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ISSUE BRIEF

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Actuarial Issues in Medicare Expansion

Most Americans under the age of 65 receive their health care coverage through employment-based programs. Almost all Americans age 65 and over are covered through the Medicare program. Because of concern that those approaching age 65 are less likely than younger individuals to have access to health care coverage through employment and that, due to deteriorating health, they may be less able to purchase individual health insurance, the Clinton Administration has proposed expanding the Medicare program to allow certain individuals between the ages of 55 and 64 to participate on a voluntary "buy-in" basis. The buy-in expansion is intended to be essentially self-supporting financially when viewed over the lifetime of program participants. This issue brief discusses the actuarial aspects and potential impact of the proposal.

Key conclusions of this Academy brief include:

- The cost of the program will be strongly influenced by the health status of those who choose to participate.
- The reduction in the size of the uninsured population will likely be relatively small.
- The age 62-64 buy-in will generate losses initially, but could become essentially self-supporting over time.
- The amortization premium concept is innovative but unproven.
- Timing differences between benefit and premium payments for the age 62-64 buy-in will result in Part A trust fund balances being somewhat lower than would otherwise be expected.
- The age 55-61 buy-in will likely generate continuing losses.
- Savings from anti-fraud initiatives are intended to offset losses from the Medicare buy-in initiatives. It is unclear whether these savings will fully offset the cost of the buy-in program. We have not attempted to estimate the potential savings from the proposed anti-fraud initiatives.

Background and Overview

One of the motivations for the proposed expansion is a hope that it will provide coverage for some of those who are currently uninsured. Approximately

three million Americans between the ages of 55 and 64, or 13.9% of Americans in that age bracket, have no health insurance coverage. The corresponding figures for those between the ages of 18 and 54 are 27.8 million and 19.7%¹. Unfortunately, many of the uninsured may be financially unable to take advantage of a buy-in program. Among those uninsured between the ages of 55 and 64 (the "near elderly"), approximately half have an income below 200% of the federal poverty level² (or approximately \$21,000 for a family of two).

Medicare eligibility currently begins at age 65. Social Security Old Age benefit eligibility is scheduled to rise from 65 to 67. Growing concern over projected future funding shortfalls in the Medicare program, particularly once the baby boom generation begins to retire, has prompted many to suggest raising the eligibility age for Medicare benefits also. This proposal

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AMERICAN ACADEMY of ACTUARIES

1100 Seventeenth Street NW 7th Floor Washington, DC 20036
Tel 202 223 8196 Fax 202 872 1948

John Trout, Director of Public Policy
Ken Krehbiel, Director of Communications
Alison Kocz, Health Policy Analyst

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¹Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey*, EBRI Issue Brief Number 192, Table 11, page 22, Employee Benefit Research Institute, December 1997

²Paul Fronstin, *Medicare as an Option for Americans Ages 55-64: Issues to Consider*, EBRI Notes, Vol. 19 Number 2, Employee Benefit Research Institute, February 1998

extends a buy-in privilege to those below age 65, as part of a package of Medicare proposals that are intended to be financially self-supporting.

The Clinton Administration's proposed Medicare expansion consists of two separate buy-in arrangements. The first arrangement is for individuals aged 62 to 64. Individuals in that age group would pay a "current premium" (established at a "standard risk" level) of approximately \$300 each month. Because participants in the program are expected to have higher-than-average medical expenses, they would also pay an additional monthly "amortization premium" after age 65 and up through age 84. The monthly amortization premium is anticipated to be approximately \$16 initially.

The second arrangement is for individuals aged 55 to 61 who become uninsured due to losing their jobs. Individuals in this age group would pay a premium that would cover their full expected medical costs. The monthly buy-in premium for this group is anticipated to be approximately \$400.

In addition, the Administration has proposed extending employer-provided COBRA continuation coverage to retirees who lose coverage due to the discontinuation of an employer-provided retiree health benefits plan. While COBRA expansion is a part of the Administration's proposal, it will not be discussed further in this issue brief.

The Administration has also linked these proposed Medicare expansions to several initiatives to reduce fraud and overpayments in the Medicare program. The savings from these anti-fraud initiatives are intended to offset the cost and initial cash outflow of the Medicare buy-in expansions. We have not attempted to estimate the potential savings from the proposed anti-fraud initiatives.

General Considerations for Both Medicare Buy-In Programs

It is important for the Medicare buy-in programs to attract as many healthy individuals as possible, in order to keep program costs at manageable levels. There are many factors that will influence individual consumers' choices about participation. One of the most fundamental is the premium they must pay in

order to participate. Those eligible for these buy-in programs will often have other health insurance coverage available to them within the private sector, and many of those eligible will find private sector options that provide equivalent coverage at a more attractive price.

