unemployment Levels, April 1–June 30	
	30 Million Workers	40 Million Workers
Employer Provided Health Insurance	12.9 million	17.2 million
Individual/Direct Market	2.3 million	3.1 million
Covered by Other Person's Private Insurance Policy	6.9 million	9.2 million
Public Insurance	3.9 million	5.2 million
Uninsured	4.0 million	5.3 million

Sources: See Appendix 1.

TABLE 2
Costs of Medicare Crisis Support 1:
12.9 Million Unemployed Workers Losing Employer-Provided Insurance,
Assuming 30 Million Unemployment Insurance Claims; 3 Months Coverage

Average Health Care Costs Through Employer-Provided Insurance

Family Members Covered by Employer-Provided Insurance	1) Average Annual Costs per Family Member (age-adjusted)	2) Average Costs per 3 Months of Coverage (age-adjusted)
1. Unemployed Worker—Average age: 44 years old	\$5,810	\$1,453
2. Spouse of Unemployed Worker	\$5,810	\$1,453
3. Child of Unemployed Worker	\$2,529	\$632
4. Cost of COVID Testing and Treatment	NA	\$73
5. Total (= rows 1 +2 + 3+4)	\$14,149	\$3,611

Note: COVID testing and treatment costs are averaged over the entire population; they are not age-adjusted.
Sources: See Appendices 2 and 5.

Cost of 3 Months of Medicare Crisis Support

1. Coverage for Average Worker and Family	\$3,611
2. Number of Unemployed Workers in Category, assuming 30 million unemployed	12.9 million
3. Administrative Overhead of Program	2%
4. Total Costs of Medicare Crisis Support	\$47.5 billion (= (rows 1 x 2) x (1.02 for administrative overhead))

er prior to having gotten laid off. The average extent of coverage for this family includes three people—the worker, her spouse, and one child. As we see in the upper panel of Table 2, annual health care expenditures for this worker and her spouse average \$5,810 each, while the health care expenditures for one child average \$2,529. This totals to \$14,149 for the three-person family over a year.⁹

In column 2, we then calculate these costs over a 3-month period. We first simply divide the annual cost figures by four in rows 1–3. We then also add the average COVID testing and treatment costs per family, estimated for all U.S. families that presently include unemployed workers. This comes to an average of \$73 per family, following from our estimate as to the proportion of unemployed workers and family members that will be receiving COVID testing and treatment. Thus, the total health care costs for the family during the COVID crisis totals to \$3,611. In Appendix 2, we describe how we derive the average health care cost estimates other than the COVID figures. We explain how we derive the COVID cost figure in Appendix 5.

In the lower panel, we then estimate the total costs of coverage for three months for the families of 12.9 million unemployed workers in this category. After adding two percent administrative costs for Medicare,¹⁰ this totals to \$47.5 billion for three months.

In Tables 3 and 4, we then perform the same set of calculations for unemployed workers who were carrying individual market insurance plans or who were uninsured when they became unemployed. As we see in these tables, the figures for average health care costs for adults differ from those we show in Table 2. This is because, in all three categories of

TABLE 3

Costs of Medicare Crisis Support 2:
 2.3 Million Unemployed Workers with **Individual Market Insurance Plans**,
 Assuming 30 Million Unemployment Insurance Claims; 3 Months Coverage

Average Health Care Costs Through Individual Market Plan

Family Members Covered by Individual Market Insurance	1) Average Annual Costs per Family Member (age-adjusted)	2) Average Costs per 3 Months of Coverage (age-adjusted)
1. Unemployed Worker—Average age: 48 years old	\$6,977	\$1,744
2. Spouse of Unemployed Worker	\$6,977	\$1,744
3. Child of Unemployed Worker	\$2,529	\$632
4. Cost of COVID Testing and Treatment	NA	\$73
5. Total (= rows 1 + 2 + 3 + 4)	\$16,484	\$4,193

Note: COVID testing and treatment costs are averaged over the entire population; they are not age-adjusted.
 Sources: See Appendices 2 and 5.

Cost of 3 Months of Medicare Crisis Support

1. Coverage for Average Worker and Family	\$4,193
2. Number of Unemployed Workers in Category, assuming 30 million unemployed	2.3 million
3. Administrative Overhead of Program	2%
4. Total Costs of Medicare Crisis Support	\$9.8 billion (= (rows 1 x 2) x (1.02 for administrative overhead))

TABLE 4

Costs of Medicare Crisis Support 3:
 4.0 Million **Uninsured** Unemployed Workers,
 Assuming 30 Million Unemployment Insurance Claims; 3 Months Coverage

Average Health Care Costs of Uninsured

Uninsured Family Members	1) Average Annual Costs per Family Member (age-adjusted)	2) Average Costs per 3 Months of Coverage (age-adjusted)
1. Unemployed Worker—Average age: 38 years old	\$4,793	\$1,198
2. Spouse of Unemployed Worker	\$4,793	\$1,198
3. Child of Unemployed Worker	\$2,529	\$632
4. Cost of COVID Testing and Treatment	NA	\$73
4. Total (= rows 1 + 2 + 3 + 4)	\$12,115	\$3,101

Note: COVID testing and treatment costs are averaged over the entire population; they are not age-adjusted.
 Sources: See Appendices 2 and 5.

Cost of 3 Months of Medicare Crisis Support

1. Coverage for Average Worker and Family	\$3,101
2. Number of Unemployed Workers in Category, assuming 25 million unemployed	4.0 million
3. Administrative Overhead of Program	2%
4. Total Costs of Medicare Crisis Support	\$12.7 billion (= (rows 1 x 2) x (1.02 for administrative overhead))

unemployed workers—those who, before becoming unemployed, carried employer-based coverage; those with individual market plans; and the uninsured—the average costs for non-COVID treatments are based on the average age levels of workers in each category. Thus, in Table 3, we show that the average health care costs for an adult covered through an individual market plan will be \$6,977. This is 20 percent higher than the \$5,810 average for workers on employer-sponsored plans. The difference reflects the fact that, on average, workers with individual market plans are somewhat older than those carrying employer-sponsored plans—48 years old vs. 44 years old, respectively. Similarly, we see in Table 4 that the average costs for unemployed workers who were uninsured when they became unemployed is \$4,793, 17 percent lower than the average for workers carrying employer-sponsored plans. Here again, the difference results because the average age of uninsured workers is 38 years old.

Table 5 summarizes the results we showed in Tables 2–4. We report figures in Table 5 based on three months of Medicare Crisis coverage. We also show figures assuming average levels of unemployment between April 1 and June 30 at 40 million as well as 30 million. As we see, if unemployment averages 30 million people between April 1 and June 30, Medicare Crisis would cover 19.2 million unemployed workers and their families, at a total cost of \$70.0 billion for the three months of coverage. If unemployment over this period averages 40 million people, Medicare Crisis would cover 25.6 million unemployed workers and their families. The total cost of the three months of the program would then be \$93.3 billion.

