

Medicare
Buy-in File

March 9, 1998

MEMORANDUM

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

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

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

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

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

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

- \$305 per month in 1999, \$307 in 2000, and \$319 in 2001, representing the average monthly cost each year if everyone in the 62-64 population were covered.
- \$48 per month at ages 65 through 84 (to amortize the Medicare costs incurred prior to age 65 in excess of the premiums paid).

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

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

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

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

- In the short run, benefit costs and administrative expenses would outweigh premium collections since about one-third of the initial costs at ages 62-64 would not be paid by enrollees until after age 65, rather than year-by-year as the costs are incurred.³
- Although the premiums would be determined on the basis of the estimated costs for those who are expected to ultimately enroll, the *first* people to sign up at program inception would tend to be uninsured individuals in relatively poor health. The premiums paid by these initial enrollees would not be sufficient to cover their costs, resulting in a one-time permanent cost to Medicare, estimated to total about \$0.3 billion.

In addition to these Medicare costs, there would be an increase in OASDI benefit payments and administrative expenses. Some individuals who are currently working and covered by employer-sponsored health insurance would elect to retire if they could obtain Medicare coverage prior to age 65. The Office of the Chief Actuary at the Social Security Administration has estimated that these OASDI costs would total \$0.5 billion over fiscal years 1999-2003. This cost would not be covered by premium payments over time, since the premium determination would be designed only to finance the additional Medicare costs prior to age 65. Under the Administration's Budget legislative package, however, the net Medicare and OASDI costs described above would be offset by other Medicare savings proposals (see memorandum dated March 11, 1998 by Solomon M. Mussey).

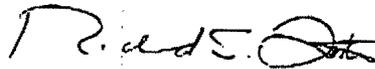
² For example, someone terminating coverage after 18 months of participation would be required to pay amortization premiums at ages 65-84 as if they had participated for a full 24 months.

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

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

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

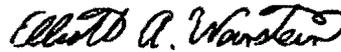
The estimates shown in this memorandum are based on the assumptions underlying the President's 1999 Budget. The estimated numbers of people who would voluntarily enroll in Medicare under this proposal, and the associated changes in Medicare benefits, administrative expenses, and premiums, are based on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



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

Attachments (2)

Table 1

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

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

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

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

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

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

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

Table 2

**Estimated increases in Medicare benefit payments, administrative expenses,
and premium revenues, under a proposal to allow voluntary purchase of
Medicare coverage at ages 62 to 64**

(In billions)

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

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

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

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

Office of the Actuary
Health Care Financing Admin.
March 9, 1998

MEMORANDUM

March 10, 1998

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

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

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

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

- Are eligible for Unemployment Insurance benefits at the time of displacement;
- Have lost health insurance coverage as a result of an involuntary termination of employment and who had such coverage for at least one year prior to termination;
- Have no access to employer-sponsored health insurance, including COBRA continuation rights³ or coverage through a spouse; and
- Are not eligible for Medicaid or any other Federal public health insurance program.

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

² In both respects, this proposal differs significantly from the proposal to allow voluntary enrollment for certain persons at ages 62-64. For the latter proposal, premiums would be payable from the time of enrollment through age 84 and are intended to cover enrollees' entire cost of Medicare benefits and administrative expenses prior to age 65. See our memorandum dated March 9, 1998 for further details.

³ In other words, displaced workers eligible for continuation of group health insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) must first elect and exhaust such coverage before becoming eligible to purchase Medicare coverage under this proposal.

In addition, individuals would have to enroll within 62 days of displacement (or, if later, the loss of their eligibility for other coverage, e.g., COBRA continuation).⁴ Enrollees would be offered the full choice of Medicare managed care or fee-for-service options. Once enrolled prior to age 62, participants could withdraw from participation but could not re-enroll unless they again met all of the qualifying conditions listed above. Displaced worker enrollees who subsequently became re-employed could continue their voluntary Medicare coverage, if they remained without access to other public or employer-sponsored health insurance. Spouses of displaced workers would also be eligible to enroll at any age if they, too, met the eligibility and enrollment conditions (other than having lost a job). Medicare coverage under this proposal would end once the displaced worker attained age 62; such individuals could continue coverage under the age 62-64 enrollment provisions if they met the eligibility criteria. Spouses' coverage could continue through age 61 as long as the displaced worker remained covered and the spouse did not have access to public or employer-based coverage.

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

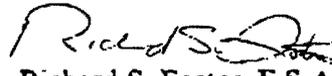
In practice, many individuals choosing to enroll in Medicare under this proposal would do so only if they anticipated receiving health care coverage with a value at least equal to their premium payments. As a result of this "antiselection" tendency in the enrollment decision, the cost of the enrollment group would exceed their premium revenue and the Medicare program would experience a net cost under the proposal. Table 2 (attached) presents the estimated increases in Medicare benefit payments, administrative expenses, and premium revenues, and the overall net cost to Medicare under the subject proposal. The total net cost to Medicare over the first 5 calendar years (1999-2003), is \$0.2 billion. Under the Administration's Budget legislative package, this net Medicare cost would be offset by savings from other Medicare proposals (see memorandum dated March 11, 1998 by Solomon M. Mussey).

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

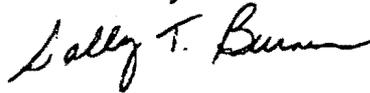
Category of enrollee	Number of Medicare enrollees, by health status		
	Above avg.	Below avg.	All
Displaced workers	4,000	12,000	16,000
Re-employed displaced workers ...	15,500	47,500	63,000
Spouses	19,500	19,500	39,000
Total	39,000	79,000	118,000

⁴ The proposal is assumed to become effective on July 1, 1999; workers displaced since January 1, 1998 would be initially eligible for voluntary coverage.

The estimates shown in this memorandum are based on the assumptions underlying the President's 1999 Budget. The estimated numbers of people who would voluntarily enroll in Medicare under this proposal, and the associated changes in Medicare benefits, administrative expenses, and premiums, are based on limited data and necessarily involve a substantial degree of behavior modeling and judgment. Moreover, there was limited time available for the preparation of these estimates. Consequently, while we prepared these estimates to the best of our abilities within the available time, the results are necessarily uncertain. Actual future costs resulting from enactment of this proposal could vary significantly from these estimates.



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

Attachments (2)

Table 1

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

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

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

Office of the Actuary
Health Care Financing Admin.
March 10, 1998

Table 2

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

(In billions)

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

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

¹ Assumes a July 1, 1999 effective date.

² Less than \$50 million.

MEMORANDUM

March 11, 1998

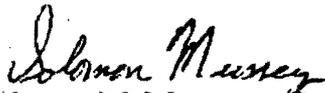
FROM: Solomon M. Mussey
Office of the Actuary

SUBJECT: Estimated Short-Range Financial Effects of the Proposed Medicare Legislation in the President's 1999 Budget

This memorandum summarizes our estimates of the short-range financial effects of the proposed Medicare legislation in the President's 1999 Budget. The details of the proposals in this package are available from the Office of Legislation.

The estimated savings under this package are \$0.2 billion for HI and \$0.6 billion for SMI over the 5-year period FY 1999 to FY 2003, based on the economic assumptions specified by OMB in the President's 1999 Budget.¹ The corresponding 10-year impacts (FY 1999 to FY 2008) are \$1.1 billion for HI and \$2.1 billion for SMI. The estimated impacts shown here and in the attached table do not include the effects of certain other proposals, such as program management and user fee initiatives. The collective impact of these initiatives on benefits is estimated to be negligible. The estimated impacts of the HI proposals in the President's Budget do not have a significant impact on the estimated depletion date of the HI trust fund.

The attached table shows the change in expenditures net of any premium revenue impact under each proposal through fiscal year 2008. The table presents estimates on a "stand alone" basis—that is, the estimates shown for each individual provision represent the financial impact of that provision only, excluding possible interactions with other provisions in the package. Such interactions would have a negligible financial impact. The estimates shown in this memorandum are subject to significant uncertainty. Actual future savings or costs under these proposals could differ significantly from these estimates.


Solomon M. Mussey, A.S.A.
Director, Medicare and Medicaid
Cost Estimates Group

Attachment

¹ "Savings" include the net reduction in HI and SMI benefit expenditures plus the net increase in premiums and other revenues. Changes in administrative costs are not reflected, except for the two proposals to extend Medicare coverage on a voluntary basis to certain individuals below age 65.

