

A Medicare Buy-in Program

A Medicare Buy-in program has appeal as a way to expand coverage to people approaching the age of Medicare eligibility who may currently have difficulty accessing and affording good health coverage. Medicare is a well known and popular program. For a buy-in to significantly reduce the ranks of uninsured in the target population key design issues need to be addressed—not least of which is the availability of subsidies to make premiums affordable.

A variety of approaches to expanding access to health coverage to those who are currently uninsured or underinsured have been proposed as part of the broader health care reform debate. Some proposals to expand coverage for uninsured Americans include a policy to allow people who do not now qualify for Medicare to pay a premium and join the program and receive benefits.

Commonly, this approach targets adults in their 50s and early 60s who may face unique challenges accessing health coverage.¹ As Medicare is a stable, well-regarded public insurance program, this idea holds great policy appeal. However, a key question is whether buying into the program will be an attractive, affordable option for people in this age group.

To help answer that question, we review the general advantages and disadvantages of a Medicare buy-in program in relation to the population in their 50s and early 60s, discuss recent proposals, and identify a number of design questions for a Medicare buy-in program.

Why a Medicare Buy-in Program?

Medicare is by many measures a tremendous success story, providing health care coverage for the elderly and disabled. Before the program started in

the 1960s, the elderly had great difficulty purchasing health care coverage and faced challenges accessing health care. Even though the program could be improved, Medicare has largely addressed the fundamental problem of access to coverage for the age 65+ population, while keeping administrative costs down. So, expanding this program to other groups of people facing challenges accessing insurance coverage and health care is a logical idea.

Advantages of a Medicare buy-in include the following.

Guaranteed access and continuity of coverage. For those approaching the age of Medicare eligibility who might otherwise not have coverage, being allowed to purchase Medicare coverage offers an option for access to health insurance that they would stay with for the long term. Continuity of plan and providers offers stability.

Better health and lower future Medicare costs. Research has found that people without health care coverage tend to be sicker as they reach Medicare age and use more services, driving up costs (McWilliams et al. 2007). This suggests that a buy-in program may actually benefit the Medicare program if it means

that people have access to preventive and other services that can improve their health as they become eligible for Medicare under the traditional rules.

Efficiency and speed of building on existing infrastructure. Medicare buy-in provides an opportunity to build on an existing program rather than creating a new one which would allow it to be up and running relatively quickly. Medicare covers many services and it has enrollment procedures and an administrative framework in place. Its administrative costs are low, the program has no requirement for profit, and it is able to exert market power in setting payment rates for doctors and hospitals. For these reasons, a Medicare buy-in program would be expected to be relatively efficient at providing care.

There are some potential disadvantages of a Medicare buy-in, however.

Increased federal entitlement spending. Since Medicare's inception, the costs of health care have continued to rise, and total spending for the program is of concern to policymakers. Expanding the program to more people could raise federal spending even further if their care is made affordable through subsidies that would be funded by the existing Medicare trust funds.

Further erosion of employer-sponsored retiree health benefits. A buy-in program might displace retiree coverage now available through employers. As health care costs tend to rise with age, employers might have the incentive to find ways to avoid offering private coverage for early retirees if other, reasonable options are available. If this happened, enrollment in the Medicare buy-in program might be higher than projected for the currently uninsured population due to shifts in coverage from people whose employer

used to offer and contribute to their health insurance.

Adverse selection could limit its impact. Since a buy-in for people ages 55 to 64 will reflect the average cost of that population, the premium may be to uncompetitive for those who don't use much health care and unaffordable for those with modest incomes. This may limit buy-in enrollment and drive up cost further.

Need to supplement Medicare benefit package. Because the Medicare benefit package has large cost-sharing requirements for some services, enrollees can face significant out of pocket spending. Without access to a supplement, buy-in enrollees would still be exposed to potentially significant cost sharing if they need a lot of health care.

Broader-based option might be better. President Obama and Senator Baucus have each proposed development of a health insurance exchange that would make health plans broadly available and provide subsidies to help lower-income people afford this coverage. Such an option might end up being superior to coverage through Medicare (particularly if Medicare coverage were offered without subsidies). A broader option might also be better because the risk pool would potentially enroll people with a wider age and health profile, generating lower health costs than a pool composed of only older adults.

Challenges for Older Adults in Obtaining Coverage

Older adults under age 65 without access to health care coverage through an employer can face hurdles getting other coverage. Buying coverage on their own in the private market can be difficult, and older adults generally do not qualify for public coverage unless they are disabled.

In most states, insurers selling coverage in the nongroup market are free to turn down applicants. Industry data show that at age 50, nearly one in six applicants is rejected—and that rises to more than one in four at age 60 (AHIP 2007). Many older adults may not even apply because they do not think they will be accepted or that they can afford the cost of coverage.

In 35 states, someone with a health problem may only be able to buy coverage in a high-risk pool. Risk pool premiums are even more expensive, and insufficient funding means high-risk pools often have long waiting lists before applicants can obtain coverage. Once enrolled, risk pool participants may face a waiting period before pre-existing health conditions will be covered.

