

# **Developing a Medicare Buy-in Program**

**American College of Physicians  
A Position Paper  
2006**

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A Position Paper of the  
American College of Physicians

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## Executive Summary

Of the 26 million Americans aged 55-64 – also known as the near-elderly – roughly 2.6 million are uninsured because they are not qualified for either Medicare disability or Medicaid benefits and cannot obtain employer or private plan coverage. Not being insured has been linked to poorer health outcomes, and that trend holds up in the case of those aged 55-64. Several policymakers have proposed allowing those over age 55 who are not qualified for Medicare or Medicaid to buy into the Medicare program. Pursuing such a policy raises several issues. This paper will attempt to outline these issues and the policy that should be taken. In particular, this paper will attempt to discuss who should pay for a Medicare Buy-in program.

Since the proposal involves the beneficiary purchasing a premium, one might assume that it would be the beneficiary who pays for the benefit. However, this paper will describe the difficulties that many of the near-elderly (especially those uninsured) would experience in paying for a Medicare buy-in. For example, about half of the near-elderly uninsured are below 200% of the Federal Poverty Level - FPL (2 X \$9,310 for an individual = \$18,620). The Clinton/Gore proposal priced a Medicare Buy-in annual premium at \$3,000-\$4,000, and the current per capita annual Medicare expenditure is \$6,647 for all of the Medicare program's services. Hence, the benefit would be very difficult for many near-elderly uninsured to afford. This paper will discuss avenues of financing that could help those who need – but are less able to afford – a Medicare Buy-in. Also, this paper will discuss the issue of eligibility. Several policy makers have taken different approaches to deciding which ages and insurance statuses should qualify a person for participation in a Medicare buy-in. This paper will discuss how including the near-elderly population's younger beneficiaries – with better health status and less health care expenditures – can improve the insurance pool risk, helping to avoid adverse selection.

Finally, the paper will discuss how the benefits and responsibilities of the Medicare program should match that of a Medicare Buy-in. In particular, the paper will discuss how required enrollment should not be a part of a Medicare Buy-in program, but the full range of benefits and responsibilities should still be in effect. The paper will discuss how the late enrollment penalties for Parts B and D should still apply, as should the necessitated enrollment in Part A – if a person voluntarily chooses to participate in a Medicare Buy-in. However, these requirements do not imply that someone who is eligible to sign up for a Medicare Buy-in necessarily should be required to do so. In considering all of these matters, the American College of Physicians recommends:

**Position 1:** A Medicare Buy-in Program must include a financing structure separate from the trust funds for the other Medicare parts (separate from financing for Medicare Part A, Part B, Medicare Advantage, and Part D).

**Position 2:** A Medicare Buy-in Program should include subsidies for lower-income beneficiaries to participate.

**Position 3:** Eligibility for a Medicare Buy-in Program should include those aged 55-64 regardless of their insurance status.

**Position 4:** Enrollment in a Medicare Buy-in program should be optional for eligible beneficiaries, and – for those who do voluntarily enroll – should include the full range and responsibilities of Medicare benefits (Parts A, B, Medicare Advantage and Part D).

## Background

Data from the National Survey of America's Families show for 2002 that the majority (73.1% - 18.7 million) of near elderly Americans aged 55-64 have insurance coverage through their employer (1). Five percent (1.29 million) receive coverage through one of State, Medicaid, or SCHIP programs. Medicare covers the 3.6% (930,000) of the near-elderly who meet the disabled requirements for Medicare disability. And private non-group insurance covers 8.0% (just over 2 million) of the near-elderly. The rest – roughly 2.6 million (or 10%) – do not have insurance coverage. Not having insurance coverage has been linked to poorer health outcomes, and this trend continues with the near elderly (2). For example, near-elderly uninsured had an 8-year mortality rate of 10.5% while insured near-elderly was only 7.5%. Half (50.4%) of all uninsured near elderly have incomes at or below 200% of the FPL. Seventy-seven percent of the near-elderly uninsured are non-retirees. Of those uninsured near-elderly who are at or below 200% of the FPL, 66.7% are non-retirees. This last population (uninsured non-retiree near-elderly below 200% FPL) composes over 34% of all near-elderly uninsured (the largest proportion of all near-elderly uninsured). The next largest proportion of near-elderly insured is the non-retirees at 200-400% of the FPL (31%). Hence, the largest numbers of the uninsured near-elderly tend to be in the non-retirees in the lower or middle-income brackets.

