

File Ruth Kain

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HEADLINE: REMARKS BY PRESIDENT BILL CLINTON AND
VICE PRESIDENT AL GORE, AT MEDICARE EVENT
THE WHITE HOUSE, THE ROOSEVELT ROOM
WASHINGTON, DC

BODY:

VICE PRESIDENT GORE: Please be seated, ladies and gentlemen. On behalf of the president, I would like to welcome all of you to the White House. We're excited about the announcement the president's going to make. And I want to acknowledge my colleagues in the Cabinet: Secretary Donna Shalala, who has done such wonderful work on expanding health care coverage; Secretary Alexis Herman, who's been a great champion for working men and women; and the chair of the National Economic Council, Gene Sperling, who coordinates the president's economic policies.

And I want to welcome Ruth Kain. I'll introduce her in just a moment, and she's going to present the president. And I want to acknowledge her husband, Rufus Kain, who is here. We appreciate you being here, Mr. and Mrs. Kain.

In the audience with us today are some great champions of the cause of expanding health care access. Senator Ted Kennedy and Congressman Pete Stark have been long-time leaders on health care policy. Everyone knows that, and we're especially grateful for their presence today. Congressman Gerald Kleczka has been a tireless fighter, especially for those who have had promises broken and have lost their health care coverage, and has played a key role also in today's policy.

I want to acknowledge the other members of the president's team, including Ken Apfel, commissioner of the Social Security Administration. And I want to welcome Jeanette Takamora (sp), the new assistant secretary for aging. Welcome. And to all of the representatives of the Leadership Council of Aging Organizations, thank you for what you have done to make today possible. To Linda Chavez Thompson, executive VP of the AFL-CIO, thank you very much. John Sweeney couldn't be here, but don't ever underestimate that vice president position! (Laughter.)

We're here today to take an important new step to expand access to affordable, high-quality health care for those who lack it today and for those who might lose it tomorrow. As President Clinton has so often said, this is an age of enormous possibility,

and that's especially true when it comes to medicine and health care. Every week, it seems, brings us astonishing new breakthroughs in our battle against illness and disease, such as AIDS and cancer, diabetes, spinal cord injuries and others. Right now, thanks to the human genome project, we're on the verge of literally mapping out the genetic code of life itself. So the 21st century promises to be the healthiest and most hopeful time in human history. But, of course, our challenge is to make sure that all Americans can share in those breakthroughs. And because of President Clinton's commitment to improving the nation's health care, we are making record progress. Last summer's balanced budget will extend health care to as many as five million more children. We passed a law, under President Clinton's leadership, that guarantees families won't lose their health care just because they move from job to job, or just because a family member is sick. We protected mothers and newborns from being rushed out of the hospital in less than 48 hours. We reformed FDA to speed the approval of life-saving new medicines. And we're working to make sure that changes in the health care system do not mean lower quality or less attention to patients' rights.

And as we have protected and strengthened Medicare, extending the life of the trust fund by more than a decade, we have offered more choices and new preventive benefits for those on Medicare. And we're doing more to help the lowest-income Medicare recipients pay for their health coverage.

I must say, I'm very proud to serve with and work along side a president who has made such a remarkable difference in the health of American families. And today's announcement builds on the president's vision by reaching out to Americans between the ages of 55 and 65, who have less access to employer-based health insurance, are twice as likely to have health problems, and are at greater risk of losing their coverage than are average Americans.

And to those who are already opposing the president's plan without even looking at the details, we must ask, what will you do to help this vulnerable group of Americans? If you don't think these problems are real, you don't know Ruth Kain. It is my pleasure now to introduce her and ask her to share her experience in trying to find health insurance after her husband Rufus (sp) turned 65.

Ruth Kain.

MS. KAIN: Mr. President, Mr. Vice President, members of Cabinet and members of Congress, I'm pleased that you're all here today to address the problem with health care in this country.

My husband and I are going to celebrate our 47th wedding anniversary tomorrow. We moved to California early in our marriage and raised four lovely daughters. My husband worked hard to provide for us, and I was a stay-at-home mom, and we had excellent health-care benefits through the company where he worked. When he retired in 1990, we were fortunate enough to keep our health benefits until he turned 65 and was eligible for Medicare. His company gave me the option of taking a Cobra plan for 36 months. Because I had been diagnosed with a heart condition in 1970, after my Cobra plan expired, I had trouble finding

insurance. At age 63, I was only able to get a short-term, one-year policy that partially covered my heart condition. But during that year, I had to get a pacemaker that cost me personally \$10,000. After that policy expired, I was denied coverage by several insurance companies and was forced to take a policy that covered everything but the preexisting condition.

This past November, I started having severe chest pain. On the Saturday before Thanksgiving, my husband and daughter insisted I go to the doctor. I didn't want to go because I didn't want to incur more doctor bills and I didn't want to have to "sell the farm," so to speak.

We happen to live on a -- excuse me -- on a farm, and my husband said that if that's what it takes, then that's what we'll do.

So I did go to the doctor and they put me in a hospital. I had a stent put in and I am feeling much better. Unfortunately, that hospital visit cost me \$14,000 out-of-pocket -- will cost -- not including the doctor bills. My insurance company doesn't cover any of it.

People like my husband and I, who work hard to make sure we could take care of ourselves in our retirement years, shouldn't have to literally "sell the farm" to have access to health care. We did everything we could to make sure that we did not have to depend upon our children or anyone else. We're willing to support ourselves and we want to pay for our own health care. But people like us need options.

Mr. President, the steps you are proposing today would have given me the option to pay for full health care coverage and not live in fear of not being able to go to the doctor. My husband should not have to choose between a wife and a home.

Thank you for the opportunity to be here today, and I am pleased now to present the president of the United States, Bill Clinton.
(Applause.)

PRESIDENT CLINTON: Thank you, Ruth. I think she has made clearer than I could ever hope to that, for many Americans, access to quality health care can mean the difference between a secure, healthy and productive life and the enormous burden of illness and worry, and enormous financial strain.

Today, the proposals I am making are designed to address the problems of some of our most vulnerable older Americans.

I propose three new health-care options that would give them the security they deserve.

The centerpiece of our plan will let many more of these Americans buy into one of our nation's greatest achievements -- Medicare. When Medicare was first enacted, President Johnson said, and I quote, "It proved that the vitality of

our democracy can shape the oldest of our values to the needs and obligations of changing times."

Once again, we are faced with changing times; a new economy that changes the way we work and the way we live, new technologies and medical breakthroughs holding out hope for longer healthier lives, a new century brimming with promise but still full of challenge and much more rapid change.

The values remain the same, but the new times demand that we find new ways to create opportunity for all Americans. For the past five years, we have had an economic strategy designed to expand opportunity and strengthen our families in changing times, insisting on fiscal responsibility, expanding trade, investing in all our people. Yesterday, I announced that the budget I will submit to Congress in three weeks will be a balanced budget, the first one in 30 years. Within this balanced budget, we propose to expand health-care access for millions of Americans.

Last summer, with the balanced-budget agreement I signed, we took action to extend the life of the Medicare Trust Fund until at least 2010, and we appointed a Medicare Commission to make sure that Medicare can meet the needs of the Baby Boom generation. We took action to root out fraud and abuse in the Medicare system; assigning more prosecutors, shutting down fly-by-night home health-care providers, taking steps to put an end to overpayments for prescription drugs. Since I took office, we have saved over \$20 billion in health-care claims; money that would have been wasted, gone instead to provide quality health care for some of our most vulnerable citizens.

We want to continue to do everything possible to ensure that the same system that served our parents can also serve our children. That means bringing Medicare into the 21st century in a fiscally responsible way that recognizes the changing needs of our people in the new era.

We know that for different reasons, more and more Americans are retiring or leaving the workforce before they become eligible for Medicare at age 65. We know that far too many of these men and women do not have health insurance. Some of them lose their health coverage when their spouse becomes eligible for

Medicare and loses his or her health insurance at work. That's the story we heard today. Some lose their coverage when they lose their jobs because of downsizing or layoffs. Still others lose their insurance when their employers unexpectedly drop their retirement health care plans. These people have spent their lifetimes working hard, supporting their families, contributing to society, and just at the time they most need health care, they are least attractive to health insurers, who demand higher premiums or deny coverage outright.

The legislation that I propose today recognizes these new conditions and takes action to expand access to health care to millions of Americans. First, for the first time, people between the ages of 62 and 65 would be able to buy into the Medicare program at a fixed premium rate that for many is far more affordable

than private insurance, but firmly based in the actual cost of insuring people in this age group. And as you just heard from what Ruth said, far, far more affordable than the out-of-pocket costs that people have to pay if they need it. This is an entirely new way of adapting a program that has worked in the past to the needs of the future. It is a fiscally responsible plan that finances itself by charging an affordable premium up-front and a small payment later to ensure that this places no new burdens on Medicare. It will provide access to health care for hundreds of thousands of Americans. And it is clearly the right thing to do.

Second, statistics show that older Americans who lose their jobs are much less likely to find new employment. And far too often, when they lose their jobs, they also lose their health insurance.

Under this proposal, people between the ages of 55 and 65 who have been laid off or displaced will also be able to buy into Medicare early, protecting them against the debilitating costs of unforeseen illness.

Third, we know that in recent years too many employers have walked away from their commitments to provide retirement health benefits to long-time, loyal employees. Under our proposal, these employees also between the ages of 55 and 65 will be allowed to buy into their former employers' health plans until they qualify for Medicare.

Thank you, Congressman, for your long fight on this issue.

Taken together, these steps will help to take our health care system into the 21st century, providing more American families with the health care they need to thrive, maintaining the fiscal responsibility that is giving more Americans the chance to live out their dreams, shaping our most enduring values to meet the needs of changing times. It is the right thing to do. And thank you, Ruth, for demonstrating it -- that to us today.

Thank you very much. (Applause.)

END

LANGUAGE: ENGLISH

LOAD-DATE: January 7, 1998

PRESIDENT CLINTON ANNOUNCES NEW PROPOSALS TO PROVIDE AMERICANS AGES 55 TO 65 IMPROVED ACCESS TO HEALTH INSURANCE

January 6, 1998

President Clinton today announced a targeted, paid-for proposal to give Americans under 65 new options to obtain health care coverage. The President's proposal:

- ✓ **Enables Americans Ages 62 to 65 To Buy into Medicare**, by paying a full premium.
- ✓ **Provides Vulnerable Displaced Workers over 55 Access to Medicare** by offering those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option.
- ✓ **Provides Americans Over 55 Whose Companies Reneged on Their Commitment to Provide Retiree Health Benefits A New Health Option**, by extending "COBRA" continuation coverage until age 65.

Americans ages 55 to 65 are one of the most difficult to insure populations: they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely to have health problems. Some lose their employer-based health insurance when their spouse (frequently the husband) becomes eligible for Medicare. Many lose their coverage because they lose their jobs due to company downsizing or plant closings. Still others lose insurance when their retiree health coverage is dropped unexpectedly.

These older Americans are often left to buy into the individual insurance market, which can be prohibitively expensive (in some cases, more than \$1,000 per month for a person with a pre-existing condition) and altogether unavailable for many older Americans with health problems. In virtually all states, people purchasing individual policies pay much higher insurance rates because of a pre-existing condition; in many, they can be denied coverage altogether.

The President's targeted proposal provides greater access to health coverage by:

- ✓ **ENABLING AMERICANS AGES 62 TO 65 TO BUY INTO MEDICARE**, by paying a premium. The premium will be paid for in a two-part "payment plan." First, participants will pay a base premium of about \$300 per month — the average cost of insuring Americans this age range. Second, participants will pay an additional monthly payment, estimated at \$10 to \$20, for each year that they buy into the Medicare program. This premium, to be paid once participants enter Medicare at age 65, covers the extra costs of sicker participants. This two part "payment plan" enables these older Americans to buy into Medicare at a more affordable premium, while ensuring that the buy-in option is self-financing in the long run.

- ✓ **PROVIDING VULNERABLE DISPLACED WORKERS OVER 55 ACCESS TO MEDICARE** by offering those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option. Individuals choosing this option will pay the entire premium at the time they receive the benefit without any Medicare "loan," in order to ensure that Medicare does not pay excessive up-front costs and participants do not have to make large payments after they turn 65. This policy responds to the increased vulnerability of older Americans to work transitions and company layoffs. Such workers have a harder time finding new jobs: only 52 percent are reemployed compared to over 70 percent of younger workers. Nearly half of these unemployed, displaced workers who had health insurance remained uninsured.

- ✓ **PROVIDING AMERICANS OVER 55 WHOSE COMPANIES RENEGED ON THEIR COMMITMENT TO PROVIDE RETIREE HEALTH BENEFITS A NEW HEALTH OPTION**, by extending "COBRA" continuation coverage until age 65. This proposal allows these retirees to buy into their former employers' health plan through age 65 by extending the availability of COBRA coverage to these families. In recent years, the number of companies offering retiree benefits has declined: in 1993, only about half of full-time workers in medium to large firms had access to retiree health insurance, compared to 75 percent in 1985. Some companies have ended coverage only for future retirees, but others have dropped coverage for individuals who have already retired. This policy provides much needed access to affordable health care for these retirees and their dependents whose health care coverage is eliminated after they have retired. Retirees will pay a premium similar to that of other COBRA participants.