Those who can get private coverage in the nongroup market or a high-risk pool are often charged higher premiums due to their age and their health. The result is that nongroup coverage for individuals over age 50 can be very expensive, and often this coverage is not as comprehensive as that available through employers. Average premiums for those age 50 may be one-and-a-half to two times those charged to someone age 25. For those with low or modest incomes, the cost of average premiums alone may be upwards of 9 percent of their income. On top of this, they likely have large cost-sharing in order to lower their premiums.

For most older adults who can't afford to buy insurance on their own in the private market, there is no safety net in the form of a public coverage program. Even if they are poor, they may not qualify for Medicaid unless they are disabled or the parent of a minor child. Medicare covers adults under age 65 only if they are receiving Social Security disability benefits or have end-stage renal disease.

Those in their 50s and early 60s who are ineligible for public coverage and priced

out or excluded from private insurance must pay for care on their own or rely on charity care. This situation has led to proposals to open Medicare to this age group.

Recent Proposals

Although a number of studies have looked at the potential impact of a Medicare buy-in program or a buy-in as part of a proposal to raise the age of Medicare eligibility beyond age 65, we focus here on proposals that have laid out key program elements for buy-ins for those approaching age 65. The proposals offer different design options, including who is eligible, the generosity of the subsidies, and different approaches to delivering subsidies. With the exception of the Congressional Budget Office's (CBO's) recent scoring of a buy-in option, the data used in the earlier studies predate the introduction of Part D coverage of outpatient prescription drugs and the acceleration of enrollment into Medicare Advantage plans.

Loprest and Moon Proposal

Researchers from the Urban Institute offered a buy-in proposal for people ages 62 through 64, regardless of work status (Loprest and Moon 1999). In this proposal, enrollees could choose only private plans contracting with Medicare (at the time, these plans were thought to be a more efficient option), with the expectation that this would provide more comprehensive coverage than original Medicare.

In contrast to some of the later proposals, this one includes subsidies to buy-in enrollees, based on their income. The subsidy would be on a sliding scale, with full subsidies for people whose income is below 100 percent of the federal poverty level and partial subsidies for those whose income is between 100 and 200 percent of poverty. Subsidies also would be available to individuals who do not

take the buy-in option but purchase employer-based coverage.

Clinton Proposal

President Clinton proposed a Medicare buy-in program for people ages 62 through 64 and for displaced workers ages 55 through 62 (National Economic Council and Domestic Policy Council 1999). The program for people ages 62 through 64 would not be available to people with employer-based coverage. To enroll in the program, people in the older group would have to pay \$300 per month while covered by the buy-in program and then make up the costs not covered by the original buy-in premiums by paying an extra monthly premium (estimated at the time to be \$10 to \$20) once they turned 65. People in the younger group would have to pay the entire cost of the premium (approximately \$400) while covered by the buy-in program.

Rockefeller Proposal

Senator Rockefeller reintroduced the Medicare Early Access Act (S.960) in 2009, which would add a new Part E buy-in program. Representative Stark introduced H.R. 2073, a similar proposal, in 2005. The program would allow individuals between 55 and 65 who do not have public or employer coverage to enroll in Medicare by paying a premium. The Secretary of Health and Human Services would base the premium on an estimate of the national average annual per capita amount of the cost of providing services to the population.

Subsidies to help individuals pay for premiums would be available through a tax credit. Program enrollees would receive an advance, refundable credit to offset Medicare early-access premium costs that would equal 75 percent of the total cost, leaving enrollees responsible for the remaining 25 percent through the monthly premiums.

Early retirees with access to retiree coverage from their former employers could also enroll in the program while keeping their retiree coverage. For these individuals, their former employers that offered employment-based retiree health coverage could pay the 25 percent premium on the retiree's behalf and wrap around Medicare benefits.

Baucus Proposal

Senator Max Baucus released a detailed white paper that lays out elements of a broad health care reform proposal and includes a Medicare buy-in program (Baucus 2008)². The program would be available to individuals ages 55 through 64 who do not have coverage through an employer or other public program. The benefits (including Part D) would be the same as for current Medicare beneficiaries. The premium amount would be set to entirely cover the costs of the program—i.e., there would not be a subsidy.

The buy-in program would be temporary, lasting only until a new health insurance exchange program began to enroll people. However, people who had already chosen coverage through the buy-in program could continue to stay in it (but would not have to). Subsidies for lower-income people would be available only through the exchange and not the buy-in program, so lower-income people would probably choose to delay getting coverage until they could get it through the exchange.

CBO Option

The CBO recently developed a budget estimate for a Medicare buy-in program for individuals ages 62 through 64 who are not enrolled in Medicaid and do not have access to employer health insurance. As with the Baucus proposal, there are not subsidies in the CBO buy-in proposal; enrollees would pay the full price of Medicare coverage (CBO 2008).

