NLWJC - Kagan

DPC - Box 029 - Folder 016

Health - Medicare Buy - In (55 - 64)

health - medicare buy-in

THE WHITE HOUSE

WASHINGTON

March 16, 1998

MEDICARE EXPANSION LEGISLATION ANNOUNCEMENT

DATE: Tuesday, March 17, 1998
LOCATION: 1100 Longworth House Office Building
TIME: 11:05 AM-11:50 AM
FROM: Larry Stein
Janet Murguia

I. PURPOSE

To promote and highlight the Administration-sponsored Medicare expansion legislation which will be introduced by the Democratic caucuses in the House and Senate.

II. BACKGROUND

An Administration Priority

In your State of the Union address you offered a proposal which underscored the importance of providing new options for Americans ages 55 to 65 to obtain health insurance, including buying into Medicare. Accordingly, in your FY'99 budget you made Medicare expansion a top priority.

As you know, 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 as the population generally. Your proposal which will today be introduced by Sen. Patrick Moynihan of New York in the Senate and Rep. Pete Stark of California in the House gives this vulnerable population three new ways to gain access to health insurance by: (1) allowing Americans ages 62 to 65 to buy into Medicare, through a premium that ensures that this policy is self-financed; (2) assisting vulnerable displaced workers 55 and over by offering those who have involuntarily lost their jobs and health care coverage a similar buy-in option; and (3) giving Americans 55 and over who have lost their retiree benefits access to their former employers' health insurance.

NEC and DPC have worked closely with our Democratic allies to provide the technical expertise necessary to bring this legislation forward.

Congressional Support

This is one initiative which has the clear and unequivocal support of both House and Senate Democratic leaders, the ranking members of the three full and subcommittees of jurisdiction in the House and Senate (i.e., Senate Finance, House Ways and Means and Commerce committees)

Rep. Stark will lead off the program for the legislative launch by giving a general overview of the bill. He will be followed by Sen. Moynihan who will highlight the recent Congressional Budget Office estimate report validating that this initiative is affordable and will not undermine the Medicare Trust Fund. Rep. Sherrod Brown of Ohio and ranking member on the Commerce Subcommittee on Health will follow Sen. Moynihan and talk about the importance of affording access to the age 62-65 population group and provide a "real story" of a displaced worker over 55 who needs access to Medicare. Sen. Daschle will speak about the "promise-breaker" piece which allows retirees ages 55 and older whose employers dropped their health coverage access to the former employers' health plan.

Your remarks will highlight the new state-by-state study which demonstrates the difficulty Americans ages 55 to 65 have accessing health insurance and restate your commitment to Medicare solvency and the importance of getting this legislation approved by Congress.

III. PARTICIPANTS

All Democratic Members of Congress were invited.

Representatives from health organizations, senior advocacy groups, and other advocates of insuring displaced workers and the elderly not covered by Medicare.

IV. PRESS PLAN

Open Press

V. SEQUENCE OF EVENTS

-- **The President**, accompanied by Senator Thomas Daschle, Senator Patrick Moynihan, Representative Fortney "Pete" Stark, and Representative Sherrod Brown, is announced into the room.

Note: All Members of Congress present will be pre-

positioned on the stage.

-- Representative Fortney "Pete" Stark gives remarks and introduces Senator Patrick Moynihan.

-- Senator Patrick Moynihan makes remarks and introduces Representative Sherrod Brown.

-- Representative Sherrod Brown makes remarks and introduces Senator Thomas Daschle.

-- Senator Thomas Daschle make remarks and introduces **The President**.

-- **The President** makes remarks and departs.

VI. REMARKS

To be provided by speechwriting.

VII. ATTACHMENTS

None.

CC: Erskine Bowles
John Podesta
Sylvia Mathews

PRESIDENT CLINTON JOINS DEMOCRATS TO UNVEIL LEGISLATION GIVING AMERICANS AGES 55 TO 65 NEW HEALTH INSURANCE OPTIONS AND RELEASES STATE-BY-STATE STUDY UNDERSCORING THE NEED FOR THIS POLICY
March 17, 1998

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

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

✔ **Twenty-two percent of Americans ages 55 to 65 -- a total of five million people -- are either uninsured or insured through the individual insurance market.** In some states, such as North Dakota, Texas, and Nebraska, the percentage is over 30 percent.

-- **Three million are uninsured.** Some Americans ages 55 to 65 lose their employer-based health insurance when their spouse (frequently the husband) becomes eligible for Medicare. Many lose their coverage because they lose their jobs in company downsizings or plant closings. Still others lose insurance when their retiree health coverage is dropped unexpectedly.

-- **Many are left to buy into an unaffordable individual insurance market, where premiums can be as high as $1,000 per month.** Individual insurance can be prohibitively expensive, particularly for those who have pre-existing medical conditions.

✔ **In 38 states, individual insurance policies can be denied outright.** Sixteen million Americans ages 55 to 65 -- 76 percent of this population -- live in one of the 38 states where individual insurance has no guarantee issue requirement. These individuals often have nowhere to turn for health care coverage.

✔ **In 21 states, there are no assurances that pre-existing conditions are adequately covered.** Eight million Americans ages 55 to 65 -- 36 percent of this population -- live in states that allow individual insurers to decline to cover pre-existing conditions. This means that individuals may not be able to get coverage for the care they need most, such as diabetes or cancer treatment.

✔ **In 34 states, there are no protections against exorbitant premiums.** Sixteen million Americans ages 55 to 65 -- 75 percent of this population -- live in states that do not protect individuals against exorbitant premiums.

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

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

- ✔ **Enables Americans ages 62 to 65 to buy into Medicare,** by paying a premium.

- ✔ **Provides displaced workers over 55 access to Medicare** by offering those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option. These workers often have a hard time finding new jobs: only 52 percent are reemployed, compared to over 70 percent of younger workers.

- ✔ **Allows retirees ages 55 and older whose employers dropped their health coverage with access to their former employers' health plan.** This provision allows retirees whose employers dropped their health coverage after they have retired to buy into their employers' health plans through "COBRA" coverage.

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

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

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

Trust Fund.

Q & A's on Medicare Buy In
March 17, 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 full 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. The legislation being introduced today has additional provisions designed to eliminate this extremely small financing gap.

Q: Senator Breaux and almost every elite policy analyst that you should only do this policy within the context of the Medicare Commission's work. Why do you continue to push for this issue? Isn't it purely policy?

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.

health - medicare buy-in

PRESIDENT CLINTON:
HEALTH CARE FOR THE 21st CENTURY

March 17, 1998

"It is time to fulfill our obligation to older Americans. It is time to expand the availability of health care to those who need it most. This time of prosperity should not be a time of delay -- it should be a time of action."

President Bill Clinton
March 17, 1998

Today, President Clinton joins Democratic Members of Congress on Capitol Hill to unveil legislation that would provide greater health insurance options for an estimated 300,000 to 400,000 Americans ages 55 to 65.

PROTECTING AMERICA'S MOST VULNERABLE POPULATION. Adults ages 55 to 65 are part of one of the nation's most vulnerable and difficult to insure populations: they have less access to employer-based health insurance; they are twice as likely to have health problems; and they are at greater risk of losing coverage. Today, the President releases a state-by-state analysis that documents the difficulty that Americans in this age range have gaining access to health insurance. According to the report, twenty-two percent of Americans ages 55 to 65 -- a total of five million people -- are either uninsured or insured through the individual insurance market.

GIVING AMERICANS NEW CHOICES TO GAIN ACCESS TO HEALTH CARE COVERAGE. The legislation unveiled on the Hill today provides new health insurance options for Americans ages to 55 to 65. This legislation, supported by the President, would:

- **Enable Americans ages 62 to 65 to buy into Medicare,** by paying a premium.
- **Provide 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.
- **Allow retirees, ages 55 and older, whose employers dropped their health coverage, access to their former employers' health plan** through "COBRA" coverage.

PROTECTING MEDICARE FOR THE FUTURE. The Congressional Budget Office recently released estimates showing that the Medicare buy-in proposal is a carefully targeted policy that will not burden the Medicare Trust Fund:

- **Paid for by premiums and anti-fraud and overpayment savings.** The costs associated with the proposal impose only temporary costs on the Medicare program, and are paid for -- dollar-for-dollar -- by a series of anti-fraud and anti-overpayment initiatives;
- **Separate Trust Fund.** While the buy-in takes advantage of Medicare's low administrative costs and choice of providers and plans, its financing is kept completely separate from the Medicare Trust Fund.

health - medicare buy-in

Q & A's on Medicare Buy In
March 17, 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 and abuse proposals.

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 scheme 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 full 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 measures. There are always slight variations in the scoring of these types of proposals. The amount at issue here ($300 million over five years) is extremely small for the Medicare program -- a program that spends nearly double that amount every day.

Q: Isn't Senator Breaux right that Congress should wait for the Medicare Commission's recommendations before considering the President's proposal?

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 is paid for within the Medicare program and therefore does not add any new burdens to the program. We believe this is a worthy goal that is fully consistent with the charge of the Medicare Commission. 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.

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.

Health - Medicare buy-in (55-64)

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

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

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

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

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

* Numbers may not sum to total due to rounding

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

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

Premiums in 1999:

62 to 65 Year Olds $310 per month (Administration:

	$305)	
Post-65		$10 per month per year (Administration:
	$16)	
Displaced Workers		$400 per month (Administration: $400)

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

Health - Medicare buy-in

Q: WHAT IS YOUR RESPONSE TO TODAY'S *NEW YORK TIMES* STORY THAT STATES THAT SENATOR BREAUX IS ASKING THE CONGRESS TO WAIT FOR THE MEDICARE COMMISSION BEFORE CONSIDERING THE PRESIDENT'S PROPOSAL TO OFFER MEDICARE FOR AMERICANS AGES 55 TO 65?