The President's proposal is fully funded and does not burden the Medicare Program.

- ✓ **THE POLICY IS DESIGNED TO BE SELF-FINANCING.** All three proposals are designed to be paid for by the people who benefit. People ages 62 to 64 who buy into Medicare will, over time, repay the amount that Medicare "loans" them when they are buying in. Displaced workers will pay a premium that takes into account participants' costs. And, the COBRA buy-in policy has no Federal budget impact whatsoever.

- ✓ **ANY TEMPORARY COSTS WILL BE OFFSET BY MEDICARE FRAUD, ABUSE AND WASTE.** The short-term Medicare "loan" to buy-in participants, plus the costs of the displaced workers' buy-in, will cost approximately \$2 to 3 billion over 5 years. These costs will be financed by a series of new Medicare anti-fraud and waste proposals, which will be announced in the President's budget.

GIVEN TO

GENB 3:30pm

DRAFT

Medicare Buy-In File

January 15, 1998

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

RE: RESPONSE TO CRITICISM OF THE PRE-65 POLICIES

On Monday, Robert Reischauer wrote an op-ed in the *Washington Post* raising concerns about the employment effects of the pre-65 health proposals and the risk that down the road there will be subsidies. You asked us for our response. This memo outlines the substantive response to Reischauer's concerns as well as the steps that we are taking to mitigate such criticism.

Theoretically and analytically, there is no evidence that the Medicare buy-in will encourage employers to drop health coverage or workers to retire early. This is primarily because there is neither an employer contribution nor a tax subsidy for the Medicare buy-in premiums. This makes it more expensive than most employer-based plan premiums, erasing the financial incentive to participate in Medicare if you have such an option. Although employers might desire to shift their older workers and retirees into Medicare, their ability to do so is limited by age discrimination laws and the people's own preferences. These arguments are outlined in greater detail in the attached documents.

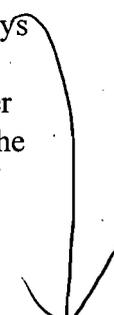
We have been countering these arguments about the labor market effects in several ways. On the day of the announcement, we had a meeting with Reischauer, Henry Aaron, Judy Feder, and several other experts to discuss the details. As a note, Aaron was arguing against Reischauer on the labor effects of this proposal. Our staff has had conference calls with the leading labor economists who study retirement behavior, confirming our own analysts' expectation that this policy's effects on retirement are small to negligible. Tomorrow, Chris will meet in a closed-door session with academics and journalists at the Brookings Institute to discuss these issues. And we are working on several rejoinder op eds response to the Reischauer piece, possibly including one by Gene and Alexis Herman, and possibly another by Uwe Reinhardt.

see attached 717

The second of Reischauer's criticisms is that there will be inevitable, irresistible pressure to subsidize the Medicare buy-in. Ironically, both our critics and our friends are making this argument, since the Democrats want us to eventually go in this direction.

In truth, we do not think that we could support subsidizing this age group outside of the context of comprehensive health reform. Not only would subsidies create the kind of incentives to retire that our policy rejected; it would be very expensive. The billions of dollars needed could probably not come from Medicare. The Republicans, academics, and elite press would argue that any major Medicare savings should be used to extend the life of the Medicare Trust Fund. Seniors and their advocates would probably also argue that major savings should be used for expanding benefits, not subsidizing a younger population. Similarly, we could not turn to Medicaid for funding, since advocates and Governors would argue that we are taking from the poor to help the not-so-poor near elderly. Ironically, Democrats who will push for subsidies will also be the biggest opponents to the required sources of savings.

Obviously, this is not our public response. We have been pointing to our record of fiscal responsibility. Our health proposals are carefully designed, targeted and financially sound. Most participants in the buy-in will pay for their costs, and if there is any shortfall, we will find ways to pay for it to keep the Trust Fund whole. If Democrats develop proposals that are fiscally sound and do not have unintended, adverse effects on the economy, we are willing to consider them. This response both affirms our commitment to paying for the proposal while leaving the door open to Democrats.



Needs work

WHY THE PRESIDENT'S HEALTH POLICIES FOR PEOPLE 55 TO 65 YEARS OLD WILL NOT HAVE A SIGNIFICANT EFFECT ON WORK AND RETIREMENT

- **Retirement is not a pre-condition for the Medicare buy in.** The Medicare buy-in is intended for anyone ages 62 to 65 who lacks access to an employer-based policy. This includes workers in small firms that do not offer health coverage; self-employed or part-time workers who frequently lack insurance options; and people who are divorced or widowed and lose their access to their spouses' health plan.
- **Current workers have no significant incentive to retire because of these policies.** The Administration estimates assume that only 1 percent of workers with employer-sponsored coverage ages 62 to 65 will stop working because of this policy. These people are probably sicker and working only to maintain health insurance. However, there is no financial incentive to retire since participants would pay a higher premium than they would in their current employer health plans. And, since participants would have to pay the full premium, they may need to continue to work to afford the coverage. This option may, in fact, encourage people to start second careers (e.g., opening their own stores; becoming a consultant) since they could purchase Medicare if they leave their current job.
- **Retirees and workers with employer-based coverage have no incentive to drop retiree health coverage to take this option.** Since employer-based insurance is both less expensive and subsidized through tax breaks, people with such coverage will have no incentive to buy into Medicare, since they have to pay the full premium. In addition, people with access to retiree health coverage are not eligible for the buy-in.
- **Employers cannot drop coverage for *active worker* due to age.** Selectively dropping older workers from health benefits is illegal because it is age discrimination.
- **The COBRA policy lowers the financial incentive to drop coverage for *current retirees*.** Today, employers may, without warning, end health coverage for workers who have already retired. While most employers carry through on obligations to their current retirees, even when ending coverage for future retirees, the few firms that renege on this promise create great hardship for the retirees left uncovered. This proposal would require such employers to provide current retirees access to their firm's health plans under COBRA continuation coverage law. Although the retirees would pay a premium 25 percent higher than that of active employee for such coverage, retirees' average costs are higher. Thus, the employer would bear some of the cost for the retirees, making dropping current retirees' coverage less attractive.
- **The Medicare buy-in will have no significant impact on employers' decisions to offer coverage to *future retirees*.** Employers who offer retiree health coverage to current workers have little new incentive to drop coverage for future retirees. This is because workers will not consider the Medicare buy-in a substitute for retiree coverage. There is no employer contribution toward the Medicare buy-in, nor is it subsidized through tax breaks the way that employer-based coverage is. This means that employers cannot argue that retiree health coverage is not needed because Medicare fills the gap. The Medicare buy-in is an important option, but not for those with access to employer-based insurance.

THE PRESIDENT HAS SEEN

1-12-98

Robert D. Reischauer

Medicare for the Almost-Old

More than 800,000 Americans between the ages of 62 and 64 have no health insurance and are, therefore, one serious medical problem away from financial ruin. About the same number purchase individual coverage, which can be quite expensive, both because they are less healthy than younger adults and because the costs of marketing and administering individual policies are high. Within these two groups, a few more than half receive reduced Social Security benefits available to early retirees age 62 to 64. Just more than one-quarter are working and not collecting Social Security. The balance, most spouses of workers whose employers do not provide group health insurance coverage, neither work nor receive Social Security. Of the total, close to 40 percent have low incomes, that is, incomes below twice the poverty level.

To address the financial risk facing the uninsured and the burden high premiums impose on purchasers of individual policies, the president has proposed that 62- to 63-year-olds be allowed to enroll in Medicare, which is now available only to the permanently disabled and those 65 and older. To keep this expansion from bankrupting a program projected to become insolvent at about the end of the first decade of the next century, the proposal would require that these enrollees buy into Medicare by paying a monthly premium of about \$300 until their 65th birthday. After that, they would pay a small surcharge on the Part B premiums all Medicare participants pay.

While the president's initiative is a positive step toward reducing both the risk of serious illnesses wiping out the retirement savings of uncovered 62- to 64-year-olds and the excessive financial burden that many older purchasers of individual policies now bear, these advances would come at a price. The Medicare buy-in would create incentives that could exacerbate undesirable trends in the nation's labor markets. Furthermore, once enacted, it would unleash political pressures for liberalization that could cause the costs of this initiative to soar.

If 62- to 64-year-olds could enroll in Medicare, those employers who now provide health insurance coverage for their retirees would feel less need to do so. Many employers already have dropped or scaled back this fringe benefit not only because it is costly but because new accounting rules require businesses to reveal now the benefit expenses they will incur in the future. These policies provide protection for millions who retire before they are eligible for Medicare. For more than one-third of retirees who are covered by Medicare, these employer-sponsored policies also provide supplementary insurance that picks up costs that Medicare does not cover. If more employers drop these policies, more of the elderly will have to turn to individual Medigap insurance for their supplemental coverage. Medigap premiums are generally higher than the premiums employers charge their retirees, and most Medigap plans don't cover some important services, such as prescription drugs, which are generally covered by employer-sponsored retiree policies.

Availability of Medicare for those age 62 to 64 also will entice more to retire early on reduced Social Security benefits. For those with chronic health problems who have continued to work just to obtain health benefits, this opportunity could be a blessing. But for those who are healthy and have saved little, early retirement could prove to be a mistake. The consequences might not become apparent for a decade or two, perhaps not until their widows try to subsist on the reduced Social Security benefits available to them. As a

consequence, more of the very old may have to rely on food stamps and SSI, the welfare program for low-income elderly and disabled. In a nation in which the work force is projected to grow at a slower and slower pace, public policy should encourage increased labor-force participation by the elderly rather than promote early retirement.

A Medicare buy-in option also might encourage employers to shift their older workers from full- to part-time status or from being regular employees to being contract employees. An older worker with a chronic health condition could cost a business that offers health benefits far more than the Medicare buy-in premium. In such a case, a business would come out ahead if it offered workers a pay raise larger than the premium they would be charged for buying into Medicare if they became contract employees.

While the president's proposal is intended to be budget-neutral to begin with—that is, the premiums charged 62- to 64-year-old

"The Medicare buy-in would create incentives that could exacerbate undesirable trends in the nation's labor markets."

participants would cover the added Medicare costs—it would prove difficult to maintain such fiscal rectitude. Most of those who take advantage of the buy-in option would be living in quite comfortable circumstances. Few of those with low and modest incomes would participate because they would feel that they can't afford to pay \$3,600 annually for Medicare coverage. Thus, those who need help the most would get the least, and many would remain uninsured. Over time, pressure would inevitably build to provide some sort of income-related subsidy to allow those with limited resources a real option to participate in the Medicare buy-in.

If, as in the past, Medicare costs rise at a much faster pace than the incomes of those eligible for the buy-in, the burden of the premium will increase. Pressure will mount for a subsidy. That is what happened to Medicare's Part B premium, which was set to cover half of the program's costs. But when costs rose faster than participants' incomes, increases in the premium were limited so that premiums now cover only one-quarter of costs.

While the president's Medicare initiative raises complex issues, it responds to a significant problem. Rather than trashing the plan, as some in the opposition have done, policymakers should work to mitigate undesirable secondary effects that inevitably accompany efforts to expand access to affordable care. Policymakers also should consider the political pressure they will be under in the long run to liberalize the program and realistically account for the budgetary consequences of that pressure.

The writer is a senior fellow at the Brookings Institution.

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The Washington Post

MONDAY, JAN. 12, 1998

[Draft: Op Ed for the Washington Post by Sperling and Herman]

Gene: Chris and I think that we should take on these arguments aggressively. We have spoken to DOL about writing a joint op ed, but have not yet shown them anything since we obviously wanted your opinion first. What do you think??

Also, it would be extremely helpful if you could talk to Henry Aaron [in particular], Alan Krueger and/or Larry Katz about these issues. We have briefed all of them on it, but coming from you, it would be better.

As the President's key advisors on economic and workforce issues, we would like to respond to charges that the Medicare buy-in proposal, recently announced by the President, is fiscally irresponsible and anti-work. Simply stated, it is neither.

The Medicare buy-in passes the three tests used by the President to judge any new policy: it address a real problem; it is fully paid for; and it does not have unintended adverse effects on the economy. This standard has guided us to ending the deficit and will ensure that new policies will prepare this nation for the next century's challenges.

Without question, this policy addresses a real problem. People approaching age 65 face greater uncertainty about both their health and their health coverage. Even compared with people ages 45 to 54, those ages 55 to 65 have twice the risk of cancer, heart disease or stroke.

At the same time, they have greater problems finding affordable health insurance. Work-based insurance becomes less common due to work and family transitions. Some of this transition is involuntary. A 60-year old worker whose firm downsizes has a much harder time finding a job with health insurance than a younger co-worker. Many women at this age lose access to coverage through their husband because of retirement (where the older husband turns 65 and gets Medicare), divorce or death.

The Medicare buy-in offers an important option for these people. People ages 62 to 65 and displaced workers age 55 and older could pay a premium to be covered by Medicare. They would pay the full freight, since there is no Federal subsidy. People would not only have a new, affordable option through Medicare, but competition with Medicare could improve private plan choices as well. And, short-term Medicare costs would be offset dollar-for-dollar by Medicare anti-fraud savings. As such, this proposal meets the President's second test: it is fiscally responsible.