FY 1998 President's Budget Proposed Law
(in \$millions)

Provision	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 1999-03	FY 1999-08
Net Medicare Cost (+) or Savings (-) ^{1/}												
Insurer Reporting												
HI	-5	-100	-110	-125	-140	-145	-155	-165	-170	-185	-480	-1,300
SMI	-5	-40	-50	-55	-60	-65	-75	-85	-90	-95	-210	-620
EPO												
HI	0	0	0	0	0	0	0	0	0	0	0	0
SMI	-45	-65	-65	-70	-75	-80	-85	-90	-95	-100	-320	-770
Partial Hospitalization												
HI	0	0	0	0	0	0	0	0	0	0	0	0
SMI	-15	-15	-20	-30	-40	-45	-50	-55	-60	-65	-120	-395
Drug Acquisition												
HI	0	0	0	0	0	0	0	0	0	0	0	0
SMI	-70	-130	-150	-160	-180	-190	-210	-220	-230	-250	-690	-1,790
Centers of Excellence												
HI	-40	-70	-110	-150	-160	-160	-170	-180	-190	-190	-530	-1,420
SMI	0	0	-10	-10	-10	-10	-10	-10	-10	-10	-30	-80
Medicare Coverage at Ages 62-64												
HI	48	182	167	150	140	133	124	116	109	101	687	1,270
SMI	47	177	182	148	137	129	121	113	108	98	669	1,236
Medicare Coverage for Displaced Workers and Spouses												
HI	3	14	17	22	29	35	41	46	50	53	85	310
SMI	3	14	17	22	28	34	40	45	48	51	84	302
Clinical Trials												
HI	2/	2/	2/	0	0	0	0	0	0	0	2/	2/
SMI	2/	2/	2/	0	0	0	0	0	0	0	2/	2/
HI Total	6	28	-36	-103	-131	-137	-160	-183	-201	-221	-238	-1,140
SMI Total	-85	-59	-116	-157	-200	-227	-269	-302	-331	-371	-617	-2,117
Medicare Total	-79	-33	-152	-260	-331	-364	-429	-485	-532	-592	-855	-3,257

1/ For each Medicare provision, each of the HI and SMI impacts are net of any premium revenue impact.

2/ Under this proposal, the benefit costs of \$110, \$137, and \$163 million for HI and \$90, \$113, and \$137 million for SMI for FY 1999 to FY 2001, respectively, are anticipated to be reimbursed by funds earmarked from the tobacco settlement proposal. Therefore, no benefit impact is shown here.

Office of the Actuary
Health Care Financing Administration
March 11, 1998

Excerpt of
**PROVIDING AMERICANS AGES 55 TO 65
NEW HEALTH INSURANCE OPTIONS**

MEDICARE EARLY ACCESS ACT OF 1998

STATE-BY-STATE ANALYSIS
March 17, 1998

MEDICARE EARLY ACCESS ACT OVERVIEW

PROBLEM THAT DEMANDS IMMEDIATE ACTION

- **Increasing number of vulnerable Americans.** The number of people ages 55 to 64 is expected to increase by 60 percent, from 21 million Americans today to 35 million by 2010.
- **Greater risk of health problems.** People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44. Even compared to those age 45 to 54, people ages 55 to 65 have average health costs 25 percent higher and are twice as likely to experience heart disease, emphysema, heart attack, stroke or cancer.
- **Fewer to no insurance options for millions of Americans.** Employer-based coverage drops by about 10 percent for people ages 55 to 65, leaving a higher proportion either uninsured or purchasing individual health insurance. About 5 million, or 22 percent of 55 to 65 year olds, are either uninsured or rely on frequently expensive individual insurance; 3 million have no insurance at all.

As a result of the Health Insurance Portability and Accountability Act, people leaving group health insurance, under certain circumstances, have guaranteed access to individual insurance policies and are guaranteed renewal of policies. However, there is no limit to how much these policies can cost and individuals who haven't had group policies don't receive these protections. As a consequence, many Americans, particularly those who have a pre-existing condition, find it difficult to impossible to find affordable insurance. Specifically, they:

- Can be denied policies in 38 states (where 16 million or 76 percent of 55-65 year olds live)
- Have no protections against pre-existing condition exclusions in 20 states (where 8 million or 36 percent of 55 to 65 year olds live)
- Have no upper limits for premiums in 34 states, and have no protections against higher rates due to health status in 40 states.

In addition, a new study to be released on March 18 by the Kaiser Foundation confirms that the individual insurance market cannot be relied upon to offer affordable insurance to all Americans. It documents insurance practices that result in denials of coverage, excessive premiums, and geographic variation, especially for older and sicker people. It reports that a 60-year old, healthy man in an average cost area could pay up to \$535 per month for coverage; if he lived in a high-cost area and had health problems, this premium could be over twice as high (250 percent of the standard premium, or over \$1,000 per month) -- or be denied coverage altogether.

NEW, RESPONSIBLE, PAID-FOR CHOICE FOR VULNERABLE AMERICANS

- **New choices:** The Early Access to Medicare Act expands health insurance choices so that:
 1. **People ages 62 to 65** without access to group insurance can buy into Medicare;
 2. **Workers ages 55 and older** who lose their insurance when their firm closes or they are laid off can buy into Medicare; and
 3. **Retirees ages 55 and older** whose employers drop their retiree health coverage after they have retired can buy into the employer's health plan through "COBRA" coverage.
- **Helps 300,000 to 400,000 Americans.** The Congressional Budget Office recently confirmed Administration estimates that hundreds of thousands of older Americans will be helped by these new choices.
- **Financed through premium payments:** People ages 62 to 65 will pay premiums through a two-part "payment plan" that enables them to buy into Medicare at an affordable premium while ensuring that the buy-in option is self-financing in the long run. Participants will pay about \$300 per month until age 65, and about \$10 to 15 per month per year of participation once they turn 65 (until they turn age 85). Displaced workers age 55 and older will pay a premium of about \$400 per month, higher than the average cost to compensate for sicker participants. And, retirees buying COBRA pay 125 percent of their former employer's active workers' premiums.

NO HARM TO MEDICARE

- **Paid for by premiums as well as anti-fraud and overpayment reforms.** Premium payments from people benefitting from the buy-in cover virtually all of the costs of the new option. Any short-fall — due mostly to the delay in the post-65 premium collection — is fully paid for by new savings from reducing Medicare fraud, waste and overpayments.
- **Separate Trust Fund.** The buy-in takes advantage of Medicare's low administrative costs and choice of providers and plans, but its financing is totally walled off from that of current Medicare beneficiaries through a separate Trust Fund.

PEOPLE AGES 55 TO 65 AND THE INDIVIDUAL HEALTH INSURANCE MARKET

STATE	PEOPLE AGES 55 TO 65			INDIVIDUAL INSURANCE MARKET		
	Uninsured & Individually Insured	All People	Percent	No Guaranteed Issue	Allows Pre-existing Condition Exclusion	No Premium Rate Restriction
U.S.	4,612,700	21,104,900	22%	38	20	34
Alabama	85,500	385,200	22%	X	X	X
Alaska	7,161	30,409	24%	X	X	X
Arizona	62,300	318,300	20%	X	X	X
Arkansas	63,200	212,900	30%	X	X	X
California	611,500	2,299,400	27%	X		X
Colorado	66,100	279,200	24%	X	X	X
Connecticut	50,900	267,300	19%	X		X
Delaware	10,900	66,000	16%	X	X	X
D.C.	7,700	52,100	15%	X	X	X
Florida	372,100	1,310,200	28%	X		X
Georgia	114,900	522,300	22%	X		X
Hawaii	12,400	98,600	13%	X	X	X
Idaho	21,500	101,500	21%			
Illinois	163,600	999,200	16%	X	X	X
Indiana	80,600	432,700	19%	X		X
Iowa	67,700	255,100	27%			
Kansas	37,100	186,500	20%	X	X	X
Kentucky	66,200	316,800	21%			
Louisiana	85,000	354,000	24%	X		
Maine	21,900	114,600	19%			
Maryland	85,800	386,300	22%	X		X
Massachusetts	88,400	482,500	18%			
Michigan	113,500	696,900	16%	X		X
Minnesota	80,000	395,500	20%	X		
Mississippi	60,400	212,000	28%	X		X
Missouri	83,400	451,600	18%	X	X	X
Montana	19,500	73,300	27%	X		X
Nebraska	42,100	128,000	33%	X	X	X
Nevada	25,600	134,600	19%	X	X	X
New Hampshire	22,300	92,400	24%			
New Jersey	123,000	638,700	19%			
New Mexico	31,700	132,400	24%	X		X
New York	308,800	1,497,600	21%			

STATE	PEOPLE AGES 55 TO 65			INDIVIDUAL INSURANCE MARKET		
	Uninsured & Individually Insured	All People	Percent	No Guaranteed Issue	Allows Pre-existing Condition Exclusion	No Premium Rate Restriction
North Carolina	129,000	645,900	20%	X	X	X
North Dakota	18,500	50,200	37%	X		
Ohio	180,600	928,500	19%			X
Oklahoma	65,000	277,500	23%	X	X	X
Oregon	44,600	261,000	17%	X		
Pennsylvania	162,800	1,033,600	16%	X	X	X
Rhode Island	15,900	82,700	19%	X		X
South Carolina	63,600	320,200	20%	X		X
South Dakota	15,500	53,800	29%			
Tennessee	78,400	454,800	17%	X	X	X
Texas	421,900	1,340,700	31%	X	X	X
Utah	24,400	107,800	23%			
Vermont	11,400	45,600	25%			
Virginia	112,800	624,800	18%	X		X
Washington	65,100	369,800	18%			
West Virginia	33,100	169,300	20%	X	X	
Wisconsin	65,687	374,499	18%	X	X	X
Wyoming	11,600	40,100	29%	X		X

Rounded to the nearest 100

SOURCES:

Projected population: Census Bureau

Health insurance statistics: DHHS analysis of the March 1997 CPS; states: 3-yr average March CPS for 1995-1997

Health status for age groups: NCHS

Average health costs for age groups: Consumer's Union analysis, 1998

Probability of health problems: Gruber, 1997

State individual health insurance regulation: BlueCross BlueShield Association, State Legislature Health Care and Insurance Issues, 1997. January 1998.