In Table 6, we show our estimates of the costs of the two features of the Medicare Crisis program that would provide support for traditional Medicare enrollees—i.e. provisions that extend beyond the core support that Medicare Crisis would provide for newly unemployed workers and their families. We document the derivation of these estimates in Appendix 6.

TABLE 5
Total Coverage and Costs of Medicare Crisis Program,
Based on 3 Months of Coverage

	1) 30 Million Unemployed		2) 40 Million Unemployed (column 1 x 4/3)	
	# of People Covered, Not Including Family Members	Total Family Costs of Family Coverage	# of People Covered, Not Including Family Members	Total Family Costs of Family Coverage
1. Workers Losing Employer-Based Coverage (Table 2)	12.9 million	\$47.5 billion	17.2 million	\$63.3 billion
2. Workers Switching Out of Individual Market Coverage (Table 3)	2.3 million	\$9.8 billion	3.1 million	\$13.1 billion
3. Uninsured Workers (Table 4)	4.0 million	\$12.7 billion	5.3 million	\$16.9 billion
4. Total (= rows 1 + 2 + 3)	19.2 million	\$70.0 billion	25.6 million	\$93.3 billion

Sources: See Tables 2, 3 and 4.

TABLE 6
Expanded Coverage for Traditional Medicare Enrollees

1. COVID Tests and Treatments for Traditional Medicare Enrollees (Plan A and Plan B) <i>37.6 million people; assume testing for 5% and treatment for 0.5% of enrollees</i>	\$6.2 billion
2. Additional Subsidies for Traditional Medicare Enrollees (Plan A and Plan B) <i>37.6 million people</i>	
2a. Medicare Premium Subsidies	\$19.1 billion
2b. Subsidies to Cover Cost-Sharing in Excess of 5% of Income	\$10.4 billion
3. TOTAL COSTS <i>(row 1 + 2a + 2b)</i>	\$35.7 billion

Source: See Appendix 6.

There are two parts to this supplemental coverage, COVID and non-COVID support. Both parts of this coverage would be available to all 37.6 million traditional Medicare enrollees. We first estimate the costs of the COVID testing and treatment provision. We base these estimates on two assumptions regarding the extent of COVID testing and treatment for traditional Medicare enrollees: 1) 5 percent of traditional Medicare enrollees, amounting to 2 million people, would be tested; and 2) 0.5 percent of traditional Medicare enrollees, amounting to 187,000 people, would require COVID treatment. In Appendix 6, we explain how we derive these assumptions. Following from these assumptions, we estimate the costs of testing and treatment for traditional Medicare enrollees would be \$6.2 billion over three months of coverage.

The non-COVID support includes, first, subsidizing the premiums for traditional Medicare enrollees for the costs of their hospitalizations and outpatient care unrelated to COVID. We estimate the costs of this provision would be \$19.1 billion for three months. Finally, we estimate that the out-of-pocket expenses in excess of 5 percent of income for traditional Medicare enrollees will total to \$10.4 billion during three months of the COVID crisis.

Overall, as row 3 of Table 6 shows, we estimate that, over a three-month period of the COVID crisis, the total costs of supporting traditional Medicare enrollees for three months through the Medicare Crisis proposal to be \$35.7 billion.

In Table 7, we summarize our estimates of the costs of all components of the Medicare Crisis proposal. That is, we report and then combine the costs of the three distinct features of the proposal: 1) all support for newly unemployed workers and their families; 2) COVID testing and treatment support for traditional Medicare; and 3) non-COVID support for traditional Medicare enrollees.

As we see, in total, this proposal would provide different levels of support for approximately 95.2 million people—29 percent of the U.S. population—over the course of the COVID crisis. We estimate the overall budget for the overall program would amount to \$105.7 billion. The proportional spending shares for each of the components of the program are: 66 percent for supporting unemployed workers and their families; 6 percent for COVID testing and treatment for traditional Medicare enrollees; and 28 percent for non-COVID support for traditional Medicare enrollees.

TABLE 7
Total Estimated Coverage and Costs for All Medicare Crisis Support
Assumes 3 Months of Coverage with 30 Million Average Unemployment

	# of People Covered	Costs	Share of Overall Costs
1. All Support for Unemployed Workers	57.6 million <i>(= 19.2 million unemployed workers and 2 family members)</i>	\$70.0 billion	66.2%
2. COVID Testing and Treatment Support for Traditional Medicare Enrollees	37.6 million <i>(assume testing for 5% and treatment for 0.5% of enrollees)</i>	\$6.2 billion	5.9%
3. Non-COVID Support for Traditional Medicare Enrollees	37.6 million	\$29.5 billion	27.9%
4. Total Costs of Medicare Crisis Proposal	95.2 million <i>(= rows 1 + 2)</i>	\$105.7 billion	100%

Note: The estimate of 57.6 million people covered under Medicare Crisis, with 30 million people unemployed, follows from: 1) the average unemployed worker covered by Medicare Crisis has a household of 3 people; and 2) the average unemployed worker who has employer provided health insurance has a family plan.

Sources: Table 5.

In Table 8, we estimate the costs of the subsidized COBRA program, assuming that, between April 1 and June 30, the average level of unemployed people is 30 million. As noted above, this COBRA program will provide support only for the 12.9 million workers who will have lost their employer-sponsored health insurance, along with their families, as opposed to the full 19.2 million unemployed workers and their families covered under Medicare Crisis. Moreover, the subsidized COBRA program covers only the premium payments for these workers. The workers themselves must still cover their deductibles, co-pays and other out-of-pocket costs. The Medicare Crisis proposal would also provide support for 38 million additional people within the traditional Medicare program.

As Table 8 shows, we first estimate the costs of the subsidized COBRA program more narrowly, in terms of the costs to the government alone, and then more broadly, to include the cost-sharing requirements for the workers. We also include the two percent administrative costs of the COBRA program.¹¹ These costs are in addition to the administrative costs and profits that the private health insurance companies will receive, since the COBRA program operates within the framework of the existing private health insurance structure. The only change with the subsidized COBRA program will be that the government is covering the COBRA premiums as opposed to the unemployed workers. As we show in rows 7 and 8 of Table 8, we estimate that for three months of operating the subsidized COBRA program, the government will spend \$59.5 billion. The full costs of the program, including out-of-pocket payments by unemployed workers, will be \$69.8 billion.

From these Table 8 results, we are then able, in Table 9, to directly compare costs of the Medicare Crisis program with subsidized COBRA. The figures in Table 9 are for the three months of coverage with unemployment levels at 30 million and 40 million respectively.