Though 2.6 million of those Americans aged 55-64 are uninsured, 73.1% of all near-elderly Americans still maintain some type of employer coverage – but that coverage evaporates with increasing age. For example, according to the National Surveys of America's Families, employers increase coverage with age until age 45-54. Through that age group, employer coverage increases to the point where an employer covers 78% of their working population aged 45-54. The proportion of coverage an average employer offers declines to about 70% for the age group 60-64. The purpose behind this difference is not well-known, but several reasons could exist. There could be selectively higher premiums at this age group that price people out of the market because of a pre-existing condition (3), or some other health status issue. Also, employers could be increasing coverage for younger workers relative to their older workers. Finally, decreases in employer health coverage may be part of the general retiree benefit decline. For example, data from a Kaiser/Hewitt survey shows that large firms in general are decreasing their coverage of retiree health benefits (from 66% to 36% from 1998 to 2004) (4). The total percent of uninsured people aged 55-64 steadily rises from 5% before age 55, to 6% at age 55-59, and finally to 10% for age 60-64.

On the surface, 10% of an age group may not seem a large problem. However, it is important to note that not everyone who is insured in that group has reasonably affordable insurance. For example, studies of privately insured near-elderly have shown that the near-elderly – as they approach Medicare age – experience sharply rising premiums in the individual market (5). These studies have documented corresponding increases in health expenditures (50% between ages 45-54 and 55-64). Even those with adequate – but expensive – individually purchased insurance would benefit through lower premiums if they were allowed to participate in group plans. For example, a study from the National Medical Expenditure panel conducted in 2002 indicated that individual insurance pays on average 63% of the health care bill while group insurance covers 75%. Furthermore, at 200 percent of poverty (where half of those aged 55-64 fall) the top quarter of health care users with individual coverage would spend 11% of their income out-of-pocket while those in group coverage would spend 6%. In addition to an opportunity to provide better access to an age group, covering those aged 55-64 through a Medicare Buy-in option poses a unique opportu-

nity for increasing the quality, financing, and overall control of the Medicare program as further discussed below.

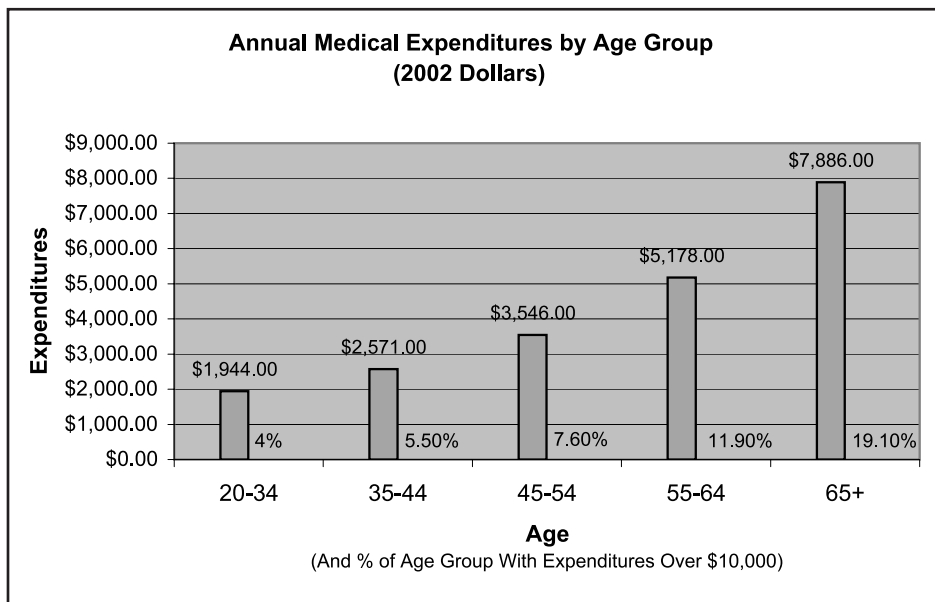
Adding potentially younger groups with less medical expenditures (see Figure 1) can spread risk (lowering premiums) and ease the transition into the type of chronic care that Medicare carriers are finally beginning to espouse. The episodic care that has so frequently followed from Medicare's coding system does not lend itself well to chronic issues and the skyrocketing costs of more developed medical technology (6, 7). At the age of 65, opportunities for starting on better chronic care have already begun to pass. For example, although CVD (coronary vascular disease – accounting for over 40% of all deaths in the United States) is more prevalent among those over 65, over one in six people with CVD is under age 65 (8).

