

BILL THOMAS, CALIFORNIA, CHAIRMAN
SUBCOMMITTEE ON HEALTH

NANCY L. JOHNSON, CONNECTICUT
JIM McCREERY, LOUISIANA
JOHN ENSIGN, NEVADA
JON CHRISTENSEN, NEBRASKA
PHILIP M. CRANE, ILLINOIS
AMD HOUGHTON, NEW YORK
SAM JOHNSON, TEXAS

FORTNEY PETE STARK, CALIFORNIA
BENJAMIN L. CARDIN, MARYLAND
GERALD D. KLECZKA, WISCONSIN
JOHN LEWIS, GEORGIA
XAVIER BECERRA, CALIFORNIA

Ex Office:
BILL ARCHER, TEXAS
CHARLES B. RANGEL, NEW YORK

BILL ARCHER, TEXAS, CHAIRMAN
COMMITTEE ON WAYS AND MEANS

A. L. SINGLETON, CHIEF OF STAFF
CHARLES N. KAHN III, SUBCOMMITTEE STAFF DIRECTOR

JANICE MAYS, MINORITY CHIEF COUNSEL
BILL VAUGHAN, SUBCOMMITTEE MINORITY

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

October 6, 1997

*Medicare Buy-in
Proposed*

To: Members of the Ways and Means Health Subcommittee;
Seniors Organizations, and Others

From: Rep. Pete Stark

Re: Bill to permit affordable "buy in" to Medicare at age 62.

Attached is a draft bill that I would appreciate your comments and feedback on. I hope to refine the bill and introduce it before the end of the First Session. Any comments--or support--you could give me by October 29th would be deeply appreciated.

Briefly, the bill requires the Secretary of HHS to determine what would be an actuarially sound price for the Medicare package of benefits if all Americans between 62 and 65 were enrolled in this plan. Individuals could buy into Medicare beginning after age 62 at this monthly rate.

Because this rate would be about \$400 a month and too expensive for many retirees, the Secretary would also estimate what rate a person could pay (through reduced Social Security payments) if they spread-out the buy-in over the remainder of their estimated life.

Since this is a voluntary program, there will obviously be some adverse selection. Cigarette taxes would be raised enough (in this bill 10 cents/pack) to prevent any drain on the Medicare Trust Fund. The final figure will depend on CBO's analysis of the extent of adverse selection.

For example, the Secretary may estimate that the cost of the Medicare package for all people 62, 63, and 64 is \$4800/year. People could buy in at \$400 a month. She may also estimate that people electing this option have a life expectancy of 75

years of age and therefore could pay in a smaller amount all the rest of their life--a figure around \$92 a month, but depending on interest rate assumptions, it will need to be higher.

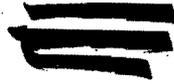
Since 62-64 year olds most in need of health insurance will elect this option (adverse selection), the \$4800 figure is obviously too low and would result in a drain on the Trust Fund. To prevent this, the money from the cigarette/tobacco tax increase is dedicated to the Medicare Trust Fund.

Again, I would appreciate your comments and suggestions--and hopefully your eventual support.

Attachment: 19 page discussion draft

Bill Vaughan of the Subcommittee staff and Katie Horton of my personal office are working on this project. Bill can be reached at 225-4318. Fax is 226-4969. Email is bill.vaughan@mail.house.gov

Katie can be reached at 225-5065, fax 226-3805, and email is khorton@hr.house.gov



105TH CONGRESS
1ST SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. STARK introduced the following bill; which was referred to the Committee
on _____

A BILL

To amend title XVIII of the Social Security Act to permit early retirees age 62 or older to purchase coverage under the medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. OPTIONAL ENROLLMENT OF EARLY RETIREES**
4 **UNDER THE MEDICARE PROGRAM.**

5 (a) PART A BUY-IN OPTION.—Part A of title XVIII
6 of the Social Security Act is amended by inserting after
7 section 1818A the following new section:

1 "HOSPITAL INSURANCE BENEFITS FOR UNINSURED
2 ELDERLY INDIVIDUALS

3 SEC. 1818B. (a) IN GENERAL.—Every individual
4 who—

5 "(1) has attained the age of 62,

6 "(2) would be entitled to benefits under this
7 part under section 226(a) if the individual were 65
8 years of age, and

9 "(3) is not otherwise entitled to benefits under
10 this part,

11 shall be eligible to enroll in the insurance program estab-
12 lished by this part.

13 "(b) FORM OF ENROLLMENT.—An individual may
14 enroll under this section only in such manner and form
15 as may be prescribed in regulations, and only during an
16 enrollment period prescribed in or under this section.

17 "(c) DETERMINATION OF MONTHLY PREMIUM.—

18 "(1) DETERMINATION OF BASIC ACTUARIAL
19 RATE.—The Secretary shall, during September of
20 each year (beginning with 1998), estimate the basic
21 monthly actuarial rate for months in the succeeding
22 year. Such basic actuarial rate shall be one-twelfth
23 of the amount which the Secretary estimates (on an
24 average, per capita basis) is equal to 100 percent of
25 the benefits and administrative costs which would be

1 payable from the Federal Hospital Insurance Trust
2 Fund for services performed and related administra-
3 tive costs incurred in the succeeding year with re-
4 spect ~~to the class of individuals who~~ to the class of individuals who
5 have attained the age of 62, but not attained the age
6 of 65, and who would be eligible for benefits under
7 this part under section 226(a) but for age, if all
8 such individuals were enrolled under this part during
9 that year.

10 “(2) PROMULGATION OF BASIC PREMIUM.—The
11 Secretary shall, during September of each year de-
12 termine and promulgate the dollar amount which
13 shall be applicable for basic premiums for months
14 occurring in the following year. Subject to paragraph
15 (3), the amount of an individual’s monthly premium
16 under this section shall be equal to the basic month-
17 ly actuarial rate determined under paragraph (1) for
18 that following year. Any amount determined under
19 the preceding sentence which is not a multiple of \$1
20 shall be rounded to the nearest multiple of \$1 (or,
21 if it is a multiple of 50 cents but not a multiple of
22 \$1, to the next higher multiple of \$1). Amounts pay-
23 able under this paragraph shall only apply to months
24 in which the individual is enrolled under this section.

1 “(3) ELECTION OF ALTERNATIVE PREMIUM;
2 PROMULGATION OF ACTUARIAL REPAYMENT PLAN.—

3 “(A) ELECTION.—At the time an individ-
4 ual first enrolls under this section, the individ-
5 ual may elect to have premiums computed and
6 paid under this paragraph, rather than under
7 paragraph (2). Such an election shall be made
8 only at the time the individual first elects cov-
9 erage under this section and, once made, may
10 not be revoked [, even if the individual no
11 longer decides to be no longer enrolled under
12 this section] . Under such an election—

13 “(i) the monthly premium shall be the
14 amount determined under subparagraph
15 (B), rather than the basic monthly actuar-
16 ial rate determined under paragraph (2),
17 and

18 “(ii) such premium shall be payable
19 beginning with the month in which the in-
20 dividual is first enrolled under this section
21 and ending with the month in which the
22 individual dies.

23 “(B) PROMULGATION OF ALTERNATIVE
24 MONTHLY PREMIUM.—

1 “(i) IN GENERAL.—The Secretary
2 shall, from time to time, promulgate an al-
3 ternative monthly premium for individuals
4 who make the election described in sub-
5 paragraph (A). The amount of the alter-
6 native monthly premium under this para-
7 graph shall not change for an individual
8 over the duration of an individual’s life.
9 [review application of imputed interest on
10 basic payments:]

11 “(ii) ACTUARIAL EQUIVALENT.—The
12 Secretary shall estimate such an amount
13 so that the total amount of premiums paid
14 under this election over the time period of
15 an individual’s life is actuarially equivalent
16 to the total amount of premiums that
17 would have been paid in premiums for the
18 individual under this section if the election
19 had not been made under subparagraph
20 (A).

21 “(iii) VARIATIONS.—[review policy
22 here:] The amount of the alternative
23 monthly premium under this subparagraph
24 shall be computed based only on the age
25 [and gender] of the individual involved

1 and shall not take into account any other
2 individual characteristics, including health
3 status.

4 “(4) PUBLICATION.—Whenever the Secretary
5 promulgates the dollar amount which shall be appli-
6 cable as a basic or alternative monthly premium
7 under this section, the Secretary shall, at the time
8 such promulgation is announced, issue a public
9 statement setting forth the actuarial assumptions
10 and bases employed by him in arriving at such
11 amounts.

12 “(d) APPLICATION OF ENROLLMENT PROVISIONS.—
13 The provisions of section 1837 (except subsection (f)
14 thereof), section 1838, subsection (b) of section 1839, and
15 subsections (f) and (h) of section 1840 shall apply to per-
16 sons authorized to enroll under this section except that—

17 “(1) individuals who meet the conditions of sub-
18 section (a) on or before the last day of the seventh
19 month after the month in which this section is en-
20 acted may enroll under this part and may also enroll
21 under part B during an initial general enrollment
22 period which shall begin on the first day of the sec-
23 ond month which begins after the date on which this
24 section is enacted and shall end on the last day of

1 the tenth month after the month in which this sec-
2 tion is enacted;

3 “(2) in the case of an individual who first meets
4 the conditions of eligibility under this section on or
5 after the first day of the eighth month after the
6 month in which this section is enacted, the initial en-
7 rollment period shall begin on the first day of the
8 third month before the month in which he first be-
9 comes eligible and shall end 7 months later;

10 “(3) in the case of an individual who enrolls
11 pursuant to paragraph (1) of this subsection, entitle-
12 ment to benefits shall begin on—

13 “(A) the first day of the second month
14 after the month in which he enrolls,

15 “(B) January 1, 1999. or

16 “(C) the first day of the first month in
17 which he meets the requirements of subsection
18 (a),

19 whichever is the latest;

20 “(4) an individual’s entitlement under this sec-
21 tion shall terminate with the month before the first
22 month in which he becomes eligible for hospital in-
23 surance benefits under section 226 of this Act or
24 section 103 of the Social Security Amendments of
25 1965; and upon such termination, such individual

1 shall be deemed, solely for purposes of hospital in-
2 surance entitlement, to have filed in such first
3 month any application required to establish such en-
4 titlement;

5 “(5) an individual who meets the conditions of
6 subsection (a) may enroll under this part during a
7 special enrollment period that includes any month
8 during any part of which the individual is enrolled
9 under section 1876 with an eligible organization [or
10 under part C with a Medicare+Choice organization]
11 and ending with the last day of the 8th consecutive
12 month in which the individual is at no time so en-
13 rolled;

14 “(6) in the case of an individual who enrolls
15 during a special enrollment period under paragraph
16 (5)—

17 “(A) in any month of the special enroll-
18 ment period in which the individual is at any
19 time enrolled under section 1876 with an eligi-
20 ble organization [or under part C with a
21 Medicare+Choice organization] or in the first
22 month following such a month, the coverage pe-
23 riod shall begin on the first day of the month
24 in which the individual so enrolls (or, at the op-

1 tion of the individual, on the first day of any
2 of the following three months), or

3 “(B) in any other month of the special en-
4 rollment period, the coverage period shall begin
5 on the first day of the month following the
6 month in which the individual so enrolls; and

7 “(7) in applying the provisions of section
8 1839(b), there shall not be taken into account
9 months for which the individual can demonstrate
10 that the individual was enrolled under section 1876
11 with an eligible organization [or under part C with
12 a Medicare+Choice organization].