We compare these costs only for unemployed workers who, along with their families, had been previously insured through their employers, since that is the only population cohort covered by subsidized COBRA. We first compare the costs to the federal government

TABLE 8
Cost of Government-Supported COBRA Coverage for Unemployed Workers
Losing Employer-Sponsored Coverage
Assuming 30 Million Unemployment Insurance Claims

Costs to Government	1) Family-Plan Coverage	2) Individual Plan Coverage	3) Totals
1. Annual Costs of Private Insurance Premiums	\$20,576	\$7,188	\$18,085 <i>(= weighted average of columns 1 + 2)</i>
2. Number of Unemployed Workers in Category	10.5 million workers	2.4 million workers	12.9 million workers
3. COBRA Administrative Overhead	2%	2%	2%
4. Annual Costs to Government <i>(= (rows 1 x 2) x (1.02 for administrative overhead))</i>	\$220.4 billion	\$17.6 billion	\$238.0 billion
5. Out-of-Pocket Annual Costs to Workers <i>(15% of total costs)</i>	\$38.1 billion	\$3.0 billion	\$41.2 billion
6. Total Annual Costs to Government and Workers <i>(= rows 4 + 5)</i>	\$258.5 billion	\$20.6 billion	\$279.2 billion
7. Government Costs for 3 Months COBRA Coverage <i>(= row 4/4)</i>	\$55.1 billion	\$4.4 billion	\$59.5 billion
8.. Total Costs to Government and Workers for 3 Months Coverage <i>(= row 6/4)</i>	\$64.6 billion	\$5.2 billion	\$69.8 billion

Sources: Details on sources and estimating methods in Appendices 1 and 3.

only of the two programs. We then report the full costs of the two programs, including the out-of-pocket costs for unemployed workers as well as government costs under subsidized COBRA.

As rows 1–4 of Table 9 show, we estimate the government’s costs only of the two programs for 30 million unemployed to be \$47.5 billion for Medicare Crisis and \$59.5 billion for subsidized COBRA. Subsidized COBRA is therefore 25 percent more expensive, even while it is covering only the unemployed workers’ premiums, not their out-of-pocket costs. The proportional cost difference between the two programs remains the same 25 percent if average unemployment rises to 40 million over April 1–June 30. In dollar terms, the difference becomes \$16.0 billion, with Medicare Crisis at \$63.3 billion and subsidized COBRA at \$79.3 billion.

In rows 5–7 of Table 9, we then compare the full costs of both programs, including the out-of-pocket expenses of the unemployed workers. With the Medicare Crisis program, the full costs are unchanged, since the program includes no cost-sharing. With subsidized COBRA, the full costs, including workers’ out-of-pocket expenses, rise to \$69.8 billion with

TABLE 9
Cost Comparison of Medicare Crisis Program vs. Government-Financed COBRA Support for Workers Losing Employer-Provided Insurance: 3 Months of Coverage
Assuming 3 Months Average Unemployment Levels at 30 and 40 Million

	1) 30 Million Unemployed	2) 40 Million Unemployed <i>(= column 1 x (4/3))</i>
1. Medicare Crisis Program <i>(Table 5, row 1)</i>	\$47.5 billion	\$63.3 billion
2. Government Costs of COBRA <i>(Table 8, row 7)</i>	\$59.5 billion	\$79.3 billion
3. Difference between Medicare Crisis and COBRA Costs to Government for 3 Months of Coverage <i>(row 2 – 1)</i>	\$12.0 billion	\$16.0 billion
4. % Increased Costs to Government through COBRA <i>(= (row 2/row 1)-1)</i>	+25.3%	+25.3%
5. Full Costs of Coverage Through COBRA: Government Plus Workers Out-of-Pocket Costs <i>(Table 8, row 8)</i>	\$69.8 billion	\$93.1 billion
6. Difference between Medicare Crisis and Full Costs of Coverage Through COBRA: Government Plus Worker Out-of-Pocket Costs Through COBRA <i>(row 5 – row 1)</i>	\$22.0 billion	\$29.8 billion
7. % Increased Full Costs to Government and Workers Through COBRA <i>(=(row 5/row 1)-1)</i>	+46.9%	+47.1%

Sources: See Tables 5 and 8.

unemployment averaging 30 million and to \$93.1 billion with unemployment averaging 40 million. As such, in comparing the full costs of the two programs, we see that Medicare Crisis is able to provide coverage for unemployed workers who had lost their employer-provided health insurance at nearly 50 percent lower costs than subsidized COBRA.

Conclusion

The Medicare Crisis program proposed by Representatives Jayapal and Kennedy is a generous and cost-effective measure for delivering critical health insurance coverage for U.S. workers and their families after these workers have become unemployed. In comparison with the alternative subsidized COBRA proposal, Medicare Crisis would support 50 percent more unemployed workers and their families. In terms of direct cost comparisons—i.e., considering only the relatively limited cohort of unemployed workers who would be covered under subsidized COBRA, those who had previously carried employer-based coverage—we estimate that Medicare Crisis provides comparable support at nearly 50 percent lower overall costs than subsidized COBRA.

In addition, and in contrast with subsidized COBRA, Medicare Crisis also provides significant supplemental short-term support for the nearly 38 million people enrolled in the

traditional Medicare program. Inevitably, a high proportion of this population cohort is experiencing anxiety and a range of economic challenges as the recession unfolds. Relieving them of all COVID-related health care costs as well as most of their non-COVID treatment out-of-pocket costs will provide them with a measure of security during the crisis.

More broadly still, the proposed Medicare Crisis Program would constitute a significant intervention on behalf of 95 million people—nearly 30 percent of the U.S. population—that will also serve to counteract the severe economic downturn.

Appendix 1

Estimating the Health Insurance Status and Other Characteristics of Workers Unemployed Due to COVID-19

To identify characteristics of workers who have, in recent weeks, lost their jobs due to COVID-19—such as their health insurance status—we use data on the industry affiliation of workers who are filing initial unemployment insurance claims in recent weeks and then approximate the characteristics of those workers, based on their industry affiliation, through standard labor market data sources.

Estimating the Industry Composition of Workers Unemployed Due to COVID-19

The methodology we employ to approximate the industry composition of workers who have lost their jobs in recent weeks largely mirrors that developed by the researchers at the Economic Policy Institute (EPI). In particular, we use the unemployment insurance (UI) initial claims data for the weeks ending 3/14/20 to 4/4/20 from the twelve states that report initial unemployment insurance claims by industry (at the 2-digit NAICS level). These states include: Alabama, Kansas, Maine, Massachusetts, Michigan, Nebraska, Nevada, New York, North Dakota, Oregon, Washington, and Wyoming. These data were compiled from researchers Jori Kandra, Andrew Van Dam, and Ben Zipperer at the Economic Policy Institute (EPI) and are available at: https://economic.github.io/ui_state_detailed/ (accessed April 27, 2020).