Furthermore, having a younger and – for the most part – healthier population could create a better risk pool with lower premium costs. Besides getting a better handle on financial and medical concerns (e.g. CVD cost over \$350 billion in 2003) for the near-elderly, providing a Medicare Buy-in option could address certain administrative issues. For one, there would be a smoother transition into the Medicare program when those aged 55-64 turn age 65. In addition, incorporating a Medicare Buy-in option would do much to capture those 65 and older who fail to sign up for Parts B and (with the passage of the Medicare Modernization Act) Part D. In both instances, failing to sign up in time would result in premium increases that would follow the beneficiary for the rest of the time they were involved in the Medicare program.

Despite the potential benefits of a Medicare Buy-in option, there are significant hurdles. Most hurdles concern participation. If a Medicare Buy-in can spread risk and subsequently lower premiums, it will be attractive to most insurance programs. For the risk to be optimal, the healthier near-elderly beneficiaries would need to participate, because over 33% of uninsured near-elderly regard themselves in fair to poor health (which is bad for risk). However, such actions assume those aged 55-64 in better health who can participate will do so. Unfortunately, for many of those aged 55-64 who are insured, the incentive to participate is not very attractive given the coverage they receive from their employer (either retired or current). For example, of those insured working people aged 55-64, 78.5% receive coverage from their employer, and 83.3% of retired aged 55-64 have employer coverage as well. Only 8% of all aged 55-64 beneficiaries opt for private non-group coverage. Since only just over 10% of those aged 55-64 are uninsured, only 18% (10% uninsured plus 8% private nongroup coverage) of those aged 55-64 would ever likely experience better care or lower premiums from a Medicare Buy-in. Also, those aged 55-64 with higher incomes tend to have insurance and be in better health, while those in worse health tend to have less income and insurance (9). Hence, it will likely be the most risk-prone and least affluent population who will flock to a Medicare Buy-in, driving up risk and premiums – a problem known as adverse selection. Finally, the more risk-prone will in many cases be unable to afford the kind of investment that a Medicare Buy-in would entail if the same premium cost-sharing was flatly spread across all income levels. This last conclusion would probably mean that only the most medically desperate would ever invest in a Medicare Buy-in – contributing to the adverse selection problem and resulting premium rise discussed earlier.

Beyond the adverse selection issues, there also is the issue of considering what effect a Medicare Buy-in program will have on the available work force. Many of those aged 55-64 who are still employed choose to stay at their jobs only because of the health benefits (10). A Medicare Buy-in option could provide incentive for those aged 55-64 still employed to leave their work, dimin-

ishing the workforce of possibly valuable experience. In cases where employees, because of their age or other reasons, are no longer as productive as they previously were, then clearing work space for younger more capable employees could actually benefit the work force. However, no data exist to measure the impact of these two possible results on the workforce. In addition to possible effects on the workforce, this program's administration faces unique challenges. These challenges include the tracking of unemployed persons – difficult, especially for the Social Security Administration (which would probably administer the benefit). Also, there would be added administrative and regulatory costs involved if there is to be any subsidy provided to less affluent beneficiaries.



Source: John Holahan. Kaiser Commission of Medicaid and the Uninsured. Health Insurance Coverage of the Near Elderly. Report 7114. July 2004.

**Figure 1**

## Positions

**Position 1:** A Medicare Buy-in Program must include financing that assures that premiums and any subsidies are sufficient to fully cover expenses without further undermining the solvency of the Medicare trust funds.

The financial solvency of the Medicare program is already endangered. Medicare spending is projected to increase at an average rate of 7.5% per year from 2004 to 2013, except for 2006 when the increase will be much larger as Part D coverage for prescription drugs begins. HI trust fund spending jumped by 12% in 2004, as changes from the MMA were enacted, but thereafter are projected to increase at an annual rate of 6% until 2013 (11). A cash flow deficit for the Medicare HI Trust Fund started in 2004, and the fund is now estimated to be exhausted by 2020 (12).

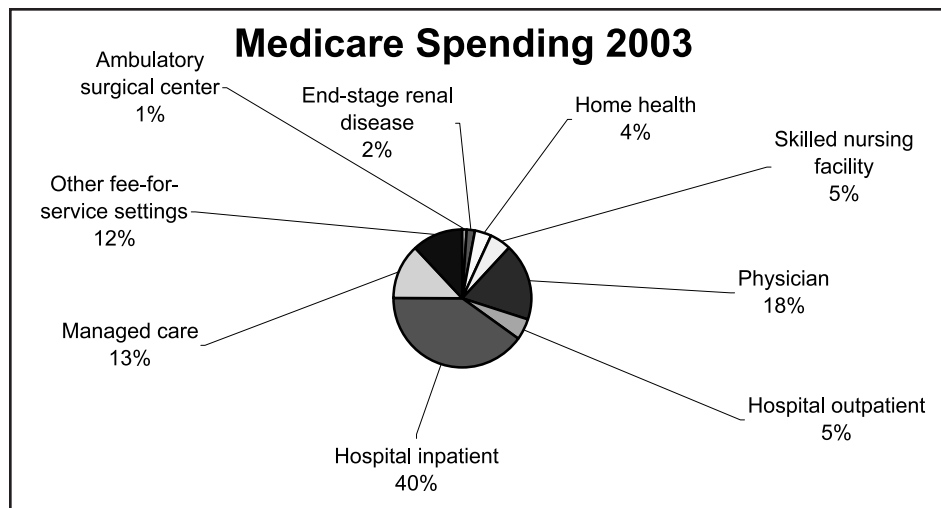
The Part B SMI Trust Fund is adequately financed over the next 10 years because of the automatic financing for Parts B and D from federal general and beneficiary premiums. However, the average annual increase in Part B pay-