A: **We do not believe that this story fully reflects Senator Breaux's views on this issue.** Senator Breaux has accurately stated that the Medicare Commission has been charged with the responsibility of looking at this issue as well as a wide range of other issues. But Senator Breaux is not saying that he would explicitly stand in the way of legislation that expands coverage options, such as the President's proposal.

The President believes that this is a financially responsible and targeted policy that addresses a vulnerable population that the private insurance market has failed to serve. 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 proposed by the President are paid for and responsible, and will help people with few affordable choices for health insurance.

While the work of the Medicare Commission will be extremely important, the President does not believe that the American public would sanction holding up a targeted, important proposal that would help hundreds of thousands of Americans with access to health insurance. The President is confident that as Congress examines the needs of this population and the proposal to address it, the necessary consensus to move this legislation forward will be achieved.

Q: ISN'T THIS EXACTLY 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 President has a targeted proposal that is paid for within the Medicare program and therefore does not add any new burdens to the program. We believe this is a worthy goal that is fully consistent with the charge of the Medicare Commission. The Medicare Commission will be working to develop proposals for the overall financing of Medicare. The President's proposed policy will not conflict with the Commission's work in this area.

Health- Medicare Buy-in

cc: Bruce Reed, Elena K, Ulne Sperling, Tom Freedman, Jeanne Lambrew + returned me — Tina, + Sarah

The Harris Poll

THE HARRIS POLL #6
Wednesday, February 4, 1998

STRONG SUPPORT FOR PRESIDENT'S PROPOSAL ALLOWING SOME PEOPLE AGED 55-64 TO BUY INTO MEDICARE, ALTHOUGH MAJORITY DO NOT BELIEVE IT WOULD BE SELF-FINANCING

Only 54% of the public have heard about the proposal.

---

by Humphrey Taylor

The president's proposal to allow some people aged 55-64 to buy into the Medicare health insurance program is popular with most people who have heard about it. And the two main elements of the proposal, allowing retired workers aged 62 to 64, and laid-off workers aged 55 to 64, to buy into Medicare are strongly supported by most people, whether or not they have heard about the proposal. The majority support the proposals even though – by an equally large majority – most people do not believe the president's claim that it will be paid for in full by those insured. They believe that the government and taxpayers will eventually pay a substantial part of the cost.

Some of the major findings of this Harris survey, conducted among a nationwide survey of 1,000 adults between January 14 and 18, 1998 are:

- Just over half of all adults (54%) say they have seen, heard or read about the president's proposal to allow some people aged 55 to 64 to buy into Medicare.

- Among this 54% who have heard about it, a substantial 63%-28% favor it. A virtually identical 63%-26% of people aged 55 to 64 feel this way.

- A substantial 68%-27% majority of the public (and a 67%-29% of those who have heard about the proposal) support the proposal "that people aged 62 to 64 who have retired should be allowed to buy into Medicare if they pay the full cost."

- A virtually identical 67%-29% majority also supports the proposal to "allow laid-off workers aged 55 to 64 to buy into Medicare" if they also pay the full cost.

- A majority of the public accepts one criticism of the plan (by 68%-29%) that "the government and taxpayers will eventually pay a substantial part of the cost."

- However, only a 44% minority agrees with another criticism that "this is an undesirable increase in the government's involvement with health insurance."

The survey is not large enough to provide accurate data about how many people might actually buy into Medicare if these proposals become law. However, it suggests that the number would be small. Only about one out of every five people aged 55 to 65 does not have health insurance now, and only about a quarter of those without health insurance (i.e. 4% of all people aged 55 to 64) say they would buy it.

Nevertheless, the poll suggests that, at least initially, the president's proposals sound attractive to most people, whether or not they have heard about them.

Humphrey Taylor is the Chairman and CEO of Louis Harris and Associates, Inc.

TABLE 1

SEEN, HEARD, READ ABOUT PRESIDENT'S PLAN TO ALLOW PEOPLE TO BUY INTO MEDICARE

Base: All Adults

"President Clinton has proposed that some people aged 55 to 64, who wish to do so, should be able to buy into the Medicare health insurance program for the elderly. Have you seen, read or heard about this proposal or not?"

	Total %	People Aged 55-64 %
Seen, read or heard about it	54	75
Not done so	46	25

TABLE 2

SUPPORT/OPPOSE PRESIDENT'S PROPOSAL

Base: Seen, read or heard about President Clinton's plan

"On balance, do you support or oppose this idea?"

	Total %	People Aged 55-64 %
Support	63	63
Oppose	28	26
Don't know/Refused	9	11

TABLE 3

SUPPORT/OPPOSE ALLOWING RETIRED WORKERS AGED 62-64 TO BUY INTO MEDICARE

Base: All Adults

"Under this proposal, people aged 62 to 64 **who have retired** would be allowed to buy into Medicare if they paid the full cost, so that it would not increase the cost of the Medicare program to taxpayers. Do you support or oppose this idea?"

	Adults %	Familiar with Clinton's Proposal %	People Aged 55-64 %
Support	68	67	56
Oppose	27	29	39
Don't know/Refused	5	3	5

TABLE 4

SUPPORT/OPPOSE ALLOWING LAID-OFF WORKERS AGED 55-64 TO BUY INTO MEDICARE

Base: All Adults

"Another part of the proposal would allow **laid-off workers** aged 55 to 64 to buy into Medicare, also paying the full cost so that there would be no cost to the taxpayers. Do you support or oppose this idea?"

	Adults %	Familiar with Clinton's Proposal %	People Aged 55-64 %
Support	67	68	61
Oppose	29	29	36
Don't know/Refused	3	3	3

TABLE 5

AGREE/DISAGREE WITH TWO CRITICISMS OF PRESIDENT'S PROPOSALS

Base: All Adults

"Critics of the proposal make two points, please tell me if you agree or disagree with them."

AGED 55-64		TOTAL			PEOPLE		
		Agree	Disagree	Not Sure	Agree	Disagree	Not Sure
This is an undesirable increase of the government's involvement with health insurance	%	44	52	4	42	47	10
Even though the president denies it, the government and taxpayers will eventually pay a substantial part of the costs	%	68	29	3	72	21	7

TABLE 6

HOW MANY PEOPLE HAVE OR DO NOT HAVE HEALTH INSURANCE

Base: Aged 55 to 64

"Do you have health insurance or not?"

	Total %
Yes, have	81
Do not have	19

NOTE: Approximately **one-third of those without health insurance say they would buy it** if it cost "$5,000 a year or just over $400 a month." **However, this is based on a very small sample and should be treated with great caution.**

Methodology

This Harris Poll was conducted by telephone within the United States between January 14 to 18, among a nationwide cross section of 1,000 adults. Figures for age, sex, race, education and number of adults in household were weighted where necessary to bring them into line with their actual proportions in the population.

In theory, with a sample of this size, one can say with 95 percent certainty that the results have a statistical precision of plus or minus 3 percentage points of what they would be if the entire adult population had been polled with complete accuracy. Unfortunately, there are several other possible sources of error in all polls or surveys that are probably more serious than theoretical calculations of sampling error. They include refusals to be interviewed (non-response), question wording and question order, interviewer bias, weighting by demographic control data and screening (e.g., for likely voters). It is difficult or impossible to quantify the errors that may result from these factors.

These statements conform to the principles of disclosure of the National Council on Public Polls.

818375
Q310-380

Contact Louis Harris and Associates, Inc. 111 Fifth Avenue, New York, NY 10003, (212) 539-9697, for complete demographic details for the questions in this release.

FAX (212) 539 - 9669
Compuserve address: 76702,2063
Other E-mail: achurch@lha.gsbc.com

COPYRIGHT 1998 CREATORS SYNDICATE, INC.
ISSN 0895-7983

Health- Medicare buy-in

PPI
PROGRESSIVE POLICY INSTITUTE

February 20, 1998

Dear Friend:

President Clinton's new proposal to let older Americans buy into Medicare before turning age 65 commendably returns access to health care to the front burner of the domestic policy agenda. But while the goal of expanding health care coverage is critical, there is a better vehicle for reaching it than the troubled Medicare program.

In a new report from the Progressive Policy Institute (PPI), Senior Analyst for Health Care Policy David B. Kendall proposes that the President and Congress instead seek to extend coverage through the financially sound Federal Employees Health Benefits Program (FEHBP). According to Kendall, FEHBP is the superior option because it restrains costs through competition rather than bureaucratic price controls; offers greater choices of plans to suit individual needs and preferences; and eliminates, through the range of benefits offered, the need for Medicare participants to purchase additional coverage.

Past experience has shown that efforts to reform America's health care system typically fall flat when they rely on large, bureaucratic solutions. Now is the time to break this pattern of failure by rallying support for an incremental approach to universal coverage that uses market means to expand the purchasing power of consumers, make health care affordable, and put individuals in charge of their own health care coverage.

Please visit our website at http://www.dlcppi.org/, or call us at 202/547-0001, if you would like additional information on this or other policy topics.