Participation will require the ability to pay a significant annual buy-in premium (approximately \$3,600 per individual, or \$7,200 for a couple in the case of the age 62-64 buy-in, and approximately \$4,800 per individual, or \$9,600 per couple in the case of the age 55-61 buy-in). This would be beyond the reach of many of the uninsured. Those who can afford the premium will have to choose between the Medicare buy-in coverage and whatever private insurance may be available to them. Particularly in states where underwriting is allowed, those who are healthy may find private insurance less expensive.

A recent study of the individual health insurance market in ten states found premiums for a 60-year-old male in an intermediate cost area generally ranging from \$149 to \$535 per month (of course, rates in high cost geographic areas, or for those in poor health may be much higher)³. For example, sample rates in New York ranged from \$210 to \$264, rates in Washington State ranged from \$149 to \$331, rates in Louisiana ranged from \$233 to \$425, rates in California ranged from \$240 to \$260, and rates in Pennsylvania ranged from \$149 to \$278⁴. It is likely that individuals who are significantly less healthy than the average for the age group will have fewer, and less affordable, options available when purchasing private health insurance coverage and will be more likely to choose the Medicare buy-in coverage. This "self-selection" when choosing between health care coverage alternatives, operating across all those individuals aged 55 to 64 who are eligible for buy-in coverage, will be a major determinant of the cost of the Medicare buy-in program. The extent to which this participant self-selection occurs will partly depend on how potential participants perceive the costs and benefits of the program.

The majority of current Medicare beneficiaries purchase Medicare Supplement insurance (over 75% of elderly beneficiaries purchase private insurance to

³Deborah J. Chollet and Adele M. Kirk, *Understanding Individual Health Insurance Markets: Structure, Practices and Products in Ten States*, page iii, Alpha Center, March 1998

⁴Ibid., Table 18, page 46

supplement their Medicare benefits⁵). Because of the structure of the fee-for-service Medicare benefits, particularly the lack of any limit on annual out-of-pocket expenses, most beneficiaries consider a supplemental policy necessary to ensure comprehensive coverage of their medical care needs. When weighing their coverage options, consumers may view Medicare and Medicare Supplement coverage as complementary pieces of a coverage package. If they view the premium for a supplemental policy as part of the total cost of coverage under the Medicare buy-in, then the buy-in option will appear less attractive and relatively fewer healthy individuals will choose to participate.

Buy-In for Ages 62-64

Premiums and Program Costs

The age 62-64 buy-in program is intended to be self-supporting, so the question of who will choose to participate is vital. The program will need to attract as many healthy individuals as possible, in order to keep the program costs at levels that will allow the program to be financed on a basis that is self-supporting over time. A key factor determining the attractiveness of the program to healthy individuals will be the way in which premiums will be established, and especially how premiums will be adjusted when costs differ from original expectations. Even though limiting the current premium to a "standard risk" level will help mitigate the impact of participant self-selection, as could certain restrictions on eligibility and enrollment, it is still likely that individuals selecting Medicare buy-in coverage will be significantly less healthy than an average individual in this age group.

The exact impact of this self-selection by consumers is impossible to predict with certainty, however, and may well change over time. This makes the process for setting premiums particularly important. Presumably the current premium would be established annually on a prospective basis using recent Medicare claim statistics, as a part of the current process for establishing the Part B premium and reimbursement rates for risk contractors. These claim statistics should be age adjusted, because the health care utilization patterns of the near elderly, and their dependents, may be significantly different from those of the average Medicare beneficiary. Unless shortfalls were recouped in the premiums for

later years, which would make the program less attractive to healthy individuals in those years, losses would be absorbed by the Medicare system. Any such losses could be corrected with the next year's premium increase.

The buy-in program for those aged 62 to 64 is intended to be both affordable and financially self-supporting. The program proposes to accomplish this through an affordable current premium, paid during the years in which coverage is provided, which will be supplemented by later amortization premiums paid by buy-in participants after age 65 and up to age 85. The amortization premiums are, in effect, installment payments on a loan made by the program during the coverage years. This concept is innovative but unproven. We are well aware that projecting premiums three years in advance has proven a daunting actuarial task for health insurance programs with stable participation levels and will undoubtedly be an ongoing challenge in regard to the potentially variable participation in the buy-in program. In addition, the amortization premium, which is to be paid by each cohort of participants for twenty years after their coverage ends, must be accurately estimated in advance to keep the program self-supporting over the long run. The actuarial and financial experience must be carefully monitored for current cost levels and outstanding liabilities.