13 Termination of entitlement under paragraph (4) shall not
14 affect an individual’s liability for premiums under an elec-
15 tion made under subsection (c)(3).

16 “(e) PAYMENT OF PREMIUMS BY THIRD PARTIES.—
17 Payment of the monthly premiums on behalf of any indi-
18 vidual who meets the conditions of subsection (a) may be
19 made by any public or private agency or organization
20 under a contract or other arrangement entered into be-
21 tween it and the Secretary if the Secretary determines
22 that payment of such premiums under such contract or
23 arrangement is administratively feasible.

24 “(f) DEPOSIT OF PREMIUMS.—Amounts paid to the
25 Secretary for coverage under this section shall be depos-

1 ited in the Treasury to the credit of the Federal Hospital
2 Insurance Trust Fund.

[review treatment of qualified medicare beneficiaries
generally:]

3 “(g) BUY-IN FOR QUALIFIED MEDICARE BENE-
4 FICIARIES.—

5 “(1) OPTION.—The Secretary shall, at the re-
6 quest of a State made after 1989, enter into a modi-
7 fication of an agreement entered into with the State
8 pursuant to section 1843(a) under which the agree-
9 ment provides for enrollment in the program estab-
10 lished by this part of qualified medicare beneficiaries
11 (as defined in section 1905(p)(1)).

12 [“(2) APPLICATION OF TERMS AND CONDI-
13 TIONS.—(A) Except as provided in subparagraph
14 (B), the provisions of subsections (c), (d), (e), and
15 (f) of section 1843 shall apply to qualified medicare
16 beneficiaries enrolled, pursuant to such agreement,
17 in the program established by this part in the same
18 manner and to the same extent as they apply to
19 qualified medicare beneficiaries enrolled, pursuant to
20 such agreement, in part B.

21 [“(B) For purposes of this subsection, section
22 1843(d)(1) shall be applied by substituting section
23 1818’ for section 1839’ and ‘subsection (c)(6) (with

1 reference to subsection (b) of section 1839) for
2 'subsection (b).]”.

3 (b) PAYMENT OF FULL PART B PREMIUM.—Section
4 1839 of such Act (42 U.S.C. 1395r) is amended by adding
5 at the end the following new subsection:

6 “(h)(1) Notwithstanding the previous provisions of
7 this section, in the case of an individual who is eligible
8 for enrollment under this part only because of the applica-
9 tion of section 1818B, the amount of the monthly pre-
10 mium under this section shall be, subject to paragraph (3),
11 the basic monthly actuarial rate determined by the Sec-
12 retary under paragraph (2).

13 “(2) In September before the beginning of each year
14 (beginning with 1999), the Secretary shall estimate a
15 basic monthly amount for such calendar year that, when
16 applied to individuals described in paragraph (1) who are
17 enrolled under this part during the year (and who have
18 not made the election described in paragraph (3)), will
19 equal the total of the benefits and administrative costs
20 which the Secretary estimates will be payable from the
21 Federal Supplementary Medical Insurance Trust Fund for
22 services performed and related administrative costs in-
23 curred in such calendar year with respect to such enroll-
24 ees. In calculating the monthly actuarial rate, the Sec-

1 retary shall include an appropriate amount for a contin-
2 gency margin.

3 “(3) The provisions of paragraph (3) of section
4 1818B(c) shall apply under this section in relation to the
5 basic monthly amount under paragraph (2) in the same
6 manner as they apply under section 1818B in relation to
7 the basic monthly actuarial rate under subsection (c)(2)
8 of such section.”.

9 **SEC. 2. INCREASE IN EXCISE TAXES ON TOBACCO PROD-**
10 **UCTS TO COVER ACTUARIAL SHORTFALL.**

11 (a) CIGARETTES.—Subsection (b) of section 5701 of
12 the Internal Revenue Code of 1986, as amended by section
13 9302(a) of the Balanced Budget Act of 1997, is amend-
14 ed—

15 (1) by striking “\$19.50 per thousand (\$17 per
16 thousand on cigarettes removed during 2000 or
17 2001)” in paragraph (1) and inserting “\$24.50 per
18 thousand (\$22 per thousand on cigarettes removed
19 during 2000 or 2001)”, and

20 (2) by striking “\$40.95 per thousand (\$35.70
21 per thousand on cigarettes removed during 2000 or
22 2001)” in paragraph (2) and inserting “\$51.45 per
23 thousand (\$46.20 per thousand on cigarettes re-
24 moved during 2000 or 2001)”.

1 (b) CIGARS.—Subsection (a) of section 5701 of such
2 Code is amended—

3 (1) by striking “\$1.828 cents per thousand
4 (\$1.594 cents per thousand on cigars removed dur-
5 ing 2000 or 2001)” in paragraph (1) and inserting
6 “\$2.297 cents per thousand (\$2.003 cents per thou-
7 sand on cigars removed during 2000 or 2001)”, and

8 (2) by striking “20.719 percent (18.063 percent
9 on cigars removed during 2000 or 2001) of the price
10 for which sold but not more than \$48.75 per thou-
11 sand (\$42.50 per thousand on cigars removed during
12 2000 or 2001)” and inserting “26.031 percent
13 (22.694 percent on cigars removed during 2000 or
14 2001) of the price for which sold but not more than
15 \$61.25 per thousand (\$53.40 per thousand on cigars
16 removed during 2000 or 2001).”.

17 (c) CIGARETTE PAPERS.—Subsection (c) of section
18 5701 of such Code is amended by striking “1.22 cents
19 (1.06 cents on cigarette papers removed during 2000 or
20 2001)” and inserting “1.53 cents (1.33 cents on cigarette
21 papers removed during 2000 or 2001)”.

22 (d) CIGARETTE TUBES.—Subsection (d) of section
23 5701 of such Code is amended by striking “2.44 cents
24 (2.13 cents on cigarette tubes removed during 2000 or

1 2001)" and inserting "3,07 cents (2.68 cents on cigarette
2 tubes removed during 2000 or 2001)".

3 (e) SMOKELESS TOBACCO.—Subsection (e) of section
4 5701 of such Code is amended—

5 (1) by striking "58.5 cents (51 cents on snuff
6 removed during 2000 or 2001)" in paragraph (1)
7 and inserting "73.5 cents (64 cents on snuff re-
8 moved during 2000 or 2001)", and

9 (2) by striking "19.5 cents (17 cents on chew-
10 ing tobacco removed during 2000 or 2001)" in para-
11 graph (2) and inserting "24.5 cents (21.35 cents on
12 chewing tobacco removed during 2000 or 2001)".

13 (f) PIPE TOBACCO.—Subsection (f) of section 5701
14 of such Code is amended by striking "\$1.0969 cents
15 (95.67 cents on pipe tobacco removed during 2000 or
16 2001)" and inserting "\$1.378 cents (\$1.202 cents on pipe
17 tobacco removed during 2000 or 2001)".

18 (g) TAX ON MANUFACTURE OR IMPORTATION OF
19 ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such
20 Code is amended by striking "\$1.0969 cents (95.67 cents
21 on roll-your-own tobacco removed during 2000 or 2001)"
22 and inserting "\$1.378 cents (\$1.202 cents on roll-your-
23 own tobacco removed during 2000 or 2001)".

24 (h) EFFECTIVE DATE.—The amendments made by
25 this section shall apply to articles removed (as defined in

1 section 5702(k) of the Internal Revenue Code of 1986,
2 as amended by this section) after December 31, 1998.

3 (i) FLOOR STOCKS TAXES.—

4 (1) IMPOSITION OF TAX.—On tobacco products
5 and cigarette papers and tubes manufactured in or
6 imported into the United States which are removed
7 before any tax increase date, and held on such date
8 for sale by any person, there is hereby imposed a tax
9 in an amount equal to the excess of—

10 (A) the tax which would be imposed under
11 section 5701 of the Internal Revenue Code of
12 1986 on the article if the article had been re-
13 moved on such date, over

14 (B) the prior tax (if any) imposed under
15 section 5701 of such Code on such article.

16 (2) AUTHORITY TO EXEMPT CIGARETTES HELD
17 IN VENDING MACHINES.—To the extent provided in
18 regulations prescribed by the Secretary, no tax shall
19 be imposed by paragraph (1) on cigarettes held for
20 retail sale on any tax increase date, by any person
21 in any vending machine. If the Secretary provides
22 such a benefit with respect to any person, the Sec-
23 retary may reduce the \$500 amount in paragraph
24 (3) with respect to such person.

1 (3) CREDIT AGAINST TAX.—Each person shall
2 be allowed as a credit against the taxes imposed by
3 paragraph (1) an amount equal to \$500. Such credit
4 shall not exceed the amount of taxes imposed by
5 paragraph (1) on any tax increase date, for which
6 such person is liable.