Sincerely,

Will Marshall

Will Marshall
President

518 C Street, NE • Washington, DC 20002 • 202.547.0001 • FAX 202.544.5014 • INTERNET: ppiinfo@dlcppi.org

PPI
PROGRESSIVE POLICY INSTITUTE

Policy Briefing
February 1998

President Clinton's Medicare Buy-in

Right Goal, Wrong Program

by David B. Kendall

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

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

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

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

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

518 C Street, NE • Washington, DC 20002 • 202.547.0001 • FAX 202.544.5014 • E-mail ppiinfo@dlcppi.org • WWW http://www.dlcppi.org/

A New Path to Universal Coverage

In 1997, the President and Congress started to make a significant dent in the number of uninsured by providing the states with $4 billion each year for covering up to five million children. The President's Medicare buy-in program would help only about 300,000 people because the $300 to $400 monthly premiums would be too expensive for low- and many middle- income Americans. Taken together, these two actions would still leave at least 35 million Americans without coverage and leave the nation without a clear path toward universal coverage.

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

- **Expand the opportunity for consumers to pool their purchasing power and make informed choices.** FEHBP has long been a leader in equipping consumers to make an informed choice of health insurance, and it could help not only uninsured, older Americans, but all Americans who lack this opportunity. Indeed, Sen. Tom Daschle (D-SD) has already introduced such legislation. Similarly, state-sponsored purchasing groups could also serve as vehicles for empowering individual consumers.

- **Make health care affordable to all.** A refundable tax credit for health insurance would help make it affordable for low- and many middle-income families and workers who cannot get coverage through their job.

- **Require everyone to purchase coverage.** Even when health care coverage is universally affordable and available, there will be a sizeable number of people who remain uninsured. Most likely, they will be young and healthy people who fail to see the importance of insurance or believe they can get free health care at the emergency room. In economic terms, they are "free riders," those who fail to buy insurance when they are healthy and then rely on public support when they are sick. They should be required to purchase coverage for their own protection and everyone else's benefit.

The President needs to articulate a new path toward universal coverage because his opponents have already asserted that a Medicare buy-in will lead inexorably to an expansion of Medicare and increased government control of the health system. Bolstering such claims, Rep. Pete Stark (D-CA), a long time proponent of achieving a Canadian-style, single-payer health care system through incremental Medicare expansions, has vowed to push the President's proposal in Congress.

The President's vision for universal coverage is all the more important given the

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

Buying into the Federal Employees Health Benefits Program

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

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

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

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

Avoiding Possible Pitfalls

Setting the right price is all the more difficult for a buy-in program because it will likely attract individuals who have greater health needs and are more expensive on average to insure. This problem, known as adverse selection, arises from the fact that some people risk going without insurance when they are healthy in the hope that they can buy insurance when they are sick. In fact, any buy-in program has the potential pitfall of encouraging

some people to be irresponsible by delaying purchasing coverage until they need it. This problem is similar to letting a homeowner buy insurance on a burning house, which would obviously undermine any insurance system.

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

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

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

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

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

participants should be separate from the insurance pool for federal workers and retirees.

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

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

FEHBP's Advantages over Medicare

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

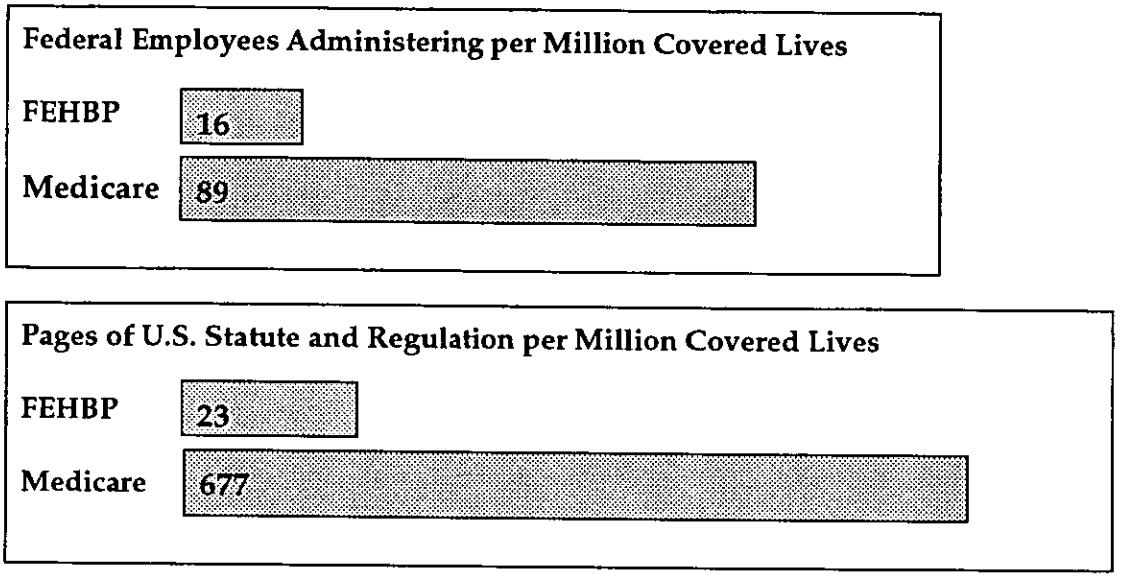
- *FEHBP uses competition, not bureaucracy to restrain costs.* Price increases in FEHBP have averaged 4 percent annually during this decade compared to 8 percent for Medicare coverage. FEHBP's success in restraining costs stems from a simple and powerful reason: health plans participating in FEHBP will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

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

  As Chart 1 illustrates, Medicare is much more bureaucratic than

FEHBP. Medicare has 29 times more pages of regulations and five times more employees for each life insured.

Chart 1: A Comparison of Bureaucracies: Medicare vs. the Federal Employees Health Benefits Plan (FEHBP)



Source: Reprinted, by permission, from Will Marshall and Martin Schram. *Mandate for Change.* New York: Berkley Books, 1993.

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

- *FEHBP's benefits offer true financial protection and do not require supplemental insurance.* At a minimum, all plans participating in FEHBP offer benefits packages that cover catastrophic health care costs, which prevents individuals from being bankrupt by an injury or disease. Medicare's basic

benefits, however, do not cover catastrophic costs, so beneficiaries with traditional fee-for-service Medicare coverage must purchase supplemental coverage, which could add $100 or more per month to the cost of a Medicare buy-in.

Next Steps Toward Universal Coverage

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

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

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

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

  A tax credit for health insurance would create alternatives to the job-based coverage. Workers who have been left out of the job-based system or

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

- **Require free-riders to purchase health coverage.** While a tax credit for health insurance would go a long way toward solving the problems of affordability and adverse selection, ultimately every individual should be required to have health insurance. Once tax credits—and any additional subsidies needed to make health care insurance affordable—are in place, the remaining uninsured would have little excuse not to pay their fair share for health insurance and stop relying on public support when they are sick. Some people will, of course, simply refuse to purchase insurance, and at some point, the enforcement costs of a mandate will exceed the benefits. To finance their care fairly and efficiently, their unclaimed tax credits could be set aside to compensate for providers' charity care.

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

Conclusion

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

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

For further information about the PPI or its publications, please call the publications department at 800-546-0027 (in the Washington, DC metro area, call 202-544-6172), write: Progressive Policy Institute, 518 C Street, NE, Washington, DC 20002, or visit PPI's Web site: http://www.dlcppi.org/.

Health - Medicare buy-in

PRESIDENT CLINTON'S PROPOSAL: HEALTH CARE SECURITY FOR THE 21st CENTURY

January 6, 1998

"For many Americans, access to quality health care can mean the difference between a healthy, productive life and the burdens of illness, worry and financial strain. Today, we are taking action to give more Americans the security they need by letting them buy into one of our nation's greatest achievements: Medicare."

President Bill Clinton
January 6, 1998

President Clinton announces a targeted proposal giving one of America's most vulnerable and difficult to insure populations new options for obtaining adequate, affordable health care coverage.

PROTECTING AMERICA'S MOST VULNERABLE POPULATION. Adults ages 55 to 65 are part of one of the nation's most vulnerable and difficult to insure populations: they have less access to employer-based health insurance; they are twice as likely to have health problems; and are at greater risk of losing coverage. The President's targeted Medicare proposal extends new security to millions of people by:

- **Offering Americans ages 62 to 65 the opportunity to buy into Medicare**. These Americans will now be able to buy into the Medicare program at a fixed premium that, for many, is far more affordable than private insurance -- but at a price that is based firmly in the costs of insuring people of this age group;

- **Providing vulnerable, displaced workers ages 55 to 65 access to Medicare.** Older Americans who lose their jobs are more likely to lose their insurance and less likely to find new employment. President Clinton's proposal gives these people an opportunity to buy into Medicare early, protecting them from the debilitating costs of unforseen illness;

- **Giving Americans ages 55 to 65 whose companies dropped their commitment to provide retiree health coverage a new option for care.** Too often, employers walk away from their commitments to provide retirement health benefits. This proposal allows these retirees to buy into their former employers' health plan through age 65 by extending the availability of COBRA coverage to these families.

PROTECTING MEDICARE FOR THE FUTURE. The President's proposal is fully funded and doesn't burden the Medicare program. All three proposals are designed to be paid for by the people who benefit. Any temporary costs will be offset by a series of new Medicare anti-fraud and waste proposals, which will be announced in the President's budget.