General individual health insurance market: Chollet & Kirk. Understanding Individual Health Insurance Markets: Structure, Practices and Products in Ten States. Kaiser Family Foundation, March 1998.

PRESIDENT CLINTON JOINS DEMOCRATS TO UNVEIL LEGISLATION GIVING AMERICANS AGES 55 TO 65 NEW HEALTH INSURANCE OPTIONS AND RELEASES STATE-BY-STATE STUDY UNDERSCORING THE NEED FOR THIS POLICY

March 17, 1998

Today, President Clinton joined Democrats on the Hill to unveil legislation that would provide greater health insurance options for Americans ages 55 to 65, and urged Congress to pass it. This targeted, paid-for proposal will give an estimated 300,000 to 400,000 vulnerable Americans new choices for more affordable health care coverage. The President also released a state-by-state analysis that documents the need for this policy. He:

RELEASED NEW STATE-BY-STATE STUDY THAT DEMONSTRATES THE DIFFICULTY AMERICANS AGES 55 TO 65 HAVE GAINING ACCESS TO HEALTH INSURANCE. The new report, prepared by the Domestic Policy Council and the National Economic Council, showed that:

- ✓ **Twenty-two percent of Americans ages 55 to 65 -- a total of five million people -- are either uninsured or insured through the individual insurance market.** In some states, such as North Dakota, Texas, and Nebraska, the percentage is over 30 percent.
 - **Three million are uninsured.** Some Americans ages 55 to 65 lose their employer-based health insurance when their spouse (frequently the husband) becomes eligible for Medicare. Many lose their coverage because they lose their jobs in company downsizings or plant closings. Still others lose insurance when their retiree health coverage is dropped unexpectedly.
 - **Many are left to buy into an unaffordable individual insurance market, where premiums can be as high as \$1,000 per month.** Individual insurance can be prohibitively expensive, particularly for those who have pre-existing medical conditions.
- ✓ **In 38 states, individual insurance policies can be denied outright.** Sixteen million Americans ages 55 to 65 -- 76 percent of this population -- live in one of the 38 states where individual insurance has no guarantee issue requirement. These individuals often have nowhere to turn for health care coverage.
- ✓ **In 21 states, there are no assurances that pre-existing conditions are adequately covered.** Eight million Americans ages 55 to 65 -- 36 percent of this population -- live in states that allow individual insurers to decline to cover pre-existing conditions. This means that individuals may not be able to get coverage for the care they need most, such as diabetes or cancer treatment.
- ✓ **In 34 states, there are no protections against exorbitant premiums.** Sixteen million Americans ages 55 to 65 -- 75 percent of this population -- live in states that do not protect individuals against exorbitant premiums.

ANNOUNCED THAT THE STATE-BY-STATE FINDINGS WILL BE LARGELY CONFIRMED BY A NEW KAISER FAMILY FOUNDATION STUDY TO BE RELEASED ON WEDNESDAY. A new study to be released on March 18 by the Kaiser Foundation confirms that the individual insurance market cannot be relied upon to offer affordable insurance. It documents insurance practices that result in denials of coverage, excessive premiums, and geographic variation, especially for older and sicker people. It reports that a 60-year old, healthy man in an average cost area could pay up to \$535 per month for coverage. However, if he lived in a high-cost area and had health problems, this premium could be over twice as high (250 percent of the standard premium, or over \$1,000 per month) -- or be denied coverage altogether.

UNVEILED LEGISLATION THAT ALLOWS AMERICANS NEW CHOICES TO GAIN ACCESS TO HEALTH CARE COVERAGE. The legislation unveiled on the Hill today provides new health insurance options for Americans ages 55 to 65. This legislation is being introduced by numerous Democrats, including both Democratic leaders (Senator Daschle and Congressman Gephardt), as well as all the ranking Democrats on the Committees of Jurisdiction: Senators Moynihan and Rockefeller (Senate Finance Committee) and Representatives Rangel, Stark (House Ways and Means Committee), Dingell, and Brown (House Commerce Committee). It:

- ✓ **Enables Americans ages 62 to 65 to buy into Medicare,** by paying a premium.
- ✓ **Provides 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. These workers often have a hard time finding new jobs: only 52 percent are reemployed, compared to over 70 percent of younger workers.
- ✓ **Allows retirees ages 55 and older whose employers dropped their health coverage with access to their former employers' health plan.** This provision allows retirees whose employers dropped their health coverage after they have retired to buy into their employers' health plans through "COBRA" coverage.

CONFIRMED THIS IS A PRUDENT, TARGETED PROPOSAL THAT GIVES AMERICANS AGES 55 TO 65 NEW CHOICES WITHOUT HARMING MEDICARE. The Congressional Budget Office recently released estimates showing that the Medicare buy-in proposal is a carefully targeted policy that will not burden the Medicare Trust Fund.

- ✓ **Paid for by premiums and anti-fraud and overpayment savings.** Under this proposal, participants would pay the premium in two parts: most up front (the base premium) and a part after they turn 65 years old (the risk portion of the premium reflecting the possibility that those who opt for this policy will have below-average health). Medicare would "loan" participants the second part of the premium until they reach 65, after which they would make a small additional payment on top of their regular Medicare Part B premium. This payment mechanism means that the legislation will impose only temporary costs on the Medicare program; these costs are paid for, dollar-for-dollar, by a series of anti-fraud and anti-overpayment initiatives.
- ✓ **Separate Trust Fund.** The buy-in takes advantage of Medicare's low administrative costs and choice of providers and plans, but its financing is kept completely separate from the Medicare Trust Fund.

Hill's Q + A - Not
Bad

JEANNE

~~Kevin~~

Tried to think of tough questions for Stark.....these might be helpful for all of us to think about?

Bill
Medicare Buy-In Act

TOUGH QUESTIONS

1. CBO said you were \$300 million short. What did you do to close the gap?

We think CBO under-estimated the savings from the pharmaceutical provisions. The HHS OIG says the savings are much higher. But we've added 3 other provisions that should ensure revenue neutrality, and if more is needed, we'll do that.

The 3 are: actual acquisition cost of parenteral nutrients, repeal of 2 Kennedy Kassebaum provisions that made it (1) hard to win cases of blatant mis-billings, and (2) to prevent kickbacks in managed care plans.

2. Why are the anti-fraud provisions in a separate bill and why isn't everyone who is sponsoring the expansion sponsoring the anti-fraud stuff?

Opponents usually use the pay-for to drag down our efforts at expansion. We want a debate on the idea of expansion on its merits.

The pay fors can be changed and adjusted, and the expansion won't go into law unless it is paid for.

If the American people believe that the expansion is a good idea, they will support any number of anti-fraud proposals.

The BBA made a BILLION dollar mistake in how we pay for HMOs. Maybe that is what we should use as a pay for. I can give you lots of examples. The anti-fraud bill is just one of an infinite number of combinations of how to pay for this program.

It takes time to get estimates from CBO. We have not had time to explain all the pay fors to all the Members. That's why I really didn't seek cosponsors for this part of the program.

3. This is a rich sick person's bill. How can Democrats be pushing a bill that requires \$300 a month to buy in?

I'd like to see a way to help subsidize low income people.

This is an incremental first step. It is a middle class bill. Better than nothing. We will build on it.

4. Isn't this part of a plot to pave the way for raising the Medicare retirement age?

Can't raise Medicare retirement age until we have a replacement system. At \$300 a month, this is NO replacement for Medicare.

5. Isn't this a plot to have Medicare take over the whole health care system-- government run health care?

No, it gives people a choice. Some competition with overpriced private health insurance. And Medicare providers are private providers; they are not government employees.

By the way, Thursday, we mark up a major expansion in socialized medicine, when the VA taps into Medicare for as much as \$375 million over 3 years so that more people can use VA facilities at Medicare's expense. Now that is government take-over of health care by the Republican leadership!

6. Doesn't the bill encourage people to quit working earlier when we need them to work longer to save Social Security?

\$300 a month plus a lifetime of higher payments? No this will only be used by people whom the private market is failing or whose health is so poor they need to retire.

Not to do this forces some very worn out people to keep working. I thought this was the era of choice and empowerment? If employers need older workers, they will raise the wage for them.