7 (4) LIABILITY FOR TAX AND METHOD OF PAY-
8 MENT.—

9 (A) LIABILITY FOR TAX.—A person hold-
10 ing cigarettes on any tax increase date, to
11 which any tax imposed by paragraph (1) applies
12 shall be liable for such tax.

13 (B) METHOD OF PAYMENT.—The tax im-
14 posed by paragraph (1) shall be paid in such
15 manner as the Secretary shall prescribe by reg-
16 ulations.

17 (C) TIME FOR PAYMENT.—The tax im-
18 posed by paragraph (1) shall be paid on or be-
19 fore April 1 following any tax increase date.

20 (5) ARTICLES IN FOREIGN TRADE ZONES.—
21 Notwithstanding the Act of June 18, 1934 (48 Stat.
22 998, 19 U.S.C. 81a) and any other provision of law,
23 any article which is located in a foreign trade zone
24 on any tax increase date, shall be subject to the tax
25 imposed by paragraph (1) if—

1 (A) internal revenue taxes have been deter-
2 mined, or customs duties liquidated, with re-
3 spect to such article before such date pursuant
4 to a request made under the 1st proviso of sec-
5 tion 3(a) of such Act, or

6 (B) such article is held on such date under
7 the supervision of a customs officer pursuant to
8 the 2d proviso of such section 3(a).

9 (6) DEFINITIONS.—For purposes of this sub-
10 section—

11 (A) IN GENERAL.—Terms used in this sub-
12 section which are also used in section 5702 of
13 the Internal Revenue Code of 1986 shall have
14 the respective meanings such terms have in
15 such section.

16 (B) TAX INCREASE DATE.—The term “tax
17 increase date” means [review:] January 1,
18 1999, ~~January and~~ January 1, 2002.

19 (C) SECRETARY.—The term “Secretary”
20 means the Secretary of the Treasury or the
21 Secretary’s delegate.

22 (7) CONTROLLED GROUPS.—Rules similar to
23 the rules of section 5061(e)(3) of such Code shall
24 apply for purposes of this subsection.

1 (8) OTHER LAWS APPLICABLE.—All provisions
2 of law, including penalties, applicable with respect to
3 the taxes imposed by section 5701 of such Code
4 shall, insofar as applicable and not inconsistent with
5 the provisions of this subsection, apply to the floor
6 stocks taxes imposed by paragraph (1), to the same
7 extent as if such taxes were imposed by such section
8 5701. The Secretary may treat any person who bore
9 the ultimate burden of the tax imposed by para-
10 graph (1) as the person to whom a credit or refund
11 under such provisions may be allowed or made.

12 (j) APPROPRIATION TO MEDICARE TRUST FUNDS.—

13 There are hereby appropriated to the Federal Hospital In-
14 surance Trust Fund and to the Federal Medical Supple-
15 mentary Insurance Trust Fund, out of any moneys in the
16 Treasury not otherwise appropriated, amounts equivalent
17 to 100 per centum of the amount of additional excise taxes
18 collected as a result of the amendments made by this sec-
19 tion. The amounts appropriated by the preceding sentence
20 shall be transferred from time to time from the general
21 fund in the Treasury to the Trust Funds, such amounts
22 to be determined on the basis of estimates by the Sec-
23 retary of the Treasury of the taxes, specified in the preced-
24 ing sentence, paid to or deposited into the Treasury; and
25 proper adjustments shall be made in amounts subse-

1 quently transferred to the extent prior estimates were in
2 excess of or were less than the taxes specified in such sen-
3 tence. The portion of such amounts to be deposited into
4 each Trust Fund shall be determined by the Secretary of
5 Health and Human Services based on the difference be-
6 tween the amount expended from (and the additional pre-
7 miums received in) the Trust Fund under the amendments
8 made by section 1 of this Act.

MEDICARE BUY-IN / CBO

Among the Administration's initiatives for mandatory spending are proposals to allow certain groups of people who do not currently have access to employer- or government-sponsored health insurance to purchase Medicare coverage. Although CBO makes somewhat different assumptions about participation rates and costs per person than the Administration does, it generally concurs with the Administration's estimate that the provisions would have a small net budgetary impact. Net costs to the federal government would be held down by the high cost of the specified premiums and the stringency of the eligibility criteria, both of which severely limit the number of people who are likely to take advantage of the proposals.

Although the hike in net spending resulting from the President's proposals reduces projected baseline surpluses, the budget is still expected to remain essentially in surplus through 2003 under the President's policies. From an expected level of \$8 billion in 1998, the surplus is projected to rise to \$51 billion in 2002 before falling in 2003.

CBO's Estimates Compared with Those of the Administration

Although the pattern in the bottom ~~line~~ suggested by CBO's analysis of the President's budget is roughly similar to ~~that~~ estimated by the Administration, the surpluses that CBO projects are smaller. In addition, CBO estimates a small deficit

Preliminary CBO Estimate: Medicare Provisions in the President's Budget for FY99

03/04/98 02:33 PM

By fiscal year, in billions of dollars	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	'98-03	'89-08
CHANGE IN DIRECT SPENDING												
Buy-in for age 62-64	1.0	1.7	1.8	2.1	2.3	2.6	2.9	3.3	3.8	4.0	8.9	25.3
Buy-in for age 55-61 displaced workers	a	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.5	1.6
Market Price for Drugs	-0.1	-0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.6	-1.4
Erythropoetin; Pay \$9 per 1000 units	a	a	a	a	a	a	a	a	-0.1	-0.1	-0.1	-0.4
MSP	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4	-1.1
Centers of Excellence	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.5
Audit Fees	0	0	0	0	0	0	0	0	0	0	0	0
Fraud and Abuse Provisions	0	0	0	0	0	0	0	0	0	0	0	0
Return to Work -- Medicare Interaction w/ DI policy	0	0	0	0	a	a	a	a	a	a	a	a
Total, Gross Medicare Mandatory Outlays	0.7	1.4	1.6	1.9	2.2	2.5	2.8	3.2	3.5	3.8	7.9	23.6
Pre-65 Premiums from buy-in for age 62-64	-0.9	-1.3	-1.5	-1.7	-1.9	-2.1	-2.4	-2.7	-3.0	-3.3	-7.3	-20.9
Post-65 Premiums from buy-in for age 62-64	0	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.2	-1.3
Premiums from buy-in for age 55-61	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-1.2
Part B Premium Interaction (does not include MCD Interaction)	0.1	0.1	a	a	a	a	a	a	0.1	0.1	0.3	0.8
Total, Medicare Part B Premium Receipts	-0.9	-1.3	-1.6	-1.8	-2.1	-2.3	-2.7	-3.1	-3.4	-3.7	-7.6	-22.8
TOTAL, MEDICARE NET OUTLAYS	-0.1	0.1	a	0.3	0.7							

Memorandum:

Part B Monthly Premium, Policy	\$48.50	\$53.10	\$58.80	\$64.70	\$71.40	\$78.60	\$85.30	\$92.00	\$98.80	\$105.60
Part B Monthly Premium, Baseline	\$48.70	\$53.20	\$58.90	\$64.80	\$71.50	\$78.70	\$85.40	\$92.10	\$99.00	\$105.70

Note:
a: savings or cost less than \$50 million

↓
COST = \$0.3 billion
over 5 years

ID:202 225 9010

MAR-04-98 18:17 FROM: CBO/BAD/HCEU

**Congressional Budget Office (CBO) Analysis of the
President's Medicare Buy-In Proposal**

As part of their analysis of the President's Budget, CBO did an analysis of the Medicare buy in. Their analysis found that :

- **No Trust Fund Impact:** The net cost of the Medicare buy-in, according to CBO, is \$300 million over 5 years — only fractions of a percent of Medicare spending.
- **More participants:** Participation is estimated to be over 33 percent higher than what the Administration estimated — 410,000.
- **Lower cost:** The post-65 premium that people ages 62 to 65 would pay is only \$10 per month per year — \$6 per month and \$72 less per year than Administration estimates.¹

Medicare Buy-In, 1999-2003 (\$ in Billions, Fiscal Years)

Spending (5 years)		
62 to 65 Year Olds	8.9	
Displaced Workers	0.5	
Total	9.3 *	
 Premium revenue (5 years)		
62 to 65 Year Olds	-7.3	
Post-65	-0.2 **	
Displaced Workers	-0.3	
Total	-7.8	
 Net Costs	 1.5	 (Administration: 1.5)
 Anti-Fraud Savings	 -1.4	
Premium offset	+0.3	(Administration: -2.4)
 NET MEDICARE	 +0.3*	 (Administration: -0.8)*

* Numbers may not sum to total due to rounding

** These premiums increase after the first 5 years as participants turn age 65

Participation when fully phased in: 410,000 (Administration: 300,000)

Premiums in 1999:

62 to 65 Year Olds	\$310 per month	(Administration: \$305)
Post-65	\$10 per month per year	(Administration: \$16)
Displaced Workers	\$400 per month	(Administration: \$400)

1. Although the base premium is slightly higher, overall premiums are much lower since the post-65 premium, which is \$6 less per month, would be paid every year until age 85.

EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS

DATE:
12/2/97

TO: CHRIS JENNINGS
DEPUTY ASST TO THE PRESIDENT FOR HEALTH POLICY
DOMESTIC POLICY COUNCIL
OFFICE OF POLICY DEVELOPMENTS

FROM: REBECCA M. BLANK

*Medicaid Buy-in
File*

2/6

EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON, D.C. 20500

December 1, 1997

MEMORANDUM FOR GENE SPERLING

FROM: REBECCA BLANK *RB*
EDWARD MONTGOMERY (DEPT OF LABOR) *EM/RB*

SUBJECT: Impact of Displacement on Workers Age 55-64

While there is little evidence that workers over age 55-64 have a higher incidence of job loss, there is some evidence that the consequences of job loss are worse for workers age 55-64 than for younger workers. In particular, these workers are less likely to be re-employed, they have larger earnings losses from their pre-displacement to their post-displacement job, and they are less likely to obtain health insurance coverage on a new job than younger workers.