The Medicare buy-in also passes the third, and perhaps most important test: it will neither enable employers to drop health benefits nor encourage workers to retire. Let's review the research. The Department of Labor has extensively studied retirement behavior, finding that subsidized, employer-based retiree health coverage does encourage people to retire earlier. However, high premiums for this coverage make much of the incentive to retire disappear.

Based on this evidence, most labor economists think that an option like the Medicare buy-in, with no tax breaks or employer contribution, would have a small to negligible effect on retirement. Health insurance on the job will always be cheaper than the buy-in. Only those workers who are sick and are willing to pay much more for health insurance would stop working.

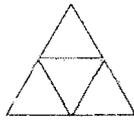
In fact, the Medicare buy-in could, on net, have a positive effect on work. Studies show that people who pay their own premiums for individual insurance rarely retire early. Instead, they continue to work, in part, to pay for their health insurance. More importantly, a buy-in would give older workers the flexibility to change jobs or become self-employed without risking losing health coverage.

There has also been speculation that the Medicare buy-in will "crowd out" employer coverage for older workers or health benefits for retirees. Indeed, there are disturbing declines in all types of employer coverage for all types of workers. Today, people ages 55 to 65 have much lower employer-based coverage than younger adults and only about 30 percent of early retirees have coverage through their former employer.

However, the Medicare buy-in offers no excuse for employers to drop health coverage. Employers who cut back on health insurance for older workers could be sued for age discrimination. Employers who drop retiree health coverage, claiming that it is not needed because of the Medicare buy-in, are mistaken. Workers know the difference between subsidized retiree coverage and an unsubsidized buy-in option; the Medicare buy-in is no substitute.

And, the President's proposal will make it harder for employers to drop health coverage for people who already retired. Employers who break their promise of retiree coverage for 55 to 65 year olds will be required to allow those retirees to buy into their workers' health plan under COBRA continuation rules.

We welcome questions about the effects of the President's proposal on labor trends because we share the belief that a healthy, strong workforce is essential to our nation's future. It is this belief that leads us to scrutinize this -- and all -- of the President's proposals. The Medicare buy-in is a creative solution to a serious problem, is fiscally sound and will not discourage employer health coverage or work. Allegations of massive retirement or disruptions of employer-based coverage are unjustifiable excuses to do nothing.



AMERICAN ACADEMY *of* ACTUARIES

Medicare Buy-In R4

January 27, 1998

The Honorable Christopher C. Jennings
Special Assistant to the President for Health Policy Development
Rm 216 Old Executive Office Building
The White House

Dear Chris,

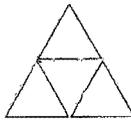
I want to thank you for the opportunity for John Trout and myself to discuss matters of mutual interest with you and Jeanne Lambrew recently. As we indicated in that meeting, the Academy will develop its official analysis of the Medicare buy-in proposals as soon as we get the details of the proposals. We will let you know as the Academy's analysis progresses.

We appreciate the offer to provide briefings on Medicare buy-in for Academy members; that will be most helpful at the appropriate time. In the meantime, we have released the enclosed letter concerning the status of the Academy's analysis of the proposals.

We stand ready to provide nonpartisan technical assistance to all interested parties on issues where actuarial expertise would be helpful.

Yours truly

Wilson W. Wyatt, Jr.
Executive Director



AMERICAN ACADEMY *of* ACTUARIES

January 27, 1998

The Honorable Christopher C. Jennings
Special Assistant to the President
216 Old Executive Office Building
White House

Dear Mr. Jennings:

The American Academy of Actuaries has taken no position in support of or in opposition to Medicare buy-in proposals announced by the President. Nor has the Academy concluded that those proposals are workable or unworkable, or that the cost estimates, premium amounts, and projected participation figures are accurate or inaccurate. The Academy provides nonpartisan analysis to elected officials and does not take positions on policy issues.

There are issues about which we need more information before the Academy can adequately analyze the Medicare buy-in proposals from an actuarial perspective. When the details of the proposals are made available, we will analyze them as thoroughly as possible. We will be happy to discuss the results of our analysis with all interested parties and stand ready to assist in the development of technically sound policies.

Similar letters are being sent to the Senate Minority Leader, the Speaker of the House, the House Minority Leader, and the Administration.

Yours truly,

William F. Bluhm
Vice President

Medicare Buy-In File

The Concord Coalition



The National Debt: \$5,487,280,357,810.54 as of 01/26/98.
Your Share: \$20,394.67

Concord Coalition Position Paper

THE PRESIDENT'S MEDICARE EXPANSION PROPOSAL January 22, 1998

I. The President's Proposal

On January 6 President Clinton announced a plan that would allow people age 62 to 64 to buy into Medicare by paying a monthly premium. A buy-in option was also proposed for those workers age 55 and over who lose their health care coverage due to involuntary loss of employment. A third element of the President's proposal would extend "COBRA" continuation coverage to those age 55 and over whose companies renege on a commitment to provide retiree health benefits.

Purpose

The President's proposal is aimed at improving access to health care coverage for those between the ages of 55 and 65. As stated by Health and Human Services Secretary Donna Shalala, "This is an issue of access. We're not solving all the financing problems of the health care system."

Approximately three million people between the ages of 55 and 65 are uninsured. The administration estimates that ten percent -- 300,000 people overall -- will take advantage of one of these new options.

Financing

According to a statement released by the administration, "The policy is designed to be self-financing. All three proposals are designed to be paid for by the people who benefit. People age 62 to 64 who buy into Medicare will, over time, repay the amount that Medicare 'loans' them when they are paying in. Displaced workers will pay a premium that takes into account participant costs. And, the COBRA buy-in policy has no Federal budget impact."

Age 62 to 64 buy-in

Those buying into Medicare at ages 62 to 64 would pay a monthly premium of about \$300. But because this would not fully pay for the cost of the program expansion they would also pay an additional \$10 to \$20 a month for each year of early eligibility after qualifying for the regular Medicare program at age 65. Gene Sperling, Director of the National Economic Council, described this two-part financing arrangement as allowing people to "take a loan on the extra premium... and spread that out."

Example: Mary Jones, age 62, purchases Medicare coverage for \$300 a month. At age 65 her monthly payment will be the normal Part B premium plus \$30 to \$60.

Displaced workers

Displaced workers buying in at age 55 to 61 would pay a monthly premium of \$400 with no added "pay back" amount for these years after they turn 65. According to Secretary Shalala, no "loan" is made to this group because it would be too expensive for Medicare to forego the full amount needed to provide coverage over the potential seven year period, and too expensive for beneficiaries to pay back after turning 65.

after turning 65.

Example: Paul Smith, age 55, is laid off and loses his employer paid health insurance. He will be permitted to buy into Medicare for \$400 a month. When he turns 62 his monthly premium will go down to \$300 (assuming he is still participating in Medicare). When he turns 65 he will pay the Part B premium plus \$30 to \$60 a month for the three years he spent in the "loan" program.

The administration is assuming that the average cost of insuring those likely to participate in the program would be approximately \$450 a month. The current monthly per beneficiary cost of Medicare is approximately \$460 per month. As noted, however, the financing arrangement is designed to allow people to buy-in at a lower amount (i.e., \$300 a month) and then pay back the difference after turning 65. This would, for the first time, produce varying premium levels for those over age 65.

COBRA

The cost of extended COBRA coverage would, as the administration suggests, have no impact on the Federal budget. The administration expects, however, that employees would pay about 120 percent of their previous employer-sponsored premium to retain coverage.

Start-up cost

The administration estimates that the program will have a start-up cost of \$2 to \$3 billion over five years. According to the administration, "These costs will be financed by a series of new Medicare anti-fraud and waste proposals, which will be announced in the President's budget."

II. Concord's Reaction

The goal of improving access to health care insurance for those age 55 to 64 is sound. The President's proposal thus addresses a legitimate need. It is also significant, and welcome, that the President has attempted to structure his proposal as a fully paid-for reform rather than as an open-ended subsidy. Nevertheless, this is one instance where an incremental reform, aimed too narrowly at one particular problem, may on balance result in more harm than good.

The Concord Coalition does not reject the idea of an early buy-in for Medicare. Any such initiative, however, should be combined with other needed reforms such as an increase in the normal eligibility age and a more equitable approach to cost sharing among all beneficiaries. Expanding access without addressing Medicare's structural needs could make a bad situation worse. On the other hand, if the President's proposal is expanded to address these other issues it may be the basis of a workable and timely reform.

In that regard, the Concord Coalition hopes the President's proposal will stimulate a debate over the extent to which Medicare should subsidize health coverage for people both below and above age 65, and at what age, if any, the existing subsidy should be universally available, regardless of income.

The fiscal risk

The Concord Coalition has always warned that relentless growth of age-based entitlement programs, such as Medicare and Social Security, threaten to devour the federal budget and damage the long-term growth of the economy. Given this, it should come as no surprise that the Concord Coalition issued a press release on January 8 cautioning that the President's proposal to expand Medicare coverage to people below the age of 65 **could end up costing more than anticipated and contribute to Medicare's already unsustainable burden.**

Even though the proposal is ostensibly self-financing there inevitably will be political pressure to subsidize buy-ins for people who cannot afford the premium, and to resist premium increases sufficient to keep pace with rising health care costs. Already, some in Congress are suggesting that the \$300 a month premium proposed by the President is too high and will not improve health insurance access for

month premium proposed by the President is too high and will not improve health insurance access for those who do not qualify for Medicaid, but who cannot afford a non-subsidized premium. **As a matter of political reality, it will be very difficult to establish and maintain a program that benefits only those who can afford to pay \$300-400 a month.**

There is also the danger that those most likely to use the new buy-in option will be those most in need of expensive medical care. While the administration expects a certain amount of such "adverse selection," the recommended premiums could fall far short of the costs of expansion if it turns out that people with unusually expensive medical needs make up a larger percentage of the new beneficiary population than anticipated.

A Repeat of History?

The difficulty of maintaining beneficiary payments at original levels is illustrated by the history of the Part B program. When Medicare was established in 1965 the Part B premium was set at a level to cover 50 percent of program costs. As medical inflation greatly outpaced the economy and Social Security benefits Congress did not permit annual Part B premium increases to exceed Social Security cost of living adjustments. As a result, the dollar amount of the premium declined to cover only 25 percent of program costs. The remaining costs of Medicare Part B are paid out of general revenues, an annual infusion of almost \$60 billion.

Similarly, the Part B deductible was originally set at \$50 and has only risen to \$100, far less than the amount required to keep pace with even non-medical inflation. This experience must be borne in mind when considering the chances that a Medicare expansion will be cost free to the taxpayers.

Medicare cost inflation is far from being solved. According to the Congressional Budget Office, the average annual rate of growth in the Medicare program from 1990 through 1996 was 10.2 percent. While this rate has moderated somewhat, Medicare costs are still expected to increase faster than the economy as a whole. Even after the reforms passed in 1997 Medicare costs per beneficiary are expected to exceed \$10,000 by 2007, up from the current average of approximately \$5,500.

To prevent a massive deficit from occurring as a result of the proposed expansion, politicians would have to raise the buy-in premium to keep pace with per beneficiary costs either through indexation or annual legislation. The experience of the past thirty years is not encouraging.

On the other hand, Concord is pleased that the administration has considered the costs of its proposal and attempted to structure it on a "paid-for" basis rather than as an open-ended subsidy.

In doing so, however, the administration has highlighted the extent to which working age taxpayers subsidize people over age 65, regardless of income, through the regular Medicare program. Under the President's plan, low income 64 year olds will have to pay \$300 a month plus a little extra upon turning 65 to cover the full costs of their benefits, whereas wealthy 65 year olds will continue to receive a subsidy of approximately 75 percent (on both Parts A and B) from the taxpayers.

The age-entitlement factor

While the administration has emphasized that its proposal is aimed at improving access to affordable health care rather than solving Medicare's financial problems, **the logic of providing such generous subsidies to those over age 65 and no subsidies to those under age 65, for access to the same package of benefits, may be questioned.** If Medicare is to be expanded, either through liberalized access or additional benefits (such as prescription drugs and preventive care), **a better strategy would be to spread the burden more equitably and fairly throughout the covered population.**

This might be accomplished, in part, by charging a more realistic premium on an income related basis to all Medicare beneficiaries, regardless of age. The Concord Coalition has long argued that relating Medicare premiums to beneficiaries' income (means-testing) would help correct the huge imbalance between the benefits being promised to tomorrow's elderly and the taxes tomorrow's workers will be

able to pay.

The President's proposal implicitly recognizes that it makes sense to charge higher premiums to those who can afford a lower level of subsidy from the taxpayers. But limiting this concept to those under age 65 would create a new inequity in the system since there is no principled reason to subsidize one group of Medicare beneficiaries so much more heavily than another based solely on age.

As Concord said in a 1997 *Facing Facts*, "The real issue is whether the number of years during which beneficiaries are entitled to receive a blank-check subsidy can keep rising without bankrupting tomorrow's workers and taxpayers" (*Alert Vol. 3, #10, July 14, 1997*).

Providing a buy-in option for younger beneficiaries would make more sense if it were combined with an increase in the eligibility age. The same demographic trends that led Congress to phase-in an increase in the normal retirement age for Social Security also justify an increase in the eligibility age for Medicare. **Such action would not only improve the program's long-term fiscal outlook, it would also send an important signal to aging Baby Boomers that retirement at age 62 or 65 may not be automatic in the future.** Providing an early buy-in option without raising the eligibility age would send the opposite signal—one that should not be sent given the demographic realities.