ments is expected to increase substantially under current actuarial assumptions. SMI expenses will consume a growing percentage of all federal individual and corporate tax receipts, rising to more than 20% in 2020, almost 30% by 2030, and if unchanged, to more than 1/3 of all income taxes by 2040. A new Medicare Buy-In program for those under the current Medicare eligibility age must not further undermine the fiscal solvency of the Medicare program.

The Medicare program has seen mammoth increases in its scope, and subsequently in its budget since the program's 1965 inception – resulting in the budget issues discussed above. Most recently the Medicare Modernization Act (MMA) incorporated – among many high-priced projects – a drug benefit: Part D. The Congressional Budget Office estimate for Part D has ballooned from less than \$400 billion over ten years to now over \$850 billion between 2004 and 2015. This result is disturbing, because estimates for outpatient drugs will only reflect one of the smaller components of Medicare's total spending (which was \$272 billion for 2003 according to MedPAC). Though drugs will be important, beneficiaries will still have greater need for physician and hospital services. Physician services and hospital costs still consume the highest proportions and make up the bulk of Medicare costs (63%). And those components do not include Medicare's spending for managed care, skilled nursing facilities, home health, end-stage renal disease, and other fee-for-service (FFS) settings (see Figure 2).

These large expenditures are well-spent. The Medicare program has been in need of a drug benefit for many years. Also, services that Medicare-funded physicians and hospitals provide are valued by the American elderly and disabled. For example, data from the 2002 Medicare Current Beneficiary Survey shows that over 31 million beneficiaries were very satisfied while just over 4 million were unsatisfied with their Medicare general care. Furthermore, the survey showed that over 19 million are very satisfied with their doctor while only just over 5 million were unsatisfied. Such value is reflected in US medical care expenditures with the Medicare program spending about one in every five medical dollars. Given total healthcare spending of over \$1.34 trillion, such a portion is substantial. From these data, one can reasonably see that the Medicare program is already spending a considerable amount to do much in providing care for Americans.



Source: CMS, Office of the Actuary, 2004 Mid-Session Review, as reported in the Medicare Chartbook 2005, Medicare Policy Project, Kaiser Family Foundation.

**Figure 2**



The possibility of a Medicare Buy-in could present further financial strain on the Medicare budget. Medicare pays \$6,647 per enrollee, and adding 26 million near elderly (or just the 2.6 million uninsured near-elderly) would probably be too much for Medicare to bear without a new revenue stream. Hence, a Medicare Buy-in program must have financing that does not further threaten the solvency of Medicare Parts A (hospital), B (physician fees), Medicare Advantage (managed care), and Medicare Part D (the outpatient drug benefit).

There are not many possible sources of new funding that a new Medicare Buy-in program could take. Medicare managed care (Medicare Advantage - MA) plans could help to provide a vehicle for financing a Medicare Buy-in. Data has shown that more Americans (even those in the higher income brackets) are willing to sacrifice their choice of physician or hospital for lower expenditures (13). Between 2001 and 2003, the proportion of Americans with employer coverage willing to sacrifice choice for savings gradually rose from 55 to 59%. Hence, beneficiaries may be likely to participate in Medicare Advantage PPO's. Provisions in the MMA already do much to provide incentives for managed care companies to take up Medicare beneficiaries. Those incentives from the MMA to MA plans included up-front financing (\$10 billion through 2013), favorable risk corridors (catastrophic reinsurance), and a competitive bidding process that rewards efficiency with lowered premium costs to the plan from CMS. Managed care companies will have a direct interest in managing the risk at early stages to avoid adverse selection in later Medicare years. This practice will help to save on expenses, generating greater revenues to subsidize an MA plan's more expensive beneficiaries.