1) Evidence on Incidence of Job Loss

Most evidence suggests that workers 55-64 have lower rates of job loss than younger workers. This probably reflects the fact that older workers have more seniority protection against job loss.

- **Between January 1993 and December 1995 there were 707,000 individuals age 55-64 displaced from their jobs.** This represents 6 percent of the 11.9 million workers displaced during this time interval.
- Most of those displaced in this age range (64 percent or 455,000 individuals) were in the 55-59 age group. **Whites and males accounted for the majority (92 and 57 percent respectively) of the 55-64 years old displaced workers.** The vast majority (72 percent) of these workers had been with their firm more than 3 years.
- **Displacement rates appear to decline with age before rising slightly to 12 % of older (55-64) workers.** Among the young 18% of workers age 20-24 and 17% of workers age 25-34 were displaced while among middle aged workers 13% of workers age 35-44 and 12% of workers age 45-54 were displaced.

2) Evidence on Impact of Job Loss

a) Re-employment:

Compared to workers age 25-54, displaced workers age 55-64 were less likely to be employed in 1996, primarily because they were more likely to withdraw from the labor market. Only 55 percent of workers age 55-64 displaced between 1993 and 1995 were re-employed in February 1996 while 27 percent were not in the labor force. For men, 63 percent were re-employed and 22 percent were not in the labor force while for women 45 percent were re-employed and 34 percent were not in the labor force.

However, displaced workers age 55-64 were only slightly less likely to be employed in 1996 than other 55-64 year olds. Displaced workers age 55-64 were 7% less likely to be employed in 1996 than all individuals age 55-64. The impact of displacement is more severe for women: displaced women age 55-64 were 15% less likely to be employed than all women 55-64, while displaced men age 55-64 were 6% less likely to be employed than all men age 55-64.

b) Earnings

Workers age 55-64 have larger earnings losses from their pre-displacement to their post-displacement job. Similar results occur if one looks only at workers who held full-time jobs before and after displacement, suggesting that earnings losses are not due to working fewer hours on the new job.

- Workers age 55-64 had earnings declines which were 10 percentage points higher than workers age 45-54, 13 percentage points higher than workers age 35-44 and 21 percentage points higher than workers age 25-34.

c) Health Insurance

Nearly two-thirds (65 percent) of displaced workers age 55-64 had health insurance on their previous job. While the vast majority of these workers who become re-employed have group health insurance on their new jobs, 18 percent of them lose their coverage even after finding a new job (about 32,000 workers).

- Displaced workers who remain unemployed are far less likely to find group coverage. Nearly half (46 percent) of them do not have group coverage and the problem is more acute for 60-64 year olds where 75 percent of them who are unemployed lack coverage.
- 45% of worker age 55-64 who have just taken a new job have health insurance available to them through their employer, compared to 54% for workers age 45-54, 57% for workers age 35-44 and 57% for workers age 25-34.
- 82% of workers age 55-64 who have an ongoing job have access to insurance through their employer, compared to 85% of workers age 45-54, 86% of workers age 35-44 and 85% of workers age 25-34.



Bringing lifetimes of experience and leadership to serve all generations.

December 3, 1997

The President
The White House
Washington, D. C.

Dear Mr. President:

Recent press reports indicate that you continue to be interested in finding ways to expand health insurance coverage options for those older Americans who are not yet eligible for Medicare. I know that this has been a long-standing interest, and write to enthusiastically encourage you to continue to advance this idea in the coming year.

The "pre-Medicare" population is among the most vulnerable with respect to health care coverage for several reasons.

- Individuals in this age range are increasingly likely to have health care problems that make it difficult or impossible for them to obtain health care coverage -- and if they can find the coverage, it may be unaffordable.
- In many cases, these health care conditions or the rapidly changing workplace have forced individuals to retire, move into smaller businesses that are less likely to provide health care coverage, or become self-employed.
- Many employers are cutting back on the health insurance that they provide to workers and retirees.

Recent history suggests that modest reforms in health care, rather than sweeping changes, are more likely to be successful. The Health Insurance Portability and Accountability Act (HIPAA) began to broaden access and portability for those who have group coverage in the private insurance market, but it did little for those who must purchase individual coverage. It is into this group that most pre-Medicare people who need health insurance fall.



The President
December 3, 1997
Page 2

For a number of years now, the possibility of an early "buy-in" to Medicare has been discussed. While this is not the only way to expand health insurance coverage to the pre-Medicare population, it certainly deserves serious consideration, and it is a concept that AARP supports. As with any health care proposal, there are many factors that must be taken into consideration to make this a workable proposal, including financing and how to sustain the commitment of employers who are currently providing coverage.

Certainly, the cost of making immediate and sweeping changes in this area would be significant. HIPAA was modest and far from perfect. One of its limitations was that it addressed access but not affordability, but it was worth doing. By the same token, it is important that we expand access to pre-Medicare individuals as a transition step to other health care or Medicare reforms which may come later, even if budget concerns limit or preclude subsidies at this time.

Therefore, as you contemplate which initiatives to include in your FY99 budget proposal, I urge you, once again, to play a leadership role in the effort to expand health care coverage for those who need it most.

If we miss the opportunity to begin now to address the health care needs of this pre-Medicare group, the workplace and demographic shifts that make health care coverage difficult for this population today are, unfortunately, likely to get worse before they get better. The enormity of the "baby boom" generation will be felt in the pre-Medicare health care marketplace, just as it will be felt in Medicare. It would certainly be a good signal to those who are nearing retirement age that even as the nation takes on another debate about Medicare -- this time about its long-term future -- that we are also thinking about those in their early 60s who find it difficult or impossible to find affordable health care coverage.

If I can be of any assistance to you as you consider these or other issues that affect older Americans, please do not hesitate to call on me.

Sincerely,



Horace B. Deets

MEDICARE EARLY ACCESS ACT OF 1998

A BILL DESIGNED TO PROVIDE AMERICANS 55 TO 65 NEW HEALTH INSURANCE OPTIONS

BACKGROUND

Americans ages 55 to 65 face special problems of access to and affordability of health insurance. They face greater risks of health problems and are twice as likely to have heart disease, strokes, or cancer as people aged 45 to 54. As people approach 65, many retire or shift to part-time work or self-employment as a bridge to retirement, sometimes involuntarily. Displaced workers aged 55 to 65 are much less likely than younger workers to be re-employed or re-insured through a new employer. As a result, more of them rely on the individual health insurance market. Without the benefits of having their costs averaged with younger people, as with employer-based insurance, these people often face high premiums.

Such access problems will increase, due to two trends: declines in retiree health coverage and the aging of the baby boom generation. Recently, businesses have cut back on offering health coverage to pre-65-year-old retirees; only 40 percent of large firms now do so. In several small but notable cases, businesses have dropped retirees' health benefits after workers have retired. These "broken promise" retirees lack access to employer continuation coverage and could have problems finding affordable individual insurance. Finally, the number of people 55 to 65 years old will rise from 22 million to 35 million by 2010 - or by 60 percent.

SUMMARY

This bill creates three important health insurance choices for certain people ages 55 to 65:

1. **People ages 62 to 65** without access to group insurance could buy into Medicare;
2. **Workers ages 55 and older** and their spouses who lose their health insurance when their firm closes or they are laid off could buy into Medicare; and
3. **Retirees ages 55 and older** whose employers drop their retiree health coverage after they have retired could buy into the employer's health plan through "COBRA" coverage.

Participants would pay premiums to cover almost the entire costs of coverage. Any shortfall would be paid for by policies to reduce Medicare fraud and overpayments, proposed in a companion bill called the Medicare Anti-Fraud and Overpayment Act of 1998.

The Medicare buy-in would be completely walled off from the Medicare Trust Funds, to ensure that it does not in any way affect current beneficiaries.

TITLE I. Access to Medicare Benefits for Individuals 62-to-65 Years of Age

The centerpiece of this initiative is the Medicare buy-in for people ages 62 to 65.

Eligibility: People ages 62 to 65 who do not have access to employer sponsored or federal health insurance may participate.

Premium Payments: Participants would pay two separate premiums-- one before age 65 and one between age 65 and 85:

- **Base premium:** The base premium would be paid monthly between enrollment and when the participant turns age 65. It is the part of the full premium that represents what Medicare would pay on average for all people in this age group. CBO estimates that this would be about \$300 per month. It would be adjusted for geographic variation, but the maximum premium would be limited to ensure participation in all areas of the country.

- **Deferred premium:** The deferred premium would be paid monthly beginning at age 65 until the beneficiary turns age 85. It is the part of the premium that covers the extra costs for participants who are sicker than average. Participants will be told before they enroll what their deferred premium will be. CBO estimates that this would be about \$10 per month per year of participation.

This two-part payment plan acts like a mortgage: it makes the up-front premium affordable but requires participants to pay back the Medicare "loan" with interest. It also ensures that in the long-run, this buy-in is self-financing.

Enrollment: Eligible people can enroll within two months of either turning 62 or losing access to employer-based or Federal insurance.

Applicability of Medicare Rules: Services covered and cost sharing would be, for paying participants, the same as those of Medicare beneficiaries. Participants would have the choice of fee-for-service or managed care. No Medicaid assistance would be offered to participants for premiums or cost sharing. Medigap policy protections would apply, but the open enrollment provision remains at age 65.

Disenrollment: People could stop buying into Medicare at any time. People who disenroll would pay the deferred premium as though they had been enrolled for a full year (e.g., a person who buys in for 3 months in 1999 would pay the deferred premium as though they participated for 12 months). This is intended to act as a disincentive for temporary enrollment.

TITLE II. Access to Medicare Benefits for Displaced Workers 55-to-62 Years of Age

In addition to people ages 62 to 65, a targeted group of 55 to 61 year olds could buy into Medicare. The Medicare buy-in would be the same as above, with the following exceptions.