To encourage participation in the program it may be necessary to provide that the monthly amortization premium will not change after an individual enters the program. Otherwise, because of the uncertain level of the future financial commitment, individuals may be wary about participating unless serious health problems give them no other option, leading to higher average costs. If the amortization premium is fixed for the cohort entering in a particular year, any underestimation in establishing the premium (due, for instance, to unexpected inflation or the impact of new medical technology) could result in a loss to the system over the lifetime of that cohort. Updated estimates would presumably be used for future cohorts when the next year's premiums are established. However, unless shortfalls were recouped by increasing the premiums for later cohorts, which would make the program less attractive to healthy individuals, the loss would be absorbed by the Medicare system. In the event of a

⁵Medigap Insurance: Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting, U. S. General Accounting Office, September 1996

shortfall, the amortization premium for the following cohorts would likely be higher, due to the use of updated estimates, even if it is not raised to subsidize the "loss cohort."

The potential for a premium shortfall is a particular concern for the first few cohorts entering the system. It is likely that they will be on average less healthy than later cohorts, because many healthy individuals who would be eligible during the early years of the program will have already purchased or made plans to purchase private insurance. Recognizing this in the amortization premiums for these cohorts will reduce the attractiveness of the program, increasing the average cost and potentially damaging its acceptance among the public. Not recognizing these higher costs will result in a net loss to the Medicare system.

Because health care costs vary significantly across different regions of the country, it will be important to vary premium rates geographically. This has not been necessary in the past because the Medicare Part B premium represents a small enough portion of total costs that a national average premium is a good deal for consumers everywhere. If a national average premium is used when the consumer is paying all or most of the cost, then individuals in high-cost areas will be more likely to participate than those living in low-cost areas, driving up the overall average cost. To ensure equity between participants in different areas of the country it may well be necessary to vary both the current and amortization premiums geographically.

The amortization premium essentially represents a long-term loan that is forgiven at death. The premium required and the financial impact on the Medicare program depend on many factors, including the interest rate used and the mortality of program participants. If the interest rate equals the rate that would otherwise be earned by the Medicare trust funds, then there would be no investment loss to the program. Using a lower interest rate would reduce the amortization premium, but would result in a net loss to the Medicare program. A higher interest rate would produce a gain to the Medicare program, but would make the buy-in option less attractive.

The required premium level also depends on how long participants live past age 65. The longer the average life expectancy of buy-in participants, the longer amortization premiums will be received on

average (resulting in a larger total amount paid), and the lower each premium payment can be. Since participants will tend to be less healthy than average for their age group, it seems reasonable to expect them to experience higher-than-average mortality rates. This will shorten the amortization period and thus increase the amortization premium needed.

Program Administration

If area specific premiums are used it will significantly complicate the administration of the program. Actual residence must be tracked, not just eligibility and mailing address. To equitably allocate costs, the amortization premium should be determined based on residence during the period of coverage, and should "follow" an individual through subsequent moves. An enrollee who changes residence several times from age 62 to 65 could have a final amortization premium based on multiple different geographic rates. Automatically deducting the amortization premium from Social Security Old Age benefits (as with the current Part B premium) will avoid the necessity for a separate billing process, but will not make it easier to determine the correct amount to collect.

It will also be necessary to identify and notify eligible individuals. This will be complicated if eligibility is extended only to those who do not have other federal or private group insurance coverage available, because the availability of such coverage must be recorded and tracked. Other provisions that might be considered to reduce consumer self-selection, such as allowing enrollment only when a person first becomes eligible or restricting participants' ability to leave the program and reenter it at a later time, would tend to further complicate the administration.

Other Considerations

Existing public and private insurance programs typically provide either for premiums that are payable during the period of coverage, such as private health insurance and term life insurance, or for advance funding of benefits, such as pension, annuity, and long-term care programs. The proposed amortization premiums will be payable for twenty years after benefits have ceased. The presence of a "premium" payment without any current or future benefit may cause some dissatisfaction, leading to pressure to reduce or forgive the amortization premiums. Explicitly describing the arrangement as a loan

might improve understanding and forestall such pressures, but might also reduce participation if individuals see it as entailing a significant debt.

The type of "loan" proposed is also somewhat unusual. Because liability ends at death it is essentially a reverse annuity, rather than a simple amortized payment. Those who live longer than average will pay more over their lifetime than those who die earlier. Unless sex-distinct amortization premiums are established, because of their generally lower death rates, women will, on average, pay more than men.

Buy-In for Ages 55-61

Premiums and Program Costs

Because healthy individuals will have a choice between the Medicare buy-in program and individually purchased private insurance, with no mandate to enter the Medicare program or subsidy to lower its direct cost, it is unlikely that a self-supporting premium can be established for this portion of the program. Many healthy individuals can be expected to purchase private insurance whenever it is less expensive than the Medicare buy-in premium. Increasing the buy-in premium will not solve the problem, because it will make private coverage attractive to even more consumers, resulting in even higher average costs among the buy-in program participants.