We then do the following:

First, we exclude UI claims that do not have an industry identification. We also dropped data from Wyoming because that state's UI claims are classified under a different industry sector scheme than the other states. Additionally, we recoded New York's UI claims that were reported for the NAICS sectors 22 (utilities) and 23 (construction) combined. We instead assigned those UI claims to NAICS sector 23 (construction) as the UI claims from the other states indicate clearly that the construction sector represents a significantly larger level of job loss relative to the utilities sector.

Second, with each of the remaining 11 states, we estimate each industry's share of total UI claims. We use this industry distribution of UI claims—again, based on UI claims reported from weeks ending 3/14/20 to 4/4/20—and apply it to the total UI claims among these states as reported from weeks ending 3/24/20 through 4/18/20 in order to scale up the data to the level of claims at the time of this report's development. This step produces an approximation of the number of UI claims by industry and state from the weeks ending 3/24 through 4/18.

Third, we then calculate, by industry, the total UI claims as a percent of total employment, across these 11 states. We use industry employment levels as reported by the Labor Department's Quarterly Census of Employment and Wages (QCEW) for the 3rd quarter of 2019, including both public and private sector workers.¹² In other words, we estimate what share of each industry's employment has been lost across these 11 states.

Fourth, we apply these industry shares—i.e., the share of jobs lost—to the industry employment levels in each of the 51 states (including Washington D.C. as a state), in order to generate for each state its own industry composition of lost jobs. We use this state-specific industry composition of lost jobs and apply it to each state's total level of UI claims from 3/24/20 through 4/18/20. This produces the numbers of jobs lost by industry and state scaled to the total number of UI claims from the weeks ending 3/24/20 through 4/18/20.

Fifth, we generate the national industry composition of lost jobs by adding up the lost jobs, across the 50 states plus Washington D.C., by industry, from step 4. We present these figures in Table A.1, in column 1.

Finally, we use the national industry composition of lost jobs (Table A.1 column 1) and apply it to anticipated unemployment levels of between 30 million and 40 million lost jobs (see Table A.2) to estimate the number of jobs lost by industry. That is, we use the national industry composition of lost

TABLE A.1
Estimate of National Industry Composition of Lost Jobs due to COVID-19

Industry (2-DIGIT NAICS)	% of Total Jobs Lost by Industry
Sector 11: Agriculture, Forestry, Fishing and Hunting	0.3%
Sector 21: Mining, Quarrying, and Oil and Gas Extraction	0.3%
Sector 22: Utilities	0.1%
Sector 23: Construction	8.8%
Sector 31-33: Manufacturing	11.5%
Sector 42: Wholesale Trade	3.3%
Sector 44-45: Retail Trade	11.9%
Sector 48-49: Transportation and Warehousing	3.8%
Sector 51: Information	1.2%
Sector 52: Finance and Insurance	0.6%
Sector 53: Real Estate and Rental and Leasing	1.4%
Sector 54: Professional, Scientific, and Technical Services	3.7%
Sector 55: Management of Companies and Enterprises	0.8%
Sector 56: Administrative and Support and Waste Management and Remediation Services	8.0%
Sector 61: Educational Services	2.2%
Sector 62: Health Care and Social Assistance	11.0%
Sector 71: Arts, Entertainment, and Recreation	3.4%
Sector 72: Accommodation and Food Services	21.4%
Sector 81: Other Services (except Public Administration)	5.6%
Sector 92: Public Administration	0.6%
Total	100%

Source: See appendix text.

jobs to estimate the job loss level by industry, assuming a total of 30 million jobs lost or a total of 40 million jobs lost.

Estimating Characteristics of Workers Unemployed Due to COVID-19

Our primary data source on worker characteristics is the 2019 Annual Social and Economic supplement (ASEC) of the Current Population Survey (CPS).¹³

Health insurance status. There is no information about the health insurance status of workers who have filed UI claims as a result of the impact of COVID-19 on the U.S. economy. However, we know that a worker’s health insurance status, including whether the worker has employer provided health insurance (EPHI), is strongly influenced by which industry the worker is employed in.

Table A.3 shows our estimates of the insurance status of workers by industry in 2018, estimated from the 2019 CPS-ASEC data file. We use these figures to approximate the health insurance status of unemployed workers due to COVID-19. We do this by applying the health insurance status of work-

TABLE A.2
Estimate of Job Losses by Industry: at 30 Million Unemployed, and 40 Million Unemployed

Industry (2-DIGIT NAICS)	(1) # of Jobs Lost by Industry, 30 Million Jobs Lost	(2) # of Jobs Lost by Industry, 40 Million Jobs Lost
Sector 11: Agriculture, Forestry, Fishing and Hunting	83,752	111,670
Sector 21: Mining, Quarrying, and Oil and Gas Extraction	93,949	125,265
Sector 22: Utilities	17,140	22,853
Sector 23: Construction	2,648,730	3,531,640
Sector 31-33: Manufacturing	3,459,038	4,612,051
Sector 42: Wholesale Trade	992,633	1,323,510
Sector 44-45: Retail Trade	3,583,600	4,778,133
Sector 48-49: Transportation and Warehousing	1,154,477	1,539,303
Sector 51: Information	361,754	482,339
Sector 52: Finance and Insurance	183,549	244,732
Sector 53: Real Estate and Rental and Leasing	421,520	562,026
Sector 54: Professional, Scientific, and Technical Services	1,104,712	1,472,949
Sector 55: Management of Companies and Enterprises	237,797	317,062
Sector 56: Administrative and Support and Waste Management and Remediation Services	2,408,727	3,211,636
Sector 61: Educational Services	661,029	881,372
Sector 62: Health Care and Social Assistance	3,310,377	4,413,836
Sector 71: Arts, Entertainment, and Recreation	1,019,343	1,359,124
Sector 72: Accommodation and Food Services	6,406,992	8,542,656
Sector 81: Other Services (except Public Administration)	1,665,778	2,221,037
Sector 92: Public Administration	185,105	246,806
Total	30,000,000	40,000,000

Source: See appendix text.

ers by industry (shown in Table A.3) to the industry composition of the jobs lost due to COVID-19 (shown in Table A.2).

Other characteristics. We also use the industry composition of jobs lost (shown in Table A.2) to determine various other characteristics about workers who have lost their jobs due to COVID-19. These include:

1. Among workers with EPHI through their own employer, what percent purchase family plans versus individual plans.
2. The average unemployed worker's household size and composition.
3. The age composition of unemployed workers and their household members.