Eligibility: People would be eligible if they are between ages 55 and 61 and: (1) lost their job because their firm closed, downsized, or moved, or their position was eliminated (defined as being eligible for unemployment insurance) after January 6, 1998; (2) had health insurance through their previous job for at least one year (certified through the process created under HIPAA to guarantee continuation coverage); and (3) do not have access to employer sponsored, COBRA, or federal health insurance. Spouses of these eligible people may also buy into Medicare.

Premium Payments: Participants would pay one, geographically adjusted premium, with no Medicare "loan". This premium represents what Medicare would pay on average for all people in this age group plus an add-on (65 percent of the age average) to compensate for some of the extra costs of participants who may be sicker than average. These premiums would be about \$400 per month.

Disenrollment: Like people ages 62 to 65, eligible displaced workers and their spouses must enroll in the buy-in within 63 days of becoming eligible. Participants continue to pay premiums until they voluntarily disenroll, gain access to federal or employer-based insurance or turn 62 and become eligible for the more general Medicare buy-in. Once they disenroll, they may only re-enroll if they meet all the eligibility rules again.

TITLE III. Retiree Health Benefits Protection Act

The bill would also help retirees and their dependents whose former employer unexpectedly drops their retiree health insurance, leaving them uncovered and with few places to turn.

Eligibility: People ages 55 to 65 and their dependents who were receiving retiree health coverage but whose coverage was terminated or substantially reduced (benefits' value reduced by half or premiums increased to a level above 125 percent of the applicable premium) would qualify them for "COBRA" continuation coverage.

Premium Payments: Participants would pay 125 percent of the applicable premium. This premium is higher than what most other COBRA participants pay (102 percent) to help offset the additional costs of participants.

Enrollment: Participants would enroll through their former employer, following the same rules as other COBRA eligibles.

Disenrollment: Retirees would be eligible until they turn 65 years old.

COMPANION BILL: Medicare Anti-Fraud and Overpayment Act of 1998

This bill improves the financial integrity of Medicare and helps fund the Medicare buy-in. It does this through a series of policies, including:

Eliminating Excessive Medicare Reimbursement for Drugs. A recent report by the HHS Inspector General found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. For more than one-third of these drugs, Medicare pays more than double the actual acquisition costs, and in one case, pays as high as ten times the amount. This proposal would ensure that Medicare payments are provider's actual acquisition cost of the drug without mark-ups.

Eliminating Overpayments for Epogen. A 1997 HHS Inspector General report found that Medicare overpays for Epogen (a drug used for kidney dialysis patients). This policy would change Medicare reimbursement to reflect current market prices (from \$10 per 1,000 units administered to \$9).

Eliminating Abuse of Medicare's Outpatient Mental Health Benefits. The HHS Inspector General has found abuses in Medicare's outpatient mental health benefit - specifically, that Medicare is sometimes billed for services in inpatient or residential settings. This proposal would eliminate this abuse by requiring that these services are only provided in the appropriate treatment setting.

Ensuring Medicare Does Not Pay For Claims Owed By Private Insurers.

Too often, Medicare pays claims that are owed by private insurers because Medicare has no way of knowing the private insurer is the primary payer. This proposal would require insurers to report any Medicare beneficiaries they cover. Also, Medicare would be allowed to recoup double the amount owed by insurers who purposely let Medicare pay claims that they should have paid, and impose fines for failure to report no-fault or liability settlements for which Medicare should have been reimbursed.

Enabling Medicare to Negotiate Single, Simplified Payments for Certain Routine Surgical Procedures. This proposal would expand HCFA's current "Centers of Excellence" demonstration that enables Medicare to pay for hospital and physician services for certain high-cost surgical procedures through a single negotiated payment. This lets Medicare receive volume discounts and, in return, enables hospitals to increase their market share, gain clinical expertise, and improve quality.

Deleting Civil Monetary Penalty Provision that Weakens Ability to Reduce Fraud and Abuse. HIPAA limited the standard used in imposing civil monetary penalties regarding false Medicare claims. It limited the duty on providers to exercise reasonable diligence to submit

true and accurate claims. This provision would repeal this weakening of the standard.

Deleting the Exceptions from Anti-Kickback Statute for Certain Managed Care Arrangements. Current law makes an exception from the anti-kickback rules for any arrangement where a medical provider is at "substantial financial risk" whether through a "withhold, capitation, incentive pool, per diem payment, or any other risk arrangement." Because of the difficulty of defining this exception, this provision may be serving as a loophole to get around the anti-kickback provisions. This provision would eliminate the exception.

Parenteral Nutrition Reform. According to the Office of the Inspector General, there is an overpayment for these services. This proposal would pay for these products at actual acquisition cost and add a requirement that the Secretary provides for administrative costs and sets standards for the quality of delivery of parenteral nutrition.

Congressional Budget Office (CBO) Analysis of the President's Medicare Buy-In Proposal

As part of their analysis of the President's Budget, CBO did an analysis of the Medicare buy in. Their analysis found that :

- **No Trust Fund Impact:** The net cost of the Medicare buy-in, according to CBO, is \$300 million over 5 years — only fractions of a percent of Medicare spending.
- **More participants:** Participation is estimated to be over 33 percent higher than what the Administration estimated — 410,000.
- **Lower cost:** The post-65 premium that people ages 62 to 65 would pay is only \$10 per month per year — \$6 per month and \$72 less per year than Administration estimates.¹

Medicare Buy-In, 1999-2003 (\$ in Billions, Fiscal Years)

Spending (5 years)		
62 to 65 Year Olds	8.9	
Displaced Workers	0.5	
Total	9.3 *	
Premium revenue (5 years)		
62 to 65 Year Olds	-7.3	
Post-65	-0.2 **	
Displaced Workers	-0.3	
Total	-7.8	
Net Costs	1.5	(Administration: 1.5)
Anti-Fraud Savings	-1.4	
Premium offset	+0.3	(Administration: -2.4)
NET MEDICARE	+0.3*	(Administration: -0.8)*

*CBS on this
= day*

* Numbers may not sum to total due to rounding

** These premiums increase after the first 5 years as participants turn age 65

Participation when fully phased in: 410,000 (Administration: 300,000)

Premiums in 1999:

62 to 65 Year Olds	\$310 per month	(Administration: \$305)
Post-65	\$10 per month per year	(Administration: \$16)
Displaced Workers	\$400 per month	(Administration: \$400)

1. Although the base premium is slightly higher, overall premiums are much lower since the post-65 premium, which is \$6 less per month, would be paid every year until age 85.

Uninsured Medicaid Eligible Children by Race & Ethnicity

Race	Frequency	Percent
White	1,730,263	39%
Black	1,092,341	25%
Hispanic	1,321,881	30%
Asian	164,243	4%
Native American	73,445	2%
Total	4,382,173	100%

Source: March 1997 CPS

address of mental care be
with any
As vaccine
Both

5:15 - Jack Lewin
vaccine for children
1.2 million kids
No Medicaid / purchasing COOP instead
VFC course can be established to coverage

TJL

(703)

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.

QUESTIONS AND ANSWERS ON PRE-65 YEAR OLDS

Q. ISN'T THIS POLICY JUST ANOTHER EXAMPLE OF A GOVERNMENT TAKE-OVER OF THE PRIVATE HEALTH INSURANCE SYSTEM?

- A. Absolutely not. This is a carefully targeted proposal that is designed to make sure that older Americans have access to health care coverage. Older Americans have less access to employer-based health insurance, are twice as likely to have health problems, and are at greater risk of losing coverage. Some have no insurance options, and others are left to buy into the individual insurance market which can be prohibitively expensive because of their poorer health. This helps this vulnerable population get access to health care coverage by:

Enabling Americans Ages 62 to 65 Buy into the Medicare Program, by paying a full premium.

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.

Providing Americans Over 55 Whose Companies Reneged on Their Commitment to Provide Retiree Health Benefits A New Health Option, by extending (COBRA) coverage until age 65.

Q. ISN'T THIS POLICY A MEDICARE ENTITLEMENT EXPANSION, AT A TIME WHEN MEDICARE CAN LEAST AFFORD IT?

- A. Absolutely not. There is no impact on the Medicare Trust Fund because participants would pay their full premium over time, and any and all of the temporary costs associated with this proposal are completely offset by Medicare fraud, abuse and waste savings.

This Administration has made strengthening and preserving the Medicare Trust Fund a top priority since the President took office. In 1993, the President enacted a budget -- without the vote of a single Republican -- that extended the life of the Trust Fund through 2002. The Balanced Budget the President signed into law last summer extended the life of the Trust Fund beyond 2010. This new policy is a carefully targeted policy that will in no way compromise our commitment to strengthen the Medicare program.

Q. WON'T YOU BE PRESSURED TO ADD SUBSIDIES?

A. The Administration will only be open to modifications that are fiscally sound and paid-for. Under no circumstance will we support proposals that negatively affect Medicare's Trust Fund.

Q. SHOULDN'T YOU WAIT FOR THE MEDICARE COMMISSION TO MAKE ANY SUCH RECOMMENDATIONS?

A. The purpose of the Commission is to develop proposals for the overall program and financing of Medicare and this policy in no way changes that. This policy has no overall impact on the Medicare Trust Fund since it is fully financed.

However, at the same time, the Administration will continue to consider policies that address the changing needs of the health care system. This is a carefully targeted proposal that is designed to make sure that older Americans have access to health care coverage. Those that have some type of pre-existing condition often have no insurance options, and are often left to buy into the individual insurance market which can be prohibitively expensive because of their poorer health.

Q. WHY ARE THERE ANY COSTS ASSOCIATED WITH THIS POLICY IF IT IS SELF-FINANCING?

A. There is a relatively modest cost to this proposal because participants would pay the premium in two parts: most up front and a part after they turn 65 years old. This will help these older Americans to buy into Medicare with affordable premiums. Medicare would in effect "loan" participants the second part of the premium until they reach 65 when they would make a small payment as an add on their regular Medicare Part B premium. That "loan" accounts for most of Medicare costs of this policy. Since the additional costs would be repaid with interest, this policy would not burden the Medicare program over the long run.

Q. HOW WILL YOU PAY FOR THIS COST?

A. The President's budget will include initiatives to offset these temporary costs by Medicare waste, fraud and abuse reforms. Because the loan amounts are collected with the Part B premium, there should be no problems with non-payments.