BUILDING HEALTH CARE SECURITY FOR THE 21ST CENTURY. This proposal is an important part of President Clinton's plan to ensure the health care security of all Americans while containing health care costs for working families and businesses; and it builds on the success of President Clinton's health care policies, including last year's:

- **Children's Health Initiative**: the single largest investment in health care for children since passage of Medicaid in 1965, this initiative provides significant health care coverage for up to 5 million uninsured children, including support for prescription drugs, vision, hearing and mental health services;

- **Medicare Reform**: the President's balanced budget plan protects, modernizes and extends the Medicare Trust Fund at least a decade while saving up to $450 billion dollars over ten years; the plan also expands preventive benefits including additional coverage for mammograms, colorectal screening, and improved self management of diseases like diabetes.

Health - Medicare Buy-in
and
Fam - child care policy - general

1/8/98

NOTE TO: Rahm Emanuel
Bruce Reed
Gene Sperling
Chris Jennings

Could you let me know if you have thoughts/comments on the attached Q and A? I'm planning to use them as a supplement to your documents to brief Secretary Shalala for "Face the Nation" this weekend.

Our fax here is 690-5673.

Thanks.

Melissa

Melissa Skolfield

01/08/98 THU 15:59 FAX 2026903613 OMB/NSTA

Additional Q and As

Q: In a previous State of the Union address, the President said that "the era of big government is over." This year, he seems to be saying that "the era of big government is back." What do you say to critics warning that your Medicare and child care proposals are expansive new government programs?

A: They're wrong. First, let's remember that these initiatives are being proposed as part of the first balanced budget in 30 years – at a time when the government work force is substantially smaller than it was when President Clinton took office. Within that context, we still ought to be responding to the real needs of our citizens. For working parents, it's child care. And for those approaching retirement age, it's access to health care. It's that simple.

Q: Senator Gramm has said of your Medicare proposal that "if your mother is on the Titanic and the Titanic is sinking, the last thing on Earth you want to be preoccupied with is getting more passengers on the Titanic." What is your response?

A: With all due respect, he just hasn't been paying attention. Thanks to President Clinton, legislation was enacted in 1993 to extend the life of the Medicare trust fund without a single Republican vote. Last year, Congress adopted our plan to extend the life of the trust fund for at least another decade. And the President has appointed a Medicare commission to recommend additional steps we can take.

But our proposal will not cost the Medicare trust fund one dime. It's a carefully targeted proposal that is designed to be self-financing.

Q: Senator Gramm has warned that your proposal will encourage more people to retire early, thus jeopardizing both the Medicare and Social Security trust funds. What is your response?

A: We don't think that will happen, for two reasons. First, the program is targeted to people who are most likely to already be out of the work force -- 62- to 65-year-old retirees, their spouses, and younger retirees who were promised health insurance by employers who later canceled it, for example. Second, the proposal requires that those who choose to take advantage of it pay the full cost, so there's no reason to think it would be more attractive than employer-sponsored health plans.

Q: Rep. Thomas and others are already saying that your Medicare proposal risks tax hikes or Medicare budget cuts to help pay for it, and those fears seem to be warranted. According to the New York Times, Gene Sperling and other unnamed Administration officials are already hinting that your Medicare proposal will not require those 55 to 65 to

pay the full premiums, so it really won't be self-financing. Can you really promise here today that you don't intend to subsidize the cost of health care for these people?

A: As we've said, our initiative is being proposed within the context of a balanced budget, and is designed to be self-financing over time. There will be costs in the first five years, and we've said that – but those upfront costs will be fully paid for by other offsets, such as savings from our efforts to reduce fraud and abuse.

Q: Isn't your child care initiative paid for with a tobacco tax? And if you're assuming that Congress will pass tobacco legislation, doesn't that make this child care initiative pretty tenuous?

A: As I've said, our budget proposal will make clear that our child care proposal can be fully paid for within the context of a balanced budget. Our budget will assume that Congress will pass tobacco legislation, and we believe they will. It is a top priority for the president, and it has bipartisan support.

Q: How much of this child care proposal is paid for by a tobacco tax? Which part?

A: Approximately one-third of the child care proposal is paid for with the revenue from tobacco legislation. We believe that is a realistic assumption. But again, let's not get hung up on the financing. As the President has said, every initiative in his budget submission, including this one, will be paid for within the context of a balanced budget. The budget we send to Congress will include a number of proposals to pay for new initiatives like this one – including tax proposals and other spending offsets. Many of our financing proposals will have bipartisan support. Child care has bipartisan support. Tobacco legislation has bipartisan support. We believe we're going to be able to work with Congress to pass this important child care initiative.

Health-Medicare buy-in

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

November 26, 1997

MEMORANDUM TO: GARY CLAXTON
JOSH GOTTBAUM
RICHARD HINZ
CHRIS JENNINGS
GENE SPERLING
LARRY SUMMERS

From: JONATHAN GRUBER JG
JEANNE LAMBREW

Re: MEDICARE BUY-IN

At the Principals meeting yesterday, there was concern expressed around the table about the impacts of a Medicare buy-in on retirement and "crowdout". Attached is a paper that lays out the case for why these effects are relatively small for an actuarially-fair Medicare buy-in for 60-64 year olds. These are obviously rough numbers, and should be confirmed by HCFA actuaries, but they show at a first pass why concerns about very large effects here may be misplaced.

Why A Medicare Buy-In Probably Will Not Cause Major Disruptions in Coverage or Work

Concerns have been raised over whether a Medicare buy-in, *even without subsidies*, will:

- "Crowd out" existing coverage, such as retiree health coverage and
- Encourage early retirement.

These concerns may be exaggerated given the following analysis, for a 60-64 year old buy-in.

Actuarially-fair Medicare Buy-In Causes Limited Crowdout

- A Medicare buy-in at an actuarially fair price will probably be:
  - More expensive than employer plans and individual policies for healthy people
  - About the same or slightly above COBRA policies
  - Less expensive than individual policies for sicker people.
- As a result, there is likely to be little crowdout of private insurance coverage
- For illustration, assume that 60-64 year olds are eligible, and participate as follows:

Base Coverage	Number (millions)	Partic-ipation	Explanation
Active Employer Coverage	4.6	0	Employees would not want since they pay full cost; those with COBRA would probably keep it since it is less costly. **Employers** are very unlikely to drop coverage for all employees because of access to Medicare for a small subset of older workers.
Retiree Coverage	1.5 *	0.4	Assume that half of employers drop coverage, and half of dropped employees participate
Individual Insurance	0.9	0.3	Assume that 33 percent participate. Since these people probably are healthy, this may be a more costly option for most.
Public Coverage	1.4	0	Prohibited from eligibility.
Uninsured	1.5	0.5	Assume that 33 percent participate. This is not unreasonable since about one-third of the uninsured have income above 300 % of poverty.
TOTAL	**9.9**	**1.2**	**12% of eligible population participates**

March 1997 CPS. * Assumes 25% of those with employer insurance are retirees, from HRS analysis of 58 - 63.

- **Over 40% of participants in this program are otherwise uninsured.**

- **An additional 25% are helped because they do not have to buy very expensive individual insurance.** For the sick in the individual market, this policy offers an actuarially fair but not excessive premium. Premiums in the individual insurance market for less healthy people are probably inflated due to medical underwriting and age and health rating.

- **Only <u>one-third</u> of participants are dropping group coverage for this option.**

- But much of the dropping of retiree health insurance may have occurred over time anyway, as witnessed by recent trends in retiree coverage. Retiree coverage is currently falling at a rate of 1-2% per year. **This policy will likely only act to accelerate the existing decline in coverage, while providing a safety net for those left behind by the restriction in group insurance access.**

- In addition, without subsidies, crowd out of retiree coverage may actually *help* rather than *hurt*.

  - *Could prevent some from retiring early*: Without the usual, large subsidy included in retiree health insurance, some might continue working to keep their active employee policy or to afford the Medicare option.

  - *Could lessen adverse selection*: Some of the healthy people who were covered under retiree health plans may choose the Medicare buy-in option.

Actuarially-fair Medicare Buy-In Has Small Retirement Effects.

- Studies suggest that COBRA, whose premiums are comparable to that of a Medicare buy in, increases the probability of retiring by 15 percent. Given a rate of retirement of 13 percent for full-time workers (HRS), an additional 2 percent of people would retire early as a result of this policy.

  - Assuming that 57 percent of people work (statistic for the 55 to 64 year olds) and there are 9.9 million total people in this age group, this suggests that <u>only about 100,000 people would retire as a result of the buy in</u>.

- **These effects could be lessened with policy options.**

  - **Tapping out COBRA:** To limit the possible increase in early retirements, we could require that people eligible for COBRA exhaust it before becoming eligible for this program. This effectively prevents people in firms with 20 or more employees from participating in this program for 18 months.

  - **Medicare as secondary payer**: We could also require that people with access to an employer plan cannot participate or can if that plan acts as primary payer.

Make sure Elena sees.