One possible solution for a Medicare Buy-in – proposed by Marilyn Moon of the Urban Institute (14) – could involve levying a tax on MA plans that seek to exclusively include those aged 55-64 with better health status, while excluding those aged 55-64 who have worse health status. Portions of the MMA explicitly forbid this behavior, but the restrictions apply to full Medicare beneficiaries and make no mention of those who may be participating in a Medicare Buy-in program. Furthermore, this process, in addition to financing the Medicare benefit for healthier, younger and more affluent beneficiaries could also help to subsidize those beneficiaries who might not be able to afford the premium charge or perhaps present less favorable risk.

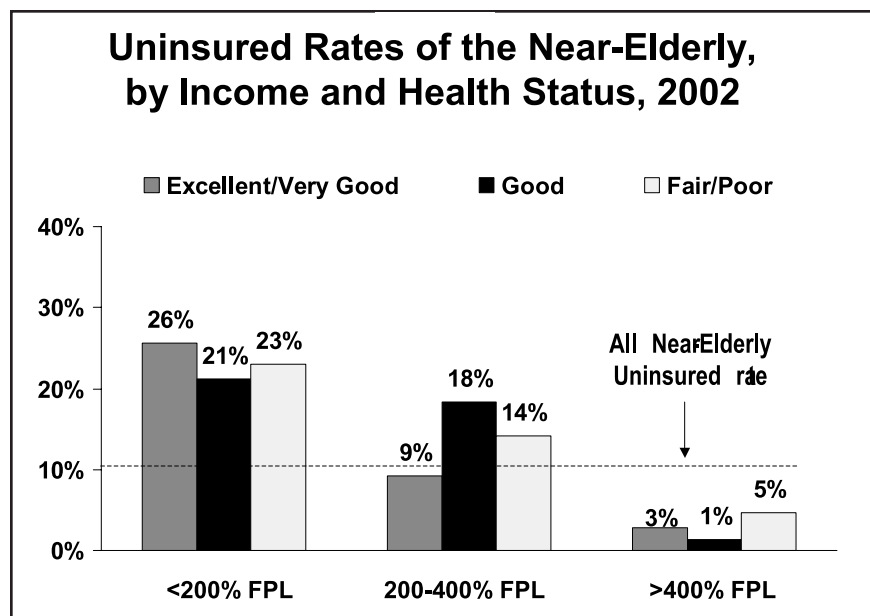
In addition to taxing Medicare Advantage plans, more funding could be derived from raising payroll taxes or from other federal revenue sources. Premiums might also be linked to income. While unattractive to the more affluent – as was the case for the Catastrophic Coverage Act of 1988 – this method would reduce premiums for middle and low-income beneficiaries. Partial funding could also be provided through tax credits to encourage those aged 55-64 to buy health insurance either through the Medicare Buy-in program or from private insurance. Tax credits could be on a sliding scale based on income, acting as extra incentive for either the individual (or the individual's employer) to participate. Also, these tax credits should be available for Medicare Advantage PPO's and individual private insurance plans. However, since private non-group insurance tends to cost more and deliver less (see Background), it is likely that most eligible recipients would choose to use the tax credits to buy Medicare coverage given complete information on both group and non-group coverage.

**Position 2:** A Medicare Buy-in Program should include subsidies for lower-income beneficiaries to participate.

About half of the near-elderly uninsured are below 200% of the Federal Poverty Level - FPL (2 X \$9,310 for an individual = \$18,620). The

Clinton/Gore proposal priced a Medicare Buy-in annual premium at \$3,000-\$4,000, and the current average annual Medicare expenditure is \$6,647 for all of the Medicare program's services. Hence, many of the low-income near-elderly not covered by Medicaid will need some assistance to buy into Medicare. If the government does not subsidize the cost as in Medicare Part B, the beneficiary (or their insurance) will probably be paying substantially more for the premium than beneficiaries over age 65.

Therefore, the new revenue streams for a Medicare Buy-in would need to address those in lower income brackets. This population must be addressed, because even though access to the Medicare program can present an opportunity for better risk (for younger and healthier members), it is those in the lower income brackets that will benefit the most. The members of those aged 55-64 at or below 200% poverty compose half of the uninsured and have poorer health status (please see Figure 3).



Percentages above bars refer to percent of uninsured near elderly in that income bracket (e.g. far left bar means 26% of near elderly below 200% of the FPL are in excellent or good health, but uninsured). Source: John Holahan. Kaiser Commission of Medicaid and the Uninsured. Health Insurance Coverage of the Near Elderly. Report 7114. July 2004.