TABLE A.3
Health Insurance Status of U.S. Workers by Industry

Industry	Health Insurance Status				
	Employer-Provided	Individual/Direct Market	Covered by Other Person's Private Policy	Public Insurance	Uninsured
Agriculture, Forestry, Fishing and Hunting	25%	14%	21%	20%	19%
Mining, Quarrying, and Oil and Gas Extraction	72%	4%	13%	5%	6%
Utilities	78%	3%	13%	2%	4%
Construction	39%	10%	17%	11%	23%
Manufacturing	65%	5%	16%	7%	7%
Wholesale Trade	60%	7%	18%	8%	7%
Retail Trade	40%	8%	27%	14%	11%
Transportation and Warehousing	53%	8%	16%	12%	11%
Information	60%	7%	20%	7%	7%
Finance and Insurance	67%	6%	20%	4%	4%
Real Estate and Rental and Leasing	41%	15%	22%	11%	10%
Professional, Scientific, and Technical Services	57%	10%	23%	6%	4%
Management of Companies and Enterprises	55%	5%	19%	7%	15%
Administrative and Support and Waste Management and Remediation Services	36%	8%	18%	17%	20%
Educational Services	58%	6%	25%	7%	4%
Health Care and Social Assistance	54%	6%	23%	10%	7%
Arts, Entertainment, and Recreation	33%	10%	35%	13%	9%
Accommodation and Food Services	23%	7%	30%	20%	20%
Other Services (except Public Administration)	31%	12%	26%	16%	15%
Public Administration	73%	4%	14%	6%	3%

Source: See appendix text.

Appendix 2

Estimating Age-Adjusted Total Health Care Expenditures

To estimate the average health care expenditures of workers and their household members we combine three sets of data.

First, for total health expenditures by age, we use health care expenditure data published in the January 16, 2019 article “How do health expenditures vary across the population?” by Bradley Sawyer and Gary Claxton on the Peterson-KFF Health System Tracker website (see: <https://www.health-systemtracker.org/chart-collection/health-expenditures-vary-across-population/#item-start>). In this article, Sawyer and Claxton provide total health expenditures by the following age groups, by gender: under 19 yrs., 19-34, 35-44, 45-54, 55-64, and 65 and over.

TABLE A.4
Average Total Health Care Expenditures in 2020, by Age

Age Group	Average Annual Total Health Care Expenditures
Under 19	\$2,529
19-34 years old	\$3,059
35-44 years old	\$4,626
45-54 years old	\$6,051
55-64 years old	\$9,280
65 years and over	\$13,508

Source: See appendix text.

For our total health expenditures by age for 2020, we averaged the expenditure figures across gender, and then inflated the 2016 figures to 2020 using the average annual growth rate in health consumption expenditures reported by the U.S. Centers for Medicare & Medicaid Services. These annual growth rates are as follows: 4 percent in 2017, 4.7 percent in 2018, 4.6 percent in 2019, and 5.2 percent in 2020. We present the age expenditure figures we used, by age, in Table A.4.

Next, to determine the number of workers by industry in each of three groups: those workers who had employer provided health insurance (EPHI), those workers with insurance they bought on the individual market, and uninsured workers, we use the industry composition of unemployed workers and the health insurance status of workers by industry, as we described above (using figures from Tables A.2 and A.3).

We then apply the age composition of the workforce by industry to the number of workers in each of the three health insurance status groups by industry to approximate the age composition of each of the three health insurance status groups. For example, we applied the age composition of the workforce by industry to the number of workers who had EPHI by industry to determine the age composition of the unemployed workers who had EPHI. We then combined the age composition of the unemployed workers who had EPHI with total health expenditures data by age to calculate the average health expenditures of unemployed workers who had EPHI. We repeat the same steps for unemployed workers with insurance they bought on the individual market, and for unemployed workers with no insurance.

Table A.5 presents the basic figures we used to derive the age-adjusted average health expenditures of unemployed workers in each of the three health insurance status groups.

Finally, to estimate the total health expenditures per unemployed worker we take into account their dependents. As noted above, we estimate the household size and composition of the average unemployed worker using the 2019 ASEC-CPS data file. The household size of the average unemployed worker is 3, including 2 adults and one child. We therefore approximate the total health expenditures per unemployed worker to equal the health expenditure of two adults (same average age) plus one child under 19 years old.

TABLE A.5
Average Health Expenditures and Age Composition of Unemployed Workers
by Health Insurance Status

	Age Group					Average Health Expenditure by Health Insurance Status—Age Weighted
	<34 years old	35-44	45-54	55-64	65+	
Average Health Expenditure	\$3,059	\$4,626	\$6,051	\$9,280	\$13,508	
% of Unemployed Workers with EPHI	31.8%	21.2%	22.1%	19.9%	5.0%	\$5,810
% Unemployed Workers with Individual-Market Insurance	27.3%	16.7%	18.1%	19.8%	18.0%	6,977\$
% Unemployed, Uninsured Workers	46.7%	22.2%	18.7%	11.2%	1.2%	\$4,793

Source: See appendix text.

Appendix 3

Estimating COBRA Program Costs

To estimate the COBRA program costs, we use the annual insurance premium estimates from the Kaiser Family Foundation’s 2019 Employer Health Benefits Survey (see: <https://www.kff.org/report-section/ehbs-2019-section-1-cost-of-health-insurance/#figure11>).

To estimate the out-of-pocket costs for workers with employer provided health insurance, we use data from the February 2020 “2018 Health Care Cost and Utilization Report,” by the Health Care Cost Institute (see: <https://healthcostinstitute.org/annual-reports/2020-02-13-18-20-19>). According to this report, in 2018, out-of-pocket costs represented 15 percent of total health care spending among those with employer provided health insurance.

Appendix 4

Medicare-Crisis Program Cost Estimate Robustness Check

In this appendix, we estimate the costs of the Medicare Crisis program using a different methodology, in order to check the robustness of the estimates we report in the main text of this report. In particular, we estimate the cost of the Medicare Crisis program for those unemployed workers losing their employer-sponsored health insurance plans.

This alternative approach begins with the costs of private health insurance to cover the unemployed workers losing their employer sponsored health insurance plans, and then we adjust these costs two ways to reflect what the costs would be under the Medicare Crisis program.

First, we adjust the private health insurance figures downward, to reflect the lower administrative costs of the current Medicare program relative to private health insurance plans. This amounts to a downward adjustment of roughly 10 percent as Medicare’s administrative overhead amounts to two percent of spending compared to 12 percent among private health insurance plans.

Therefore, we start with our basic cost figures of private insurance plans subsidized by the COBRA program from Table 8 in the main text. In particular, we see that the average annual cost of private insurance premiums for the 12.9 million unemployed workers losing their EPHI (assuming a

total of 30 million unemployed) is \$18,085 (Table 8, row 1). These annual premiums, therefore, add up to a total of \$233.3 billion. We also know that the co-pays for these unemployed workers amount to \$41.2 billion (Table 8, row 5). Therefore, health care insurance premiums and out of pocket costs (OOP) for these workers, and their dependents, add up to \$274.5 billion. This figure approximates the total annual spending represented by private health insurance plans to cover these 12.9 million unemployed workers and their dependents. This same figure, for 3 months of coverage, is equal to \$69 billion (\$274.5 billion/4).