Thursday morning
Draft

Health - Medicare buy-in (55-64)

HEALTH CARE INVESTMENT OPTIONS FOR FY 1999 BUDGET

December 4, 1997

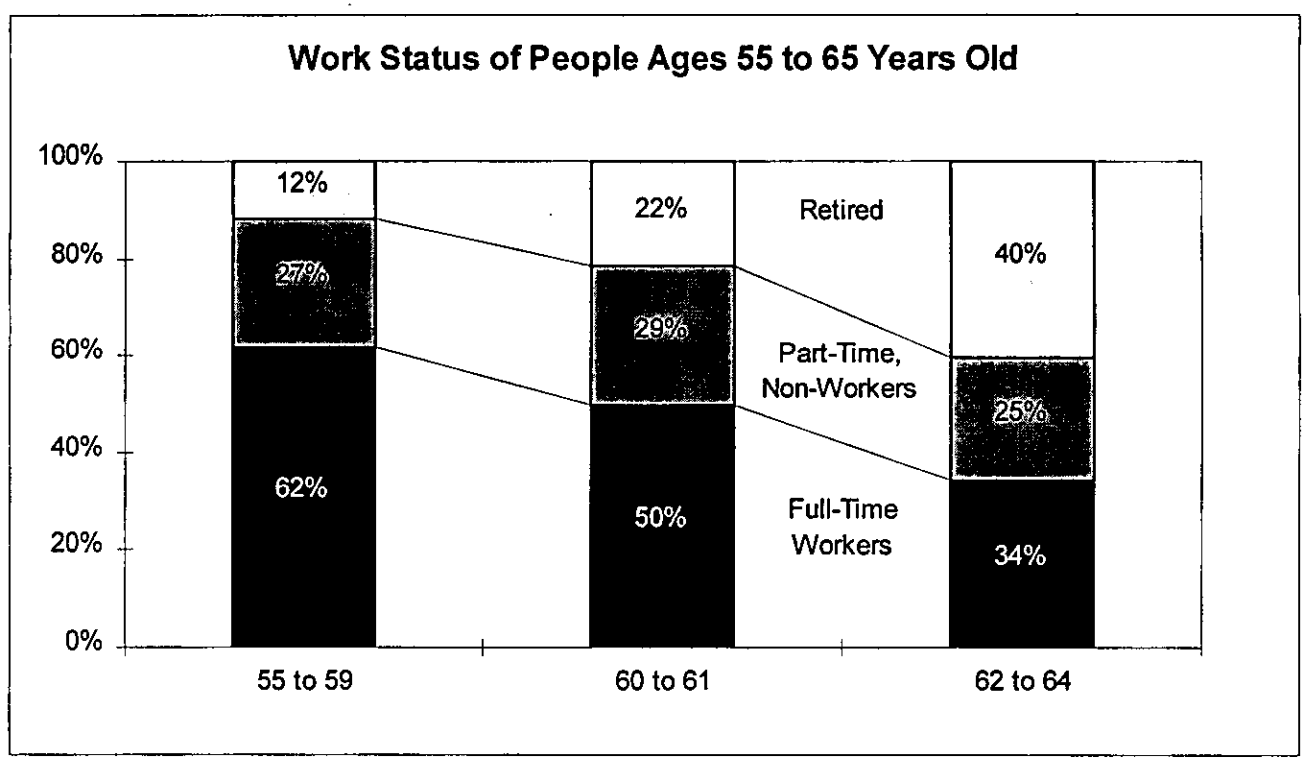
AGENDA

- Pre-65 Options
- Other Health Investment Initiatives

CLOSER LOOK AT PEOPLE 55 TO 65 YEARS OLD

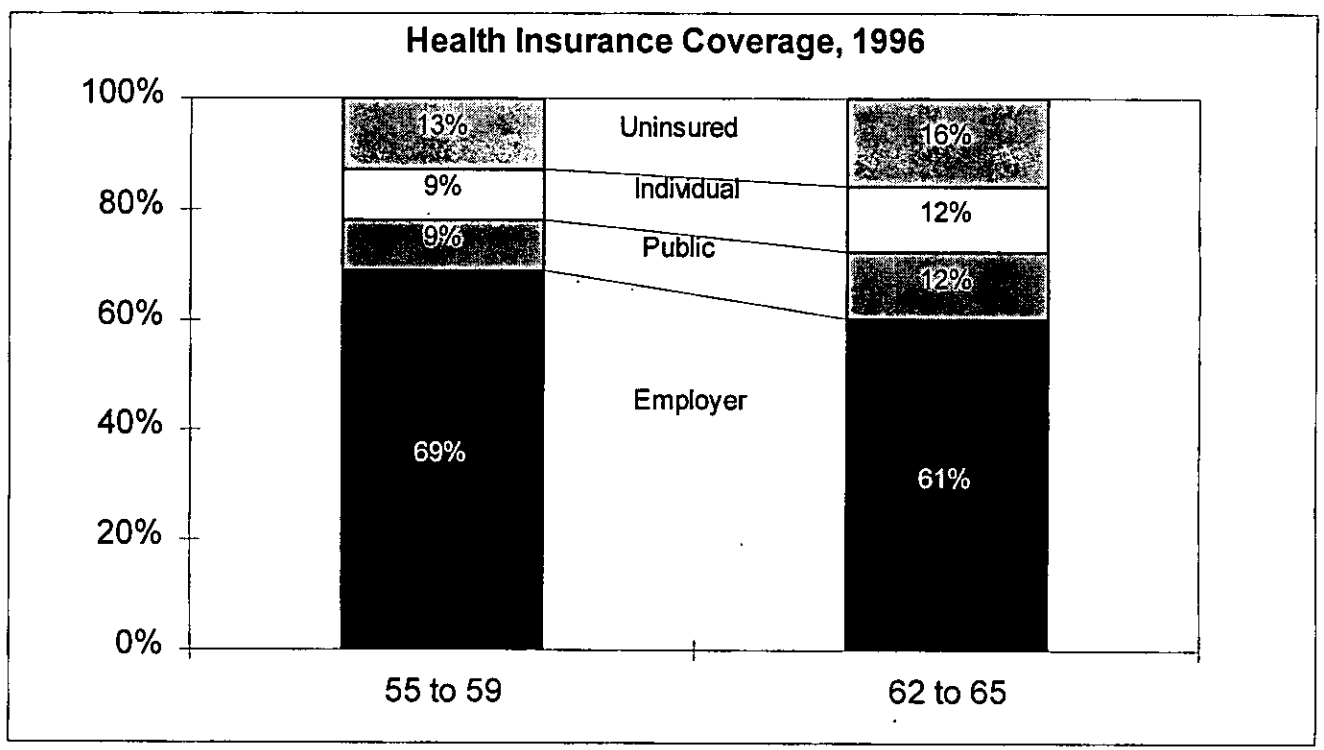
- As people approach 65 years old, they are less likely to work full-time (chart).

- Similarly, the proportion of the uninsured who are retired increases:
  - 12 percent of uninsured ages 55 to 59 are retired, compared to
  - 43 percent of the uninsured ages 62 to 65.



As Proportion of Workers Declines, So Does Access to Affordable Health Insurance

- People ages 62 to 65, compared to people ages 55 to 59, are:
  - More likely to be uninsured: 16 versus 13 percent
  - 33 percent more likely to purchase more costly individual insurance (9 to 12 percent).
- This age group also has increased health problems compared to the 55 to 59 year olds:
  - 25 percent more likely to report fair to poor health (20 versus 25 percent).



GROUPS WITH SPECIAL ACCESS PROBLEMS

- **"Broken Promise" Retirees**: Some employers have terminated retiree health coverage programs, leaving retirees without work and often without health coverage options.
  - Although the number affected is unknown and likely small, this group is highly visible.

- **Displaced Workers**: About 700,000 workers ages 55 to 65 lose their jobs due to plant closings, their jobs being eliminated and other unforeseen events.
  - About 55 percent are re-employed, relative to 75 percent of workers ages 25 to 54.
  - Nearly one in four displaced workers who remains unemployed loses group coverage.

- **Widows, Divorcees, and Never Married People**: About 40 percent of all uninsured in this age bracket are widowed, divorced or never married.
  - About 750,000 women ages 55 to 65 are uninsured and unmarried.

- **Medicare Spouses**: About 420,000 of the 3 million uninsured ages 55 to 65 have spouses covered by Medicare.
  - Almost all (92 percent) are women.
  - Only about 15 percent of these uninsured spouses are full-time workers.

PROBLEM: AFFORDABILITY AND / OR ACCESS

- As with younger populations, many of the uninsured pre-65 year olds simply cannot afford health insurance.
  - One-third of the uninsured people ages 55 to 65 years old are poor.
  - Nearly half of all uninsured 55 to 65 year olds who report fair to poor health are poor.

- However, this population has unique access problems.
  - Older people tend to be sicker:

    People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44.

    People ages 55 to 65 have twice the probability of experiencing heart disease, emphysema, heart attack, stroke and cancer as people ages 45 to 54.
  - Access to employer-based insurance declines as people approach age 65.
  - The reliance on individual insurance — which can be prohibitively expensive due to underwriting or age rating — increases.

    Premiums for a healthy 59 year olds range from $3,500 to $10,000 per year.

    In some states like New York it is virtually impossible to find an individual policy.

STAFF BASE POLICY RECOMMENDATIONS

- **Restrict Eligibility to People Ages 62 to 65 Year Olds**
  - This age group is:
    - Less likely to have access to employer insurance and COBRA
    - Less likely to work (so the policy does not induce retirement)
    - More likely to rely on expensive individual insurance
  - About 900,000 are uninsured and 700,000 buy individual insurance.
- **No Subsidies**
  - **Costly**: The higher costs for this age group make subsidies very expensive.
  - **Possibly reduces retiree health coverage**: May encourage employers to end coverage; could possibly increase retirement.
- **Medicare Buy-In rather than COBRA**
  - People ages 62 to 65 are less likely to have access to a COBRA option
  - Connects participants with eventual insurer
  - Avoids criticism that the policy is a business mandate and increases premiums

STRUCTURE AND POTENTIAL ANNUAL COST OF BUY-IN

- Eligible people pay premiums (without subsidies) to buy into Medicare.
  - **Standard premium**: This amount is paid while enrolled, like private premiums.
  - **"Amortized" amount**: The additional amount due to the extra costs of this group would be amortized, or paid for in installments for the rest of the beneficiary's life.
- Medicare would cover the non-amortized amount of the premium up front, at a cost, but would recover that cost over time as the beneficiary pays the amortized premium amount.