The number of people age 65 and over will double within the next 35 years, while the number of people age 20 to 64 will increase by only 20 percent. This will have a corrosive effect on the number of workers supporting each Medicare beneficiary. From 3.9 workers per beneficiary in 1996 for Medicare Part A, the ratio will drop to 2.3 by 2030. Moreover, as work force growth slows to an expected annual rate of 0.2 percent by 2010, sustained economic growth will depend on many Baby Boomers postponing traditional retirement.

The Medicare Commission

The 1997 Balanced Budget Act created a bipartisan commission to look into several aspects of Medicare's long-term challenges and to make recommendations. One of the specific duties of the commission is to "make recommendations on modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI [Social Security] program *and on the feasibility of allowing individuals between the age of 62 and the Medicare eligibility age to buy into the Medicare program.*" (italics added)

The logic of combining an early buy-in with an increase in the eligibility age for more heavily subsidized benefits was thus recognized in designing the commission's mandate. Since the commission has specifically been asked to make a recommendation on the feasibility of doing essentially what the President is now proposing, it seems that action on any legislative initiative at this time would be premature.

Unintended Consequences

Another concern is the potential unintended consequences of the President's proposal on employer provided health insurance. Creating a Medicare buy-in option at a rate substantially lower than rates at which individuals can purchase health care insurance in the private market could encourage people to retire early at a time when policy makers should be encouraging people to remain in the work force beyond age 65.

It is also likely that the plan would tempt employers to drop older workers and retirees from their health care plans, or pressure older workers to give up their coverage (which may well be more generous than Medicare) in return for having the employer pay the cost of the Medicare buy-in premium. If this happens, those who have serious medical problems may be "dumped" onto the Medicare market, improving the bottom line for employers but raising the costs to Medicare. Many employers are already scaling back or eliminating retiree health benefits. The President's proposal could well speed up this trend.

An old chestnut

As for relying on waste fraud and abuse to fund the start-up costs, Concord believes that any such savings should be used to fund the shortfall in the current program, which has been running a cash deficit since 1992.

Medicare Part A annual spending already exceeds revenues from the payroll tax by about \$26 billion and is projected to run even greater deficits in the future. Even when interest income and trust fund assets are added in, the program is projected to be insolvent by 2007-before the first Baby Boomer is eligible (even at age 62). The general revenue subsidy to Medicare Part B already approaches \$60 billion a year. In 1997, the combined annual cash deficit for Medicare Parts A and B was approximately \$80 billion.

Conclusion

While Concord does not endorse the President's proposal, there are certain aspects of it that raise opportunities for a more open dialogue about Medicare's future. Aside from expressing skepticism about the proposal's financing structure and adverse incentives, Concord will use the debate over Medicare's expansion to make some broader points about the current structure of the program and its needs for the future, including the possibility of an early buy-in as part of a comprehensive reform package.

Send e-mail to the Concord Coalition at: webmaster@concordcoalition.org.

Last updated: 27 Jan 1998

President Clinton's Medicare Buy-in

Right Goal, Wrong Program

David B. Kendall

**Policy Briefing
February 1998**

With a new proposal to let older Americans buy into Medicare before they turn age 65, President Clinton has focused debate on the critical national problem that 42 million Americans lack health insurance. With double-digit medical inflation now a distant memory, the President deserves great praise for seizing the opportunity to put access to health insurance back on the national agenda. Moreover, he has carefully chosen a population group that is vulnerable due to both corporate downsizing and the prospect that Medicare's eligibility age will be raised in order to stave off bankruptcy. Medicare, however, is not the best choice to achieve the President's goal.

Medicare cannot sustain its current obligations let alone take on new ones. Medicare's trust fund will be running a deficit by 2004 and be bankrupt by 2010, just when retiring baby boomers will put unprecedented demands on Medicare, Social Security, and Medicaid. Given Medicare's problems, the President and congressional leaders should extend new coverage through a financially sound system: the Federal Employees Health Benefits Program (FEHBP).

FEHBP is a better choice for a buy-in program for three reasons. First, it has restrained costs more successfully than Medicare by using competition among private health plans instead of Medicare's bureaucratic price controls. Second, it offers a greater choice of health plans to suit individual needs and preferences. Finally, its health plans offer comprehensive benefits that avoid the need for Medicare participants to purchase supplemental coverage. Indeed, FEHBP is attractive not only as a buy-in program, but also as a model for reforming Medicare itself.

FEHBP's virtues are by no means unique. Most state governments have similar purchasing systems for their employees, and some states have created public purchasing groups for private employers. In California, for example, the California Public Employees Retirement System (CalPERS) serves about one million state and local workers, retirees, and their families, and the Health Insurance Plan of California (HIPC) serves about 140,000 small business workers and their families. Consumers would have even more choice if individuals and employers could join state-sponsored purchasing groups in addition to FEHBP.

This policy briefing examines how a FEHBP buy-in program can be the first step toward the larger goal of universal coverage, how FEHBP can provide immediate assistance to older Americans who lack health insurance, how to avoid possible pitfalls, FEHBP's advantages over Medicare, and the next steps for achieving universal coverage.

A New Path to Universal Coverage

In 1997, the President and Congress started to make a significant dent in the number of uninsured by providing the states with \$4 billion each year for covering up to five million children. The President's Medicare buy-in program would help only about 300,000 people because the \$300 to \$400 monthly premiums would be too expensive for low- and many middle- income Americans. Taken together, these

two actions would still leave at least 35 million Americans without coverage and leave the nation without a clear path toward universal coverage.

Universal coverage does not require that Congress enact a broad, new entitlement such as Medicare that the country can ill-afford. Instead, both federal and state governments should ensure that everyone has the opportunity and responsibility to secure their own health care coverage. This path to universal coverage has three steps:

- **Expand the opportunity for consumers to pool their purchasing power and make informed choices.** FEHBP has long been a leader in equipping consumers to make an informed choice of health insurance, and it could help not only uninsured, older Americans, but all Americans who lack this opportunity. Indeed, Sen. Tom Daschle (D-SD) has already introduced such legislation. Similarly, state-sponsored purchasing groups could also serve as vehicles for empowering individual consumers.
- **Make health care affordable to all.** A refundable tax credit for health insurance would help make it affordable for low- and many middle-income families and workers who cannot get coverage through their job.
- **Require everyone to purchase coverage.** Even when health care coverage is universally affordable and available, there will be a sizeable number of people who remain uninsured. Most likely, they will be young and healthy people who fail to see the importance of insurance or believe they can get free health care at the emergency room. In economic terms, they are "free riders," those who fail to buy insurance when they are healthy and then rely on public support when they are sick. They should be required to purchase coverage for their own protection and everyone else's benefit.
- **The President needs to articulate a new path toward universal coverage because his opponents have already asserted that a Medicare buy-in will lead inexorably to an expansion of Medicare and increased government control of the health system.** Bolstering such claims, Rep. Pete Stark (D-CA), a long time proponent of achieving a Canadian-style, single-payer health care system through incremental Medicare expansions, has vowed to push the President's proposal in Congress.

The President's vision for universal coverage is all the more important given the failure of Republican leaders to articulate a comprehensive health policy. Their "just say no" reactions to his proposal contribute to a political vacuum in which extreme ideological positions prevail and gridlock results. By using FEHBP as a model for a competitive system that restrains the public costs of subsidizing health care coverage, the President and Congress could galvanize broad public support and avoid the many pitfalls associated with expanding Medicare.

Buying into the Federal Employees Health Benefits Program

FEHBP is well positioned to serve uninsured, older Americans. Of the nearly nine million lives it covers, roughly one million are federal workers over age 55, retirees who do not yet qualify for Medicare, and their families. It offers at least one health plan in all 50 states and a choice of three or more plans in all but three states. The choices also vary by the type of plan (health maintenance organizations, fee-for-service, etc.) and the level of benefits (varying deductibles, copayments, and scope of services), which allow consumers to shop and pay for the insurance coverage they prefer.

The primary focus of a buy-in program should be on workers who do not have access to job-based coverage because their employer does not offer it. This situation affects about 20 percent of workers between ages 55 and 64, or about two million workers. Another vulnerable group is workers' spouses who are not old enough to qualify for Medicare and who lose job-based coverage when the worker turns 65, retires, and joins Medicare.

Today, workers and retirees without job-based coverage must either purchase an individual policy on the open market or go without insurance altogether. While individual policies have the advantage of being customized for insurance deductibles and benefits, they have substantial disadvantages compared to policies purchased through large groups that can provide a better value through economies of scale, increased competition, and comparison shopping.

Without a doubt, the massive purchasing power of either Medicare or FEHBP could help uninsured, older Americans. The key difference is that under FEHBP, private health plans--not the government--are responsible for projecting and paying the costs of care. With a Medicare buy-in, government actuaries who have often grossly underestimated the costs of new health programs, would put taxpayers--not themselves or a private company--at risk for making up the difference if they set the wrong price.

Avoiding Possible Pitfalls

Setting the right price is all the more difficult for a buy-in program because it will likely attract individuals who have greater health needs and are more expensive on average to insure. This problem, known as adverse selection, arises from the fact that some people risk going without insurance when they are healthy in the hope that they can buy insurance when they are sick. In fact, any buy-in program has the potential pitfall of encouraging some people to be irresponsible by delaying purchasing coverage until they need it. This problem is similar to letting a homeowner buy insurance on a burning house, which would obviously undermine any insurance system.

The most direct solution to adverse selection is to require everyone to purchase coverage when they are healthy. But politically, it would be difficult to enact a mandate until everyone could afford coverage. Fortunately, there are other approaches that can increase the participation of healthy individuals in a buy-in program, and thereby reduce the costs for everyone who participates.

The President's proposal tries to minimize adverse selection by broadening the appeal of the buy-in with a deferred payment plan in the same way appliance dealers, for example, attract customers by offering no interest loans. Specifically, anyone 62- to 65 years-old could join Medicare by paying a monthly premium of about \$300, and after turning 65, the early joiners would pay a monthly surcharge of \$10 to \$20 for every year that they participated in the buy-in. Deferred payments might minimize adverse selection by attracting relatively more healthy people who would find the lower up-front price easier to stomach. (For obscure budgetary reasons, the proposal does not allow workers over 55--who can buy into Medicare if they are laid-off--to make deferred payments, but instead requires them to make higher up-front payments of about \$400 per month.)

A deferred payment plan might help reduce adverse selection, but other approaches are likely to be more effective. One alternative is to offer a benefits package with higher out-of-pocket costs that might appeal to healthier individuals who can assume greater financial risk. Another approach is to discount coverage for individuals who are healthier because, for instance, they do not smoke. An even more powerful approach would be to permit employers who currently do not offer health insurance to join FEHBP, which would encourage the ongoing participation of both healthy and sick employees because all

workers could receive the tax break for job-based coverage and insurance premiums would be automatically withheld from paychecks.

Given the diverse approaches to minimizing adverse selection, a FEHBP-like alternative should have the flexibility to pursue a variety of approaches rather than facing a legal requirement to use a deferred payment plan as the Medicare buy-in proposal does. FEHBP, unlike Medicare, already operates with this kind of flexibility, which would be particularly important should a buy-in program prove to be unworkable. FEHBP officials working with private plans could detect and avert a major problem much more quickly than Medicare officials who would need an act of Congress to change or even halt the program.

Another possible pitfall lawmakers should avoid with a buy-in program is to require insurers to set the same insurance premiums for both buy-in program participants and regular participants. Because buy-in participants would be on average older and thus more expensive than federal workers, making both groups pay the same price would be a boon to the buy-in participants but a bust for federal workers, thereby causing some of them--especially younger workers--to drop coverage. In other words, some people would get health insurance even as others drop it. For this reason, the insurance pool for buy-in participants should be separate from the insurance pool for federal workers and retirees.

To its credit, the President's Medicare buy-in proposal does not make the mistake of mixing insurance pools because the price paid by the buy-in participants is designed to cover no more and no less than the participants' actual health care costs. Still, it is possible that the insurance pools could become mixed as Medicare buy-in participants sign up for private health plans in Medicare that also serve older Americans over 65.

A related proposal by the President, however, would clearly have the unintended consequence of eroding employer coverage of retirement benefits as a result of adverse selection. The proposal would require employers that drop retiree health benefits to let the retirees rejoin the employer's health plan for a price just slightly more than the group rate for all the employer's workers, thereby mixing the insurance pools for workers and retirees. The retirees who rejoin the employer's group would be less healthy and more costly on average to insure. As a result, the total cost of retirement benefits would rise, and fewer employers would offer retirement benefits in the first place.