7. Doesn't this encourage business to drop health insurance?

At \$300 a month plus a lifetime of higher payments? Most employers would get bad press and employee morale if they dumped their workers in favor of this program.

8. By using Medicare anti-fraud money, this takes away another tool to save

Medicare in the long-run, so it really does hurt Medicare in the long run.

We need to close the loopholes ASAP. As people repay Medicare through the deferred premium, the 62-65 program will become fully self-financed over a 23 year period. At the end of that period, we will be ahead of the game by having this extra anti-fraud money.

The 55-62 program is a permanent small subsidy to unemployed and uninsured workers that is never fully recovered and which needs the anti-fraud money—but that is surely a worthy target audience.

9. Anti-fraud provision will destroy cancer treatment in America.

No. The OIG has shown that doctors often charge Medicare a mark-up of between 100% clear up to 1000% (10 times) for drugs. The OIG said that if all Medicare drugs were paid at actual acquisition cost, we'd save over \$600 million a year. Note that patients would save by only having to pay 20% of a lower figure.

Doctors are paid for their professional services and for the cost of running their offices—the so-called practice expense. The mark-up on drugs is pure gravy that costs Medicare and patients hundreds of millions per year.

10. EPO cut will hurt kidney patients.

No, to help keep utilization high, the company that makes EPO gives a discount to dialysis centers. The more you order, the more profit you make. The profit is about \$1.50 per 1000 units. We are cutting that by a dollar. Don't worry. They are still making a profit!

11. Medicare is dying. Phil Gramm says it is the Titanic. Why put more people in it.

Phil Gramm is trying to kill Medicare, that's why it is in trouble.

Uninsured people die—they get sicker and they die sooner than insured people. Let's worry about them.

We can save Medicare. This is a small program that is self-financing. By covering more people, it actually builds support for Medicare by showing the American people that it is more of the safety net, and that is really why people like Gramm hate it.

Over 5 years, total spending on the program will be about 0.7% of total Medicare spending, and it is totally paid for. Give me a break!

11. Bill Thomas says wait on the Bipartisan Commission.

Bill Thomas has health insurance.

Subsidized by the taxpayer.

12. Senator Breaux says we should use something like FEHBP instead of Medicare.

Fine. We could make that a good idea, but it will take more money because the FEHBP benefit is a much richer benefit than Medicare.

So until the Senator finds the money, lets start with this program.

13. Seniors Coalition and 60 Plus Association say this will drain the regular Medicare program.

Funny, they hate Medicare. You'd think they'd want to drain it. These are the groups who raise money by scaring seniors with mailings about the Kyl Amendment.

We set up a separate trust fund. The money from the anti-fraud bill and the premiums goes into that trust fund. No regular Medicare money goes in. We provide for the Trustees to report on this, make recommendations to keep this new Medicare Part D Trust Fund solvent, without hurting the rest of Medicare. We provide for GAO audits to make sure this program is not hurting the post-65 Medicare program.

These conservative groups urge that younger people rely on State risk pools. In most states those programs are a failure, and the

insurance is priced impossibly high.

14. HIPAA/Kennedy-Kassebaum takes care of the problem of uninsurance for most people, why this?

KK doesn't! The GAO released a report just last month showing how insurance companies are evading the intent of the law and grossly overpricing the guaranteed issue individual insurance policies.

In Alaska, you have a choice of 2 policies. A \$200 deductible policy for nearly \$17,000 or you can buy a policy for over \$3,000 with a \$10,000 deductible!! That's a failure.

15. Private actuaries say the numbers don't work.

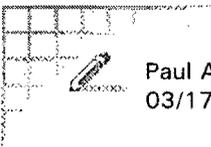
CBO and HCFA say it do.

How could they—they did have the bill to examine. We encourage independent actuaries, not in the pay of insurance companies, to look at the bill.

If there are problems, we can change it.

Toland M

Medicare Buy-In Act



Paul A. Tuchmann
03/17/98 12:18:05 PM

Record Type: Record

To: Sarah A. Bianchi/OPD/EOP
cc:
Subject: 1998-3-17 remarks on Medicare announcement

Just another day at the office...

----- Forwarded by Paul A. Tuchmann/WHO/EOP on 03/17/98 12:20 PM -----



SUNTUM M @ A1
03/17/98 12:08:00 PM

Record Type: Record

To: See the distribution list at the bottom of this message
cc:
Subject: 1998-3-17 remarks on Medicare announcement

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release : March 17, 1998

**REMARKS BY THE PRESIDENT
AT ANNOUNCEMENT OF MEDICARE EXPANSION LEGISLATION**

Longworth Building
Capitol Hill

11:35 A.M. EST

THE PRESIDENT: Thank you very much. Senator Kennedy is even more exuberant than normal today, but you have to forgive him and me and Senator Moynihan and isolated others -- this is St. Patrick's Day, and were feeling pretty good, the Irish are. (Laughter.)

Thank you, Congressman Stark, for your long leadership and your willingness to push this legislation. Thank you, Senator Moynihan, for making it utterly clear, so that no one can dispute it, that this legislation presents no threat to the integrity of the Medicare program or the security of the trust fund. Thank you, Sherrod Brown, for your initiative and your leadership. As always, thank you, Senator Kennedy.

And I'd like to say a word of thanks to one person who has not spoken here today -- our Senate Democratic leader, Tom Daschle, who has worked so hard to help one particular group of Americans here -- Americans who retired early, in part because they were promised health care benefits which were then denied to them. This will take care of them, and we can keep the promise that others made to them. And I think we have to do it. And thank you, Tom Daschle, for fighting for them. (Applause.)

I'd also like to thank Leader Gephardt and Congressman Dingell and all the members of the House Caucus who are here -- thank you very, very much. And I can't help noting that this may be the first public appearance in Washington for the newest member of this Caucus, Representative Lois Capps, from California. (Applause.)

Let me begin with a point I have made over and over to the American people since the State of the Union address. This is a remarkable time for our country. I look at all these young people who are working here, and I think how glad I am they are coming of age at a time when America is working; when we are making progress, economically, we're making progress on our social problems, we're making progress in our quest for peace and security in the world.

But everybody knows that the world is changing very rapidly. And so the question is, what should we be doing in the midst of good times. I believe the last thing we should be doing is sitting on our lead -- if I could use a sports analogy. Good times give us the confidence, the resources and the space not only to dream about the future we want in the 21st century, but to take action to deal with it. It is wrong to sit idly by when we can be taking steps to prepare for that future. That's why I don't want us to spend a surplus that is only now beginning to materialize until we have saved

Social Security for the 21st century. That's why I want us to work together to make sure we deal with the long-term challenges of Medicare.

But it's also why I think we should not let a single day go by when Americans have problems that we can remedy in ways that will not weaken our present success, but instead will reinforce it. That's why I hope we get a comprehensive bill through to deal with the tobacco problem, because there are a thousand kids a day whose lives are at stake. And that's why I believe we should be dealing with this issue now.

President Johnson said when Medicare was first enacted that it proved the vitality of our democracy can shape the oldest of

our values to the needs and obligations of changing times. That's what these leaders are doing here today.

You heard Senator Moynihan say most people don't wait until they're 65 to retire. But the fastest growing group of people are people over 65. There are huge numbers of people in this age group. There are people 62 and over who have lost their health insurance, but can't buy into Medicare. There are people under 65 who are married to somebody who's 65 or older who had the health insurance, and that person retired, got into Medicare, but the spouse lost the health insurance. There are people who are 55 and over who have been downsized, or who actually retired, early retirement, because their employer actually promised them they would have health insurance, and then the promise was not kept.

I want to say that this is not an entirely disinterested thing. In 2001, I will be 55 and unemployed, through no fault of my own. (Laughter.) And this bill has a lot of appeal to me. (Laughter.) I say that to make you laugh. I get a lot of letters from people that I've known a long time who are my age, who are middle class people -- people I grew up with, whose spouses are beginning to have the health problems that go along with just working your way through life; people who don't have a great health insurance coverage, like I've been privileged to have. And they are terrified that they will spend the years between 55 and 65 with maybe the most challenging health problems in their entire lives cropping up, with no insurance.

Now, I believe that this is an issue on which Democrats and Republicans should be able to unite. We ask the Republicans to come and help us on this. Let's don't play election year games on this. We don't want to, either. We want to do it in a bipartisan fashion and get it behind us. There are hundreds of thousands of people out there in America who need this initiative.

People say, well, why don't you wait until the Medicare Commission comes in and issues its report. My answer is Senator Moynihan's answer -- because we have the Congressional Budget Office estimates. They told us that this will add nothing to the burden of the Medicare trust fund, it will cost less than we had originally thought and we can insure more people.