POTENTIAL ANNUAL COSTS

POTENTIAL ENROLLMENT	AVERAGE MONTHLY COSTS	STANDARD PREMIUM	AVG. COSTS MINUS PREMIUM	POSSIBLE MEDICARE PAYMENT
100,000 People in Poor Health *	$915	$305	$610	$0.7 billion
200,000 People in Fair Health*	$458	$305	$153	$0.4 billion
300,000: Both Groups	$610	$305	$305	$1.1 billion

Notes:
Approximates the first-year Medicare costs; does not take into account payment of amortized premium.
Assumes that the cost is the difference between the actual average monthly costs and the standard premium.
* These numbers represent about 100 percent of the uninsured/ individually insured people in poor health and 80 percent of the uninsured/ individually insured people in fair health in the 62 to 65 year old age group.

OTHER OPTIONS TO BUILD ON BASE POLICY

- **"COBRA" Option for "Broken Promise" Retirees**

  - Retirees 55 to 65 who had health coverage but whose former employer "broke the promise" to continue that coverage could buy into that employers' plan, like COBRA

  - Premium could be set at 125 to 150 percent of the group rate.

  - *Rationale*: Gives retirees an affordable option and holds employer somewhat accountable ending coverage for retirees

- **Medicare Buy-In for Special Groups**

  - Certain groups of 55 to 65 year olds lacking access to employer insurance and often COBRA (listed below) could buy into Medicare in the same way that the 62 to 65 year olds would:

    Displaced workers who have been uninsured and unemployed

    Medicare beneficiaries' spouses who lose coverage when their spouse retires

    Unmarried people without access to a spouse's insurance.

  - *Rationale*: Their small numbers, lower access to COBRA, and low risk of crowding out other types of coverage may argue for a Medicare option for these groups.

OTHER PRIORITY HEALTH INVESTMENT OPTIONS

MEDICARE

- **Private long-term care options**: Allow standardized private long-term care plans to market to Medicare beneficiaries through the managed care information system ($x million over 5)

- **Clinical cancer trial coverage**: Cover the patient care costs associated with certain, high-quality cancer treatment clinical trials ($1.7 to 3 billion over 5)

COVERAGE INITIATIVES

- **Children's health outreach**: Options range from providing bonus payments for enrolling Medicaid eligible uninsured to expanding presumptive eligibility ($0.5 to 4 billion over 5)

- **Demonstration for workers changing jobs**: Fund several states to help pay for premiums for families losing coverage due to job change using different models ($1 to 4 billion over 5)

- **Demonstration for de-institutionalizing people with disabilities:** Fund several state demonstration of approaches to help people live in the community ($50 to 100 million over 5)

- **Small business group purchasing**: Fund voluntary purchasing cooperatives for small businesses; explore other ideas for lowering their insurance costs ($50 to 100 million over 5)

RESEARCH

- **Increase the National Institutes of Health (NIH) budget** ($5 to 15 billion over 5)

PUBLIC HEALTH

- **Race Initiative**: Target public health programs to reduce racial disparities in infant mortality, cancer, heart disease, stroke, diabetes, AIDS, and immunization ($100 to 200 million over 5)

HEALTH CARE INVESTMENT OPTIONS FOR FY 1999 BUDGET

December 4, 1997

AGENDA

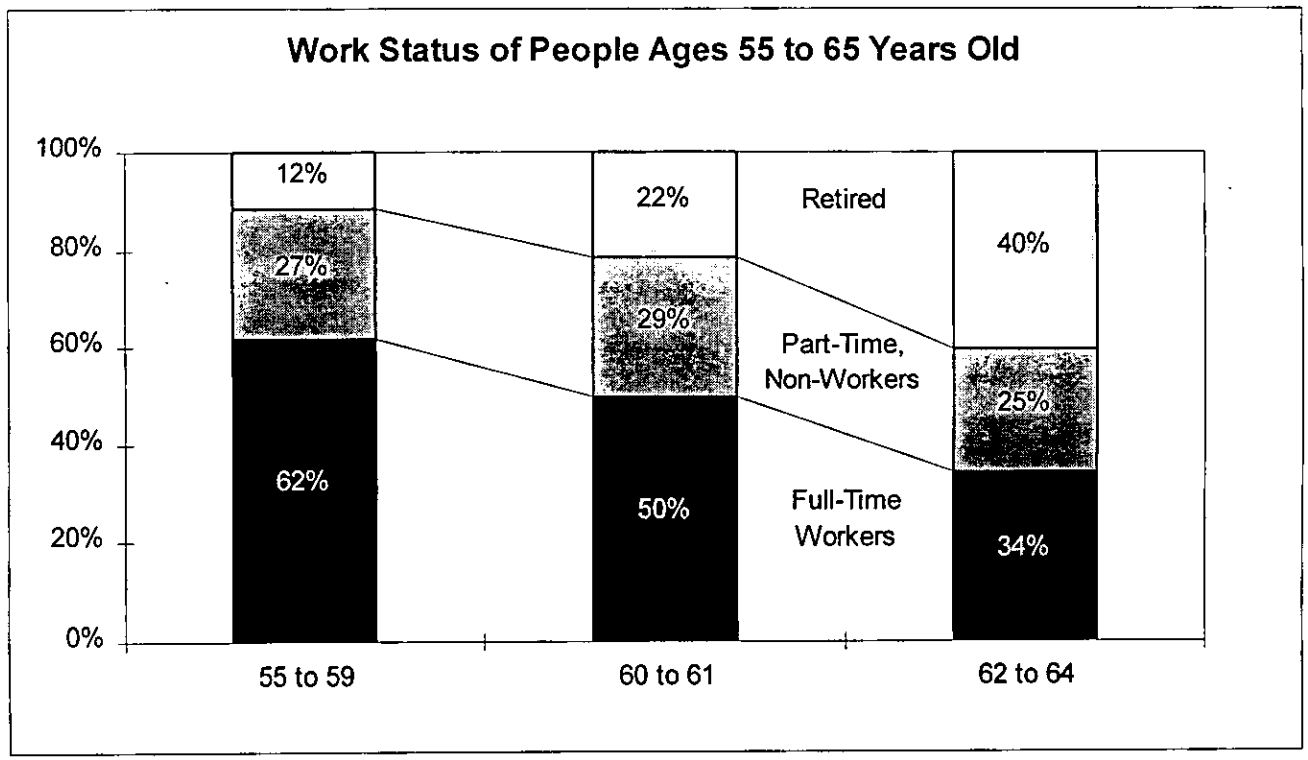
- Pre-65 Options
- Other Health Investment Initiatives

Health-medicare (55-64) buy-in

CLOSER LOOK AT PEOPLE 55 TO 65 YEARS OLD

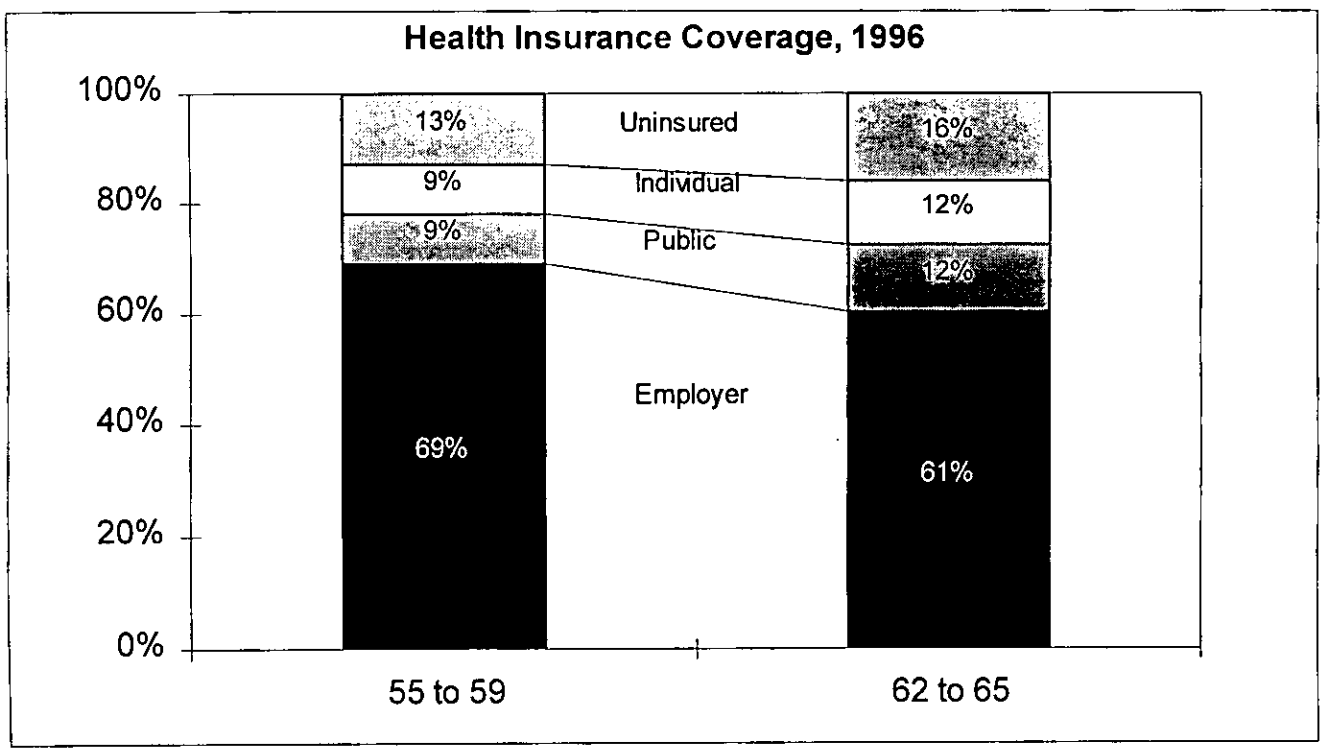
- As people approach 65 years old, they are less likely to work full-time (chart).