The only cost to the federal government of this program would come from higher Social Security spending that would be expected from people deciding to retire earlier because they now had health insurance coverage. CBO estimates that the annual premium for this option (including Part D coverage) would be \$7,600 in 2011, i.e., \$634 per month. By 2014, about 300,000 people would participate. Only 80,000 of them would have been previously uninsured; most (200,000) of the rest of the people who would be in the program would have purchased nongroup coverage on their own. CBO notes that this approach would reduce the number of uninsured in this age group by 9 percent.

Participants' premiums would be based on the cost of benefits for the buy-in group (so would be priced to reflect the likely higher risk of people apt to take up the option) plus an additional 5 percent for administrative costs. Further, if Medicare actuaries underestimated these costs, participants would have to make up the difference by paying an extra premium until they reach age 85.

Key Design Questions

These varying proposals illustrate some of the fundamental design questions for a buy-in program that bear some discussion. These include the eligibility criteria and financing of the program, which will affect the cost and reach of a buy-in program. Other program elements are also worth some consideration as they can affect the success of the program in providing a viable coverage option for people who have trouble affording coverage in other ways. They include the adequacy of Medicare coverage, whether or not to have a national premium, and the interaction with other, private coverage.

As we sort through the design questions, we should bear in mind what we would

want any health care reform proposal to accomplish:

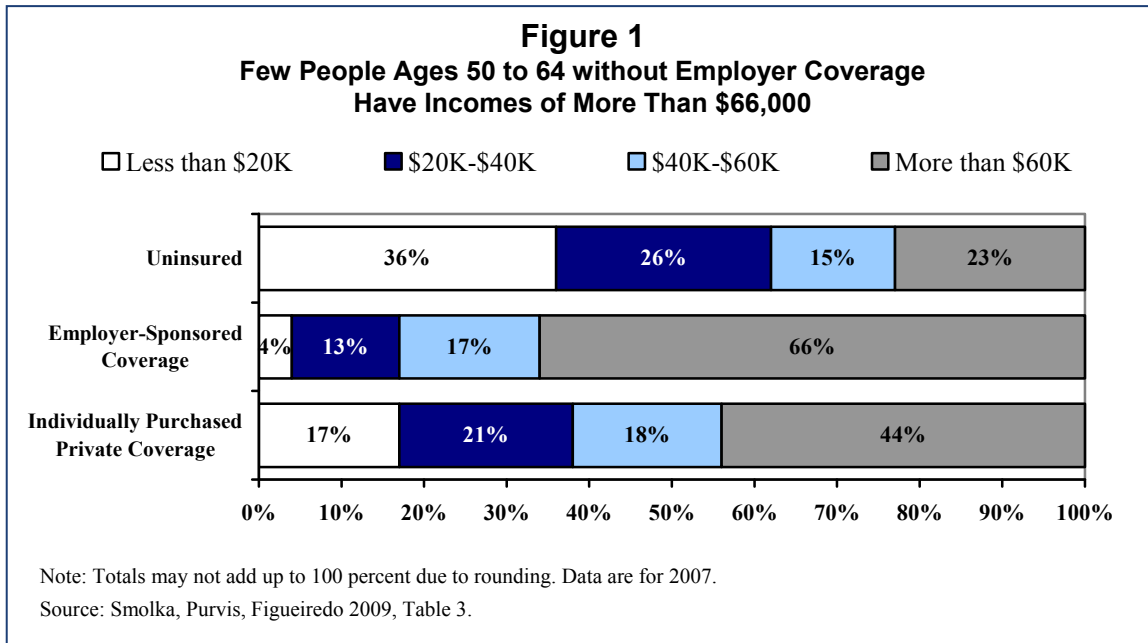
- Offer coverage options that are affordable (ideally, requiring people to spend no more than 10 percent of their incomes on out-of-pocket spending and premiums) and provide adequate benefits.
- Maintain a reasonable balance of financial responsibility among employers, individuals, and the government. In practice, we would want to minimize incentives for employers to reduce their offerings.
- Operate efficiently.

To Subsidize or Not: Trade-offs between Selection, Affordability, and Program Costs

A primary challenge in designing a Medicare buy-in program is that an older adult population tends to need more health care services in general, so the potential for risk selection to lead to unstable premiums for this group is very high. Health care spending for 50–64-year-olds averaged \$5,069 per year in 2005, or \$422 per month, which reflects both what people and their employers pay. Spending varies, however, depending on the presence of chronic health conditions (see table 1). This

Table 1	
Average Annual Total Health Spending for Individuals Ages 50 to 64, by Number of Chronic Conditions	
Number of Chronic Conditions	Average Annual Total Health Spending
Average	\$5,069
0 chronic conditions	\$1,368
1 chronic condition	\$3,350
2 chronic conditions	\$5,066
3 chronic conditions	\$7,368
4 chronic conditions	\$8,362
5+ chronic conditions	\$16,057

Source: Johns Hopkins Bloomberg School of Public Health analysis of Medical Expenditure Panel Survey, 2005, unpublished analysis for the AARP Public Policy Institute.