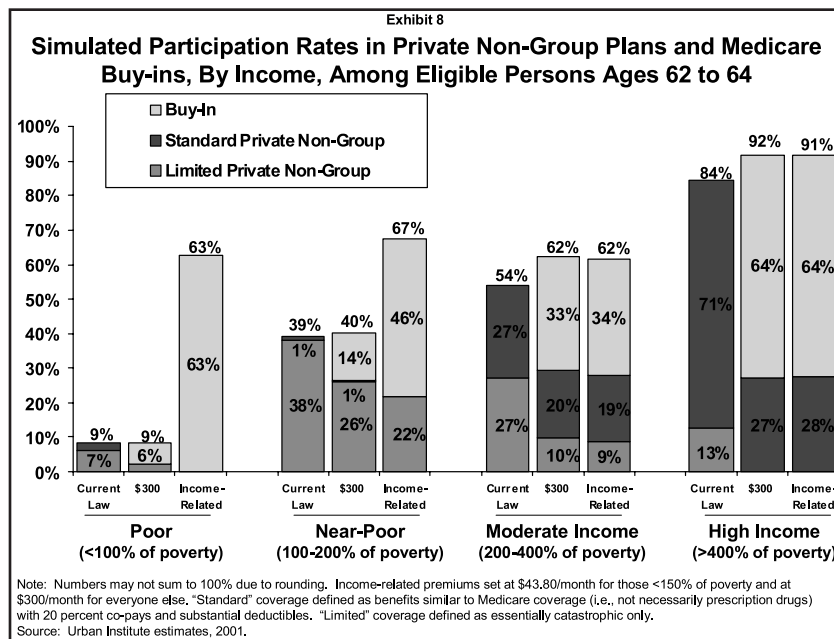
**Figure 3**

The American College of Physicians in its proposal for buying into the Federal Employee Health Benefits Program (FEHBP) has advocated that the program be targeted initially toward individuals and families with incomes 100-200% of the FPL. To be consistent and correct, policy for a Medicare Buy-in must follow this practice. Also, if tax credits are to be issued, ACP policy advocates that the subsidy be high enough for low wage workers to afford coverage.

Those near-elderly who are uninsured with poorer health status will only pose more of a care burden when they enter Medicare, because their chronic issues will be unaddressed. For example, only 59.3% of uninsured near-elderly manage to be able to see a doctor, compared to 87.7% and 84.2% of privately and publicly insured near-elderly respectively. Before getting a more regular source of medical care in the Medicare program, whatever chronic care issues

they have will be unaddressed and worsen, and expenditures will continue to rise for the beneficiary. Opportunities for prevention in chronic care should be pursued. For example, research has advocated that diabetes – a disease costing \$92 billion in direct medical costs (15) – be approached from a proactive public health perspective, rather than a reactive, traditional medical perspective. This proactive approach would stress the importance of early diagnosis and secondary intervention programs for prevention and early detection of diabetes complications. However, for these policies to be integrated into a Medicare Buy-in, there must be financial means.

Analysis shows that lower-income beneficiaries would likely respond positively to a Medicare Buy-in if the necessary subsidies were provided (16). Such analysis concludes that without subsidies, the Medicare program would only be reasonably attractive to uninsured and individually insured people above 200% of poverty. Other analysis, for ages 62 (age at which social security payments can first be drawn) to 64 showed similar positive participation when subsidies were included in a Medicare Buy-in (please see Figure 4). This analysis showed participation for low-income persons aged 55–64 as rapidly rising with income-based subsidies.



Source: Johnson RW, Davidoff AJ, and Moon M. A Medicare Buy-in for the Near-Elderly: Design Issues and Potential Effects on Coverage. Prepared for the Henry J. Kaiser Family Foundation. February 2002.

**Figure 4**

Less healthy near-elderly present an unattractive risk for many insurance companies. Hence, a tax levied against MA plans for picking the best risks, or subsidies for taking up such high-risk beneficiaries (as in the subsidizing of dual-eligible Part D premiums) may be necessary to bring managed care into the fold of a Medicare Buy-in. As discussed, though these expenditures are significant and probably will be difficult to bear, the trade-off will be in insuring that those individuals will be easier to treat (because their disease status will ideally not have advanced) once they reach Medicare age. Evidence from implementing Dr. Wagner's Chronic Care Model has shown the financial benefits that can come from more efficient prevention practices. For example, average

cost savings from the Chronic Care Model have been found in practice to be around \$200-\$500 per patient per year (17).

**Position 3:** Eligibility for a Medicare Buy-in Program should include adults age 55-64 regardless of their insurance status.