- Similarly, the proportion of the uninsured who are retired increases:
  - 12 percent of uninsured ages 55 to 59 are retired, compared to
  - 43 percent of the uninsured ages 62 to 65.



As Proportion of Workers Declines, So Does Access to Affordable Health Insurance

- People ages 62 to 65, compared to people ages 55 to 59, are (chart):
  - More likely to be uninsured: 16 versus 13 percent
  - More likely to purchase more costly individual insurance (12 to 9 percent).
- This age group also has increased health problems compared to the 55 to 59 year olds:
  - More likely to report fair to poor health (26 versus 20 percent).



GROUPS WITH SPECIAL ACCESS PROBLEMS

- **"Broken Promise" Retirees**: Some employers have terminated retiree health coverage programs, leaving retirees without work and often without health coverage options.
  - Although the number affected is unknown and likely small, this group is highly visible.

- **Displaced Workers**: About 700,000 workers ages 55 to 65 lose their jobs due to plant closings, their jobs being eliminated and other unforeseen events.
  - About 55 percent are re-employed, relative to 75 percent of workers ages 25 to 54.
  - Nearly half of those remaining unemployed lose group coverage.

- **Widows, Divorcees, and Never Married People**: About 40 percent of all uninsured in this age bracket are widowed, divorced or never married.
  - About 750,000 women ages 55 to 65 are uninsured and unmarried.

- **Medicare Spouses**: About 420,000 of the 3 million uninsured ages 55 to 65 have spouses covered by Medicare.
  - Almost all (92 percent) are women.
  - Only about 15 percent of these uninsured spouses are full-time workers.

PROBLEM: AFFORDABILITY AND / OR ACCESS

- As with younger populations, many of the uninsured pre-65 year olds simply cannot afford health insurance.

  - One-third of the uninsured people ages 55 to 65 years old are poor.

  - Nearly half of all uninsured 55 to 65 year olds who report fair to poor health are poor.

- However, this population has unique access problems.

  - Older people tend to be sicker:

    People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44.

    People ages 55 to 65 have twice the probability of experiencing heart disease, emphysema, heart attack, stroke and cancer as people ages 45 to 54.

  - Access to employer-based insurance declines as people approach age 65.

  - The reliance on individual insurance — which can be prohibitively expensive due to underwriting or age rating — increases.

    Premiums for a healthy 59 year olds range from $3,500 to $10,000 per year.

    In states like Florida, policies are often underwritten, increasing costs significantly

BASE POLICY OPTION

- **Restrict Eligibility to People Ages 62 to 65 Year Olds**
  - This age group is:
    - Less likely to have access to employer insurance and COBRA
    - Less likely to work (so the policy does not induce retirement)
    - More likely to rely on expensive individual insurance
  - About 900,000 are uninsured and 700,000 buy individual insurance.
- **"Amortized" Payments but No Subsidies**
  - **Costly**: The higher costs for this age group make subsidies very expensive.
  - **Possibly reduces retiree health coverage**: May encourage employers to end coverage; could possibly increase retirement.
- **Medicare Buy-In rather than COBRA**
  - People ages 62 to 65 are less likely to have access to a COBRA option
  - Connects participants with eventual insurer
  - Avoids criticism that the policy is a business mandate and increases premiums

STRUCTURE AND POTENTIAL ANNUAL COST OF BUY-IN

- Eligible people pay premiums (without subsidies) to buy into Medicare.
  - **Standard premium**: This amount is paid while enrolled, like private premiums.
  - **"Amortized" amount**: The additional amount due to the extra costs of this group would be amortized, or paid for in installments for the rest of the beneficiary's life.
- Medicare would cover the non-amortized amount of the premium up front, at a cost, but would recover that cost over time as the beneficiary pays the amortized premium amount.

POTENTIAL ANNUAL COSTS

POTENTIAL ENROLLMENT	AVERAGE MONTHLY COSTS	STANDARD PREMIUM	AVG. COSTS MINUS PREMIUM	POSSIBLE MEDICARE PAYMENT
100,000 People in Poor Health *	$915	$305	$610	$0.7 billion
200,000 People in Fair Health*	$458	$305	$153	$0.4 billion
300,000: Both Groups	$610	$305	$305	$1.1 billion

Notes:
Approximates the first-year Medicare costs; assumes participants would not begin paying amortized premium until age 65
Assumes that the cost is the difference between the actual average monthly costs and the standard premium.
* These numbers represent about 100 percent of the uninsured/ individually insured people in poor health and 80 percent of the uninsured/ individually insured people in fair health in the 62 to 65 year old age group.

OTHER POSSIBLE OPTIONS

- **"COBRA" Option for "Broken Promise" Retirees**

  - Retirees 55 to 65 who had health coverage but whose former employer "broke the promise" to continue that coverage could buy into that employers' plan, like COBRA

  - Premium could be set at 125 to 150 percent of the group rate.

  - *Rationale*: Gives retirees an affordable option and holds employer somewhat accountable for ending coverage for retirees

- **Medicare Buy-In for Special Groups**

  - Certain groups of 55 to 65 year olds lacking access to employer insurance and often COBRA (listed below) could buy into Medicare in the same way that the 62 to 65 year olds would:

    Displaced workers who have been uninsured and unemployed

    Medicare beneficiaries' spouses who lose coverage when their spouse retires (OMB would learn here)

    Unmarried people without access to a spouse's insurance.

  - *Rationale*: Their small numbers, lower access to COBRA, and low risk of crowding out other types of coverage may argue for a Medicare option for these groups.

OTHER PRIORITY HEALTH INVESTMENT OPTIONS

MEDICARE

- **Private long-term care options**: Allow standardized private long-term care plans to market to beneficiaries through the managed care information system ($20 to 25 million over 5)

- **Clinical cancer trial coverage**: Cover the patient care costs associated with certain, high-quality cancer treatment clinical trials ($1.7 to 3 billion over 5)

COVERAGE INITIATIVES

- **Children's health outreach**: Options range from providing bonus payments for enrolling Medicaid eligible uninsured to expanding presumptive eligibility ($0.5 to 4 billion over 5)

- **Demonstration for workers changing jobs**: Fund several states to help pay for premiums for families losing coverage due to job change using different models ($1 to 4 billion over 5)

- **Demonstration for de-institutionalizing people with disabilities:** Fund several state demonstration of approaches to help people live in the community ($50 to 100 million over 5)

- **Small business group purchasing**: Fund voluntary purchasing cooperatives for small businesses; explore other ideas for lowering their insurance costs ($50 to 100 million over 5)

RESEARCH

- **Increase the National Institutes of Health (NIH) budget** ($5 to 15 billion over 5)

HEALTH CARE SPENDING PRIORITIES FOR 1998

OVERVIEW OF HEALTH CARE INVESTMENT OPTIONS

- Research Trust Fund

- Coverage Initiatives:
  - Access for the Pre-65 Year Olds
  - Children's Health Outreach
  - Workers Between Jobs Demonstration
  - Voluntary Purchasing Cooperatives

- Medicare Reforms: Clinical Cancer Trial Coverage and Private Long-Term Care Options

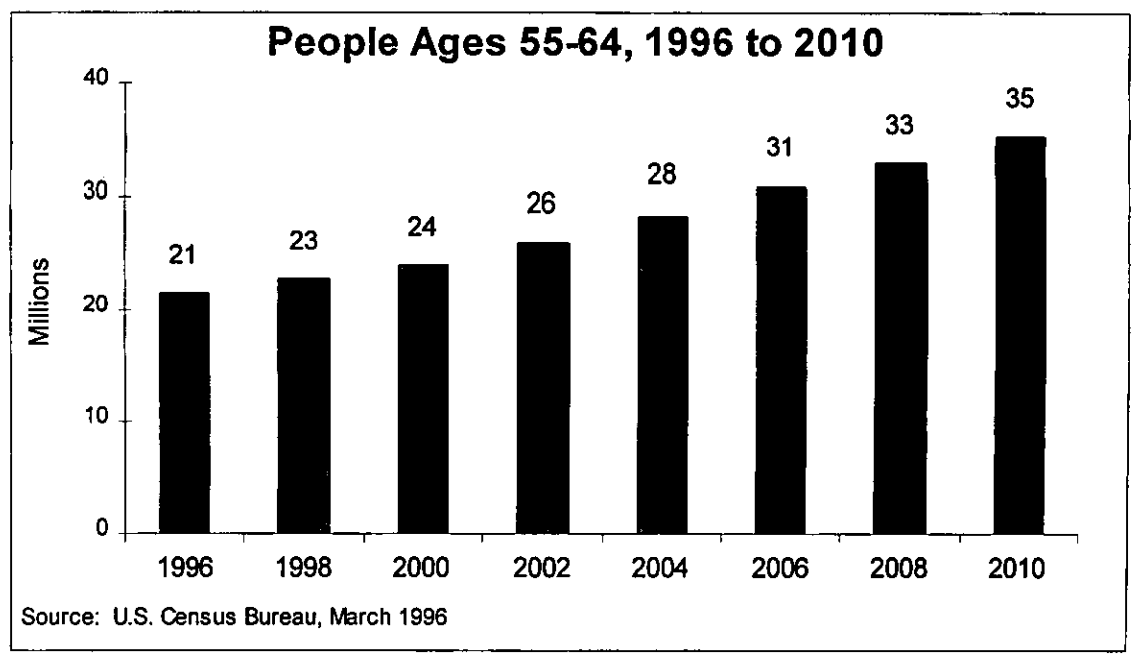
Need info -
1. Breakdown 55-62 / 62-65
2. Tax: brands people laid off in windmill/divorce?