variation means that plans with premiums and benefit designs that provide good value for sicker people may end up attracting higher-cost individuals, driving the premium costs higher and making these plans less affordable and attractive to the general population.³

To illustrate this issue of risk selection in the context of a Medicare buy-in program, let us say that the expected spending for the older adult population for a Medicare benefit package (including drug coverage

and the administrative costs of operating a plan) is around \$550 per month, or \$6,600 per year. Using 10 percent of income as a test of affordability for this premium (not considering the cost-sharing expenses), the premium would be affordable only to people with annual family incomes of \$66,000 or more. Few people without employer coverage have incomes this great (see figure 1). These premiums might be a reasonable deal for people who expect to spend more than \$6,600 on

Table 2 Comparative Cost of Possible Coverage Options	
Coverage	Monthly Premium
Medicare buy-in ages 62–64 in 2011 (CBO)	\$634
Medicare cost for ages 65+ in 2009	\$775
Medicare cost for ages <65 disabled in 2009	\$735
AARP Aetna policy for 60-year-old woman in Maryland who passes underwriting Policy with a \$1,500 medical deductible and \$250 Rx deductible in 2009	\$509
Maryland Health Insurance Plan (high-risk pool) rates for 60-year-old as of July 2008	
PPO with:	
\$1,000 medical deductible and \$250 Rx deductible with six-month exclusion for preexisting conditions	\$410
Rider for one year to remove six-month exclusion	\$773
HMO with:	
Six-month exclusion for preexisting conditions	\$827
Rider for one year to remove six-month exclusion	\$1,241

health care, but products with lower premiums are available in the nongroup market for less than \$550 per month if the enrollee meets the insurer's tests for preexisting conditions (see table 2).

Thus, people with higher health care needs will tend to be attracted to the Medicare buy-in plans, while others, deterred by the high premium, will buy less comprehensive private coverage with a lower price tag, or go without coverage. This dynamic will drive up the average cost of the buy-in, making the premium less attractive and affordable to fewer people.

One way to avoid this dynamic would be to subsidize the premium so that lower-income and healthier people will enroll in the program and help keep the per-person cost of the program at a level that reflects a wider distribution of health risks. This raises the question of the size of the subsidies needed to ensure participation high enough to attract broader enrollment and minimize adverse selection.

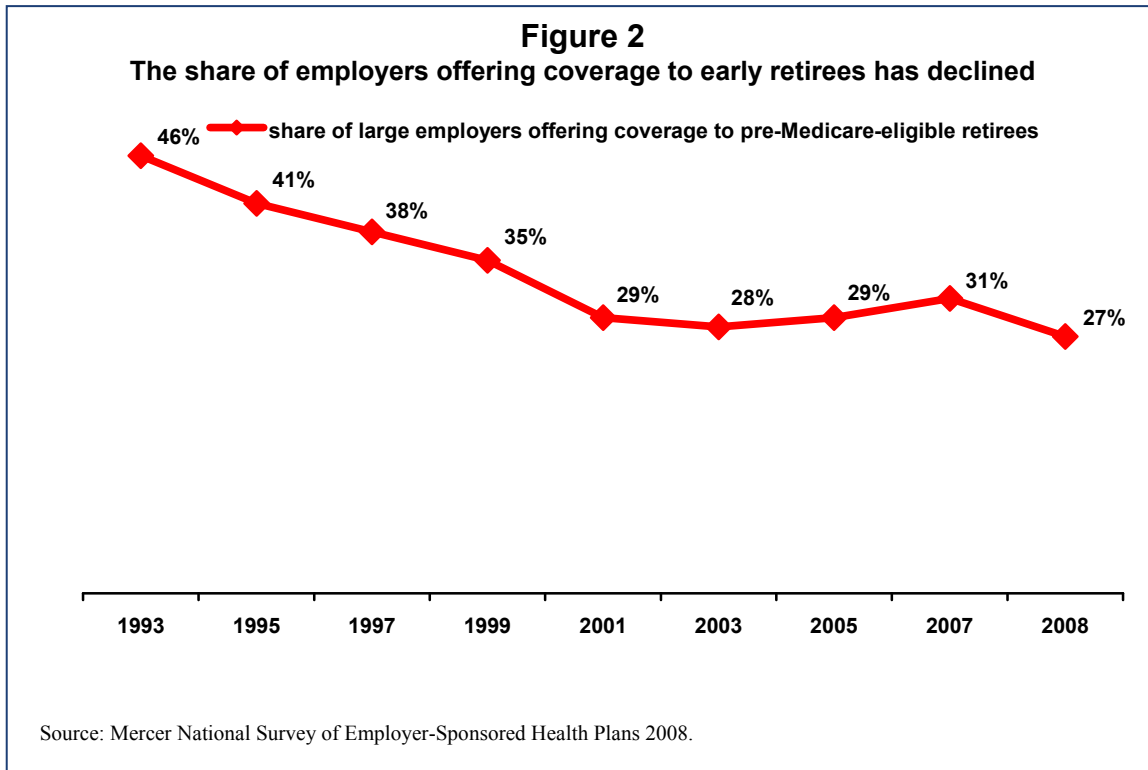
How Would the Buy-in Fit in the Landscape of Current Employer and Private Market Coverage?