FEHBP's Advantages over Medicare

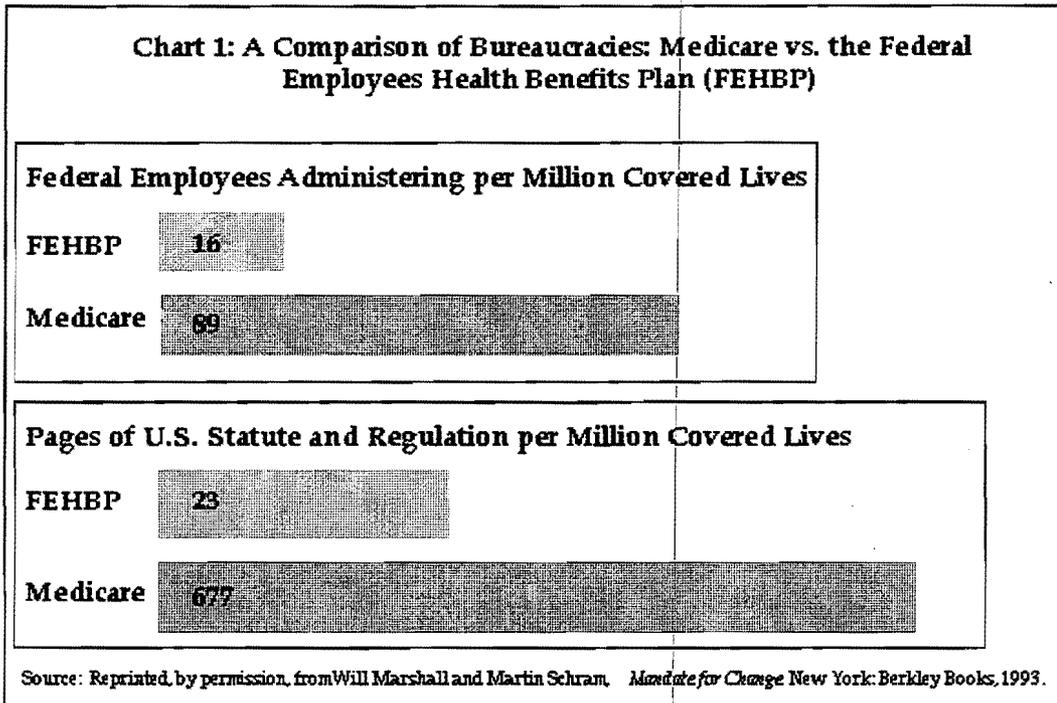
The virtues of FEHBP have been hailed by such diverse groups and leaders as the conservative Heritage Foundation, New Democrat Senator John Breaux (D-LA), and liberal Senator Edward Kennedy (D-MA). Indeed, in the final days of the health care reform debate in 1994, FEHBP emerged as a potential bipartisan compromise to expand access to coverage for all the uninsured. In addition to its broad political support, FEHBP has the following three policy advantages over Medicare.

- *FEHBP uses competition, not bureaucracy to restrain costs.* Price increases in FEHBP have averaged 4 percent annually during this decade compared to 8 percent for Medicare coverage. FEHBP's success in restraining costs stems from a simple and powerful reason: health plans participating in FEHBP will lose business to competitors if they fail to restrain costs. Federal workers and retirees are responsible for paying a portion of the health plan's premiums beyond a basic contribution from their employing agency, and thus are sensitive to the prices charged by health plans.

In contrast, Medicare insulates beneficiaries by guaranteeing to pay for the most expensive form o

coverage: fee-for-service medicine. Medicare regulations attempt to control costs by limiting the fees that doctors and hospitals can charge for each service. These price controls give providers an incentive to avoid them by finding loopholes, and to fight them by lobbying members of Congress. Price controls discourage providers from developing innovative techniques and services that make health care less costly or higher quality. In response, more Medicare rules are issued, and the government assumes more and more responsibility for how health care is delivered.

As Chart 1 illustrates, Medicare is much more bureaucratic than FEHBP. Medicare has 29 times more pages of regulations and five times more employees for each life insured.



FEHBP gives

consumers greater choice and more information. Health insurance plans in FEHBP can offer varying degrees of coverage options because they have considerably more latitude to develop their benefits and services than health plans in Medicare. This flexibility helps reduce adverse selection because healthy individuals who generally would prefer less generous insurance coverage can purchase coverage at lower rates. Under Medicare, a wide range of health plans can participate, but they must provide benefits at least as expensive as traditional fee-for-service coverage. FEHBP has had a long history of providing consumers with useful and usable information to comparison shop. Most recently, it has been an early adopter of new performance measures developed by the Foundation for Accountability (FACCT), which promises to answer critical questions about how well a plan performs in treating and preventing illness. While Medicare is moving toward the same type of system as a result of reforms enacted as a part of the Balanced Budget Act, it has a long way to go before catching up with FEHBP.

- *FEHBP's benefits offer true financial protection and do not require supplemental insurance.* At a minimum, all plans participating in FEHBP offer benefits packages that cover catastrophic health

care costs, which prevents individuals from being bankrupt by an injury or disease. Medicare's basic benefits, however, do not cover catastrophic costs, so beneficiaries with traditional fee-for-service Medicare coverage must purchase supplemental coverage, which could add \$100 or more per month to the cost of a Medicare buy-in.

Next Steps Toward Universal Coverage

Looking ahead, if a FEHBP buy-in for uninsured, older Americans proves successful, uninsured Americans of all ages should be invited to participate. But universal coverage requires two additional steps.

- **Provide a refundable tax credit to individuals who purchase their own coverage.** The existing tax break for job-based coverage is the single most important force holding the current private health insurance system together. It encourages both healthy and sick employees to seek coverage through employers because the health insurance premiums paid by employers are excluded from federal and state income and payroll taxes, which reduces the price of insurance for middle-income Americans by 30 percent to 50 percent. Self-employed workers receive a partial deduction for health insurance, which is scheduled by law to expand gradually to 80 percent by the year 2006.

But an unlimited tax exclusion for health insurance has several flaws. It is a regressive subsidy because like all tax deductions, it is worth more to workers in higher income tax brackets, and the subsidy is too small to benefit many low-wage workers. It shortchanges workers in small businesses because large companies can substantially reduce their costs through economies of scale. It fails to encourage employers to cover families because family coverage amounts to a hidden raise at the expense of single workers. It creates a barrier for workers who do not like the health benefits offered by their employer, to opt out. Finally, it encourages employees to demand, and employers to offer, the most costly health insurance because a dollar paid in benefits is worth more than a dollar paid in wages.

A better solution would be a tax credit that individuals could use to purchase their own coverage. The amount of the tax credit should be roughly equivalent to the value of the tax exclusion, which is about \$1,200 per family per year. The tax credit should be refundable so that it is available to lower-income workers who have no income tax liability. It should also be adjusted up or down to reflect age and other factors. It should, of course, not be available to individuals who are already insured through Medicaid or Medicare. Like many other tax credits and deductions, it should be gradually phased out for upper-income Americans. The revenue lost from the credit could be largely offset by capping the current exclusion at the average price of a typical health insurance plan, which would end federal subsidies for the most expensive health insurance plans.

A tax credit for health insurance would create alternatives to the job-based coverage. Workers who have been left out of the job-based system or whose employers do not offer good health plans would be empowered to seek coverage on their own or through large purchasing systems such as FEHBP. While some employers might drop their coverage, the tax credit would ultimately improve the job-based system by giving employers an additional incentive to provide good benefits and health plan choices.

- **Require free-riders to purchase health coverage.** While a tax credit for health insurance would go a long way toward solving the problems of affordability and adverse selection, ultimately every individual should be required to have health insurance. Once tax credits--and any additional

subsidies needed to make health care insurance affordable--are in place, the remaining uninsured would have little excuse not to pay their fair share for health insurance and stop relying on public support when they are sick. Some people will, of course, simply refuse to purchase insurance, and at some point, the enforcement costs of a mandate will exceed the benefits. To finance their care fairly and efficiently, their unclaimed tax credits could be set aside to compensate for providers' charity care.

State governments should take similar steps to either mirror or outpace federal action. In addition to creating more choice by allowing individuals to buy into state- sponsored purchasing groups, states with an income tax should also provide a tax credit to encourage individuals to purchase their own coverage when they do not have job-based coverage. In addition, states that have already made health care affordable for children, for instance, should adopt a requirement that all children have coverage. As a means of enforcement, state income tax forms could require proof of health care coverage in order for parents to claim an income tax exemption for their children.

Conclusion

Several times during this century, major efforts to achieve universal coverage have failed because by creating a broad entitlement to health care coverage, they would have put the government in control of the health care system. Now is the time to break this pattern of failure by solidifying support for an incremental approach that achieves the public goal of universal coverage through market means. By building on the bipartisan efforts to enact the Kassebaum-Kennedy bill in 1996 and children's health insurance legislation in 1997, President Clinton and Congress can lead the country toward a fiscally disciplined system of universal coverage that gives consumers purchasing power, makes health care affordable, and ultimately rests on each individual's responsibility for their own health care coverage.

David B. Kendall is PPI's Senior Analyst for Health Policy. PPI Health Research Analyst Joni Hong assisted with this briefing.

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Medicare Buy-In File

Medicaid

FEB 19 1998

Health Care Financing Administration

Office of Legislation

Request for Clearance

To: Jean Lambrew, White House
Mark Miller, OMB
Ashley Files, ASMB
Jane Horvath, ASL
Gary Claxton, ASPE

From: Nancy De Lew, HCFA

Subject: Hill request for actuarial memo on Medicare buy-in proposal

As you know, at the Feb. 10 briefing for Hill staff on the Medicare buy-in proposals, we were requested to provide actuarial data, including 10 year estimates, on the proposals. I have attached a paper prepared by Rick Foster in response to this request. Please let me know if you have any concerns about sending this paper to the Hill by COB Friday Feb. 20.

cc
Debbie Chang
Peter Hickman
Shawna Stephens

February 19, 1998

NOTE TO: Barbara Cooper
Nancy DeLew

SUBJECT: Information Requested by Congressional Staff

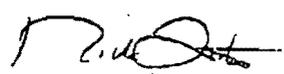
At the February 10 briefing of Congressional staffs on the Medicare buy-in proposals, staff representatives requested a written summary of the estimated financial impact of the proposals. I believe the attached information would satisfy their request.

The February 17 memorandum is an updated version of our original documentation for the age 62-64 buy-in estimates. It reflects subsequent changes in the proposal, such as the July 1, 1999 effective date and the cutoff of amortization premiums at age 85. Please note that the latter change was specified after the Budget estimates were locked in, with the result that the estimates for the current proposal differ a bit from the Budget estimates. (We cautioned everyone during the most recent conference call that the age-85 cutoff would have this effect.)

The February 18 memorandum is new but contains corresponding information and estimates for the displaced worker buy-in proposal. Its summary of the proposal borrows significantly from Sharman's write-up of the proposal specifications (thanks!)

Finally, the two tables respond to Howard Cohen's request for 10-year estimates (since the memos only cover the first 5 years).

Please let me know if you have any questions.


Rick Foster

cc: Sharman Stephens

Attachments (4)

OPTIONAL FORM 90 (7-90)

FAX TRANSMITTAL

To: Nancy DeLew		From: Rick Foster	
Dept/Agency		Phone # OACT	
Fax #		Fax # 410 786 1295	

of pages 13

NSN 7540-01-317-7268 5099-101 GENERAL SERVICES ADMINISTRATION

MEMORANDUM

February 17, 1998

FROM: Richard S. Foster
Sally T. Burner
Elliott A. Weinstein
Office of the Actuary

SUBJECT: Estimated Financial Impact of the Administration Proposal To Allow Voluntary Purchase of Medicare Coverage at Ages 62 to 64

On January 6, 1998, President Clinton announced a proposal to expand Medicare coverage to certain categories of individuals below age 65 on a voluntary basis. The first category includes certain persons at ages 62 to 64; in addition, individuals at ages 55 to 61 who meet certain requirements could enroll as "displaced workers." This memorandum describes our estimates of the financial impact on the Medicare program of the first part of the proposal, namely the voluntary coverage of certain persons at ages 62 to 64. The estimates in this memorandum are subject to change if the specifications for the proposal are modified.

Under present law, eligibility for Medicare benefits is generally limited to persons who are age 65 or older.¹ Under the subject proposal, individuals at ages 62 through 64 would be allowed to voluntarily purchase Medicare coverage through payment of monthly premiums. These premiums would be paid from the time of enrollment through age 84 and would be designed to cover the full cost of benefits prior to age 65. Voluntary enrollment would be limited to persons who do not have employer-sponsored health insurance, Medicaid, or other Federal group health insurance coverage. In addition, individuals would have to enroll at the first opportunity (e.g., at age 62 or upon cessation of their group insurance coverage at a later age). Enrollees would be offered the full choice of Medicare managed care or fee-for-service options. Once enrolled prior to age 65, participants could withdraw from participation but would generally face a premium penalty (described below) and could not re-enroll prior to age 65.

To purchase coverage, enrolling individuals would pay monthly premiums in two stages: The first stage, referred to as the "standard premium," would be payable prior to age 65 and would equal the average per capita cost of coverage if *all* individuals between ages 62 and 65 were covered by Medicare. At ages 65 through 84, an "amortization premium" would be payable equal to the amortized value of the difference between total Medicare costs prior to age 65 and the corresponding standard premiums at those ages.

For example, under the subject proposal an individual enrolling at age 62 in 1999 would pay the following premiums:

- \$305 per month in 1999, \$307 in 2000, and \$319 in 2001, representing the average monthly cost each year if everyone in the 62-64 population were covered.

¹ Individuals who have received Social Security disability benefits for at least 24 months and persons with end-stage renal disease are also eligible.