The financial dynamics of this buy-in proposal are fundamentally different from those of COBRA continuation coverage, where the employer plan provides a significant subsidy, and from those of a more traditional guaranteed-issue market where healthy individuals must participate in the same rating pool as the unhealthy if they want coverage at all. The Administration's proposal is analogous to group conversion coverage, or to a state high-risk pool. In the latter two cases, stable premium rates are achieved only because some level of subsidy is ultimately provided.

Program Administration

Significant regional differences in medical costs make area-specific premiums as important for the age 55 to 61 buy-in program as they are for the age 62 to 64 buy-in. Because there is no amortization premium, the premium administration will be less complex, however.

Identification and notification of eligible individuals may be difficult. In addition to age, it will be necessary to verify prior health insurance coverage and that the loss of coverage resulted from job loss due to layoff or job displacement. Verifying the reason for job loss will be critical, but difficult. Employers will have no direct interest in distinguishing between voluntary early retirees and those who are displaced. In many cases the nature of a termination is unclear, with employees resigning or retiring in order to avoid involuntary termination.

Multiple periods of eligibility are possible as individuals reenter the labor market. If there are eligibility restrictions designed to reduce the effects of selection, it will become important to distinguish between those who truly reenter the labor force and suffer another displacement and those who try to game the system by creating the appearance of a second qualifying event. It is not clear who will be responsible for verifying ongoing eligibility, including any change in employment status. It also is not clear whether obtaining a new job terminates eligibility for buy-in coverage. If not, it is possible that some employers might encourage new hires with Medicare buy-in coverage to maintain it rather than enroll in any employer-provided health plan.

Other Considerations

With potential participants as young as age 55, the questions of dependent coverage and maternity coverage become more important than they would be for an aged population. Some individuals in this age group will have younger spouses. Many will have dependent children. To provide financial protection to the family group, both maternity coverage and coverage for dependent children may be needed. If they are not provided, the program may be considerably less attractive to those individuals with families.

Potential Impact

On the Uninsured

The proposed buy-in expansions of Medicare are unlikely to have a significant impact on the number of Americans without health insurance. Many of the uninsured will be unable to pay the required premiums. Others will not meet the eligibility criteria. The Congressional Budget Office estimates that approximately 320,000 people will buy in to

Medicare. Of those, roughly two-thirds are already covered through private health insurance.

On the Problem of "Job-Lock"

The proposed buy-in expansions of Medicare will have relatively little effect on workers moving from one job with health benefits to another, but may be of more assistance to workers who leave the labor force entirely or move to jobs that do not provide health benefits. Because eligibility for the age 55 to 61 buy-in program is limited to those who have lost employer-sponsored coverage due to involuntary job loss, if it is effectively administered it should not facilitate voluntary job movement. This eligibility restriction does not apply to the age 62 to 64 buy-in program.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides significant protection to workers moving directly from one employee benefit plan to another. COBRA continuation coverage also provides significant short-term protection to individuals leaving employers with twenty or more employees. HIPAA also mandates long-term protection for those leaving covered employment, but the cost of that protection varies significantly from state to state. Many, but not all, states provided some form of long-term protection for the uninsurable even before the advent of HIPAA, typically through high-risk pools or some form of guaranteed issue requirement.

In states where underwriting is allowed, healthy individuals most likely already find private coverage that is less expensive than the Medicare buy-in option. COBRA continuation coverage, when available, will often be less expensive than the Medicare buy-in for employees aged 62 to 64, and almost always be less expensive for those ages 55 to 61. In a recent survey of midsize to large employers, average monthly premiums for single coverage were \$192 for conventional coverage, \$160 for HMO coverage, \$169 for PPO coverage and \$168 for POS coverage⁶ (enrollee premiums for COBRA continuation coverage are limited to 102% of the premium for active employees). The relationship between the Medicare buy-in option and HIPAA individual portability coverage will vary by state, with the Medicare buy-in

option premium rates being more attractive in some states and HIPAA individual portability being less expensive in others. Perhaps the one group that will benefit most will be individuals who lost covered employment before the advent of HIPAA in those states that did not already provide some form of long-term protection.

On Employee Benefit Plans

The proposed buy-in expansions of Medicare should have little if any impact on health benefits for active employees. The potential impact is greater for post-retirement health benefits. The 1990s have seen a general trend of employers limiting or eliminating their post-retirement medical benefits in the wake of FAS 106. One recent survey of employer-sponsored health plans found that 38% of employers provide health coverage to retirees under age 65, and only 31% provide coverage to Medicare-eligible employees⁷. Post-retirement packages for Medicare-eligible retirees focus on benefits that supplement Medicare. More comprehensive "bridge" benefits are offered to retirees under age 65 to encourage early retirement by ensuring the availability of health insurance until Medicare benefits become available.