Q. WON'T THIS COST INCREASE AS THE BABY BOOM GENERATION AGES?

A. The program is specifically intended to be self-financing so Medicare will always recoup its costs.

Q. DOES YOUR SUPPORT OF THIS POLICY MEAN THAT YOU ALSO SUPPORT AN EXTENSION OF MEDICARE ELIGIBILITY TO 67 YEARS OLD?

A. We have been and continue to be concerned that postponing Medicare eligibility to 67 years old could increase the number of uninsured elderly since there are fewer affordable insurance options for people this age. Although the Medicare buy-in could help with this problem, it is too soon to advocate for an eligibility change until we have proven options in place that ensure that there will be no increase in the number of uninsured elderly.

Q. DIDN'T THE KASSEBAUM-KENNEDY INSURANCE REFORM GUARANTEE ACCESS FOR PEOPLE MOVING FROM EMPLOYER-BASED TO INDIVIDUAL INSURANCE? WHAT MORE IS NEEDED?

A. The Kassebaum-Kennedy bill did make health insurance more accessible for many Americans, including pre-65 year olds. However, it did not end rating practices that can make insurance prohibitively expensive for sicker people. This set of policies gives many pre-65 year olds an affordable insurance option, free from excessive premium mark-ups and high administrative costs. It adds health insurance options rather than regulates private insurance.

Q. WHY NOT EXTEND COBRA ELIGIBILITY RATHER THAN ALLOW A MEDICARE BUY-IN?

A. For many pre-65 year olds, COBRA is not an option since they worked in a small firm (not subject to COBRA), their firms closed, or they already have used their 18 months of eligibility. Clearly, some pre-65 year olds will continue to take advantage of COBRA. For many, it may be less costly than a Medicare buy-in. But COBRA is limited and extending COBRA would have a costly impact on businesses. We believe that the only logical expansion of COBRA should be limited to those retirees whose employers take away their retiree health insurance coverage.

Q. SOME STUDIES SUGGEST THAT OFFERING HEALTH INSURANCE COVERAGE TO THE PRE-65 YEAR OLDS WILL ENCOURAGE EARLY RETIREMENT. ISN'T THIS EXACTLY THE WRONG DIRECTION THAT WE SHOULD BE HEADED IN AS THE BABY BOOM GENERATION APPROACHES RETIREMENT?

A. We agree that it is important to avoid policies that encourage people to decrease work. We believe that this initiative will not have such an effect. First, there are no traditional subsidies, like the retiree health plans cited in most studies. This may actually encourage people to continue work so they can pay for the full premium. Second, we have limited eligibility to groups that are less likely to be working (62 to 65 year olds who are usually retired, displaced workers who are unemployed, and retirees whose coverage is dropped after they have retired).

Q. WHY CHOOSE 62 YEARS OLD AS THE AGE LIMIT FOR THIS POLICY? WHY NOT 55 YEARS OLD?

A. First of all, this policy does give access to health coverage to a targeted group of Americans over 55. It allows those over 55 who are displaced workers to buy into Medicare and allows those retirees who have their retiree health coverage unexpectedly dropped to buy into their former employers' health plan. It also enables all Americans between the ages of 62 and 65 to buy into Medicare because people this age and older have worse health and worse access to health insurance than younger groups. It also is the age when people become eligible for with Social Security benefits and the age when many people retire.

Q. WHAT HAPPENS IF A PERSON DOES NOT PAY BACK THIS MEDICARE "LOAN"? IS IT AUTOMATICALLY DEDUCTED FROM SOCIAL SECURITY CHECKS?

A. We expect that people who can afford to buy into Medicare will also have sufficient retirement income to pay back the Medicare loan. One option is to automatically add this amount to the Medicare Part B premium for those who have taken advantage of this option. Since over 98 percent of the elderly elect Part B, this could be simple to administer.

Q. HOW MANY PEOPLE WILL BE COVERED BY THIS POLICY?

A. We project approximately 200,000 to 300,000 people will participate in any given year when the program is fully operational. As the population ages, current declines in employer-based insurance continue, and people become familiar with the option, more may participate. But the most important element of this option that it provides security to many pre-65 year olds, one of most difficult-to-insure populations, who fear that the mere existence of a health problem makes them virtually uninsurable.

Q. ISN'T THE COBRA POLICY YET ANOTHER EMPLOYER MANDATE THAT WILL DISCOURAGE EMPLOYERS FROM OFFERING HEALTH COVERAGE TO BEGIN WITH?

A. The COBRA policy applies only to a small subset of firms who have dropped retiree health benefits after they have promised to provide them. Also, it requires retirees to pay a premium without an employer contribution, so the costs to the employer would be minimal. As a consequence, there is no reason to believe that employers will make a decision to drop health coverage simply because this policy exists.

Q. ISN'T THE REAL PROBLEM AFFORDABILITY, NOT ACCESS TO HEALTH INSURANCE? WHY NOT SUBSIDIZE PRIVATE COVERAGE INSTEAD?

A. This is a carefully targeted policy that represents an important step in removing barriers to coverage for an extremely vulnerable population. It also does address, to some extent, the issues of affordability for this population, as currently many Americans ages 55 to 65 only have the option of buying into the individual health insurance market which can be prohibitively expensive.

That being said, affordability of health insurance is a serious problem for all Americans, not just the pre-65 year olds. Even average priced premiums are often too expensive for some working families. This is why this Administration has supported states' expansions of Medicaid and passed the Children's Health Insurance Program. This new proposal tackles a different problem: the difficulty of finding a fairly priced health insurance policy for many pre-65 year olds. This group's health is vulnerable and its options most limited. The policies won't solve all the problems for this group but represent an important step in removing barriers to coverage.

Q. THERE IS NO MENTION OF THE PREMIUMS THAT DISPLACED WORKERS WOULD PAY TO BUY INTO MEDICARE. WHAT IS THAT PREMIUM?

A. Displaced workers would pay one premium, that includes an add-on for any extra costs, up front. This amount is still being estimated, but will be about \$400 per month. Americans choosing this option would pay the entire premium without any Medicare "loan," in order to ensure that Medicare does not pay excessive up-front costs and participants are not burdened by expensive re-payments after they turn age 65.

MEDICARE EARLY ACCESS ACT OF 1998

A BILL DESIGNED TO PROVIDE AMERICANS 55 TO 65 NEW HEALTH INSURANCE OPTIONS

BACKGROUND

Americans ages 55 to 65 face special problems of access to and affordability of health insurance. They face greater risks of health problems and are twice as likely to have heart disease, strokes, or cancer as people aged 45 to 54. As people approach 65, many retire or shift to part-time work or self-employment as a bridge to retirement, sometimes involuntarily. Displaced workers aged 55 to 65 are much less likely than younger workers to be re-employed or re-insured through a new employer. As a result, more of them rely on the individual health insurance market. Without the benefits of having their costs averaged with younger people, as with employer-based insurance, these people often face high premiums.

Such access problems will increase, due to two trends: declines in retiree health coverage and the aging of the baby boom generation. Recently, businesses have cut back on offering health coverage to pre-65-year-old retirees; only 40 percent of large firms now do so. In several small but notable cases, businesses have dropped retirees' health benefits after workers have retired. These "broken promise" retirees lack access to employer continuation coverage and could have problems finding affordable individual insurance. Finally, the number of people 55 to 65 years old will rise from 22 million to 35 million by 2010 — or by 60 percent.

SUMMARY

This bill creates three important, health insurance choices for certain people ages 55 to 65:

1. **People ages 62 to 65** without access to group insurance could buy into Medicare;
2. **Workers ages 55 and older** and their spouses who lose their health insurance when their firm closes or they are laid off could buy into Medicare; and
3. **Retirees ages 55 and older** whose employers drop their retiree health coverage after they have retired could buy into the employer's health plan through "COBRA" coverage.

Participants would pay premiums to cover almost the entire costs of coverage. Any shortfall would be paid for by policies to reduce Medicare fraud and overpayments, proposed in a companion bill called the Medicare Anti-Fraud and Overpayment Act of 1998.

The Medicare buy-in would be completely walled off from the Medicare Trust Funds, to ensure that it does not in any way affect current beneficiaries.

TITLE I. Access to Medicare Benefits for Individuals 62-to-65 Years of Age

The centerpiece of this initiative is the Medicare buy-in for people ages 62 to 65.

- **Eligibility:** People ages 62 to 65 who do not have access to employer sponsored or Federal health insurance may participate.
- **Premium Payments:** Participants would pay two premiums:
 - **Base premium:** The base premium would be paid monthly between enrollment and when the participant turns age 65. It is the part of the full premium that represents what Medicare would pay on average for all people in this age group. CBO estimates that this would be about \$300 per month. It would be adjusted for geographic variation, but the maximum premium would be limited to ensure participation in all areas of the country.
 - **Deferred premium:** The deferred premium would be paid monthly beginning at age 65 until the beneficiary turns age 85. It is the part of the premium that covers the extra costs for participants who are sicker than average. Participants will be told before they enroll what their deferred premium will be. CBO estimates that this would be about \$10 per month per year of participation.

This two-part payment plan acts like a mortgage: it makes the up-front premium affordable but requires participants to pay back the Medicare “loan” with interest. It also ensures that in the long-run, this buy-in is self-financing.

- **Enrollment:** Eligible people can enroll within two months of either turning 62 or losing access to employer-based or Federal insurance.
- **Applicability of Medicare Rules:** Services covered and cost sharing would be, for paying participants, the same as those of Medicare beneficiaries. Participants would have the choice of fee-for-service or managed care. No Medicaid assistance would be offered to participants for premiums or cost sharing. Medigap policy protections would apply, but the open enrollment provision remains at age 65.
- **Disenrollment:** People could stop buying into Medicare at any time. People who disenroll would pay the deferred premium as though they had been enrolled for a full year (e.g., a person who buys in for 3 months in 1999 would pay the deferred premium as though they participated for 12 months). This is intended to act as a disincentive for temporary enrollment.