A key tension for any health reform proposal is to improve coverage and affordability without displacing or crowding out too much of the current set of choices, which raises the cost. It is probably unrealistic to expect that any reform program, including a Medicare buy-in, would be available just to people who are uninsured. People who are paying for coverage in the nongroup market, who have no other choice but to try their luck with a waiting list for a high-risk pool, who have retiree benefits that are increasingly expensive, or who are risking financial insecurity by going without coverage are all likely candidates for taking up a more affordable option.

Most working-age adults and their dependents have health coverage through their employers and like this arrangement. However, a buy-in program could affect employer coverage as well. The Age Discrimination in Employment Act prohibits employers from discriminating on the basis of age in offering benefits, and the Health Insurance Portability and Accountability Act prohibits employers from charging employees different premiums based on their health characteristics. But employers, particularly small employers, with an older workforce that are having difficulty affording health coverage might consider dropping coverage if their employees could get it elsewhere.

A buy-in program also might encourage employers that continue to offer health benefits to early retirees to stop doing so, accelerating the trend shown in figure 2. Those that continue to offer retiree benefit plans to retirees younger than age 65 could see the buy-in as an opportunity for them to drop their plans. Whether a buy-in encourages employers to drop retiree health benefits or gives them an incentive to continue their programs depends in part on how it is structured. If eligibility is limited to people ages 62 to 64, employers may be less inclined to drop these benefits and leave younger retirees to the individual market or uninsured. But if employers are finding their early retiree benefit programs unaffordable, a buy-in may make it easier for them to discontinue these programs, knowing that at least some of their retirees could take advantage of it.

In the few states where insurers are required to accept all applicants to nongroup products, the buy-in would offer an alternative for those who are eligible. If the benefits offered through the buy-in program are better or if the buy-in offers comparable coverage for a lower premium, the buy-in program could attract



the privately insured. The number of people with private nongroup coverage in these states could fall, but coverage in the nongroup market might become more affordable if the remaining risk pool was younger and healthier. If, however, the benefits and cost in the nongroup market are more attractive, people may prefer to stay in the private market.

In states where the only avenue for coverage is a high-risk pool, the effect will likely be different. If eligibility for the buy-in is limited to a narrow group (probably defined by age), high-risk pools will continue to have a role in covering younger people. One question may be whether high-risk pools would close eligibility to those eligible for the buy-in rather than offer alternative products. If so, costs in the risk pool could translate into somewhat lower premiums.

Eligibility Criteria

Key policy objectives drive the eligibility criteria for a buy-in program. The proposals discussed in this paper

focus on some subset of the population that is just a few years away from becoming eligible for Medicare who may be facing high premiums for nongroup coverage and who may be delaying retirement because of a lack of health insurance coverage.

A goal of encouraging people to work longer and limiting the effects on people's decisions to retire before 65 will lead one to a very narrow age range, close to that age. However, within this group there are people in a variety of circumstances. Some are working and expect to continue to do so beyond 65; others have already stopped working because they have chosen to do so, cannot find a job, or have been laid off; and others are working but would like to retire except for worries about access to health coverage. Another group is already disabled and unable to work and either waiting for or enrolled in Medicaid or Medicare.

Some policy decisionmakers have concerns that a buy-in would lead to more

people retiring early. Data show that in firms that offer early retiree health benefits, the average retirement age is 61; where such benefits are not available, the average retirement age is 64 (Mercer 2009). But the effect of a buy-in would seem to depend not just on eligibility, but also on whether eligible individuals have adequate income (e.g., wages, pensions, other retirement income) to allow them to support themselves and buy coverage. The availability of subsidies would also be a factor.

A goal of targeting the uninsured will limit eligibility to those who do not have employer-based coverage. Most of the proposals we reviewed in the earlier section have this provision. Targeting those without employer-based coverage would not deter people who are buying coverage themselves to take advantage of the buy-in option if it proves to be a better deal. Indeed, some of the people who are now buying nongroup coverage will likely drop it if the coverage available through Medicare is more affordable or comprehensive. As the CBO scoring demonstrates, the majority of people who would be expected to participate in the Medicare buy-in program would come from this group. Dropping individual coverage is not necessarily a bad outcome: options in the nongroup market are often inadequate, not available to everyone, and expensive.

Another question is whether a buy-in program would shore up or displace retiree coverage through its eligibility and payment rules. Although the Rockefeller proposal (and related Stark proposal) would not allow employers to buy coverage for their active employees, it would allow them to do so for retirees for whom they are providing coverage. A design like this likely would appeal to employers that would like to reduce their commitments to this population, but their use of the option would depend on the price they would have to pay.

Employers that require retirees to pay the full premium or a very large share of the premium might not jump at the opportunity to pay for 25 percent of the premium.