For our first adjustment, we discount this overall spending figure of \$69 billion to reflect Medicare's lower administrative costs—administrative costs that are 10 percentage points lower. This adjustment brings the figure down to \$63 billion (\$69 billion/1.10 = \$63 billion).

Second, we adjust the private health insurance figures downward again to reflect the lower reimbursement rates that Medicare pays relative to private health insurance plans for health care services. According to the March 2020 MedPAC report, "Report to Congress: Medicare Payment Policy," the Medicare reimbursement rate for physician and other professional services is 35 percent lower relative to private insurance reimbursement rates.¹⁴ A study by Cooper et al. (2019)¹⁵ indicates that Medicare's reimbursement rate for inpatient care is even lower. In order not to overstate the cost savings represented by Medicare, we assume that the Medicare reimbursement rates are about 65 percent of the private insurance reimbursement rates.

Our second adjustment, to discount the private insurance spending to reflect Medicare's lower reimbursement rates, brings the \$63 billion figure down to \$41 billion (= \$63 billion x 65% = \$41 billion).

According to this alternative methodology, we estimate that the Medicare Crisis costs to cover 12.9 million unemployed workers losing employer-provided insurance, for three months is \$41 billion.

We can compare this \$41 billion cost figure to our cost estimates reported in the main text, in Table 2. In particular, we can see that our estimates in the main text (from rows 1-3 of the upper panel of Table 2) indicate that the health care costs for the unemployed worker and his/her family over 3 months *minus* the costs of COVID-19 testing and treatment amount to \$3,538. This totals to \$45.6 billion for 12.9 million unemployed workers losing their employer-provided health insurance (i.e., 12.9 million x \$3,538=\$45.6 billion). The fact that these two estimates differ only by about 10-11 percent suggests that the Medicare Crisis cost estimates we report in the main text are robust. Moreover, the cost estimate we use in the main text of our report is *higher* than our alternative cost estimate. This gives us confidence that we are not understating the costs of the Medicare Crisis program.

Appendix 5

Estimating the Costs of COVID-19 Treatment and Testing for Medicare Crisis Enrollees

In this appendix, we describe how we estimated the cost of COVID-19 treatment and tests for each unemployed worker we expect will be covered by the Medicare Crisis program.

The Projected Number of Covid-19 Cases

We first need to estimate the likely number of COVID-19 cases from April through the end of June.

The number of cases for April and early May are known: the number of reported cases rose from 188,000 on March 31 to 1,152,372 by May 4. Therefore, for the month of April and the first four days of May, the number of new COVID-19 cases is 964,372 (<https://analytics-tools.shinyapps.io/covid19simulator03/> and <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>, both accessed May 4, 2020).

Projections of COVID-19 cases are reported by several sources and are revised daily. We therefore cite both the source and the date we accessed the projected case numbers here. To project the number of cases for the remainder of May and through June, we use the projections published by Massachusetts General Hospital Institute for Technology Assessment and Harvard Medical School, along with Georgia Tech and Boston Medical Center (see: <https://analytics-tools.shinyapps.io/>

[covid19simulator04/?fbclid=IwAR3Sal5jVqaa8BJ8GPi624RBS2S0LX8e9BNOFxfZotVtxwjc-V7KKgWA9a4](https://www.covid19simulator.org/?fbclid=IwAR3Sal5jVqaa8BJ8GPi624RBS2S0LX8e9BNOFxfZotVtxwjc-V7KKgWA9a4), accessed May 4, 2020). We chose this source over the popularly cited University of Washington's Institute for Health Metrics and Evaluation (IHME) figures due to recent criticisms that the IHME projects have consistently been overly optimistic (see: <https://www.vox.com/future-perfect/2020/5/2/21241261/coronavirus-modeling-us-deaths-ihme-pandemic?emci=0c57142b-8f8c-ea11-86e9-00155d03b5dd&emdi=b00c4607-908c-ea11-86e9-00155d03b5dd&ceid=1112297>).

According to this MGH modeling, the number of daily new cases will be as follows (assuming current social distancing measures remain in place): May 15: 23,100 and June 15: 3,320. We use these mid-month projections to estimate the total number of cases for each month. That is, since the MGH model forecasts 23,100 new cases in mid-May, we estimate that the total number of new COVID-19 cases from the remaining 27 days in May (i.e., May 5 through May 31) will be 623,700 (i.e., 23,100 daily new cases x 27 days = 623,700). For June, we estimate an additional 99,600 cases (i.e., 3,320 daily new cases x 30 days). In total, we therefore estimate approximately 1.7 million cases from April 1 through June 30.

The Projected Number of Covid-19 Cases Covered by the Medicare Crisis Program

Next, we need to approximate what share of these 1.7 million cases of COVID-19 cases will be covered by the Medicare Crisis program. To do this, we start with the scenario of 30 million unemployed and our estimate that Medicare Crisis enrollees—now counting 19.2 million unemployed workers and their two other household members—will total to 57.6 million people (i.e., 19.2 million x 3). 57.6 million people represent 17 percent of the U.S. population (330 million). We then assume that the number of COVID-19 cases covered by Medicare Crisis is proportional to the number of Medicare Crisis enrollees relative to the population, i.e., 17 percent. Therefore, we estimate that 17 percent of the 1.7 million COVID-19 cases—or about 289,000 cases—will be covered by the Medicare Crisis program.

The Projected Cost of Treating and Testing Covid-19 Cases Covered by the Medicare Crisis Program, 30 million unemployed

To estimate the total cost of treating and testing COVID-19 cases covered by the Medicare Crisis program we estimate three figures: the cost of hospitalizations, the cost of office visits, and the cost of testing. We then use these cost figures to estimate the cost of treating and testing for COVID-19 *per unemployed worker* covered by the Medicare Crisis program.

Hospitalizations. We know that roughly 15-20 percent of people infected with COVID-19 require hospitalization (<https://www.healthsystemtracker.org/brief/how-health-costs-might-change-with-covid-19/>) (<https://globalepidemics.org/our-data/hospital-capacity/>), so we estimate that of these 289,000 cases, 20 percent will require hospitalization, or 57,800 cases. We assume that the remaining 231,200 cases only require office visits/telehealth appointments.

According to modeling of hospital capacity to handle COVID-19 by the Harvard Global Health Institute and the Harvard T.H. Chan School of Public Health, about one-fifth of those hospitalized would need treatment in an intensive care unit (<https://globalepidemics.org/our-data/hospital-capacity/>). Based on these data, we estimate that of the 57,800 cases that require hospitalization, 20 percent—11,600 cases—will require a high level of care.