But remember the human dimension. Remember Ruth Cain, who spoke when we announced this program in January. When her husband turned 65, her employer dropped their insurance benefits. He got Medicare, she didn't. But she had a heart condition and they couldn't afford health insurance. So she didn't get health insurance. She went to the hospital one time and the bill was \$13,000. Some people have said of our proposal, well, this bill costs a lot of money for retired people -- \$300 a month or something. One trip to the hospital for anything will more than likely be more than twice as much in one pop as a whole year's annual premiums. The most minor trip to the hospital. The Cains and families like them, the families that Congressman Brown mentioned, they ought to have

another choice.

Today, I am releasing a report that shows state by state how many Americans need these protections -- state by state. And we

will see, state by state, the human lives we're talking about and the number of people that will be put at risk if we wait another year to do this.

Tomorrow the Kaiser Foundation will unveil a study that shows that the individual insurance market often denies coverage or charges excessive premiums to older, sicker Americans, the very people this policy would help to protect. Senator Moynihan said, I want to reiterate because I have heard Senator Kennedy mention the criticisms of this program -- I want to say this a second time -- the Congressional Budget Office -- not the administration's Budget Office, the Congressional Budget Office -- reports this plan will cost individuals even less and benefit even more people than we first estimated. It will give somewhere between 300,000 and 400,000 Americans new options for health care coverage at a vulnerable time in their lives.

Let me say one other thing. The bipartisan Kennedy-Kassebaum legislation we adopted last year -- or in 1996 -- was also designed to help Americans keep their health care when they changed jobs or when someone in their family got sick -- a bill like this one, designed to give people peace of mind. But we now see on news reports today -- another good reason why it's better for us to do this in this way -- because just today we see that some insurers are finding ways around that law, giving insurance agents incentives to delay or deny coverage to vulnerable Americans. These practices have to be stopped. I am directing Secretary Shalala and the Department of Health and Human Services to conduct a thorough review of the options for strengthening the protections of the Kennedy-Kassebaum law. (Applause.)

And tomorrow the Department will send a notice to every insurer in every state in our country affirming what we already know, that impeding anyone's access to health care in violation of this law is illegal. It's not just wrong, it's illegal. The law is vital to the health and stability of America's workers and their families. We intend to enforce it vigorously.

But let me say, you see the problems we have with that kind of approach. With this kind of approach, anybody who can afford the premium or whose children or relatives will help them to afford this premium, won't have to worry about whether they have health care coverage. We won't have to worry about some regulation or waiting for a report to come in to tell us whether this or that or the other person is complying. We will know that we're helping hundreds of thousands of people who have worked hard all their lives and played by the rules and been good citizens to have the decent, secure time in a vulnerable period of their lives. We can extend this

opportunity in a responsible way.

Medicare is one of the crowning achievements of this century for the American people. With this legislation, and with the other challenges that we intend to face and overcome, we can make sure, as we become an older and older and older country -- which is, I always say, a high-class problem -- that Medicare will be one of the crowning achievements of the 21st century as well.

Thank you very much. (Applause.)

END

11:47 A.M. EST

Message Sent To:

Clinton Pushes Proposal to Open Medicare to Millions of People Ages 55 to 64

By ROBERT PEAR

WASHINGTON, March 17 — President Clinton went to Capitol Hill today and, at a rally with three dozen Democratic members of Congress, pushed his proposal to open Medicare to millions of people 55 to 64 years old.

Hundreds of supporters, lobbyists and labor union members cheered the President, who clearly relished the opportunity to show that he was doing business, undistracted by any grand jury investigation.

Mr. Clinton also expressed alarm at reports that some insurance companies had found ways around a 1996 law intended to make coverage available to people who change jobs or lose their jobs. "These practices have to be stopped," he said.

He ordered the Secretary of Health and Human Services, Donna E. Shalala, "to conduct a thorough review of the options for strengthening the protections" of the 1996 statute, known as the Kassebaum-Kennedy law. "We intend to enforce it vigorously," Mr. Clinton said.

Senator Edward M. Kennedy, the Massachusetts Democrat who was a co-author of the law, said he would introduce legislation this week to set limits on the premiums that can be charged to people exercising their rights to buy individual health insurance coverage under the law. The insurance industry adamantly opposes Federal regulation of rates.

The General Accounting Office, an investigative arm of Congress, found that people with medical problems, though theoretically guaranteed access to insurance under the 1996 law, could be "priced out of the market" because they were charged premi-



Stephen Crowley/The New York Times

Democratic leaders and Administration officials applauded President Clinton's proposal yesterday to open Medicare to people ages 55 to 64.

ums far higher than the standard rates.

Representative Nancy L. Johnson, Republican of Connecticut, said: "This is an outrage. It makes a farce of the Kassebaum-Kennedy bill. If the G.A.O. report is accurate, the industry is circumventing the spirit of the law and may be circumventing the letter of the law."

Charles N. Kahn 3d, chief operating officer of the Health Insurance Association of America, said: "You can regulate rates all you want, but if you have a few million-dollar cases, premiums for everybody will still go up. It would be much better to have broad-based subsidies for the insur-

ance premiums of high-risk individuals, rather than regulating rates."

Republicans have generally been cool to the President's proposal. But Democrats said they would take the issue to the Senate floor, bypassing the Finance Committee and forcing Republicans to vote on expansion of Medicare in this election year.

The President said his proposal "presents no threat to the integrity of the Medicare program or the security of the trust fund."

Mr. Clinton would offer Medicare coverage to two groups: people 62 to 64 who cannot get health benefits through an employer and unemployed people 55 to 61 who lost insur-

ance coverage along with their jobs.

People 55 to 64 years old could buy Medicare coverage by paying premiums of \$300 to \$400 a month. People ages 62 to 64 who chose this option would also have to pay surcharges on their regular Medicare premiums after they reached the standard eligibility age of 65.

The premiums and surcharges, combined with measures to crack down on Medicare fraud, would pay for the coverage, Mr. Clinton said. He observed that people 55 to 64 were often unable to find affordable insurance.

Legislation to carry out the President's proposal is being introduced

by Senator Daniel Patrick Moynihan of New York, the ranking Democrat on the Finance Committee, and Representative Pete Stark of California the ranking Democrat in the House Ways and Means Subcommittee on Health. Cosponsors include Mr. Kennedy and Senator Tom Daschle of South Dakota, the minority leader.

Representative Bill Thomas, the California Republican who heads the Subcommittee on Health, said, "The first need to fix the current shortfall in Medicare and Social Security is to consider the President's proposal to increase Government spending and expand yet another Government program."

Conservative Wins Primary In Illinois

By DIRK JOHNSON

CHICAGO March 17 — Rejecting their party's



Points

- market screw up

Thanks to Kaiser Family Foundation, Deborah Chollet

PROBLEM

This report is an important contribution to understanding the individual health insurance market which insures 16 million Americans today. It finds that:

- There's extreme variability across states, in terms of number of insurers, types of plans offered, premiums and participation

the least healthy

- Variability is not due to giving people choices but "in fact it most clearly represents insurers' eagerness to underwrite risk in the market -- to segregate risk into separate ... classes and products"

→ heart disease, stroke, chronic ailments

Denial of coverage →

- In most places, individual insurance can be inaccessible or unaffordable. A health condition -- or even the risk of a health condition -- can trigger higher rates, exclusion of certain benefits coverage, or denial of coverage altogether.

where →

o A 60-year old, healthy man in an average cost area could pay up to \$535 per month for coverage.

o Same man in a high-cost area with a health problems could pay over twice as high (250 percent of the standard premium, or over \$1,000 per month) -- or be denied coverage altogether.

Choice not available

Confirms study released by NEC/DPC yesterday that reports on the particular problems faced by people 55 to 65 in the individual health insurance market.

People 55 to 65 disproportionately purchase individual coverage: 2 million (9 percent) of 55 to 64 year olds buy individual insurance -- nearly twice the proportion of younger people (5 percent)

starts w/ 3 million

No guarantee

In 38 states, individual insurance policies can be denied outright. Where 16 million Americans ages 55 to 65 -- 76 percent of this population -- live

No pre-existing condition

In 21 states, there are no assurances that pre-existing conditions are adequately covered. Where 8 million Americans ages 55 to 65 -- 36 percent of this population -- live

No rate bands - few community rating

In 34 states, there are no protections against exorbitant premiums. Where 16 million Americans ages 55 to 65 -- 75 percent of this population -- live

GAO report

THE PRESIDENT'S COMMITMENT

- **Commitment** to addressing the real problems of access, affordability and quality of health care, as demonstrated by:
 - Putting health reform on the agenda in 1994
 - Preserving and protecting Medicare and Medicaid in 1995
 - Passing insurance reform in HIPAA in 1996
 - Expanding children's health in 1997.

In addition, there have been countless executive directives and administrative actions that have improved the health of the nation.

- **Must not stop:** Continues to promote improvements, specifically:
 - HIPAA implementation
 - o Senate action on supplemental
 - o Bulletin
 - Medicare buy-in, introduced as the Medicare Early Access Act yesterday.