Under normal Medicare rules, people become eligible not only because of age but also because they satisfy requirements for Social Security through sufficient work (either themselves or their spouse). People who do not meet this requirement may buy Medicare coverage but do not have access to subsidies. If the buy-in were structured without subsidies, the requirements of sufficient work would not be necessary for consistency, but if subsidies were available, this second test might be needed.

Inadequacy of Medicare's Benefit Package

Medicare's coverage leaves large gaps, particularly for individuals who use hospital or other institutional care—where the deductible for a stay is \$1,068—and for those who pay 20 percent of expensive Part B services like physician-administered cancer drugs and dialysis. On average, Medicare pays about one half of individuals' health care spending, and enrollees' spending on premiums and out-of-pocket costs on Medicare services alone takes up 28 percent of their income (Nonnemaker 2009). Nearly 90 percent of beneficiaries have access to coverage that supplements Medicare (Umans and Nonnemaker, 2009): Medicaid provides this coverage to certain low-income beneficiaries, former employers provide it to some retirees, and people purchase their own coverage in Medigap and Medicare Advantage plans.

Would supplemental coverage be allowed for the buy-in population? Without it, beneficiaries are at risk of high out-of-pocket spending. However, even though supplemental coverage improves access to

health care services, it raises health care spending, although the size of the effect has been debated among experts (GAO 2002; Hogan 2009; Lemieux, Chovan, and Heath 2008). Medicare has paid Medicare Advantage plans more than coverage costs in many markets. Both higher use and the higher payments to Medicare Advantage plans would increase buy-in premiums.

Would private insurers be willing to sell supplemental policies to the buy-in population, particularly if they expect adverse selection to be a problem? Currently, they are required to do so for new Medicare enrollees if they are enrolled because they are age 65. The availability of supplemental coverage to the disabled and end-stage renal disease populations depends on state regulations. If the buy-in population is expected to be sicker than average, Medigap carriers may try to avoid this population even if it is younger, unless federal or state law required them to make coverage available to this group.

Medicare Advantage plans are required by law to be available to eligible beneficiaries (with the exception of most people with end-stage renal disease and people without both Part A and Part B coverage) and cannot use rating techniques or charge higher premiums to beneficiaries expected to have higher cost. Instead, risk-adjustment mechanisms administered through Medicare payments make up for differences in the risk mix across plans. If buy-in eligibles needed to pay their own premiums, however, the Medicare program or other administrator would need to take steps to reallocate the funds among the plans to account for differences in the risk mix.

If the buy-in population were required to pay the entire premium, it is unlikely that many of them would be able to afford another \$100 or \$150 a month for supplemental coverage. But without the

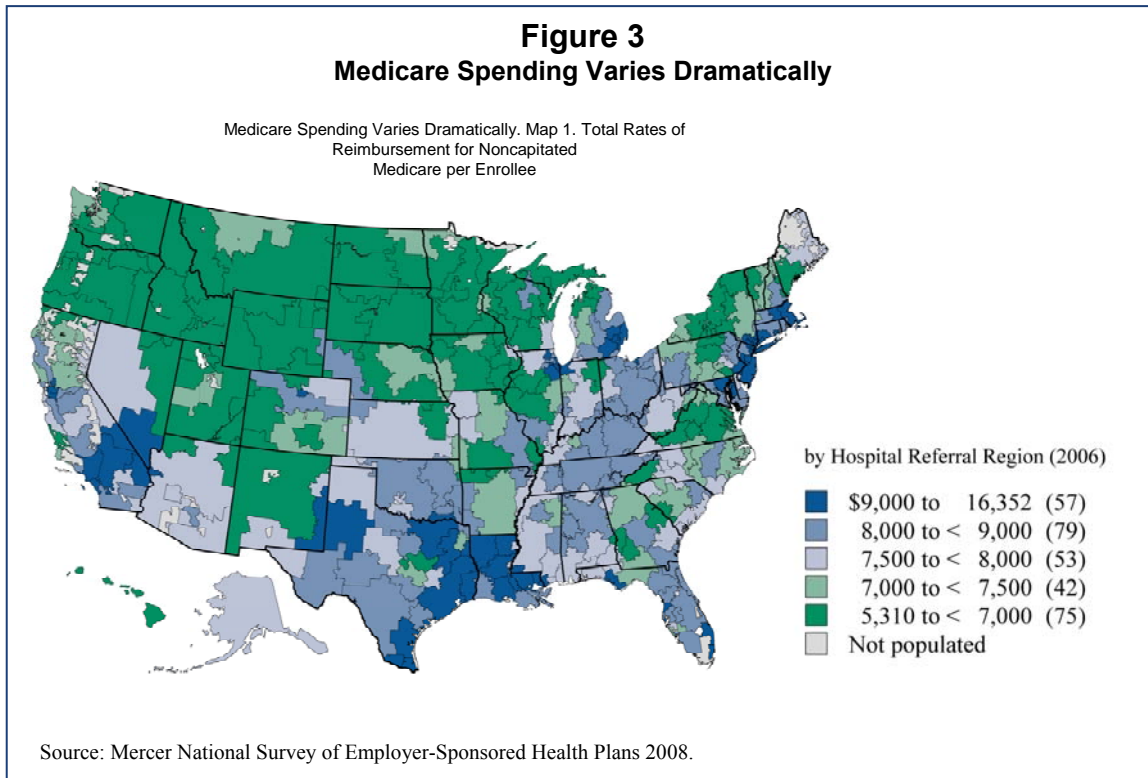
supplemental coverage, financial risk in Medicare would be very high, even with the high premiums. This might make Medicare Advantage plans more attractive if they cap out-of-pocket spending or otherwise limit exposure to cost-sharing.