Health - Medicare buy-in (55-64)

Bruce -
From NEC
Principals meeting.
Elena

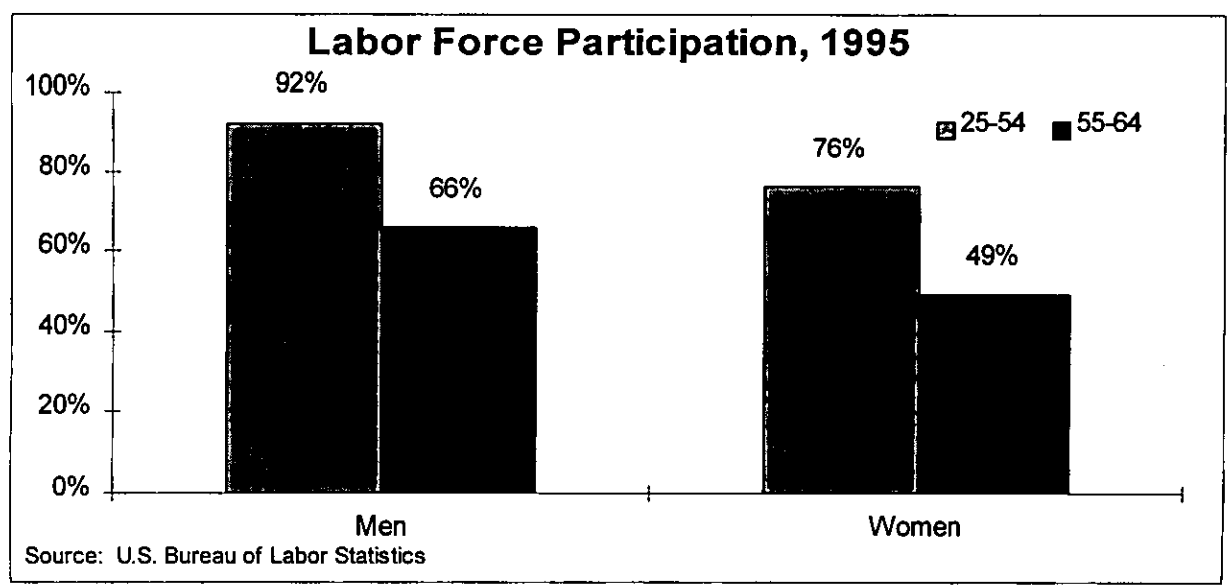
BACKGROUND ON PRE-65 YEAR OLDS

- **Growing Numbers**
  - 21 million Americans are ages 55 to 64 years old
  - By 2005, 30 million Americans will be ages 55 to 64 year olds: an increase of over 40 percent



MAKEUP OF THE PRE-65 YEAR OLD POPULATION

- 12 million (57 percent) are workers compared to 83 percent of 25 to 54 year olds
- 6 million are retired, representing one third of all retirees are under age 65
- 3 million are non-workers



HEALTH INSURANCE FOR THE PRE-65 YEAR OLDS

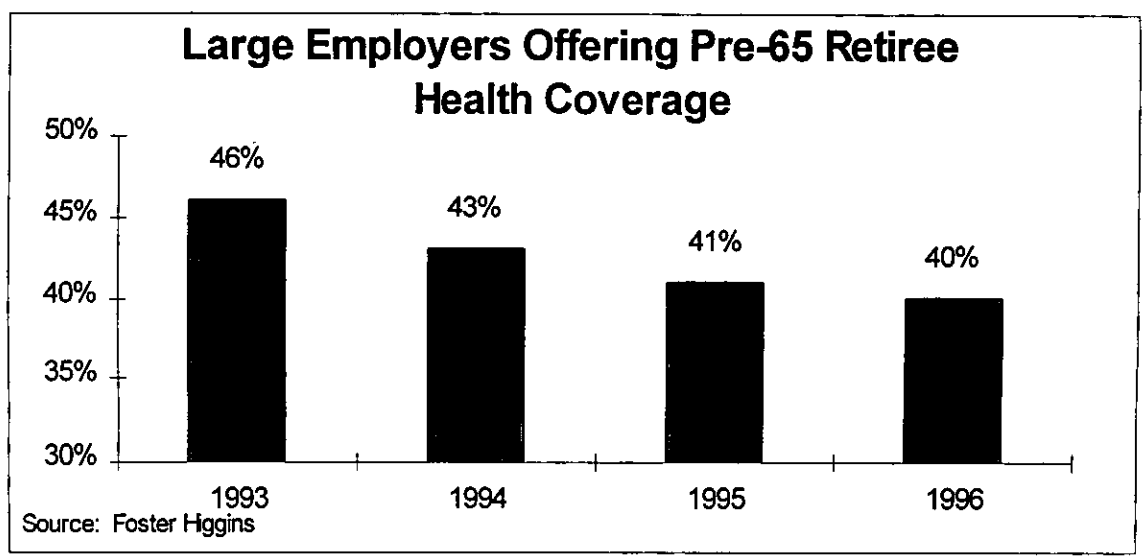
- **Three million are uninsured**: 14 percent of 55 to 64 year olds: the same rate as children
  - **Workers**: Half of the uninsured work; most (60 percent) work part time
  - **Retirees and displaced workers**: Represent 20 to 30 percent of the uninsured
  - **Low-income and less healthy**: Fewer are poor but more likely to be sick

- **Nearly 2 million covered by individual insurance**
  - Pre-65 year olds' coverage (9 percent) is nearly twice that of people ages 25 to 54

HEALTH INSURANCE AND WORK

- **Retiree health coverage is declining**
  - About one in five pre-65 year olds is insured through a retirement plan
  - Fewer firms offer retiree health coverage: 46 percent of large firms in 1993; 40 percent in 1996

- **Health insurance affects work decisions**
  - Availability of health insurance may encourage people to retire early
  - It may also eliminate "job lock": the fear of losing coverage with job change



PROS AND CONS OF PRE-65 YEAR OLDS OPTIONS

- **Advantages**
  - Without any action, trends suggest declining active employee & retiree health coverage
  - Demographic changes will likely increase access problems in this age group
  - Reduces "job lock", possibly increasing productivity of workers
  - Tests insurance options for Medicare reform / age eligibility debate

- **Disadvantages**
  - Uninsured rate not excessively high
  - Given limited funds, cannot significantly address affordability
  - Could accelerate decline in retiree health coverage
  - Could encourage early retirement
  - Uncertainty of costs and participation

POLICY OPTIONS: COBRA

- **Extending COBRA**

  - "COBRA" allows certain workers leaving firms with 20 or more employees to buy coverage through that firm for up 18 months at 102 percent of the costs

  - COBRA could be extended to more people and/or for longer to increase access to employer-based insurance

- **Advantages**

  - Private coverage option

  - Less risk to the Federal government relative to costs

  - Targets the population who are losing jobs due to downsizing

  - Allows people to continue their current coverage

- **Disadvantages**

  - Only some workers are eligible; not a policy for the uninsured or low-wage workers

  - Would likely raise premiums

  - Policy vulnerable when linked to mental health parity, quality reforms, etc.

  - Mandate and fear of costs would ensure business opposition

POLICY OPTIONS: MEDICARE BUY IN

- **Medicare Buy-In**
  - Pre-65 year olds could "buy into" Medicare at a full or reduced premium

- **Advantages**
  - Provides access to an important insurance option
  - Accessible to broader population than COBRA policy
  - Tests coverage option in the event of Medicare age eligibility extension
  - Businesses and aging groups would be more supportive

- **Disadvantages**
  - Risks Medicare Trust Fund if only the sick enroll or if subsidized
  - Could be viewed as a government take over of private insurance
  - Could be difficult to administer
  - Gets ahead of the Medicare Commission

POLICY PARAMETERS

- **Age**
  - Begin at 55, 60, 62 years old
- **Amount of the premium and premium assistance** (if any)
  - Actuarially fair
  - Actuarially fair but part is paid on an "amortized" basis
  - Pay part of the premium (Medicare buy-in) or employers' costs (COBRA)
- **Length of coverage**
  - Until Medicare eligibility
  - Time limited (e.g., 18 months for COBRA)
- **Demonstration or nationwide**
  - Limited to certain states / market areas; time limited
  - Test of different models

NEXT STEPS

- Cost and coverage estimates of premiums and subsidies
- Assessment of feasibility of each option
- Additional Principals' meetings