MEDICARE BUY IN

- **New choices:** Expands health insurance choices so that:
 1. **People ages 62 to 65** without access to group insurance can buy into Medicare;
 2. **Workers ages 55 and older** who lose their insurance when their firm closes or they are laid off can buy into Medicare; and
 3. **Retirees ages 55 and older** whose employers drop their retiree health coverage after they have retired can buy into the employer's health plan through "COBRA" coverage.
- **Helps 300,000 to 400,000 Americans.** The Congressional Budget Office recently confirmed Administration estimates that hundreds of thousands of older Americans will be helped by these new choices.
- **Paid for by premiums as well as anti-fraud and overpayment reforms.**
- **Separate Trust Fund.** The buy-in takes advantage of Medicare's low administrative costs and choice of providers and plans, but its financing is totally walled off from that of current Medicare beneficiaries through a separate Trust Fund.

Incumbent on those who ~~do~~ oppose reform to offer viable alternatives is doing nothing. The individual market is not secure, particularly those who are or are feared to be - at risk of being sick or status quo - unacceptable

News Release

EMBARGOED FOR RELEASE UNTIL:
10:00 A.M., E.T.
Wednesday, March 18, 1998



2400 SAND HILL ROAD
MENLO PARK
CALIFORNIA 94025

For further information contact:
Heather Balas, 650/854-9400
Chris Ferris, 202/347-5270

TEL 415 854-9400
FAX 415 854-4800

New Study of Individual Health Insurance Market:

MAJOR BARRIERS IDENTIFIED IN INDIVIDUAL HEALTH INSURANCE MARKET FOR PEOPLE WITH HEALTH PROBLEMS

Rates and Regulations Vary Across Ten States Studied

Denials, Waiting Periods, and High Premiums Pose Problems for Pre-Medicare Population

Washington, DC - For many people who have health problems or who are approaching the age of retirement, coverage through the individual health insurance market may be priced out of reach or may be denied altogether, according to a new study prepared by the Alpha Center for the Kaiser Family Foundation. The study assesses policies sold in the individual market in ten states which range in size of population as well as scope of insurance regulation. According to the authors of the report:

- **Coverage in the individual market is often denied to people with health problems.** Six of the ten states studied - California, Florida, Louisiana, Montana, North Dakota, and Pennsylvania - allow insurers to deny coverage to applicants with a history of such health problems as rheumatoid arthritis, chronic headaches, kidney stones, angina, heart disease, or stroke.
- **Premiums in the individual market vary significantly based on the age of the applicant.** Premiums charged to a 60-year-old may be two to four times the premium charged to a 25-year-old. Nine out of the ten states - all except New York, the only state with community rating - allow insurers to base premiums on the applicant's age. For example, in Washington state a healthy 25-year-old who buys insurance independently would pay \$57 per month for one HMO policy, while a healthy 60-year-old would pay \$205 for the same policy.
- **Insurers often increase premiums or add riders for people in the individual market with pre-existing health conditions or risk factors.** These increases, called "rate-ups," can range from 20 to 80 percent above the base rate depending on the applicant's medical history. For example, someone who has a history of heart disease may face a premium increase or be denied coverage altogether. Seven out of the ten states - all but New York, North Dakota, and Washington state - allow insurers to set premiums based on the applicant's health status.

"In most states, insurers who sell individual policies deny coverage to people with health problems or charge them high premiums," said Deborah J. Chollet, Ph.D., lead author of the report.

New York's community rating ensures that individuals are charged the same rate regardless of age or health status. For example, a 25-year-old New Yorker would pay about \$210 per month for HMO coverage, the same rate as would be charged to a 60-year-old. In a state without community rating, premiums can vary significantly. In California, for example, a healthy 25-year-old would be charged about \$89 per month for a policy through one of the Preferred Provider Organizations (PPOs) in the state, while a healthy 60-year-old woman would pay \$250, close to three times as much. If she has high blood pressure her base premium would increase by 25 percent for her pre-existing condition. She might have to purchase additional coverage (known as a "rider") to cover prescription drugs, which range from \$8 to \$27 per month; she could pay a total of about \$340 per month.

This study comes at a time when the number of Americans without health insurance continues to grow and policymakers are considering raising the age of Medicare eligibility to 67, which could require more older Americans to turn to the individual insurance market for coverage. And, at the same time the President is proposing an early Medicare buy-in for the under 65 population to help address the insurance access problems faced by many pre-Medicare uninsured people.

"The study shows why the individual insurance market - as it looks today - is not the answer for most of America's uninsured," said Drew E. Altman, Ph.D., President of the Kaiser Family Foundation. "This is especially true for people who are low-income or already sick, for whom coverage can be priced out of reach, or denied outright."

The Individual Insurance Market and the Uninsured. People under 65 who do not have job-based coverage and are not eligible for Medicaid or Medicare often have no option but the individual insurance market for their health coverage. These health insurance policies are purchased directly by people, often through an insurance agent or broker. Some 16 million Americans received health insurance in 1996 through the individual insurance market; 41 million people remain uninsured, two-thirds of whom live in families with incomes of less than \$30,000. Pre-Medicare age seniors - those under 65 - who do not have insurance face some of the greatest difficulties obtaining coverage since they are more likely than younger people to have health problems.

The Health Insurance Portability and Accountability Act of 1996 - often known as the Kassebaum-Kennedy Law after its principal sponsors - made it easier for people with job-based health coverage to purchase insurance in the individual market after leaving their jobs. A recent study by the General Accounting Office found that insurance is still inaccessible for many individuals covered by the law because some insurers are charging very high premiums and discouraging agents from selling policies. A Congressional hearing is scheduled for Thursday, March 19 to look at implementation of HIPAA.

The study also found that people with HIV/AIDS, in particular, face unique insurance challenges when trying to obtain coverage through the individual insurance market. While five of the ten states studied – New York, North Dakota, Iowa, California, and Washington – require that HIV be treated the same as other illnesses, the remaining five allow insurers to limit coverage for this disease. Where permitted by law, health plans may impose lifetime caps on coverage ranging from \$10,000 to \$25,000 for people with HIV/AIDS. Some states also limit prescription drug benefits. For example, in California many insurers limit prescription coverage to \$2,500 a year even though the newest drug therapies available for HIV can cost up to \$10,000 annually.

Methodology

Understanding Individual Health Insurance Markets was conducted by the Alpha Center for the Kaiser Family Foundation. The study documents rates, regulations, and policies in ten states: California, Florida, Iowa, Louisiana, Montana, North Dakota, New York, Pennsylvania, Utah, and Washington. The states were selected to represent varying geographic regions, market sizes, urban/rural populations, and state regulations with regard to the individual insurance market. The health plans reviewed in each state were limited to those that sold more than \$500,000 in coverage in 1995. The rates cited in the report are from 1998. Information presented in this report is based on population surveys, insurer filings with states, and interviews with independent insurance agents.

The Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit, independent, national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. The Foundation's work is focused on four main areas: health policy, reproductive health, and HIV in the United States, and health and development in South Africa.

Copies of the study are available by calling the Kaiser Family Foundation's publication request line at 1-800-656-4533 (Ask for #1376). Other Foundation documents are available on the organization's website at www.kff.org.

Key Findings from the Kaiser Family Foundation Study
"Understanding Individual Health Insurance Markets:
Structure, Practices and Products in Ten States"

This study represents one of the most in-depth examination of the individual health insurance market, which covers 16 million Americans. These 10 states, which include 35 percent of all Americans, include: California, Florida, Iowa, Louisiana, Montana, North Dakota, New York, Pennsylvania, Utah and Washington. Key findings include:

Who is covered by individual insurance

- **16 million Americans**
 - Varies state by state, from 13 percent of population in NE, ND, SD to less than 5 percent in MA, MI, NM, OH

Who offers individual health insurance

- **Blue Cross Blue Shield:** 40 to 75 percent of the market in all states buy SD, CA
- **Not many insurers, few HMOs:** The number ranges from 7 in Montana to 50 in California – with much fewer HMOs than in the group market.

What benefits are typically offered

- **Varies widely:** Usually, insurers offer single benefit design with choice of deductible and cost sharing with riders for drugs, mental health, maternity care.

Cost sharing: Deductibles from 0 to \$10,000, coinsurance up to 50 percent of services
Benefits: Frequently excludes mental health and substance abuse services, maternity services and prescription drugs. Sometimes, prescription drugs are only available as a rider, costing from \$8 to 27 per month for an adult 50 years or older, with deductibles of \$50 to 200 and annual limits of \$1000 to 3000, and are sometimes underwritten.

 "While the diversity of products in the individual market may suggest abundant choice, in fact it most clearly represents insurers' eagerness to underwrite risk in the market...."

Premiums

- **States with guarantee issue and rating limits:** NY and WA, policies are widely available, although insurers have recently filed for large rate increases. Although no insurer in NY left the state when community rating was implemented, all but one converted to managed care and today there are fewer people covered by individual insurance, in part, because insurers may have raised average premiums.

- **States without guarantee issue and pre-existing condition exclusions:** "Insurers brokers and agents sometimes report very high rates of denials and exclusions as well as rate-ups."