The availability of a Medicare buy-in, in conjunction with HIPAA portability and COBRA continuation coverage, may make employers less likely to offer comprehensive health insurance benefits to early retirees. The availability of multiple coverage options may reduce the sense of social obligation on the part of employers, and reduce the need to provide the benefits to facilitate employees' ability and willingness to leave employment. Employer alternatives to offering comprehensive health coverage could include extending to early retirees the same Medicare supplementary benefits available to retirees over age sixty-five or increasing monthly pension or lump-sum severance benefits to offset buy-in premiums. Some employers could encourage early retirees to enroll in Medicare, with the employer paying some or all of the buy-in premium, as an attractive way to limit the cost of post-retirement medical benefits. Employers with less healthy groups are especially likely to follow this route, resulting in a disproportional

⁶Health Benefits in 1997, KPMG Peat Marwick LLP, June 1997, Figure 11, page 9

⁷Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 1997, William M. Mercer, March 1998, page 6

tionate number of less healthy lives enrolling in the buy-in program.

On the Medicare Part A Trust Fund

The amortization premium charged after age 65 for coverage from ages 62 to 64 represents a long-term, low-interest loan from the Medicare program to the insured individual. The result will be a net cash outflow during the early years of the program. This outflow will be reduced over time as participants reach age 65 and begin paying amortization premiums. If the pricing assumptions are relatively accurate and enrollment levels are stable, then the age 62-64 buy-in portion of the system should reach a steady state balance in approximately 20 to 24 years, with cash inflows roughly balancing cash outflows. The net cash outflow over this period of time will result in trust fund balances somewhat lower than would otherwise be expected. If enrollment in the buy-in program rises over time, for economic or demographic reasons (such as the retirement of the baby-boom generation), outflows may persist. Nevertheless, if the buy-in program were at some point to be discontinued, the loan to participants would be paid back over the next 20 to 24 years, ultimately making the trust fund whole.

Assuming the buy-in program is not discontinued, the trust fund balance will remain lower than would otherwise be expected. To the extent that the amortization premiums balance the additional cost arising from the age 62 to 64 buy-in, there should be no net effect on the long-term actuarial balance of the program. However, due to the reduced cash balance, exhaustion of the trust fund will be somewhat accelerated.

The trust fund will also experience gains or losses as actual experience differs from the assumptions used in establishing the current premiums for the buy-in program. For participants ages 62 through 64, the annual premium recalculation should correct any estimation errors, and the net effect over time should be negligible. Unless some form of subsidy is provided, it is likely that the age 55 to 61 buy-in program will generate continuing losses. However, if premium levels are set relatively high, they are likely to keep enrollment low, making the aggregate loss to the program smaller than it might otherwise be.

On the Federal Budget

The budget should see the same pattern of gains and losses as mentioned above for the Part A trust fund, assuming that both the current premiums and the amortization premiums are allocated to Medicare Parts A and B based on program costs. Because the Part B program is funded primarily through general revenues, gains and losses essentially flow through to the federal budget. The amortization premium portion of the program will generate a net cash outflow during the early years of the program that should gradually diminish over time, with cash inflows eventually roughly balancing cash outflows. The current premium for the age 62 through 64 buy-in may produce short-term gains or losses, but the net effect over time should be negligible. The age 55 to 61 buy-in program will likely generate continuing losses. The size of these losses will depend on a number of factors, the most important of which will likely be the number of program participants. Savings from efforts to reduce fraud and overpayments in the Medicare program are intended to offset the cost of the buy-in programs, primarily the age 55-61 buy-in, but also the initial cash outflow from the age 62-64 buy-in. This could be seen as using reduced overpayments in the overall Medicare program to indirectly contribute to financing the buy-in options for the near elderly.

On the OASDI Trust Fund

The proposed Medicare buy-in expansions may also have an indirect effect on the OASDI trust fund. To the extent that early retirement is encouraged, OASDI payroll taxes will be reduced and benefit payment levels increased. Because OAS benefits are actuarially reduced for early retirement, there should be no net effect on the long-term actuarial balance of the program. However, the onset of a net cash outflow for that individual is accelerated. For the program as a whole, the effect of this acceleration should be relatively small.

On the Medicare Supplement Market

The presence of a buy-in option will lead to a demand among early retirees for supplemental policies. An inability to qualify for private Medicare sup-

plement policies may make the buy-in program less attractive to high-risk individuals under age 65. Guaranteed-issue requirements on private insurance, however, would increase the cost of the policies for all seniors.

On Medicare+Choice Plans

Allowing Medicare buy-in participants to participate in Medicare+Choice plans would likely reduce the cost of coverage while providing more comprehensive benefits than are available under the Medicare fee-for-service program. Equitable payment to the Medicare+Choice plans would require a payment rate that reflects the relatively poor health of buy-in enrollees. While encouraging Medicare+Choice participation may be desirable, it is unclear how attractive these plans would be to buy-in participants. Individuals in poor health often prefer fee-for-service benefits to managed care programs.