To estimate the costs of 11,600 severe cases that require hospitalization along with 46,200 average cases that require hospitalization, we use figures on the costs of treatment reported by the Kaiser Family Foundation (KFF). The KFF reports that:

For example, average hospital payments for pneumonia with major comorbidities or complications are \$10,010 under Medicare, and hospitalizations for respiratory system infections requiring ventilator support are \$40,218. Under the CARES Act, Medicare will pay a 20% premium for COVID-19 treatment, but per admission payment is still less than that for the same type of admission for people with private plans, on average. (Source: Cox, Cynthia. Robin Rudowitz, Tricia Neuman, et al. “How health costs might change with COVID-19.” Kaiser Family Foundation, April 15, 2020. <https://bit.ly/2xWmr4l>)

That is, the costs to Medicare for COVID-19 cases will be, for the typical case \$12,012 (\$10,012 x 120%), and \$48,262 (\$40,218 x 120%) for severe cases.

Combining these figures, we estimate that the cost of hospitalization for Medicare Crisis enrollees will be as follows:

- Severe cases: 11,600 cases at \$48,262 each for a total of \$560 million.
- Typical cases: 46,200 cases at \$12,012 each for a total of \$555 million

In sum, we estimate that the total cost of COVID-19 hospitalizations for Medicare Crisis enrollees will be \$1.1 billion.

Office Visits. We use an estimate of \$50 per COVID-19 related office visit based on research by FAIR Health, reported in, “COVID-19: The Projected Economic Impact of the COVID-19 Pandemic on the US Healthcare System” (March 25, 2020, see: <https://go.aws/2KGMHCz>). According to this research, the average allowed charge for telehealth visits (with private insurance) for COVID-19 related issues is about \$50. Additionally, private health insurance can charge up to \$80 for longer in-person visits. As noted elsewhere in this report, Medicare reimbursements are typically 65 percent of private insurance. Therefore, \$50 per visit is a reasonable approximation of the cost to Medicare per COVID-19 related office visits.

As noted above, we assume that 231,200 COVID-19 cases will require office visits.

Therefore, we estimate that the total cost of COVID-19 related office visits for Medicare Crisis enrollees will total to \$12 million (231,200 x \$50).

Testing. We know that as of April 28, 2020, 5,628,374 tests have been conducted in the U.S. (Source: COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU), <https://coronavirus.jhu.edu/map.html>, accessed April 28, 2020).

It is difficult to forecast how many COVID-19 tests will be administered over the coming months of May and June. We therefore simply assume, as a potentially high-end figure, that the monthly number of tests conducted over April through June will be equal to the *total* number of tests that have been conducted as of April 28, 2020. That is, we assume that over April through June, 18 million tests will be conducted.

We therefore assume that 17 percent of these tests (i.e., the number of Medicare Crisis enrollees as a percent of the U.S. population) will be covered by the Medicare Crisis program, or 3.1 million tests. According to recent reporting (see: <https://www.usatoday.com/story/news/2020/04/30/coronavirus-testing-stunted-low-medicare-reimbursement/3048943001/>) the Medicare reimbursement rate for these tests is \$100 per test.

Therefore, we estimate that the total cost of COVID-19 tests for Medicare Crisis enrollees is \$310 million.

Taking all these costs together, the total cost of COVID-19 tests and treatments for Medicare Crisis enrollees—assuming 30 million unemployed—is \$1.4 billion. The total cost of COVID-19 tests and treatments per unemployed worker covered by the Medicare Crisis program is \$73 (= \$1.4 billion/19.2 million unemployed workers).

Appendix 6

Estimating the Expanded Medicare Benefits for Traditional Medicare Enrollees

As discussed in the main text, the Medicare Crisis proposal expands Medicare benefits for traditional Medicare enrollees in two ways. First, the proposal covers COVID-19 testing and treatment for traditional Medicare enrollees with no cost sharing. Second, the proposal covers premiums and out of pocket costs (OPP) for traditional Medicare enrollees that exceed 5 percent of their income.

Coverage of COVID-19 Tests and Treatment

To estimate the cost of COVID-19 tests and treatment for the 37.6 million traditional Medicare enrollees,¹⁶ we conduct similar calculations as in Appendix 5 with three basic differences. First, traditional Medicare enrollees represent 11 percent of the U.S. population. Therefore, we assume that 11 percent of the projected 1.7 million COVID-19 cases occurring from April through June will be among traditional Medicare enrollees. Second, we assume that the hospitalization rate among the traditional Medicare enrollees is much higher than that of the general population. Specifically, the CDC reports that, “The overall cumulative hospitalization rate is 40.4 per 100,000, with the highest rates in people 65 years and older (131.6 per 100,000) and 50-64 years (63.7 per 100,000).” (see: <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>). Based on these observations, we assume that the hospitalization rate among traditional Medicare enrollees is 3.3 times that of the general population ($131.6/40.4 = 3.3$). Recall from Appendix 5 that we assume a hospitalization rate of 20 percent across all COVID-19 cases. Therefore, we assume a 66 percent hospitalization rate for traditional Medicare enrollees. Third, we assume a higher rate of severe cases among those traditional Medicare enrollees who are hospitalized. We know of no estimates of the proportion of hospitalizations among those 65 years and older that are severe cases. We therefore make the assumption that all hospitalizations among those 65 years and older are severe cases.

With these assumptions, the basic cost figures of the tests and treatment of COVID-19 among traditional Medicare enrollees is as follows:

Hospitalizations:

- (1) Total COVID-19 cases covered by traditional Medicare (11% of 1.7 million): 187,000
- (2) Total COVID-19 cases covered by traditional Medicare requiring hospitalization (66% of 187,000): 123,400.
- (3) Total COVID-19 cases covered by traditional Medicare enrollees requiring office visits/telehealth appointments: 63,600.
- (4) 123,400 hospitalizations will be severe, each costing \$48,262 for a total of \$6.0 billion.
- (5) *The total cost of COVID-19 hospitalizations for traditional Medicare enrollees: \$6.0 billion.*

Office visits:

- (1) Total COVID-19 cases office visits/telehealth appointments: 63,600 (from above).
- (2) *Total cost of office visits/telehealth appointments at \$50 each: \$3.2 million.*

Tests:

- (1) Assume 18 million tests over 3 months.
- (2) Total COVID-19 tests covered for traditional Medicare Enrollees (11% of 18 million): 2.0 million tests.
- (3) Total cost of COVID-19 tests at \$100 each: \$200 million.

The total cost of COVID-19 tests and treatments for traditional Medicare enrollees is \$6.2 billion.

Coverage of Premiums for Traditional Medicare Enrollees

The Medicare Crisis program will cover premiums for all Part A and Part B Medicare enrollees.

According to the 2020 Medicare Trustees report (cited above), the standard monthly premium in 2020 is \$144.60 (see p. 191). The report then also shows (on p. 193) that 5.1 million of the 37.6 million traditional Medicare enrollees pay more than the standard premium; these 5.1 million enrollees pay \$11 billion—over the year—in excess of the standard premium.