Given the shortcomings of the Medicare benefit package in providing adequate coverage, redesigning benefits to limit the potential for enrollees to be exposed to catastrophic costs could make the program better and more affordable for all Medicare beneficiaries, including the buy-in population. For example, a cap on out-of-pocket spending would be very useful to improve coverage. Making sense of revising cost-sharing for Part A and B services is worth some discussion, as is the possibility of standardizing benefits in Medicare Advantage. A redesigned Medicare benefit package could make a buy-in a more attractive proposition, particularly if it reduced the need for supplemental coverage.

Geographic Variation in Spending and Unsubsidized Premiums

Another design issue to be considered is whether to vary the premium for buy-in coverage by geographic area. As many researchers have shown, Medicare spending varies widely across geographic areas. Spending is higher in areas with a higher volume of service—for example, Miami, Florida—and in areas where payment rates are high to reflect high costs and a mix of services—for example, New York City (see figure 3). Spending is lower in rural areas.

Medicare does not charge different premiums for Part A (for the people who already buy into this part) or Part B based on differences in geographic costs of the program, but the large subsidies for these parts mean that the program is a good deal for anyone. In Part D, the premiums are set through a competitive process held in different regions, which



results in the premium varying by these geographic areas. But again, because of the high subsidy, Part D coverage also is a good deal for almost everyone.

If a buy-in premium were not subsidized and uniform across the country, geographic variation could raise concerns about equity. A national premium would be higher than expected costs in rural areas and lower than expected costs in areas like Miami and New York City. This phenomenon could be another source of adverse selection, where take up would be higher in high-cost areas. Given that these areas tend to be where wealthier individuals live, one would expect higher enrollment there anyway.

Financing Subsidies

Given the likely high cost of Medicare buy-in coverage for most individuals, subsidies would be needed to make this coverage affordable. Options for financing these subsidies include monies from the Medicare Trust Fund, or new revenues from general funds or other

dedicated sources. Using Medicare Trust Fund dollars for this purpose would put more pressure on the program's long-term financial sustainability. Perhaps the funding could be from the same sources necessary to finance broader health reform.

Alternatively, the people who buy into Medicare could pay back the subsidies over time. The Clinton and CBO proposals discussed earlier include a provision that if premiums in the buy-in years proved too low to fully cover the actual costs under the program, buy-in participants would pay a premium surcharge between ages 65 and 85 to cover these excess costs. In essence, people would still pay the full premiums themselves, but defer some of the costs down the road with the government covering excess costs up front. This deferred buy-in premium poses two questions—one relating to beneficiaries, the other to program administration.

The first question is how to explain the potential future premium surcharge to

potential beneficiaries. What should they anticipate the amount of the surcharge will be? Will the uncertainty of taking on that extra cost deter them from enrolling? The concern is whether beneficiaries could afford these additional amounts, which will be assessed as they age, lose income and assets, and need more money to pay for long-term care services and supports.

The second question relates to the additional level of complexity in the program. For years, the simplicity of a uniform Medicare premium for all beneficiaries ages 65 and over has been a plus. Uniform premiums have the advantage of being simple for the public to understand and simple to administer. There is already some experience of variation on the basic Medicare Part B premium for both those enrolling late and, more recently, those with high incomes. A small number of people who lack adequate work quarters to qualify for Part A also elect to pay premiums to buy into that part of the program. And premiums in Part D vary depending upon the private plan a beneficiary elects. But is greater and greater complexity desirable? Some policymakers and consumer advocates have concerns that a premium structure that gets more complex from year to year increases the difficulty for both beneficiaries, who must understand their costs and choices under the program, and those administering the premium structure.

Would subsidies be related to income? The advantage to a sliding scale of subsidies would be to target them to those most in need of support and to minimize the total cost. The disadvantages are that it would reduce general interest in the program, possibly aggravating selection, and require a potentially burdensome eligibility and verification process to make sure that the right levels of subsidies go to the intended beneficiaries.

Outreach and Enrollment

A final design question is how people would find out about a buy-in option and what process they would use to demonstrate their eligibility and enroll. The likely scenario would be to enroll people through Social Security offices, which have been under considerable administrative strain in recent years. A commitment to substantial outreach, much like that made for Medicare Part D, would be needed with funds committed to this purpose. The Department of Health and Human Services and the Social Security Administration would need to modify computer systems to track people who enrolled through the buy-in program, and would need to set up a process for charging and collecting premiums. Medicare premiums currently are deducted from Social Security checks; however, many in the buy-in population would not necessarily be receiving Social Security payments. Enrollment also could be managed by private organizations, but these would require rigorous oversight to make sure that they followed standards for eligibility and privacy.