On Providers

For those buy-in enrollees choosing fee-for-service Medicare benefits rather than participation in a Medicare+Choice plan, provider reimbursements will be limited by the Medicare allowable charges. This reimbursement level may often be lower than that provided by many private plans. The impact of reduced reimbursement levels should be limited by the relatively low number of expected buy-in participants. While provider revenues may be reduced in the case of individuals who would otherwise purchase private coverage, they may actually rise in the case of individuals who would otherwise be uninsured. Furthermore, providers will tend to increase charges for individuals covered under private plans in order to offset the reduced revenue on buy-in program participants.

On Seniors

The proposed Medicare buy-in expansion should have little direct effect on current Medicare beneficiaries. Indirect effects could arise if guaranteed-issue requirements are placed on Medicare Supplement insurance that raise the cost of coverage, or if Medicare+Choice reimbursement rates do not reflect the true cost of buy-in enrollees. The effect on the overall financing of the program should be relatively small.

The most direct impact on future seniors will be the post-65 amortization premium. Based on the Administration's statements, an individual enrolling at age 62 would have a monthly amortization premium after age 65 roughly equal to the current Part B premium. This could be significant for seniors with fixed incomes and declining assets. While deducting the amortization premium directly from Social Security Old Age benefits can ensure that it is always collectable, there may be a desire to avoid reducing the Social Security payments of very-low-income seniors. If reducing the Social Security payments of low-income seniors is to be avoided, it will require raising the amortization premium, requiring Medicaid or some other third party to pay the premium, or simply allowing the Medicare program to absorb the loss.

Actuarial Standards

A key factor in the success of the proposed expansions is attracting a broad range of participating individuals, including healthy individuals as well as those with significant medical expenses. This in turn depends on the direct cost of the program to consumers. Because of the sensitivity of both enrollment and financing adequacy to changes in premium levels, it is vital that the premiums be established in accordance with sound actuarial principles. If such Medicare buy-in options are established, we strongly recommend (as we do for all other aspects of the Medicare system) that premiums and reimbursement rates for them be established by a qualified actuary in accordance with the actuarial standards of practice promulgated by the Actuarial Standards Board, in particular Actuarial Standard of Practice (ASOP) No. 32, "Social Insurance" and with reference to those standards that address long-term health-care valuations, such as ASOP No. 6, "Measuring and Allocating Actuarial Present Values of Retiree Health Care and Death Benefits" and ASOP No. 18, "Long-term Care Insurance." To ensure public accountability, we recommend that a formal actuarial statement opinion be required for the premiums established each year, certifying that, in the appointed actuary's opinion, premiums and reimbursement rates for the program have been developed in accordance with all applicable actuarial standards of practice and relevant legal requirements.

Medicare Buy-In File

Facts on People Ages 55 to 65

- **Fastest growing number of uninsured.** The number of uninsured increased from 41.7 million in 1996 to 43.4 million in 1997, a 4 percent increase. The number of uninsured ages 55 to 64 increased from 2.8 million to 3.2 million, a 7 percent increase. Only the number of uninsured ages 35 to 44 grew as fast. (U.S. Census Bureau, 1998 Current Population Survey, released 9/28/98)
- **Greatest purchasers of individual insurance.** People ages 55 to 64 are less likely to be covered by less expensive employer-based insurance (64 percent v 69 percent for people ages 25-54) and twice as likely to purchase individual insurance (10 percent versus 5 percent for people ages 25-54). Only last year, the proportion covered by employer insurance was higher (66 percent) and covered by individual insurance was lower (9 percent) (U.S. Census Bureau, 1998 Current Population Survey, released 9/28/98)
- **The number of 55 to 64 year olds will rise rapidly in the next decade.** As the Baby Boom generation enters its 50s, both the number and proportion of pre-65 year olds will rise. As a result, the number of people between 55 and 64 years old is expected to increase to from 21 to 30 million by 2005 and 35 million by 2010 — to 12 percent of the U.S. population, over a 50 percent increase. (U.S. Census Bureau, 1998)
- **Individual insurance can be inaccessible or unaffordable for people ages 55 to 65.** According to a Kaiser Family Foundation study (4/98), 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. For example:
 - Higher rates: 25 percent for mild hypertension or emphysema
 - Exclusion riders: Allergies, ulcer, osteoarthritis
 - Denials: Rheumatoid arthritis, severe headaches, angina

People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44. The probability of experiencing health problems such as heart disease, emphysema, heart attack, stroke & cancer is double that of people ages 45 to 54.

State regulation of individual insurance also varies (NEC/DPC analysis, 3/98):

- In 38 states where 16 million people ages 55 to 65 (76 percent of this group) live, individual insurance policies can be denied outright.
- In 21 states, where 8 million people ages 55 to 65 (36 percent) live, there are no assurances that pre-existing conditions are adequately covered.