Practice like rate-ups, denials and exclusions "has kept standard premiums in the individual market lower than they otherwise might be."

For healthy people insurance can be obtained -- not for the unhealthy.

not done

Intermediate cost are, 60 year old man:

- Intermediate cost, healthy: \$149 to 535
- High cost, healthy: \$300 to \$1,065 (50 to 100 percent higher)
- High cost, not healthy: \$370 to \$1,330 (250 percent higher)

- **Health screening:** In 8 of the study states, insurers require applicants to fill out health questions and usually requires releasing of the applicant's medical records.
- **Agent commissions:** Unconcerned about low rates, "One agent described individual insurance as a loss leader for agents in his state -- a service sometimes performed only as a favor for existing clients, or to obtain new clients who also would buy life insurance."

STATE HIGH-RISK HEALTH INSURANCE POOLS

	Year Operational	Current Enrollees	Premium Cap ¹	Funding Source
Alabama	1986	0	125-200%	Assessment
Alaska	1993	179	200%	Assessment
Arkansas	1986	401	150%	Assessment
California ³	1991	19,919	125%	Tobacco Tax
Colorado	1991	1,227	150%	Tax Surcharge
Connecticut	1976	1,477	125-150%	Assessment
Florida	1983	1,418	200-250%	Assessment
Illinois ³	1989	4,986	125-150%	Gen Revenue ⁴
Indiana	1982	4,313	150%	Assessment
Iowa	1987	810	150%	Assessment
Kansas	1993	276	-	Assessment
Louisiana	1992	677	150-200%	Gen Revenue/ Patient Surcharge
Minnesota	1976	27,562	125%	Assessment/ Provider surcharge
Mississippi	1992	1,250	150-175%	Assessment
Missouri	1992	1,076	150-200%	Assessment
Montana	1987	321	150-400%	Assessment
Nebraska	1986	3,627	135%	Assessment
New Mexico	1988	811	150%	Assessment
North Dakota	1982	1,362	125%	Assessment
Oklahoma	1996	355	125%	Assessment
Oregon	1990	5,144	125%	Assessment
South Carolina	1990	964	200%	Assessment
Texas	1998	0	150-200%	Assessment
Utah ³	1991	714	150%	Gen Revenue
Washington	1983	712	150%	Assessment
Wisconsin	1981	8,099	150-200%	Assessment/ Lower Provider Reimbursement
Wyoming	1991	349	125-150%	Assessment

¹ Refers to state-imposed limits that cap premiums at no more than a fixed percentage above the standard premium charged by private health plans for individual coverage in the state.

² Enrollment is limited to HIPAA-eligibles.

³ Risk Pool currently operates with periodic enrollment caps.

⁴ The new HIPAA-CHIP risk pool for HIPAA-eligibles is funded by an assessment of all health plans.

Source: Communicating for Agriculture, 1997 and Blue Cross and Blue Shield Association, December 1997

PRESIDENT CLINTON JOINS DEMOCRATS TO UNVEIL LEGISLATION GIVING AMERICANS AGES 55 TO 65 NEW HEALTH INSURANCE OPTIONS AND RELEASES STATE-BY-STATE STUDY UNDERSCORING THE NEED FOR THIS POLICY

March 17, 1998

Today, President Clinton joined Democrats on the Hill to unveil legislation that would provide greater health insurance options for Americans ages 55 to 65, and urged Congress to pass it. This targeted, paid-for proposal will give an estimated 300,000 to 400,000 vulnerable Americans new choices for more affordable health care coverage. The President also released a state-by-state analysis that documents the need for this policy. He:

RELEASED NEW STATE-BY-STATE STUDY THAT DEMONSTRATES THE DIFFICULTY AMERICANS AGES 55 TO 65 HAVE GAINING ACCESS TO HEALTH INSURANCE. The new report, prepared by the Domestic Policy Council and the National Economic Council, shows that:

- ✓ **Twenty-two percent of Americans ages 55 to 65 -- a total of five million people -- are either uninsured or insured through the individual insurance market.** In some states, such as North Dakota, Texas, and Nebraska, the percentage is over 30 percent.
 - **Three million are uninsured.** Some Americans ages 55 to 65 lose their employer-based health insurance when their spouse (frequently the husband) becomes eligible for Medicare. Many lose their coverage because they lose their jobs in company downsizings or plant closings. Still others lose insurance when their retiree health coverage is dropped unexpectedly.
 - **Many are left to buy into an unaffordable individual insurance market, where premiums can be as high as \$1,000 per month.** Individual insurance can be prohibitively expensive, particularly for those who have pre-existing medical conditions.
- ✓ **In 38 states, individual insurance policies can be denied outright.** Sixteen million Americans ages 55 to 65 -- 76 percent of this population -- live in one of the 38 states where individual insurance has no guarantee issue requirement. These individuals often have nowhere to turn for health care coverage.
- ✓ **In 21 states, there are no assurances that pre-existing conditions are adequately covered.** Eight million Americans ages 55 to 65 -- 36 percent of this population -- live in states that allow individual insurers to decline to cover pre-existing conditions. This means that individuals may not be able to get coverage for the care they need most, such as diabetes or cancer treatment.
- ✓ **In 34 states, there are no protections against exorbitant premiums.** Sixteen million Americans ages 55 to 65 -- 75 percent of this population -- live in states that have no limits on what individual market insurers can charge.

ANNOUNCED THAT THE STATE-BY-STATE FINDINGS WILL BE LARGELY CONFIRMED BY A NEW KAISER FAMILY FOUNDATION STUDY TO BE RELEASED ON WEDNESDAY. A new study to be released on March 18 by the Kaiser Foundation confirms that the individual insurance market cannot be relied upon to offer affordable insurance. It documents insurance practices that result in denials of coverage, excessive premiums, and geographic variation, especially for older and sicker people. It reports that a 60-year old, healthy man in an average cost area could pay up to \$535 per month for coverage. However, if he lived in a high-cost area and had health problems, this premium could be over twice as high (250 percent of the standard premium, or over \$1,000 per month) -- or be denied coverage altogether.

UNVEILED LEGISLATION THAT ALLOWS AMERICANS NEW CHOICES TO GAIN ACCESS TO HEALTH CARE COVERAGE. The legislation unveiled on the Hill today provides new health insurance options for Americans ages 55 to 65. This legislation is being introduced by numerous Democrats, including both Democratic leaders (Senator Daschle and Congressman Gephardt), as well as all the ranking Democrats on the Committees of Jurisdiction: Senators Moynihan and Rockefeller (Senate Finance Committee) and Representatives Rangel, Stark (House Ways and Means Committee), Dingell, and Brown (House Commerce Committee). It:

- ✓ **Enables Americans ages 62 to 65 to buy into Medicare,** by paying a premium.
- ✓ **Provides 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. These workers often have a hard time finding new jobs and getting job-based health insurance.
- ✓ **Allows retirees ages 55 and older whose employers dropped their health coverage with access to their former employers' health plan.** This provision allows retirees whose employers dropped their health coverage after they have retired to buy into their employers' health plans through "COBRA" coverage.

Paid for by premiums and anti-fraud and overpayment savings. Under this proposal, participants would pay the premium in two parts: most up front (the base premium) and a part after they turn 65 years old (the risk portion of the premium reflecting the possibility that those who opt for this policy will have below-average health). Medicare would "loan" participants the second part of the premium until they reach 65, after which they would make a small additional payment on top of their regular Medicare Part B premium. This payment mechanism means that the legislation will impose only temporary costs on the Medicare program; these costs are paid for by a series of anti-fraud and anti-overpayment initiatives.

Separate Trust Fund. The buy-in takes advantage of Medicare's low administrative costs and choice of providers and plans, but its financing is kept completely separate from the Medicare Trust Fund.

CONGRESSIONAL BUDGET OFFICE (CBO) CONFIRMED THIS IS A PRUDENT, TARGETED PROPOSAL THAT GIVES AMERICANS AGES 55 TO 65 NEW CHOICES WITHOUT HARMING MEDICARE. The Congressional Budget Office recently released estimates showing that the Medicare buy-in proposal is a carefully targeted policy that will not burden the Medicare Trust Fund. Its estimates showed that the program costs less and covers more people than the Administration estimated: 400,000.

**Q & A's on Medicare Buy In
April, 1998**

Q: Won't the President's Medicare buy-in proposal burden the Medicare Trust Fund?

A: Absolutely not. The Congressional Budget Office just released estimates confirming that the Medicare buy-in proposal is a carefully targeted policy that will not burden the Medicare Trust Fund. In fact, the CBO estimated that the policy will help more people and cost less than the Administration itself did. The CBO estimates that this proposal would provide coverage for 410,000 individuals, 33 percent higher than the Administration's estimates. Moreover, the CBO projects that Medicare beneficiaries would have to pay less in premiums after they turn 65 to cover the costs of the buy-in than the Administration assumed.