TITLE II. Access to Medicare Benefits for Displaced Workers 55-to-62 Years of Age

In addition to people ages 62 to 65, a targeted group of 55 to 61 year olds could buy into Medicare. The Medicare buy-in would be the same as above, with the following exceptions.

- **Eligibility:** People would be eligible if they are between ages 55 and 61 and: (1) lost their job because their firm closed, downsized, or moved, or their position was eliminated (defined as being eligible for unemployment insurance) after January 6, 1998; (2) had health insurance through their previous job for at least one year (certified through the process created under HIPAA to guarantee continuation coverage); and (3) do not have access to employer sponsored, COBRA, or Federal health insurance. Spouses of these eligible people may also buy into Medicare.
- **Premium Payments:** Participants would pay one, geographically adjusted premium, with no Medicare "loan". This premium represents what Medicare would pay on average for all people in this age group plus an add-on (65 percent of the age average) to compensate for some of the extra costs of participants who may be sicker than average. CBO estimates that this would be about \$400 per month.
- **Disenrollment:** Like people ages 62 to 65, eligible displaced workers and their spouses must enroll in the buy-in within 63 days of becoming eligible. Participants continue to pay premiums until they voluntarily disenroll, gain access to Federal or employer-based insurance or turn 62 and become eligible for the more general Medicare buy-in. Once they disenroll, they may only re-enroll if they meet all the eligibility rules again.

TITLE III. Retiree Health Benefits Protection Act

The bill would also help retirees and their dependents whose former employer unexpectedly drops their retiree health insurance, leaving them uncovered and with few places to turn.

- **Eligibility:** People ages 55 to 65 and their dependents who were receiving retiree health coverage but whose coverage was terminated or substantially reduced (benefits' value reduced by half or premiums increased to a level above 125 percent of the applicable premium) would qualify them for "COBRA" continuation coverage.
- **Premium Payments:** Participants would pay 125 percent of the applicable premium. This premium is higher than what most other COBRA participants pay (102 percent) to help offset the additional costs of participants.
- **Enrollment:** Participants would enroll through their former employer, following the same rules as other COBRA eligibles.
- **Disenrollment:** Retirees would be eligible until they turn 65 years old. Dependents would be eligible as long as the retiree is eligible, until they turn 65, or, in most cases, for 36 months after the retiree loses eligibility.

COMPANION BILL: Medicare Anti-Fraud and Overpayment Act of 1998

This bill improves the financial integrity of Medicare and helps fund the Medicare buy-in. It does this through a series of policies, including:

- **Eliminating Excessive Medicare Reimbursement for Drugs.** A recent report by the HHS Inspector General found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. For more than one-third of these drugs, Medicare pays more than double the actual acquisition costs, and in one case, pays as high as ten times the amount. This proposal would ensure that Medicare payments are provider's actual acquisition cost of the drug without mark-ups.
- **Eliminating Overpayments for Epogen.** A 1997 HHS Inspector General report found that Medicare overpays for Epogen (a drug used for kidney dialysis patients). This policy would change Medicare reimbursement to reflect current market prices (from \$10 per 1,000 units administered to \$9).
- **Eliminating Abuse of Medicare's Outpatient Mental Health Benefits.** The HHS Inspector General has found abuses in Medicare's outpatient mental health benefit — specifically, that Medicare is sometimes billed for services in inpatient or residential settings. This proposal would eliminate this abuse by requiring that these services are only provided in the appropriate treatment setting.
- **Ensuring Medicare Does Not Pay For Claims Owed By Private Insurers.** Too often, Medicare pays claims that are owed by private insurers because Medicare has no way of knowing the private insurer is the primary payer. This proposal would require insurers to report any Medicare beneficiaries they cover. Also, Medicare would be allowed to recoup double the amount owed by insurers who purposely let Medicare pay claims that they should have paid, and impose fines for failure to report no-fault or liability settlements for which Medicare should have been reimbursed.
- **Enabling Medicare to Negotiate Single, Simplified Payments for Certain Routine Surgical Procedures.** This proposal would expand HCFA's current "Centers of Excellence" demonstration that enables Medicare to pay for hospital and physician services for certain high-cost surgical procedures through a single, negotiated payment. This lets Medicare receive volume discounts and, in return, enables hospitals to increase their market share, gain clinical expertise, and improve quality.
- **Deleting Civil Monetary Penalty Provision that Weakens Ability to Reduce Fraud and Abuse.** HIPAA limited the standard used in imposing civil monetary penalties regarding false Medicare claims. It limited the duty on providers to exercise reasonable diligence to submit true and accurate claims. This provision would repeal this weakening of the standard.

- **Deleting the Exceptions from Anti-Kickback Statute for Certain Managed Care Arrangements.** Current law makes an exception from the anti-kickback rules for any arrangement where a medical provider is at "substantial financial risk" whether through a "withhold, capitation, incentive pool, per diem payment, or any other risk arrangement." Because of the difficulty of defining this exception, this provision may be serving as a loophole to get around the anti-kickback provisions. This provision would eliminate the exception.
- **Fallback for Competitive Pricing for DME.** To ensure savings from competitive pricing for DME, there would be a 1 percent reduction in payments.
- **Reducing in Payments for Prosthetics and Orthotics.** Medicare pays for most prosthetics and orthotics on the basis of regional fee schedules, and fees cannot exceed 120 percent of the average fees for all regions. This proposal would limit fees to 100 percent of the regional median.
- **Parental Nutrition Reform.** According to the Office of the Inspector General, there is an overpayment for these services. This proposal would add a requirement that the Secretary provides for administrative costs and sets standards for the quality of delivery of parental nutrition.

IMPROVING ACCESS TO HEALTH INSURANCE FOR PEOPLE AGES 55 TO 65

The President has proposed a three-part initiative to provide Americans ages 55 to 65 new health insurance options: (1) allowing Americans ages 62 to 65 to buy into Medicare, through a premium designed so that this policy is self-financed; (2) offering a similar Medicare buy-in to displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) giving retirees 55 and over whose retiree health benefits have been ended access to their former employers' health insurance. Any Medicare costs of these policies would be fully offset by Medicare anti-fraud, waste and abuse savings. Thus, this initiative will not add a dime to the deficit or hurt the Medicare Trust Fund.

BACKGROUND

Americans ages 55 to 65 face special problems of access and affordability. They face greater risks of health problems, with twice the chances of heart disease, strokes, and cancer as people aged 45 to 54. As people approach 65, many retire or shift to part-time work or self-employment as a bridge to retirement, sometimes involuntarily. Displaced workers aged 55 to 65 are much less likely than younger workers to be re-employed or re-insured through a new employer. As a result, more of them rely on the individual health insurance market. Without the benefits of having their costs averaged with younger people, as with employer-based insurance, these people often face high premiums.

Such access problems will increase, due to two trends: declines in retiree health coverage and the aging of the baby boom generation. Recently, businesses have cut back on offering health coverage to pre-65-year-old retirees; only 40 percent of large firms now do so. In several small but notable cases, businesses have dropped retirees' health benefits after workers have retired. These "broken promise" retirees lack access to employer continuation coverage and could have problems finding affordable individual insurance. Finally, the number of people 55 to 65 years old will rise from 22 million to 35 million by 2010 — or by 60 percent.

POLICY DESCRIPTION

The President has proposed three policy options to improve access to affordable health insurance for targeted groups of Americans ages 55 to 65.

1. Medicare Buy-In for People Ages 62 to 65

The centerpiece of this initiative is the Medicare buy-in for people ages 62 to 65.

- **Eligibility:** People ages 62 to 65 who do not have access to employer sponsored or Federal health insurance may participate.

- **Premium Payments:** Participants would pay two, geographically adjusted premiums:
 - **Pre-65 premium:** The pre-65 premium would be paid monthly between enrollment and when the participant turns age 65. It is the part of the full premium that represents the average Medicare costs for people in this age group. For 1999, it would be around \$300 per month and would be updated annually.
 - **Post-65 premium:** The post-65 premium would be paid monthly beginning at age 65 until the beneficiary turns age 85. It is the part of the premium that represents the extra costs if participants are sicker than average. For 1999, it would be around \$16 per month for each year of participation (about \$48 per month for a person who buys in from age 62 to 65). At the time of enrollment, participants would be told their post-65 premium. The post-65 premium would be re-estimated for future participants to ensure that it reflects actual experience. This premium would be added to their Part B Medicare premium.

This two-part payment plan acts like a mortgage: it makes the up-front premium affordable but requires participants to pay back the Medicare "loan" with interest.

- **Enrollment:** Eligible people would apply at Social Security offices. They would bring proof of their age and eligibility for Medicare when they turn 65. They would do this within 63 days of either turning 62 or losing access to employer-based or Federal insurance (63 days is the maximum time period that a person can be uninsured and still be protected by Health Insurance Portability and Accountability Act).
- **Applicability of Medicare Rules:** Benefits and most protections would be, for paying participants, the same as those of Medicare beneficiaries. Participants would have the choice of fee-for-service or managed care. No Medicaid assistance would be offered to participants for premiums or cost sharing. Medigap policy protections would apply, but the open enrollment provision remains at age 65.
- **Disenrollment:** People could stop buying into Medicare at any time. People who disenroll would pay the post-65 premium as though they had been enrolled for a full year (e.g., a person who buys in for 3 months in 1999 would pay the post-65 premium as though they participated for 12 months). This is intended to act as a disincentive for temporary enrollment. People may only enroll once; for example, a participant may not disenroll at age 63 and re-enroll at age 64.
- **Medicare Trust Fund Impact:** According to HCFA, the 62 to 65 year old buy-in is self-financing and will not, in the long-run, decrease the life of Medicare's Trust Funds. Premium collections will be allocated to the Trust Funds in proportion to spending from those Funds for participants. The Medicare Part B premium and managed care rates for regular Medicare beneficiaries will be calculated independently of the buy-in.

2. Medicare Buy-In for Displaced Workers Ages 55 and Over

In addition to people ages 62 to 65, a targeted group of 55 to 61 year olds could buy into Medicare. The Medicare buy-in would be the same as above, with the following exceptions.