- In 34 states where 16 million people ages 55 to 65 (75 percent of this group) live, there are no protections against exorbitant premiums.
- **Could encourage work, not retirement.** Critics argue that the Medicare buy-in will cause people to retire earlier since they don't have to wait until they turn 65 to access Medicare. Senator Gramm, at the January 5, 1999 Medicare Commission meeting, actually recommended raising Medicare eligibility age in order to lock people into their jobs for a longer period of time. 3
- **Without subsidies, health insurance alone will not cause early retirement.** A RAND study found that only access to insurance with subsidies (i.e., employer contributions) causes early retirement -- people paying full premiums for individual insurance tend to continue working. (Karoly & Rogowski, 1998)
- **Growing interest in new careers -- that often lack health insurance -- in later life.** New studies suggest that the trend toward earlier retirement, begun in post-war American, has ended. An increasing number of 60 year olds are taking "bridge jobs" to retirement -- consulting work, second careers, or part-time work (e.g., Joseph Quinn, New Paths to Retirement, April 27, 1998). These jobs typically do not offer health insurance -- making people without access to affordable insurance alternatives less likely to take them. The Medicare buy-in could allow people to take new jobs by removing the fear of losing health insurance with job change.

MEDICARE EARLY ACCESS ACT OF 1998

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

BACKGROUND

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

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

SUMMARY

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

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

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

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

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

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

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

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

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

TITLE II. Access to Medicare Benefits for Displaced Workers 55-to-62 Years of Age
In addition to people ages 62 to 65, a targeted group of 55 to 61 year olds could buy into Medicare. The Medicare buy-in would be the same as above, with the following exceptions.

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

TITLE III. Retiree Health Benefits Protection Act

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

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

CHRIS - QUIETLY GAIN THIS START TO HELP in the Modeling TF. Discussion Tamarin TOLD HIM TO SAY HE DID IT.
 DRAFT

Medicare, Private Health Insurance Personal Health Care & GDP Growth
 Expenditures Per Enrollee/Capita

Year	Medicare Annual Growth Per Enrollee	Private Health Insurance Annual Growth Per Enrollee	Years when Medicare > Private Growth	GDP Per Capita	Years when Medicare > GDP
1969	--	--			
1970	6.3	17.4		4.2	1
1971	8.5	10.3		7.3	1
1972	8.2	10.3		8.7	
1973	10.4	11.2		10.6	
1974	14.8	15.1		7.3	1
1975	18.7	15.5	1	7.8	1
1976	16.5	20.5		10.4	1
1977	13.7	15.8		10.3	1
1978	12.9	11.8	1	11.8	1
1979	13.6	17.0		10.4	1
1980	18.6	16.3	1	7.6	1
1981	17.5	16.1	1	10.8	1
1982	15.4	13.7	1	3.1	1
1983	12.0	9.9	1	7.4	1
1984	9.3	9.6		10.0	
1985	6.0	11.3		6.1	
1986	4.7	7.6		4.8	
1987	5.6	11.0		5.2	1
1988	6.5	13.5		6.6	
1989	11.5	12.8		6.7	1
1990	7.7	11.8		4.5	1
1991	8.7	11.0		1.9	1
1992	11.6	9.3	1	4.4	1
1993	6.0	6.2		3.9	1
1994	9.1	3.6	1	4.9	1
1995	9.0	2.8	1	3.6	1
1996	6.5	2.2	1	4.1	1
Correlation Coefficient		60%		50%	
Average 1	10.7	11.6	10	6.8	21

Sources: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group.
 Economic Report to the President, February 1998

NOTE: Benefits exclude administration for Medicare and net cost of insurance for private health insurance.

MEDICARE EARLY ACCESS ACT OF 1998

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

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

Premium Payments:

- Participants would pay two separate premiums-- one before age 65 and one between age 65 and 85:
 - **Base premium:** The base premium would be paid monthly between enrollment and when the participant turns age 65. It is the part of the full premium that represents what Medicare would pay on average for all people in this age group. CBO estimates that this would be about \$300 per month. It would be adjusted for geographic variation, but the maximum premium would be limited to ensure participation in all areas of the country.
 - **Deferred premium:** The deferred premium would be paid monthly beginning at age 65 until the beneficiary turns age 85. It is the part of the premium that covers the extra costs for participants who are sicker than average. Participants will be told before they enroll what their deferred premium will be. CBO estimates that this would be about \$10 per month per year of participation.
- This two-part payment plan acts like a mortgage: it makes the up-front premium affordable but requires participants to pay back the Medicare "loan" with interest. It also ensures that in the long-run, this buy-in is self-financing.