- \$48 per month at ages 65 through 84 (to amortize the Medicare costs incurred prior to age 65 in excess of the premiums paid).

The standard premium would vary each year, to match increases in program costs. The amortization premium would be a fixed amount throughout an individual's repayment period, but would vary from one participant to another, depending on his or her year of enrollment and age at enrollment. Both types of premiums would vary geographically, with enrollees in higher-cost areas paying greater premiums than those in lower-cost areas. Enrollees who terminated their Medicare coverage prior to age 65 would still be responsible for payment of amortization premiums for their period of participation, rounded up to the next higher multiple of 12 months.²

Table 1, attached, shows an illustrative matrix of standard and amortization premiums that would apply for participants in the first 5 years. Results are shown for exact ages of enrollment only (62, 63, or 64) although in practice varying amortization premiums would be required for in-between ages of enrollment. The amounts shown represent national averages; as noted above, actual premiums would vary geographically.

Table 2 (attached) presents the estimated increases in Medicare benefit payments, administrative expenses, and premium revenues, and the overall net cost to Medicare under the subject proposal. The total net cost to Medicare over the first 5 calendar years (1999-2003), is \$1.5 billion. This cost results from two factors:

- In the short run, benefit costs and administrative expenses would outweigh premium collections since about one-third of the initial costs at ages 62-64 would not be paid by enrollees until after age 65, rather than year-by-year as the costs are incurred.³
- Although the premiums would be determined on the basis of the estimated costs for those who are expected to ultimately enroll, the first people to sign up at program inception would tend to be those in poorer-than-average health status who currently are uninsured. The premiums paid by these early enrollees would not be sufficient to cover their costs, resulting in a permanent cost to Medicare. *(how much? it must be very small)* *one-time,*

In addition to these Medicare costs, there would be an increase in OASDI benefit payments and administrative expenses. Some individuals who are currently working and covered by employer-sponsored health insurance would elect to retire if they could obtain Medicare coverage prior to age 65. The Office of the Chief Actuary at the Social Security Administration has estimated that these OASDI costs would total \$0.5 billion over fiscal years 1999-2003. This cost would not be covered by premium payments over time, since the premium determination would be designed only to finance the additional Medicare costs prior to age 65. Under the Administration's Budget legislative package, however, the net Medicare and OASDI costs described above would be offset by other Medicare savings proposals.

² For example, someone terminating coverage after 18 months of participation would be required to pay amortization premiums at ages 65-84 as if they had participated for a full 24 months.

³ Over time, as the number of beneficiaries paying amortization premiums increased, the aggregate amount of premiums paid by beneficiaries at all ages in a given year would approximately offset the cost of benefits to early enrollees at ages 62 to 64 in that year. This "equilibrium level" would not be attained for roughly 20 years.

We estimate that the following numbers of people at ages 62-64 would elect to enroll in Medicare under this proposal. These figures represent the ultimate increase in the number of beneficiaries, after enrollment has fully phased in (as opposed to an annual increase in beneficiaries).

Health insurance coverage under present law	Number of Medicare enrollees, by health status			Medicare enrollment rate, by health status		
	Above avg.	Below avg.	All	Above avg.	Below avg.	All
Uninsured	18,000	49,000	67,000	3%	19%	8%
Private individual coverage	44,000	72,000	116,000	10%	82%	23%
Private group coverage (workers) ..	17,000	3,000	20,000	1%	1%	1%
All	79,000	124,000	203,000	—	—	—

Why do we need the health-status + insurance break-outs?
what's the denominator?

The estimates shown in this memorandum are based on the assumptions underlying the President's 1999 Budget. The estimated numbers of people who would voluntarily enroll in Medicare under this proposal, and the associated changes in Medicare benefits, administrative expenses, and premiums, are based on limited data and necessarily involve a substantial degree of behavior modeling and judgment. Consequently, the actual future costs resulting from enactment of this proposal could vary significantly from these estimates. **[NEED TO STAND BEHIND ESTIMATE!]**

Richard S. Foster
 Richard S. Foster, F.S.A.
 Chief Actuary

Sally T. Burner
 Sally T. Burner, A.S.A.
 Special Assistant to the Chief Actuary

Elliott A. Weinstein
 Elliott A. Weinstein, A.S.A.
 Actuary

Horrocks
largely

Note: David R. McKusick, F.S.A. and James W. Mays of Actuarial Research Corporation provided technical assistance with the preparation of the estimates shown in this memorandum.

Attachments (2)

Table 1
Illustrative standard and amortization premiums, under a proposal
to allow voluntary purchase of Medicare coverage at ages 62 to 64

**Standard premium payable at ages 62-64,
by calendar year**

Calendar year	Monthly premium payable by all voluntary enrollees at ages 62-64
1999	\$305
2000	\$307
2001	\$319
2002	\$335
2003	\$355

**Monthly amortization premium payable at ages 65
through 84, by year of enrollment and age at enrollment**

Calendar year of enrollment	Age at enrollment		
	62	63	64
1999	\$48	\$31	\$15
2000	\$50	\$31	\$15
2001	\$52	\$33	\$15
2002	\$55	\$34	\$16
2003	\$58	\$36	\$17

- Examples:
1. An individual enrolling at age 62 in 1999 would pay monthly premiums of \$305, \$307, and \$319 in 1999-2001, respectively, and a monthly premium of \$48 in 2002-2021.
 2. An individual enrolling at age 63 in 2001 would pay monthly premiums of \$319 and \$335 in 2001-2002, respectively, and a monthly premium of \$33 in 2003-2022.

Note: Standard and amortization premiums would vary geographically. The illustrative amounts shown here are based on estimated national averages.

Table 2
Estimated increases in Medicare benefit payments, administrative expenses,
and premium revenues, under a proposal to allow voluntary purchase of
Medicare coverage at ages 62 to 64
(In billions)

	Calendar year ¹					Total, 1999-2003
	1999	2000	2001	2002	2003	
Increase in Medicare benefit expenditures	\$0.5	\$1.0	\$1.0	\$1.1	\$1.2	\$4.8
Increase in Medicare administrative expenses ..	(²)	(²)	(²)	(²)	(²)	(²)
Increase in Medicare premium revenue	\$0.3	\$0.6	\$0.7	\$0.8	\$0.9	\$3.4
Net total cost to Medicare	\$0.2	\$0.4	\$0.3	\$0.3	\$0.3	\$1.5

	Fiscal year ¹					Total, 1999-2003
	1999	2000	2001	2002	2003	
Increase in Medicare benefit expenditures	\$0.2	\$1.0	\$1.0	\$1.1	\$1.2	\$4.5
Increase in Medicare administrative expenses ..	(²)	(²)	(²)	(²)	(²)	(²)
Increase in Medicare premium revenue	\$0.1	\$0.6	\$0.7	\$0.8	\$0.9	\$3.1
Net total cost to Medicare	\$0.1	\$0.4	\$0.3	\$0.3	\$0.3	\$1.4

¹ Assumes a July 1, 1999 effective date.
² Less than \$50 million.

Note: There would also be associated increases in OASDI benefit payments and administrative expenses. The Office of the Chief Actuary, SSA, has estimated that these costs would total \$0.5 billion over fiscal years 1999-2003.

Office of the Actuary
 Health Care Financing Admin.
 February 17, 1998

MEMORANDUM

February 18, 1998

FROM: Richard S. Foster
Sally T. Burner
Elliott A. Weinstein
Office of the Actuary

SUBJECT: Estimated Financial Impact of the Administration Proposal To Allow Voluntary Purchase of Medicare Coverage by Displaced Workers at Ages 55 to 61 and Their Spouses

On January 6, 1998, President Clinton announced a proposal to expand Medicare coverage to specified categories of individuals below age 65 on a voluntary basis. The first category includes certain persons at ages 62 to 64; in addition, individuals at ages 55 to 61 who meet certain requirements could enroll as "displaced workers," as could their spouses. This memorandum describes our estimates of the financial impact on the Medicare program of the second part of the proposal, namely the voluntary coverage of displaced workers at ages 55 to 61 and their spouses. The estimates in this memorandum are subject to change if the specifications for the proposal are modified.

Under present law, eligibility for Medicare benefits is generally limited to persons who are age 65 or older.¹ Under the subject proposal, displaced workers at ages 55 through 61 would be allowed to voluntarily purchase Medicare coverage through payment of monthly premiums. These premiums would be paid during the period of enrollment only ~~and are not expected to cover the full Medicare costs of the individuals enrolling~~.² Voluntary enrollment would be limited to persons who:

- Are eligible for Unemployment Insurance benefits at the time of displacement;
- Have lost health insurance coverage as a result of an involuntary termination of employment and who had such coverage for at least one year prior to termination;
- Have no access to employer-sponsored health insurance, including COBRA continuation rights or coverage through a spouse; and
- Are not eligible for Medicaid or any other Federal public health insurance program.

[This is not a specification but an outcome] DESCRIBE Later

¹ Individuals who have received Social Security disability benefits for at least 24 months and persons with end-stage renal disease are also eligible.

² In both respects, this proposal differs significantly from the proposal to allow voluntary enrollment for certain persons at ages 62-64. For the latter proposal, premiums would be payable from the time of enrollment through age 84 and are intended to cover enrollees' entire cost of Medicare benefits and administrative expenses prior to age 65. See our memorandum dated February 17, 1998 for further details.

In addition, individuals would have to enroll within 62 days of displacement (or, if later, the loss of their eligibility for other coverage, e.g., COBRA continuation).³ Enrollees would be offered the full choice of Medicare managed care or fee-for-service options. Once enrolled prior to age 62, participants could withdraw from participation but could not re-enroll unless they again met all of the qualifying conditions listed above. Displaced worker enrollees who subsequently became re-employed could continue their voluntary Medicare coverage, if they remained without access to other public or employer-sponsored health insurance. Spouses of displaced workers would also be eligible to enroll at any age if they, too, met the eligibility and enrollment conditions (other than having lost a job). Medicare coverage under this proposal would end once the displaced worker attained age 62; such individuals could continue coverage under the age 62-64 enrollment provisions if they met the eligibility criteria. Spouses' coverage could continue through age 61 as long as the displaced worker remained covered. *Spouse does not have access to public or employer-based insurance.*

Displaced workers and spouses would each pay monthly premiums throughout their period of participation. The premiums would vary geographically and by age group; at the national level, premiums would equal 165 percent of the average monthly cost if everyone in the population at those ages were covered by Medicare. Premiums would be adjusted each year to match increases in program costs. Table 1, attached, shows illustrative premiums by age in 1999, based on estimated national average amounts.

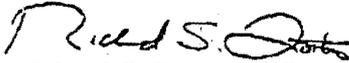
In practice, individuals choosing to enroll in Medicare under this proposal would generally do so only if they anticipated receiving health care coverage with a value at least equal to their premium payments. As a result of this "antiselection" in the enrollment decision, the cost of the enrollment group would exceed their premium revenue and the Medicare program would experience a net cost under the proposal. Table 2 (attached) presents the estimated increases in Medicare benefit payments, administrative expenses, and premium revenues, and the overall net cost to Medicare under the subject proposal. The total net cost to Medicare over the first 5 calendar years (1999-2003), is \$0.2 billion. Under the Administration's Budget legislative package, this net Medicare cost would be offset by savings from other Medicare proposals.

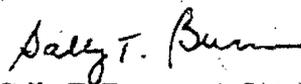
We estimate that the following numbers of displaced workers and spouses would elect to enroll in Medicare under this proposal. These figures represent the increase in the number of beneficiaries in the year 2006, after enrollment has fully phased in (as opposed to an annual increase in beneficiaries).

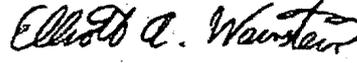
Category of enrollee	Number of Medicare enrollees, by health status		
	Above avg.	Below avg.	All
Displaced workers	4,000	12,000	16,000
Reemployed displaced workers	15,500	47,500	63,000
Spouses	19,500	19,500	39,000
Total	39,000	79,000	118,000

³ The proposal is assumed to become effective on July 1, 1999; workers displaced since January 1, 1998 would be initially eligible for voluntary coverage.

The estimates shown in this memorandum are based on the assumptions underlying the President's 1999 Budget. The estimated numbers of people who would voluntarily enroll in Medicare under this proposal, and the associated changes in Medicare benefits, administrative expenses, and premiums, are based on limited data and necessarily involve a substantial degree of behavior modeling and judgment. Consequently, the actual future costs resulting from enactment of this proposal could vary significantly from these estimates.


Richard S. Foster, F.S.A.
Chief Actuary


Sally T. Burner, A.S.A.
Special Assistant to the Chief Actuary


Elliott A. Weinstein, A.S.A.
Actuary

Note: David R. McKusick, F.S.A. of Actuarial Research Corporation provided technical assistance with the preparation of the estimates shown in this memorandum.

Attachments (2)

Table 1

Illustrative monthly premiums in 1999, under a proposal to allow voluntary purchase of Medicare coverage by displaced workers at ages 55 to 61 and their spouses, by age group

Age group	Monthly premium payable in 1999
Below age 20 ..	\$183
20-24	\$206
25-29	\$226
30-34	\$241
35-39	\$251
40-44	\$271
45-49	\$302 *
50-54	\$343 *
55-59	\$394
60-61	\$437

I don't want to think about this situation.