Based on these figures, we estimate that the cost of covering three months of standard premiums amounts to \$16.3 billion ($=37.6 \text{ million} \times \$144.6/\text{mo.} \times 3 \text{ months}$). We then add to this sum, the higher premium amount that 5.1 million enrollees pay for 3 months, or \$2.75 billion ($=\$11 \text{ billion}/4$).

In total, the cost of Medicare premiums for the 37.6 million traditional Medicare enrollees is equal to \$19.1 billion.

Reduced Cost-Sharing for Traditional Medicare Enrollees

The Medicare Crisis proposal also covers out of pocket costs (OOP) for traditional Medicare enrollees that exceed 5% of their monthly income.

According to a report by the Kaiser Family Foundation (KFF), the average traditional Medicare beneficiary spent \$5,460 on premiums and OOP costs in 2016 (<https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/>). Of this \$5,460, \$3,166 were OOP costs (i.e., cost sharing *excluding* premiums). The KFF report also estimates that the average (median) Medicare beneficiary spends 12 percent of their income on total cost sharing—OOP costs and premiums. Based on these figures, we can roughly approximate that the average traditional Medicare enrollee spends about 7 percent of their income on OOP costs (i.e., cost sharing excluding premiums). That is, according to the KFF figures, we estimate that OOP costs make up 58 percent of total cost sharing ($\$3166/\$5460 = 58$ percent). We can therefore deduce that the average Medicare enrollee's spending, as a share of their income, on cost sharing (excluding premiums) is 58 percent of 12 percent, or 7 percent.

From this, we can estimate that Medicare Crisis program's cap of 5 percent of income on OOP costs would mean that the Medicare Crisis program would have to cover 2 percentage points of this 7 percent (i.e., the amount that is in excess of 5 percent of the enrollee's income). 2 percentage points of 7 percentage points is equal to 29 percent. Therefore, the Medicare Crisis program would need to cover 29 percent of the average Medicare beneficiary's OOP costs (i.e., cost-sharing excluding premiums).

We estimate the current OOP costs of the average Medicare enrollee by inflating the KFF report's 2016 estimate of OOP costs excluding premiums (\$3,166) to \$3,800 using the growth rates in health care expenditures described in Appendix 2. The amount of OOP costs that the Medicare Crisis proposal would cover per traditional Medicare enrollee is therefore \$1,102 for one year (=29 percent of \$3,800) or \$276 per enrollee for three months.

In total, the costs to the Medicare Crisis program to cover OOP costs of 37.6 million traditional Medicare enrollees that exceed 5 percent of their income is \$10.4 billion ($\276×37.6 million).

Endnotes

- 1 The data we cite here for initial unemployment insurance claims are the actual reported numbers, not the seasonally adjusted figures. The modestly higher figures reported widely in the media are seasonally adjusted. For the purposes of this analysis, it is more accurate to work with the actual rather than the seasonally adjusted ones. Data on claims are from: <https://fred.stlouisfed.org/series/ICNSA>. In addition to these official figures, survey evidence suggests that the actual number of unemployed is likely to be roughly 50 percent higher than what the official unemployment insurance claims figures report. This is because 30–40 percent of unemployed people tried to apply but could not get through to make a claim and another 20 percent did not try to apply because it was too difficult to do so. If we add these uncounted cohorts to the pool of unemployed, that would bring the total of newly unemployed since the onset of the COVID-19 crisis at 42 million, or 25 percent of the U.S. workforce. See: <https://www.epi.org/blog/unemployment-filing-failures-new-survey-confirms-that-millions-of-jobless-were-unable-to-file-an-unemployment-insurance-claim/>.
- 2 COBRA is an acronym for Consolidated Omnibus Budget Reconciliation Act.
- 3 <https://bobbyscott.house.gov/media-center/press-releases/house-democrats-introduce-bill-to-help-workers-keep-job-based-health>; <https://www.vox.com/2020/4/14/21219461/democrats-new-plan-keep-laid-off-workers-insured>.
- 4 Note that both the COBRA subsidy program as well as the Medicare Crisis program covers workers who are furloughed as well as laid-off. Congressman Bobby Scott’s proposal explicitly covers health insurance premiums owed by furloughed workers (see previous footnote). Under the Medicare Crisis program, any worker who is eligible for unemployment insurance benefits is also eligible for Medicare Crisis. The CARES Act specifically includes furloughed workers as eligible recipients for unemployment insurance benefits (see: <https://gop-waysandmeans.house.gov/cares-act-unemployment-insurance-questions-answered/>).
- 5 The Medicare Crisis proposal provides modest support for Medicare Advantage enrollees by requiring that the private insurance companies that provide those enrollees coverage will be required to cover COVID-19 related tests and treatment with no cost-sharing.
- 6 The Medicare Crisis program covers premiums for unemployed workers and caps other cost-sharing at 5 percent of their income. We assume that the income of the newly unemployed will drop to near zero so that the cap effectively eliminates any cost-sharing.
- 7 See Appendix 4 for references and further details on this issue.
- 8 <https://www.epi.org/blog/unemployment-filing-failures-new-survey-confirms-that-millions-of-jobless-were-unable-to-file-an-unemployment-insurance-claim/>.
- 9 In Appendix 4, we present an alternative methodology for estimating the costs of the Medicare Crisis program. As we show in Appendix 4, the results we obtain through the alternative methodology correspond closely with the method we present in the main text. This provides a robustness check on our estimates.
- 10 See <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>, p. 44-45 for derivation of Medicare administrative cost estimate at 2 percent of overall costs.
- 11 See: <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employers-guide-to-group-health-continuation-coverage-under-cobra.pdf>, page 1.
- 12 The QCEW produces a near census of employment in the U.S., covering more than 95 percent of U.S. jobs.
- 13 The CPS is a household survey conducted by the U.S. Census Bureau for the Bureau of Labor Statistics of the U.S. Labor Department. The CPS surveys approximately 60,000 households monthly and its data are nationally representative when used with the CPS-provided sampling weights. We accessed the ASEC-CPS data through the *Integrated Public Use Microdata Series, Current Population Survey: Version 7.0* [dataset]. Minneapolis, MN: IPUMS, 2020. <https://doi.org/10.18128/D030.V7.0> produced by Sarah Flood, Miriam King, Renae Rodgers, Steven Ruggles and J. Robert Warren.
- 14 MedPAC. (March 2020). Report to Congress: Medicare Payment Policy. p.128. <https://bit.ly/34Mwe8R>.
- 15 Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen. “The price ain’t right? Hospital prices and health spending on the privately insured.” *The Quarterly Journal of Economics* 134, no. 1 (2019): 51-107.
- 16 According to the 2020 Medicare Trustees report (“2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,” April 22, 2020), there are 37.6 million people enrolled in traditional Medicare (p. 150 Table IV. C1).

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