Enrollment:

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

Applicability of Medicare Rules:

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

Disenrollment:

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

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

- People would be eligible if they are between ages 55 and 61 and:
 - Lost their job because their firm closed, downsized, or moved, or their position was eliminated (defined as being eligible for unemployment insurance) after January 6, 1998;
 - Had health insurance through their previous job for at least one year (certified through the process created under HIPAA to guarantee continuation coverage); and
 - Do not have access to employer sponsored, COBRA, or federal health insurance.

Spouses of these eligible people may also buy into Medicare.

Premium Payments:

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

Disenrollment:

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

TITLE III. Retiree Health Benefits Protection Act

Eligibility:

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

Premium Payments:

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

Enrollment:

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

Disenrollment:

- Retirees would be eligible until they turn 65 years old.

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

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

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

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

Ensuring Medicare Does Not Pay For Claims Owed By Private Insurers. Too often, Medicare pays claims that are owed by private insurers because Medicare has no way of knowing the private insurer is the primary payer. This proposal would require insurers to report any Medicare beneficiaries they cover. Also, Medicare would be allowed to recoup double the amount owed by insurers who purposely let Medicare pay claims that they should have paid, and impose fines for failure to report no-fault or liability settlements for which Medicare should have been reimbursed.

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

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

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

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

January '98

QUESTIONS AND ANSWERS ON PRE-65 YEAR OLDS

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

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

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

Providing Vulnerable Displaced Workers over 55 Access to Medicare by offering those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option.

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

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

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

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

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

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

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

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

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

Q. HOW WILL YOU PAY FOR THIS COST?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. The Administration will only support policies that are fiscally sound and paid-for. If Congress can come up with ideas on how to add subsidies in a way that does not jeopardize Medicare's long-run solvency, we would be happy to consider them. However, under no circumstance will we support proposals that affect Medicare's Trust Fund.

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.

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

As part of their analysis of the President's Budget, CBO analyzed the Medicare buy in proposal. Their analysis confirms the Administration's Actuaries' estimates that this policy does not hurt the Medicare Trust Fund. Specifically:

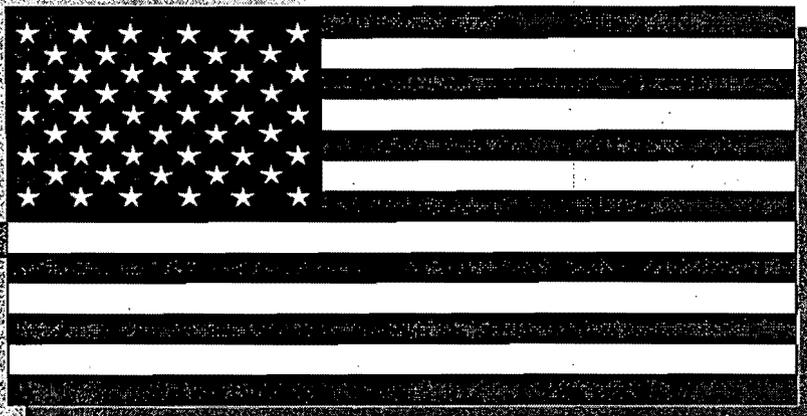
- **Less than a day's worth of Medicare spending:** The net cost of the Medicare buy-in, according to CBO, is \$300 million over 5 years — half of what Medicare spends in a single day and only 0.003 percent of Medicare spending over 5 years. The Administration will work with Congress to close this small gap.
- **More participants:** Participation is estimated to be over 33 percent higher than what the Administration estimated — 410,000.
- **Lower cost:** The post-65 premium that people ages 62 to 65 would pay is only \$10 per month per year — \$6 per month and \$72 less per year than Administration estimates.¹

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

Spending (5 years)		
62 to 65 Year Olds	8.9	
Displaced Workers	0.5	
Total	9.3 *	
Premium revenue (5 years)		
62 to 65 Year Olds	-7.3	
Post-65	-0.2 **	
Displaced Workers	-0.3	
Total	-7.8	
Net Costs	1.5	(Administration: 1.5)
Anti-Fraud Savings	-1.4	
Premium offset	+0.3	(Administration: -2.4)
NET MEDICARE	+0.3*	(Administration: -0.8)*
* Numbers may not sum to total due to rounding		
** These premiums increase after the first 5 years as participants turn age 65		
Participation when fully phased in:	410,000	(Administration: 300,000)
Premiums in 1999:		
62 to 65 Year Olds	\$310 per month	(Administration: \$305)
Post-65	\$10 per month per year	(Administration: \$16)
Displaced Workers	\$400 per month	(Administration: \$400)

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

REPORT TO THE PRESIDENT



PROVIDING NEW HEALTH INSURANCE OPTIONS FOR AMERICANS AGES 55 TO 65

THE MEDICARE EARLY ACCESS ACT OF 1998

STATE-BY-STATE ANALYSIS



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.