There will be a temporary cost to the Medicare program from this policy because Medicare will effectively loan participants part of their premium until after they turn 65. But even this cost is fully paid for by the President's proposal through a series of anti-fraud, abuse, and overpayment measures.

Background:

Why this policy has a temporary cost but would not impose a burden on the Medicare Trust Fund. There is a relatively modest cost to this proposal because participants would pay the premium in two parts: most up front (the base premium) and a part after they turn 65 years old (the risk portion of the premium that reflects the possibility that those who opt for the policy may be less healthy than average). This payment mechanism will help 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 after which they would make a small payment on top of their regular Medicare Part B premium. That "loan" accounts for most of the costs of this policy. Since the loan eventually would be repaid with interest, this policy would not burden the Medicare program over the long run.

Q: Hasn't CBO said that the Administration's anti-fraud savings will not pay the temporary costs of this program?

A: There is a slight difference -- \$300 million over five years -- between CBO and Administration estimates of the amount of money that will be saved by the Administration's proposed antifraud and overpayment measures. However, the legislation introduced by the Democratic leadership in March on behalf of the President has been designed to eliminate this extremely small financing gap.

Q: Senator Breaux and many elite policy analysts say that you should only consider the Medicare buy-in within the context of the Medicare Commission's work. Why do you continue to push for this issue? Isn't it purely politics?

A: While the work of the Medicare Commission will be extremely important, the President does not believe that Congress should hold up a financially responsible proposal that would help hundreds of thousands of vulnerable Americans gain access to health insurance. Americans ages 55 to 65 are one of the most difficult to insure populations: they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely to have health problems. The policies being unveiled today are fully paid for, and will help people who now have few affordable choices for health insurance. The President is confident that as Congress examines the needs of this population and the substance of this proposal, it will decide to move this legislation forward.

Q: Isn't this the wrong time to propose expanding Medicare -- just when the Commission is going to make recommendations about the overall financing of the program?

A: The legislation being unveiled today is a targeted proposal that does not add one dime to the deficit nor does it add any new burdens to the program. The Medicare Commission will be working to develop proposals for the overall financing of Medicare. The legislation being unveiled today will not conflict with the Commission's work in this area. The hundreds of thousands of Americans who benefit from this proposal should not have to wait. The fiscally conservative design of this proposal does not alter, in any way, the financing of the program and as such, does not conflict with the Commission's charge.

Q: Isn't the COBRA policy yet another employer mandate that will discourage employers from offering health coverage?

A: The COBRA policy applies only to a small group of firms that have dropped retiree health benefits after promising 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: What is your response to proposals to allow Americans ages 55 to 65 buy into the Federal Employees Health Benefits Program (FEHBP), rather than Medicare?

A: First of all, we applaud any proposal that recognizes the difficulties that Americans ages 55 to 65 have accessing affordable health insurance.

With regard to proposals that allow this population to buy into FEHBP, we do have some concerns that would need to be addressed. First, if Americans ages 55 to 65 were allowed to buy into FEHBP, this would no doubt raise premiums for all Federal employees. An alternative solution would be to create a separate pool for this age group. However, under this option, premiums for those in this pool would likely be more expensive than under the President's Medicare option.

Another alternative would be to have a two-part premium, as in the President's Medicare proposal, where beneficiaries pay a more affordable premium upfront and then pay an additional risk premium when they enter Medicare at age 65. However, there would be few incentives for insurers to participate in such an option. Insurers would not want to be collecting premiums after the participant was no longer receiving health insurance through them. (This would not be the case in Medicare where an individual will still be participating in the Medicare program after they turn 65 and can pay the second part of the premium as a condition of their participation in the program).

However, we applaud any and all proposals that acknowledge the vulnerabilities of these older Americans and are interested in working with anyone on the best ways to help this population access health insurance.

Q: WHAT DO YOU THINK OF SENATOR DOMENICI'S PROPOSAL TO USE RECEIPTS FROM THE TOBACCO SETTLEMENT TO "SAVE MEDICARE FIRST"?

A: We welcome support for the President's goal of national, bipartisan tobacco legislation and Senator Domenici's comments suggest that he supports this goal too. There is no doubt that the Congress, the states and many others will have a spirited debate over how exactly to use any revenue associated with tobacco legislation. Many constructive ideas, such as Senator Domenici's Medicare option, will no doubt emerge and we look forward to that discussion.

The President's investment priorities for the tobacco legislation are aimed at helping children and the victims or potential victims of smoking. His budget dedicates almost all of any tobacco revenues towards initiatives designed to reduce smoking, help find treatments and cures for diseases, and invest in our children through health care coverage, needed child care, and education. *The Administration believes that these investments have a natural link to tobacco revenue and will make a major contribution toward preparing the nation for the 21st century.*

The President certainly shares the Senator's concern about the Medicare program. No President has done more to protect and strengthen this vital program. Just last year, working with the Congress, the President enacted a package of unprecedented savings -- \$450 billion over 10 years -- and structural reforms that extended the life of the Medicare Trust Fund until 2010. He recently appointed a distinguished group of individuals as his members of the Medicare Commission. The President is committed to working with the Commission to find ways for the program to meet the longer-term financing challenges that confront it. Dedicating revenue from any tobacco legislation to Medicare is certainly an option worth considering, but it should not be the only option.

We need to enact tobacco legislation this year that will help stop our nation's children from taking up smoking in the first place. Then we can have a thorough debate about the best way to invest tobacco revenues.

AARP MEDICARE BUY-IN, Add One

The cost of private health insurance coverage varies widely for people between 62 and 64 years old. Those with employer-sponsored coverage generally pay the lowest premium costs. A worker in the 62 to 64 age group might pay \$420 a year, or 20 percent of the total premium for an active employee plan. However, individuals who purchase private coverage confront much higher costs, particularly if they are in poor health. The cost to a 62 year old can range anywhere from \$2,000 to \$16,000 a year, according to the report.

The report, *A Medicare Buy-In: Examining the Costs for Two Populations*, also examined what the cost of buying in to Medicare would be for people age 65 to 66 if the Medicare eligibility age were raised to 67. The cost would range from \$5,041 a year, or \$420 a month, with 20 percent participation, to \$3,358 a year, or \$280 a month, with full participation.

"This report will provide important information to the Bipartisan Commission on the Future of Medicare. If the Commission looks at changing the age of eligibility for Medicare, it should fully recognize the limits of the private health insurance market and make recommendations on how the private market can make insurance available and affordable to this group of people," said John Rother, AARP's Director of Legislation and Public Policy.

Average Medicare expenditures for current beneficiaries ages 65 and older were \$5,477 in 1997, considerably more than the buy-in premiums estimated for people age 62 to 64 and age 65 to 66. The buy-in premium estimates were lower because the buy-in groups would be younger than the average age of current Medicare beneficiaries, and many of the sickest people in the buy-in age cohorts would have already qualified for Medicare benefits on the basis of disability.

"The lack of access to health insurance for people in their pre-Medicare years is a problem that is only getting worse. These people are faced with a myriad of problems in receiving high quality health care and affordable comprehensive insurance. This can become an incredible financial hardship for other family members who want their loved ones to have health insurance because they understand the risks for them if one or more of their parents lack insurance coverage," Rother said.

AARP, celebrating 40 years of service to Americans of all ages, is the nation's leading organization for people age 50 and older. It serves their needs through information and education, advocacy, and community services which are provided by a network of local chapters and experienced volunteers throughout the country. The organization also offers members a wide range of benefits and services, including *Modern Maturity* magazine and the monthly *Bulletin*.

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Medicare Buy-In Fil

AARP NEWS



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FOR IMMEDIATE RELEASE

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NEW AARP REPORT PROJECTS COST OF MEDICARE BUY-IN FOR PEOPLE IN THEIR PRE-MEDICARE YEARS

Buy-In Option is Important Alternative to Individual Market

A Medicare buy-in for people age 62 to 64 will cost about \$400 per month if 20 percent of the eligible population enrolls, concludes a new AARP report released today in Washington. The analysis was conducted by Roland McDevitt of Watson Wyatt Worldwide for AARP's Public Policy Institute.

The cost for an individual between 62 and 64 years old to buy-in to Medicare would be \$4,570 a year or \$381 a month in 1997, based on the Medicare cost experience in that year.

This premium assumes that only 20 percent of 62 to 64 year olds who are not covered by a public program or an employer-sponsored plan would purchase the buy-in coverage. The analysis also assumes that people in poor health would be more likely to participate. It does not assume that a portion of the premium would be deferred until after age 65.

In contrast, the premium would drop to \$3,044 a year, or \$254 a month, if everyone not covered by a public program or employer-sponsored plan took part in the buy-in, the report found.

"In 1996, almost one million Americans between 62 and 64 years old were one illness away from financial catastrophe," said Geraldine Smolka of AARP's Public Policy Institute. "These individuals, many of whom are retired and living on fixed incomes, had no health insurance. Private health insurance is often unaffordable for them."

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