- **Eligibility:** People would be eligible if they are between ages 55 and 61 and: (1) lost their job because their firm closed, downsized, or moved, or their position was eliminated (defined as being eligible for unemployment insurance) after January 1, 1998; (2) had health insurance on their previous job for at least one year (certified through the process created under HIPAA to guarantee continuation coverage); and (3) do not have access to employer sponsored, COBRA, or Federal health insurance. Spouses of these eligible people may also buy into Medicare.
- **Premium Payments:** Participants would pay one, geographically adjusted premium, with no Medicare "loan". This premium represents the average Medicare costs for people in this age group (one premium for age 55 to 59, another for 60 to 61) plus an add-on to compensate for some of the extra costs of participants who may be sicker than average. For 1999, the premium would be \$400 per month and would be updated annually.
- **Disenrollment:** Like people ages 62 to 65, eligible displaced workers and their spouses must enroll in the buy-in within 63 days of becoming eligible. Participants continue to pay premiums until they voluntarily disenroll, gain access to employer-based insurance or turn 62 and become eligible for the more general Medicare buy-in. Once they disenroll, they may only re-enroll if they meet the eligibility rules again (e.g., are displaced again).

3. Employer Buy-In (COBRA Continuation Coverage) for Certain Retirees

The President would also help retirees whose former employer unexpectedly drops their retiree health insurance, leaving them uncovered and with few places to turn.

- **Eligibility:** Termination of retiree health benefits (i.e., they were covered but their employer ended that coverage) for retirees age 55 to 64 and their dependents would become a COBRA qualifying event.
- **Premium Payments:** Participants would pay 125 percent of the active employees' premium. This premium is higher than what most other COBRA participants pay (102 percent) to help offset the additional costs of participants.
- **Enrollment:** Participants would enroll through their former employer, following the same rules as other COBRA eligibles.
- **Disenrollment:** Retirees would be eligible until they turn 65 years old. Dependents would be eligible for other related periods of eligibility as other COBRA enrollees.
- **Federal Budget Impact:** There is no Federal budget impact because costs would be paid for by the private sector, primarily through retiree premium contributions.

Medicare Anti-Fraud, Waste and Abuse Initiatives

The Medicare buy-in would produce some costs primarily because Medicare is “loaning” participants part of the premium at ages 62 to 65. Even though in the long-run the buy-in for 62 to 65 year olds is self-financing, the President has proposed a set of anti-fraud, waste and abuse provisions to offset the up-front “loan” and any costs of the displaced workers’ buy-in. These policies also are part of the President’s ongoing effort to root out fraud and waste in Medicare. Five of the President’s anti-fraud, waste and abuse initiatives produce scorable budget savings.

- **Eliminating Excessive Medicare Reimbursement for Drugs.** A recent report by the HHS Inspector General found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. For more than one-third of these drugs, Medicare pays more than double the actual acquisition costs, and in one case pays as high as ten times the amount. This proposal would ensure that Medicare payments be provider’s actual acquisition cost of the drug without mark-ups.
- **Eliminating Overpayments for Epogen.** A 1997 HHS Inspector General report found that Medicare overpays for Epogen (a drug used for kidney dialysis patients). This policy would change Medicare reimbursement to reflect current market prices (from \$10 per 1,000 units administered to \$9).
- **Eliminating Abuse of Medicare’s Outpatient Mental Health Benefits.** The HHS Inspector General has found abuses in Medicare’s outpatient mental health benefit — specifically, that Medicare is sometimes billed for services in inpatient or residential settings. This proposal would eliminate this abuse by requiring that these services are only provided in the appropriate treatment setting.
- **Ensuring Medicare Does Not Pay For Claims Owed By Private Insurers.** Too often, Medicare pays claims that are owed by private insurers because Medicare has no way of knowing the private insurer is the primary payer. This proposal would require insurers to report any Medicare beneficiaries they cover. Also, Medicare would be allowed to recoup double the amount owed by insurers who purposely let Medicare pay claims that they should have paid, and impose fines for failure to report no-fault or liability settlements for which Medicare should have been reimbursed.
- **Enable Medicare to Negotiate Single, Simplified Payments for Certain Routine Surgical Procedures.** This proposal would expand HCFA’s current “Centers of Excellence” demonstration that enables Medicare to pay for hospital and physician services for certain high-cost surgical procedures through a single, negotiated payment. This lets Medicare receive volume discounts and, in return, enables hospitals to increase their market share, gain clinical expertise, and improve quality.

A series of other anti-fraud, waste and abuse actions are proposed as well (*see “Ten-Point Plan,” announced by the President on January 24, 1998*).

BUDGET EFFECTS

The Medicare buy-in initiative, which includes the Medicare anti-fraud, waste and abuse proposals, yields overall savings over 5 years. Thus, it will not increase the deficit.

According to the HCFA Actuaries (who also monitor the status of the Trust Funds for the Medicare Trustees), this initiative will not decrease the life of Medicare's Trust Funds.

	FY 1999 to 2003 (\$ millions)
MEDICARE	
Part A (HI)	
Medicare Buy-In Spending	2,977
Medicare Buy-In Premiums	-2,200
Anti-Fraud, Waste & Abuse	-1,010
Net Part A Savings	-233
Part B (SMI)	
Medicare Buy-In Spending	2,896
Medicare Buy-In Premiums	-2,139
Anti-Fraud, Waste & Abuse	-1,370
Net Part B Savings	-613
NET MEDICARE*	-846

* Note: There is an indirect effect on OASDI of this proposal (\$545 million over 5 years). This amount is offset in the Federal budget by the Medicare anti-fraud, waste and abuse savings, yielding a net savings of \$301 million.

**THE PRESIDENT'S FY 1999 MANDATORY BUDGET
HEALTH INITIATIVES**

(Fiscal Years, Dollars in Millions)

	1999	2000	2001	2002	2003	99-03
TOBACCO-FUNDED PRIORITIES						
Research Fund for America: Health						
National Institutes of Health Increase	1,150	2,013	2,984	4,349	6,540	17,036
AHCPR & CDC Research Increase	50	53	57	60	65	285
VA Research Increase	28	—	—	—	—	28
Medicare Beneficiaries' Cancer Clinical Trials Demonstration	200	250	300	—	—	750
Children's Health Outreach	110	150	210	210	220	900
MEDICARE						
Medicare Buy-In	101	387	364	343	339	1,534
Anti-Fraud, Waste & Abuse	-180	-420	-515	-600	-665	-2,380
Net Medicare Savings	-79	-33	-151	-257	-326	-846

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

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).

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

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.

Medicare Buy-In File

ONE HUNDRED FIFTH CONGRESS
BILL ARCHER, TEXAS, CHAIRMAN

PHILIP M. CRANE, ILLINOIS
BILL THOMAS, CALIFORNIA
E. CLAY SHAW, JR., FLORIDA
NANCY L. JOHNSON, CONNECTICUT
JIM BUNNING, KENTUCKY
ANDY ROUGHTON, NEW YORK
WALLY HERGER, CALIFORNIA
JIM MCCREERY, LOUISIANA
DAVE CAMP, MICHIGAN
JIM RAMSTAD, MINNESOTA
JIM RUSSELL, IOWA
SAM JOHNSON, TEXAS
JENNIFER DUNN, WASHINGTON
MAC COLLINS, GEORGIA
BOB PORTMAN, OHIO
PHILIP S. ENGLISH, PENNSYLVANIA
JOHN ENSIGN, NEVADA
JOHN CHRISTENSEN, NEBRASKA
WES WATKINS, OKLAHOMA
J.D. HAYWORTH, ARIZONA
JERRY WELLER, ILLINOIS
KENNY HULSHOF, MISSOURI

CHARLES B. RANGEL, NEW YORK
FORTNEY PETE STARK, CALIFORNIA
ROBERT T. MATSUI, CALIFORNIA
BARBARA B. KENNELLY, CONNECTICUT
WILLIAM J. COYNE, PENNSYLVANIA
SANDOR M. LEVIN, MICHIGAN
BENJAMIN L. CARDIN, MARYLAND
JIM McDERMOTT, WASHINGTON
GERALD D. KLECKA, WISCONSIN
JOHN LEWIS, GEORGIA
RICHARD E. NEAL, MASSACHUSETTS
MICHAEL R. MURPHY, NEW YORK
WILLIAM J. JEFFERSON, LOUISIANA
JOHN S. TANNER, TENNESSEE
XAVIER BECERRA, CALIFORNIA
KAREN L. THURMAN, FLORIDA

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515-6348

January 5, 1998

A.L. SINGLETON, CHIEF OF STAFF

JANICE MAYS, MINORITY CHIEF COUNSEL

**GIVE YOUR CONSTITUENTS AGE 62-64 AFFORDABLE, REVENUE
NEUTRAL OPTION TO BUY-INTO MEDICARE**

Dear Colleague:

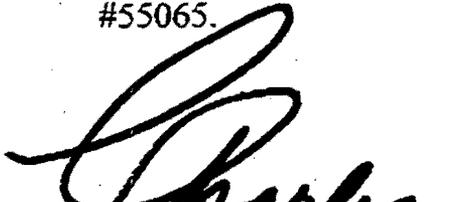
Press reports indicate that the President will request legislation to allow early retirees age 62-64 to "buy into" Medicare. We have been working on such a bill and will introduce it on January 27. We invite your cosponsorship.

Americans in their early 60's face serious health insurance problems: employers are increasingly dropping company coverage for early retirees; individual market private policies are often unaffordable.

There is an easy answer: give people the option to buy-into Medicare in a revenue neutral way, without increasing the drain on Medicare. For those who cannot afford the full cost of buying-in, provide an option where they can pay lower Medicare premiums during the 62-64 period in exchange for higher Part B premiums after 65. In all cases, the buy-in rates would be set at a level that prevents a drain on the current Medicare system.

Please join us in supporting this simple, optional plan to help people in the vulnerable, pre-65 years. If you'd like to cosponsor, please call Anne Montgomery at #55065.

Sincerely,


Charles B. Rangel
Ranking Member


Pete Stark
Ranking Member
Health Subcommittee