The literature on Medicare Buy-in proposals considers a variety of ages for possible Buy-in. Some research has looked at the 62-64 age range, because 62 is the age at which most Americans can begin withdrawing Social Security income (though at a penalty) (18). Other researchers have allowed that this range could be extended to the 60-64 range, because those who are 60 are not sufficiently different from 62 as to justify that cut-off point (19). Others – such as in the Clinton/Gore plan and Rep. Peter Stark’s Medicare Early Access Act – have suggested providing an option for Medicare Buy-in coverage for those retirees between 55-64. Some research has advocated the 55-64 age group, because they believe that even the “younger” aged 55-64 have an increasing amount of uninsured (who are hence in poorer health) due to the decreasing amount of retiree coverage from their employer (20). Data from the 2004 Kaiser/HRET Survey of Employer-Sponsored Health Benefits show that between 1988 and 2004, the proportion of employers offering retiree coverage declined from 66% to 36%. Furthermore, employer plans for the future are looking considerably bleaker. For example, in response to the Financial Accounting Standards Board (FASB) requirements of the 1990s, many firms are beginning to place caps on future retiree health benefits (21). Hence employees in their 50’s increasingly are becoming a group that would benefit greatly from a Medicare Buy-in option.

In trying to determine eligibility, the cost tends to be the driving factor. Those policy analysts advocating the more narrow age-range could easily point to the diminished cost from fewer beneficiaries (though health costs at older ages may lessen the savings – see Figure 1). Those advocating for wider ranges could claim that the premiums from the healthier population could pay the costs of the less healthy population. This latter supposition presents a greater weight now than it did when many of these analyses were being written before passage of the MMA. The Medicare Modernization Act and its provisions relating to quality of care represent new opportunities to examine the long-term care of patients. The Section 721 Chronic Care Improvement Program (scheduled for its initial phase in 2005) represents one such provision (22). With newer attention being given to long-term care in Medicare, it would behoove the program – when the opportunity presents itself – to address the needs of beneficiaries before diseases can become manifest. Hence, including beneficiaries between the ages of 55-64 in a Medicare Buy-in represents the better policy decision.

Previous analyses have also tried to address the question as to whether a Medicare Buy-in should be available only to those who are uninsured. This question arises, because addressing the uninsured is a key goal of health policy in general. As discussed earlier, the health insurance problems of those aged 55-64 extend also to those in over-priced private non-group insurance. Certain policy proposals have taken different directions on this matter. The Medicare Early Access Act provides retirees aged 55-64 who are without public or group health insurance, the option to purchase coverage under Medicare. Enrollees would receive the full range of Medicare benefits. Participants would not be required to exhaust employer-based COBRA coverage before choosing the Medicare Buy-in option. At age 65, Buy-in participants move into regular Medicare. Retirees who have access to retiree health coverage may also participate and their employers can wrap around the Medicare benefit. The Clinton/Gore proposal had similar provisions in terms of its age eligibility and COBRA policy, but the Clinton/Gore plan explicitly restricted Medicare Buy-in to those without insurance.

As discussed earlier, being more inclusive provides a good opportunity for continuity of care into the Medicare program, especially with regards to chronic issues. For example, the MMA recently introduced a “Welcome to Medicare” physical to provide screening to a beneficiary when they turn 65 to determine what needs the beneficiary may have for their medical care at the start of Medicare. Though the “Welcome to Medicare” physical provides an opportunity to examine a Medicare beneficiary at the beginning of their entry into the program, it could be of benefit to start earlier. Furthermore, those with insurance already have access to preventive services, and hence would presumably present better risk to the program (assuming they follow their physician’s guidance). Starting earlier in the Medicare program could extend (though not through its direct finances for its other components – see Position One) preventive chronic care that Medicare offers.

Though those in higher income brackets might not have the same incentive to switch over to Medicare as those who are uninsured or price-gauged (in private non-group insurance), it is important to consider that the employer is the payer in most cases of insured near-elderly. Hence, finding a way to bring the employer over to a Medicare Buy-in, without causing employers to discontinue providing existing health insurance coverage, may be the real challenge. For example, in the case of Part D, providing incentives for employers to take part – such as tax breaks on employer expenditures on actuarially equivalent drug plans – was necessary to bring employer support for the MMA’s Part D benefit. A similar approach may be necessary for Medicare Buy-in.

**Position 4:** Enrollment in a Medicare Buy-in program should be optional for eligible beneficiaries and should include the full range and responsibilities of Medicare benefits (Parts A, B, Medicare Advantage and Part D).