Do we really need to show all these eye bands? I recommend that we just show 45-59 + footnote

Note: Premiums would vary geographically. The illustrative amounts shown here are based on estimated national averages.

* These premiums are for spouses of displaced workers. If the spouse were younger, the premiums would be (proportionately) lower.

Table 2
Estimated increases in Medicare benefit payments, administrative expenses,
and premium revenues, under a proposal to allow voluntary purchase of
Medicare coverage by displaced workers at ages 55 to 61 and their spouses
 (In billions)

	Calendar year ¹					Total, 1999-2003
	1999	2000	2001	2002	2003	
Increase in Medicare benefit expenditures	\$0.1	\$0.2	\$0.3	\$0.4	\$0.5	\$1.5
Increase in Medicare administrative expenses ..	(²)	(²)	(²)	(²)	(²)	(²)
Increase in Medicare premium revenue	\$0.1	\$0.2	\$0.2	\$0.4	\$0.5	\$1.4
Net total cost to Medicare	(²)	(²)	(²)	(²)	\$0.1	\$0.2

	Fiscal year ¹					Total, 1999-2003
	1999	2000	2001	2002	2003	
Increase in Medicare benefit expenditures	(²)	\$0.2	\$0.3	\$0.4	\$0.5	\$1.4
Increase in Medicare administrative expenses ..	(²)	(²)	(²)	(²)	(²)	(²)
Increase in Medicare premium revenue	(²)	\$0.2	\$0.2	\$0.3	\$0.5	\$1.2
Net total cost to Medicare	(²)	(²)	(²)	(²)	\$0.1	\$0.2

¹ Assumes a July 1, 1999 effective date.
² Less than \$50 million.

Shouldn't this be Table 3 Attached to the previous memo.

Estimated increases in Medicare premium revenues and expenditures under a proposal to permit voluntary purchase of Medicare at ages 62 to 64
 (In millions)

Fiscal year 1/	Increase in premium revenue			Increase in expenditures			Net cost to Medicare		
	HI	SMI	Total	HI	SMI	Total	HI	SMI	Total
1999	\$68	\$66	\$134	\$116	\$113	\$229	\$48	\$47	\$95
2000	\$300	\$292	\$592	\$482	\$469	\$950	\$182	\$177	\$358
2001	\$350	\$341	\$691	\$517	\$503	\$1,020	\$167	\$162	\$329
2002	\$412	\$401	\$814	\$563	\$547	\$1,110	\$150	\$146	\$296
2003	\$460	\$447	\$907	\$600	\$584	\$1,184	\$140	\$137	\$277
2004	\$503	\$489	\$991	\$635	\$618	\$1,253	\$133	\$129	\$261
2005	\$544	\$529	\$1,073	\$668	\$650	\$1,317	\$124	\$121	\$245
2006	\$591	\$575	\$1,166	\$708	\$688	\$1,396	\$116	\$113	\$230
2007	\$641	\$624	\$1,265	\$750	\$729	\$1,479	\$109	\$106	\$214
2008	\$693	\$673	\$1,366	\$793	\$771	\$1,565	\$101	\$98	\$199
1999-2003	\$1,591	\$1,547	\$3,138	\$2,278	\$2,215	\$4,493	\$687	\$668	\$1,356
1999-2008	\$4,563	\$4,437	\$8,999	\$5,832	\$5,671	\$11,504	\$1,270	\$1,235	\$2,504

1/ Assuming 7-1-99 effective date.

Note: Totals may not add due to rounding.

Office of the Actuary
 Health Care Financing Admin.
 February 19, 1998

Table 3

Estimated increases in Medicare premium revenues and expenditures under a proposal to permit voluntary purchase of Medicare by displaced workers and their spouses
 (In millions)

Fiscal year 1/	Increase in premium revenue			Increase in expenditures			Net cost to Medicare		
	HI	SMI	Total	HI	SMI	Total	HI	SMI	Total
1999	\$19	\$19	\$38	\$22	\$22	\$44	\$3	\$3	\$6
2000	\$87	\$84	\$171	\$101	\$98	\$199	\$14	\$14	\$28
2001	\$113	\$110	\$223	\$130	\$127	\$257	\$17	\$17	\$34
2002	\$165	\$160	\$325	\$187	\$182	\$369	\$22	\$22	\$44
2003	\$230	\$224	\$454	\$259	\$251	\$510	\$29	\$28	\$56
2004	\$297	\$289	\$586	\$332	\$323	\$655	\$35	\$34	\$69
2005	\$364	\$353	\$717	\$405	\$393	\$798	\$41	\$40	\$81
2006	\$420	\$409	\$829	\$467	\$454	\$920	\$46	\$45	\$91
2007	\$453	\$441	\$894	\$503	\$489	\$992	\$50	\$48	\$98
2008	\$480	\$467	\$948	\$533	\$519	\$1,052	\$53	\$51	\$104
1999-2003	\$613	\$596	\$1,210	\$699	\$680	\$1,379	\$85	\$83	\$169
1999-2008	\$2,628	\$2,555	\$5,184	\$2,938	\$2,857	\$5,796	\$310	\$302	\$612

1/ Assuming 7-1-99 effective date.

Note: Totals may not add due to rounding.

*Add a table 4 - to both memos
 Combined costs of 62-64 +
 Displaced workers +
 Savings from Proposals.*

Office of the Actuary
 Health Care Financing Admin.
 February 19, 1998

A
CBO
REPORT

**AN ANALYSIS OF THE PRESIDENT'S
BUDGETARY PROPOSALS
FOR FISCAL YEAR 1999**

MARCH 1998

The Congress of the United States
Congressional Budget Office

The Administration's Medicare Buy-In Proposals

The President's budget contains two proposals intended to increase health insurance coverage by expanding the federal Medicare program. First, the Administration proposes to allow certain people ages 62 to 64 to purchase Medicare coverage. To the extent that premiums paid at those ages did not cover the cost of the additional benefits provided, participants would have to pay an additional premium from ages 65 to 84. Second, the Administration proposes to allow displaced workers ages 55 to 61 to purchase Medicare coverage. Under the Administration's proposal, the government would not attempt to recover the cost of adverse selection in that program.¹

In both programs, costs to the federal government would be held down by the high cost of the specified premiums and the stringency of the eligibility criteria. The Congressional Budget Office estimates that by 2003, only 6 percent of people ages 62 to 64 and 0.1 percent of people ages 55 to 61 would be eligible and choose to participate. If the premiums were reduced or the eligibility requirements were relaxed, participation in the programs could be greater and federal costs could be higher. Changes in assumptions about how people would respond to the new programs could also significantly affect the cost estimates.

1. The description and analysis of the Administration's proposals are based on information available to the Congressional Budget Office in late February.

Medicare Buy-In for People Ages 62 to 64

The Administration proposes to allow people ages 62 to 64 to enroll voluntarily in Medicare. Enrollment would be limited to people who do not have employment-based health insurance or Medicaid, and they would have to enroll as soon as they were eligible. Events that would qualify people for enrollment would include turning age 62 or losing employment-based health insurance under certain circumstances between ages 62 and 64.

Medicare premiums under the buy-in would be paid in two parts, both of which would be updated annually:

- o Premiums paid before age 65 would be set at a rate that would reflect the average expected cost of benefits if everyone ages 62 to 64 participated in the buy-in—about \$310 a month in 1999 (plus an additional \$6 a month for administrative costs). Premiums would be adjusted for geographic variation in Medicare costs.
- o Premiums paid at age 65 and thereafter would be set to recapture for the government the extra benefits Medicare would pay as a result of risk selection. Those premiums would be based on the estimated difference between the pre-65 premium and the higher average costs of people who would choose to participate. Enrollees would continue to pay post-65 premiums until they reached age 85.

To help reduce adverse risk selection, the President's plan would limit enrollment opportunities, prohibit reenrollment, and require buy-in participants who dropped Medicare before age 65 to pay the full post-65 premium for the year in which they dropped coverage.

Potential enrollees would decide whether to purchase coverage based on their comparison of the price of Medicare and the price of the private insurance available to them. The Medicare price is the pre-65 premium, which would be paid during the buy-in years, plus an amount that represents enrollees' perceptions of the present value of the post-65 premiums. If the price for the Medicare buy-in was perceived to be \$350 a month, for example, most people who could obtain other coverage for less than \$350 a month would decline to enroll. People who otherwise would have to pay more than \$350, however, would be more likely to sign up for Medicare. Assuming that Medicare's costs under the buy-in would be related to the prices people faced in the private market, covering the likely enrollees in this example would cost more than \$350 a month. If the price was raised, the composition of enrollment would change as well. Some people who could obtain private coverage for less—those who would be the least expensive to cover—would drop out, and the average cost of covering the remaining people would rise.

The Congressional Budget Office's estimate assumes that potential enrollees would heavily discount the extra premiums they would face after turning 65. As a result, they would base their decision to purchase Medicare on a price not much higher than the pre-65 premium alone. Under that assumption, and the assumption that Medicare's pre-65 premiums would be about 33 percent less than the private premiums that people of average risk would be charged for a comparable package of benefits, CBO estimates that 320,000 people would participate in 1999; 390,000 in 2003; and almost 500,000 in 2008. The estimate assumes that adverse selection would be a relatively limited problem and that the post-65 premiums would allow the program to cover its costs over the expected lifetime of each cohort of participants.

CBO estimates that Medicare costs for people who enrolled in 1999 would average about \$389 a month, about 25 percent more than the pre-65 premium of \$310. To recapture that difference, Medicare would add about \$10 a month to participants' Part B premi-

ums for each year they participated in the buy-in. Those purchasing Medicare for all three years of the buy-in period starting in 1999 would pay an additional \$31 a month from ages 65 to 84.

Budgetary Impact and Comparison with the Administration's Estimate

CBO estimates that the Medicare buy-in for people ages 62 to 64 would raise outlays for Medicare benefits by \$8.9 billion over the 1999-2003 period. Pre-65 premiums would total \$7.3 billion, and post-65 premiums would amount to \$0.2 billion (see Table B-1). The net increase in Medicare spending would be \$1.3 billion, roughly the same as the Administration's estimated net cost of \$1.4 billion over five years. Of the 320,000 people who would participate in 1999, two-thirds would otherwise have purchased private individual coverage, and about 30 percent would have been uninsured. The remainder would consist of people induced to retire because of the buy-in option.

CBO's estimates of the net cost of the buy-in are similar to the Administration's, although CBO's estimates of participation are higher. Overall, CBO concluded that participants would cost about 45 percent more than the average cost of the entire newly eligible group and about 25 percent more than the pre-65 premiums they would pay. The Administration estimated that participants would cost about 50 percent more than their pre-65 premiums. CBO's estimate of net costs per participant is lower for two reasons: it reflects the fact that some high-cost people in the eligible age group would already have Medicare because of a disability, and secondarily, it assumes higher estimated participation and slightly lower adverse selection. Reflecting the larger gap between the costs of coverage and pre-65 premiums, the Administration estimated that post-65 premiums would initially be about \$14 a month for each year of participation—higher than CBO's estimate of \$10 a month.

Like the Administration, CBO assumed that approximately 1 percent of people ages 62 to 64 would retire if they could obtain health insurance through the Medicare buy-in. As a result, Social Security benefits would increase by about \$0.2 billion a year. CBO further assumed that employers' coverage of retirees would fall by about 10 percent as a result of the buy-in, reduc-

ing employers' costs and thereby increasing federal tax revenues slightly. The estimate also includes additional costs to Medicaid for the post-65 premiums. In total, CBO estimates that the proposal would cost \$1.9 billion over the 1999-2003 period.

Basis of the Estimate

CBO's estimates of federal costs for the buy-in proposal for people ages 62 to 64 were based on several sources: population projections made by the Social

Table B-1.
Medicare Buy-In for People Ages 62 to 64 (By fiscal year, in billions of dollars)

	1999	2000	2001	2002	2003	Total, 1999-2003
Direct Spending						
Medicare Outlays						
Benefits	1.0	1.7	1.8	2.1	2.3	8.9
Premiums						
Pre-65	-0.9	-1.3	-1.5	-1.7	-1.9	-7.3
Post-65	<u>0</u>	<u>a</u>	<u>a</u>	<u>-0.1</u>	<u>-0.1</u>	<u>-0.2</u>
Subtotal	-0.9	-1.4	-1.5	-1.7	-2.0	-7.6
Outlays Net of Premiums	0.1	0.3	0.3	0.3	0.3	1.3
Social Security Benefit Payments	0	0.2	0.2	0.2	0.2	0.7
Medicaid Outlays	<u>0</u>	<u>b</u>	<u>b</u>	<u>b</u>	<u>b</u>	<u>b</u>
Total	0.1	0.5	0.5	0.5	0.5	2.0
Revenues						
Corporate Profits and Other Taxes	0	b	b	b	b	0.1
Total Cost of the Medicare Buy-In for People Ages 62 to 64						
Total	0.1	0.5	0.5	0.4	0.4	1.9
Memorandum (Calendar year):						
Participation	320,000	330,000	350,000	370,000	390,000	
Pre-65 Monthly Premium (Dollars) ^c	310	326	346	368	394	
Pre-65 Estimated Monthly Cost of Those Participating (Dollars)	389	407	431	456	486	
Post-65 Monthly Premium per Year of Participation (Dollars)	10	10	11	11	11	

SOURCE: Congressional Budget Office.