Conclusion

In the context of expanding access to affordable coverage options to older adults who are now either uninsured or pay high nongroup premiums for limited coverage, a Medicare buy-in might help people who are looking for affordable coverage, but only if the premiums are subsidized. Otherwise, the program is likely to be affordable only to those who are wealthy or those with very high health spending, which will drive up program costs even further. Other design features will also affect attractiveness to the target population, take-up, and interaction with current sources of coverage.

References

- AHIP, America's Health Insurance Plans, 2007. *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits*. Washington, DC: AHIP Center for Policy and Research. http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.
- Baucus, Max. 2008. *Call to Action: Health Reform 2009*. Washington, DC: Senate Finance Committee. <http://www.finance.senate.gov/healthreform2009/finalwhitepaper.pdf>.
- Congressional Budget Office (CBO). 2008. *Budget Options Volume 1: Health Care*. Washington, DC, Congressional Budget Office.
- Fisher, Elliott, David Goodman, Jonathan Skinner, and Kristen Bronner. 2009. "Health Care Spending, Quality and Outcomes: More Isn't Always Better." Hanover, NH: The Dartmouth Institute for Health Policy & Clinical Practice, A Dartmouth Atlas Project Topic Brief. http://www.dartmouthatlas.org/atlases/Spending_Brief_022709.pdf.
- Government Accountability Office. 2002. "Medigap: Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives." Testimony by William Scanlon before the House Ways and Means Subcommittee on Health, March 14. www.gao.gov/new.items/d02533t.pdf.
- Hogan, Christopher. 2009. Presentation to Medicare Payment Advisory Commission, March. <http://www.medpac.gov/transcripts/Hogan%20presentation%20for%203-12-2009,%20revised%203-5-2009.pdf>.
- Lemieux, Jeff, Teresa Chovan, and Karen Heath. 2008. "Medigap Coverage and Medicare Spending: A Second Look." *Health Affairs* 27 (2): 469–477. <http://content.healthaffairs.org/cgi/content/abstract/27/2/469>.
- Loprest, Pamela, and Marilyn Moon. 1999. *Medicare Buy-In Proposal*. The Kaiser Project on Incremental Health Reform, Washington, DC: Kaiser Project on Incremental Health Reform.
- McWilliams, J. Michael, Ellen Meara, Alan M. Zaslavsky, and John Z. Ayanian. 2007. "Use of Health Services by Previously Uninsured Medicare Beneficiaries." *New England Journal of Medicine* 357 (2): 143–153.
- Mercer. 2009. 2008 National Survey of Employer-Sponsored Health Plans. New York: Mercer LLC.
- National Economic Council and Domestic Policy Council. 1999, July 2. "President's Plan to Strengthen and Modernize Medicare for the 21st Century." <http://clinton2.nara.gov/WH/New/html/medicare.pdf>
- Nonnemaker, Lynn. 2009, June. "Medicare Beneficiaries Spending for Health Care Services." Washington, DC: AARP Public Policy Institute, Insight on the Issues.
- Senate Finance Committee, May 14, 2009. "Description of Policy Options, Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans." U.S. Senate. <http://finance.senate.gov/sitepages/leg/LEG%202009/051109%20Health%20Care%20Description%20of%20Policy%20Options.pdf>

Smolka, Gerry, Leigh Purvis, and Carlos Figueiredo. 2009, March. "Health Care Reform: What's at Stake for 50- to 64-Year-Olds?," Washington, DC: AARP Public Policy Institute, Insight on the Issues. http://assets.aarp.org/rgcenter/health/i24_hcr.pdf

Umans, Ben and Lynn Nonnemaker. 2009, January. "The Medicare Beneficiary Population." Washington, DC: AARP Public Policy Institute, Fact Sheet. http://www.aarp.org/research/medicare/coverage/fs149_medicare.html

U.S. Department of Health and Human Services. 1999. "President Clinton's Plan to Modernize and Strengthen Medicare for the 21st Century." Press Release. <http://www.hhs.gov/news/press/1999pres/19990629.html>.

Wagoner, George. 2009, February. "How Consumer Choice Affects Health Coverage Plan Design." Washington, DC: AARP Public Policy Institute, Insight on the Issues. http://assets.aarp.org/rgcenter/health/i23_choice.pdf.

¹ Representative Stark's AmeriCare Health Care Act of 2009 would model a national public program for all ages on key elements of the Medicare program. As it is not strictly speaking a Medicare buy-in program, it is not addressed here.

² This proposal is part of the Senate Finance Committee's May 14, 2009. description of policy options for expanding health care coverage.

³ This dynamic is discussed in more depth in a recent Public Policy Institute publication, available at http://assets.aarp.org/rgcenter/health/i23_choice.pdf.

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