NOTE: The estimate assumes that the buy-in would become available on January 1, 1999. The Administration's estimate assumes that it would become available on July 1, 1999.

- a. Offsetting receipts of less than \$50 million.
- b. Outlays or revenues of less than \$50 million.
- c. Premiums shown are for benefit costs only, to be comparable with the premiums reported by the Administration. An allowance for administrative costs would increase those premium amounts by about 2 percent each year (making the 1999 pre-65 premium equal to \$316 a month).

Security Administration, the March 1997 Current Population Survey (CPS), and Medicare claims and administrative data.

Eligibility. Population projections by the Social Security Administration indicate that 6.3 million people will be ages 62 to 64 in 1999. Of that number, about 13 percent will already have Medicare because of a disability or renal disease, and another 10 percent will have Medicaid or other public coverage. Thus, only about 77 percent of all people ages 62 to 64—or 4.8 million people—would be potentially eligible for the buy-in. Of those people, 1.6 million would be immediately eligible because they are uninsured or have only private individual insurance. The other 3.2 million would not be immediately eligible because they have employment-sponsored insurance, but they would become eligible if they lost that coverage.

Participation. Using the Current Population Survey, CBO estimated participation in the buy-in for four distinct types of people.

- o *Those who lack insurance coverage* (about 1 million people in 1999). CBO assumed that among this group, people in poor health with high income (greater than three times the poverty level) and residing in states without community rating in the individual insurance market would all participate in the buy-in.² For the remainder, the probability of participation was assumed to depend on the percentage reduction in the price of insurance (the price of the buy-in relative to the price in the private individual market).³ Overall, about 9 percent of this group would participate in the buy-in.
- o *Those who purchase individual health insurance in the private market* (600,000 people). The more these people would save in insurance premiums by switching to Medicare, the more likely they would be to do so. Even if the Medicare premium was the same as the private premium, CBO assumed that 10 percent would switch to the buy-in because of

the greater assurance of its continued availability at affordable prices. CBO further assumed that the probability of participation would increase by 10 percentage points for each additional \$10 difference in premiums, up to a maximum of 80 percent participation. Finally, CBO assumed that 20 percent of those in the private insurance market would not switch regardless of the amount they could save. Under these assumptions, about 35 percent of this group would take advantage of the buy-in.

- o *Those who are working and covered by employment-based insurance* (1.8 million people). CBO assumed that 1 percent of this group would be induced to retire because of the buy-in option.⁴ All of those retirees would participate in the buy-in.
- o *Retirees whose employers currently offer retiree health insurance* (1.5 million people). This group is expected to diminish in number in the coming years, and the buy-in option would accelerate that decline. In the absence of the buy-in, people in this group who no longer had access to employment-based insurance would either purchase individual coverage in the private market or remain uninsured until they became eligible for Medicare. CBO used logistic regression to predict who would purchase individual coverage and who would remain uninsured. Using the methods described above, CBO then determined the probability that people would participate in the buy-in. By 2003, an estimated 3 percent of this group would take advantage of the buy-in.

Premiums. The price individuals face in the private insurance market would vary based on their health status, the insurance regulations in their state, the level of medical costs in their state, and the administrative costs of the private insurance. Medicare's buy-in premium in a given year would vary by only one factor—the level of medical costs in the state.

Under CBO's projections of Medicare costs, the pre-65 Medicare premium in 1999 would average \$310 a month for benefit costs, plus an estimated 2 percent—or \$6 a month—for administrative costs. However, the

2. Under pure community rating, everyone pays the same premium, regardless of age or health status. Under modified community rating, premiums may vary by age group but not by health status.

3. See Congressional Budget Office, *Behavioral Assumptions for Estimating the Effects of Health Care Proposals*, CBO Memorandum (November 1993).

4. See J. Gruber and B. Madrian, "Health Insurance Availability and the Retirement Decision," *American Economic Review*, vol. 85, no. 4 (September 1995), pp. 938-948.

actual premium that participants paid would vary by geographic area. CBO made adjustments for differences among states' Medicare costs based on the 1997 AAPCC. (The AAPCC is the adjusted average per capita cost of Medicare in a county; values for states were calculated as a weighted average of county values.) In addition to the pre-65 premium, CBO estimated an amount to reflect participants' perception of the additional costs they would incur for the post-65 premiums for which they would be liable in later years. That perceived amount was estimated as the present value (at the start of the buy-in year) of the post-65 premiums they would pay for that buy-in year, using a 30 percent discount rate and the expected remaining lifetime for a 65-year-old person. In estimating the post-65 premium, CBO assumed that people participating in the buy-in would have mortality rates similar to other people their age.

Medicare Costs. Based on Medicare claims data, CBO estimates that people who would be newly eligible for Medicare under the buy-in proposal would cost the program about 85 percent of the average cost of everyone ages 62 to 64 if they all enrolled. About 13 percent of all people in the eligible age group are already enrolled in Medicare because of a disability or renal disease, and that excluded group is a relatively costly one. Nevertheless, the average cost to Medicare for participants in the buy-in is expected to exceed the pre-65 premium by about 25 percent because of adverse selection among those eligible to participate.

Uncertainties in the Estimate. One of the most important areas of uncertainty is the extent to which eligible people would discount the post-65 premiums for which they would be liable if they participated in the buy-in. The two-part premium structure is designed to prevent the rising premiums and declining enrollment (termed a "death spiral") that would otherwise tend to develop. Medicare would be the insurer of last resort, because private insurers (except in the few states with community rating and guaranteed issue) could selectively enroll the healthier members of the group eligible for the buy-in. If the pre-65 premium was set to cover fully the costs of people expected to select the buy-in option, it would steadily increase relative to premiums in the private market, leading to declining participation and ever greater adverse selection for the buy-in plan. The two-part premium structure would avoid a death

spiral only if buy-in participants heavily discounted the post-65 premiums, so that the cost they perceived for the buy-in option was not much higher than the pre-65 premium.

CBO's estimates assume that individuals would discount future premiums much more heavily than the rate the government pays to borrow funds. If, however, they used the same discount rate as the government (6 percent), participation would be much lower and net costs would be higher—\$2 billion from 1999 through 2003 (see the table below). If individuals took no account of future premiums (that is, they had an infinite discount rate), participation would be higher and net costs would be slightly lower because there would be less adverse selection.

Alternative Assumptions	1999 Participation	Medicare Costs, 1999-2003 (Billions of dollars)
CBO Estimate	320,000	1.3
Individuals' Discount Rate		
6 percent	160,000	2.0
Infinite	360,000	1.1
Difference in Premium Between Medicare and Private Insurance for People of Average Risk		
20 percent	170,000	2.1
45 percent	420,000	0.7

Changes in other assumptions could also affect the estimates significantly. For example, if the premiums that people of average risk would be charged for comparable individual insurance in the private market exceeded Medicare premiums by 20 percent instead of the assumed 33 percent, participation in the buy-in would be much lower but net costs would be higher because of greater adverse selection. Conversely, if private premiums exceeded Medicare premiums by a greater amount, participation would be higher and costs would be lower.

Medicare Buy-In for Displaced Workers Ages 55 to 61

The Administration also proposes to allow a limited number of workers ages 55 to 61 (and their spouses) who lose health insurance because of a job loss to buy in to the Medicare program. Unlike the buy-in for people ages 62 to 64, this program would be available only to people who met several eligibility requirements related to losing their job. Those requirements include having received employment-based health insurance coverage for the 12 months before losing their job, being eligible for unemployment insurance benefits, and exhausting the 18 months of continued coverage that is available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).⁵

Premiums for the buy-in for displaced workers would be set at \$400 a month per person in 1999 and would be updated annually. CBO assumed that updates would reflect the growth of costs per capita in the Medicare program. Premiums would also be adjusted for geographic differences in costs. By design, premiums would not fully cover the costs of the program.

Budgetary Impact and Comparison with the Administration's Estimate

The combination of stringent eligibility requirements and relatively high premiums would result in limited participation—about 18,000 full-year-equivalents in 2003. Those most likely to enroll would be people with medical expenditures that were higher than average for their age. Over the 1999-2003 period, Medicare costs would increase by almost \$470 million, and premium collections would total about \$340 million. The net increase in Medicare outlays would be about \$130 mil-

lion over that period (see Table B-2). The proposal would also encourage a small number of additional workers to seek unemployment insurance, raising federal outlays for unemployment compensation by an estimated \$9 million over five years.

The Administration estimated that Medicare costs for workers ages 55 to 61 would amount to \$1.4 billion and that premium collections would total \$1.2 billion between 1999 and 2003. According to the Administration, the net increase in Medicare spending under the buy-in would be about \$160 million, based on estimated enrollment that would rise to 80,000 in 2003.

Basis of the Estimate

The Survey of Income and Program Participation (SIPP)—with its monthly information on respondents' work status, receipt of unemployment insurance, and health insurance coverage—was used to estimate the number of people who would participate in the program.

Eligibility. Using the SIPP data, CBO directly estimated the number of people who would meet the eligibility rules for unemployment insurance and a year of health insurance coverage before losing their job. Those data also provided information on the frequency of use of COBRA coverage by people who would meet other eligibility requirements for the program and the extent of other insurance coverage. CBO assumed that people with access to less expensive coverage, such as employment-based insurance with a contribution from an employer, would not purchase Medicare for \$400 a month. SIPP also provided evidence on the distribution of hospital use and physician visits by the eligible population; that information was used to estimate the costs of people likely to participate in the buy-in.

Participation. About 1 million people ages 55 to 61 are estimated to become eligible for unemployment insurance in a typical year. Only about half of them would meet the requirement of having employment-based insurance throughout their last 12 months of work. Furthermore, most of them would continue to have access to less expensive health insurance coverage after separating from their job. Thus, fewer than 190,000 workers annually would meet the requirement for unemployment insurance, have had enough insur-

5. CBO used those eligibility rules for its estimates, based on information received in February from the Office of Management and Budget. Proposed legislation recently released by the Administration, however, incorporates less restrictive requirements for prior coverage. In particular, any "creditable coverage" (as defined in the Health Insurance Portability and Accountability Act of 1996) would count toward the requirement for 12 months of prior coverage, provided the worker had been enrolled in the employer's plan at the time of separation. Thus, COBRA coverage would count toward the 12-month requirement rather than being a separate, additional requirement. Those looser requirements would increase CBO's estimates of coverage and costs.

ance on their previous job, and have gone through a period in which they had no access to less expensive coverage.

Of the eligible people who might be interested in enrolling in Medicare, about 80 percent would have worked at a firm of 20 or more employees. They would therefore be required to purchase COBRA coverage through their former employer for 18 months before being allowed to buy in to Medicare. The vast majority of workers in those circumstances either do not choose COBRA coverage at all or do not remain on COBRA for very long; therefore, they would not become eligible for the Medicare buy-in. Although workers from small firms do not have access to COBRA coverage, most of them would not purchase individual insurance at market rates.

People eligible to enroll in Medicare would also consider the options available to them in the private

market for individual insurance. The \$400 Medicare monthly premium would be about 50 percent higher than the expected Medicare cost of the average person ages 55 to 61. Therefore, people with average or relatively good health for their age would probably opt for private coverage rather than pay for the Medicare displaced workers program. In states with relatively strong community-rating laws, the Medicare buy-in would be even less desirable compared with private coverage.

Medicare Costs. Risk selection would result in net costs of about \$130 million over the 1999-2003 period. The displaced workers (and spouses) who would choose the buy-in would tend to be relatively high health risks who could not obtain a less expensive policy in the marketplace. That selection would result in a pool of participants whose average costs exceeded the \$400 buy-in premium, resulting in net costs to Medicare.

Table B-2.
Medicare Buy-In for Displaced Workers Ages 55 to 61 (By fiscal year, in millions of dollars)

	1999	2000	2001	2002	2003	Total, 1999-2003
Medicare Outlays						
Benefits	13	71	102	127	152	465
Premiums	<u>-9</u>	<u>-51</u>	<u>-74</u>	<u>-92</u>	<u>-110</u>	<u>-337</u>
Outlays Net of Premiums	4	20	28	35	42	128
Unemployment Compensation	<u>0</u>	<u>2</u>	<u>2</u>	<u>3</u>	<u>3</u>	<u>9</u>
Total Cost	4	21	30	37	45	137
Memorandum (Calendar year):						
Full-Year-Equivalent Participation	2,000	10,000	14,000	16,000	18,000	
Monthly Premium (Dollars)	400	420	447	475	508	
Estimated Monthly Cost of Those Participating (Dollars)	552	580	617	656	702	

SOURCE: Congressional Budget Office.

NOTE: CBO's estimates are based on information about the program's eligibility rules received in February from the Office of Management and Budget. Those rules would require displaced workers to have been enrolled in their employer's health plan for at least 12 months before losing their job and, in addition, to have exhausted their 18 months of COBRA coverage. Proposed legislation recently released by the Administration, however, incorporates less restrictive requirements for prior coverage. Although 12 months of previous health insurance coverage would still be required, COBRA coverage would count toward that requirement. Those looser requirements would increase CBO's estimates of coverage and costs.