One of Medicare’s largest successes as an insurance program is that for the last 40 years it has been able to establish universal coverage for those Americans over age 65 and the disabled. Medicare enrollment in Part A is automatic and the vast majority of beneficiaries sign up for Part B. Participation in Medicare Advantage (formerly known as Part C) and the new prescription drug coverage under Part D is also voluntary. However, there are substantial penalties that can accrue to significant amounts if beneficiaries do not sign up for Part B or Part D when enrollment first becomes available.

Providing incentives for the majority to participate – or making it a requirement – has done much to cover those who would otherwise be uninsured while providing some degree of fiscally responsible risk management in the Medicare program. In its policy to achieve universally affordable health coverage, the College has also proposed automatic enrollment in government health care (SCHIP, Medicaid, etc.) to discourage enrollment in over-priced individual policies. However, the College has never advocated that expanding insurance coverage involve mandatory participation on those who could benefit. Hence, the American College of Physicians recommends that participation in a Medicare Buy-in be completely voluntary. Furthermore, such voluntary participation should not preclude those who participate in a Medicare Buy-in from receiving the full-range of Medicare benefits including access to all Medicare components, safety from balance-billing, screening benefits available from the MMA, and other required Medicare components.

This position might conflict with certain proposed aspects of Position One. For example, Position One proposed allowing MA plans to exclusively pursue healthier near-elderly in return for fees (in the form of higher taxes) Medicare could use to help finance a Buy-in program. Doing so would be in explicit conflict with MMA Section 222 concerning MA plans who discriminate based on



disease-status or other markers. If CMS allows an exception for MA plans who participate in Medicare Buy-in plans, the fees generated from taxes on MA plans with discriminatory practices must be sufficient to cover those who would be excluded from those MA-plans. Covering those beneficiaries would mean helping to finance – either in part or whole – entry into some type of Medicare Buy-in.

However, the College believes that those near-elderly who buy into Medicare should not only have a right to receive the full Medicare benefits package, but they should fully share the responsibilities as well. For example, a beneficiary who participates in a Medicare Buy-in should be required to pay some of the costs of Medicare Part A that can be attributable to their early enrollment, perhaps continuing to pay their share of FICA payroll taxes until the age of normal Medicare eligibility. The other components should be voluntary to the beneficiary with premiums assessed as they are in the full Medicare program.

## Conclusion

It is clear that there is a definitive population under age 65 that could benefit directly from participating in a Medicare Buy-in program. In order for this policy to be as useful as possible to as many as possible (on both the beneficiary and payer side), reasonable incentives will need to be in place for participation. These incentives are necessary, because without them only those who will actually use the insurance (the less wealthy and less healthy) will participate – driving risk to unreasonable levels. Incentives to participate in a Medicare Buy-in might best be marketable to employers, since they provide the majority of care among the insured near-elderly.

As mentioned earlier, employers were a key target in garnering enough support to pass the MMA with its Part D benefit. This support was aimed at getting employers to incorporate the Part D benefit, or something actuarially equivalent, into their retiree plans. Consequently the MMA provided for subsidies (premium support) for employers maintaining prescription drug coverage for their retirees. However, there was concern among employee unions that employers might lower benefits only to meet Part D standards and that employers would simply keep the payments and pass the remainder of the premium to the beneficiaries. Fortunately, the final rule saw a reasonable compromise that all sides could support. A Medicare Buy-in may face the same challenges from employee unions. In which case, there may need to be another discussion to make sure that employers are paying their fair share, while beneficiaries keep the quality of their plans.

In addition to the challenges of participation, there is also the aforementioned issue of financing. Medicare Advantage plans are not likely to be receptive to proposals to participate in and pay a tax for their beneficiaries– even with the better risk. Furthermore, asking the US federal government to spend in an environment that consistently sees expenditures as well as estimates rise will be difficult at best. The most likely avenue of financing – if a Medicare Buy-in is to exist – will most likely have to come through differential premiums based on income. Based on the fiasco of the failed Catastrophic Coverage Act of 1988 (which had a similar idea), most would conclude such an income-based premium to be very unlikely. However, the MMA – in addition to helping chronic care into the program – has helped usher income-related premiums for Part B. Hence, precedent exists for financing a Medicare Buy-in based on income. Such small triumphs for the promising future of the MMA may also bode well for the promise of early Medicare access: an investment for the future.

## Glossary

**CCA:** Comparative Cost Adjustment Program: Section 241 of the Medicare Modernization Act; 6 year demonstration competitive bidding program that puts Medicare fee-for-service in direct competition with Medicare Advantage plans for Medicare funding.

**CMS:** The Centers for Medicare and Medicaid Services: the component of the US Department of Health and Human Services responsible for administering Medicare and Medicaid.

**COBRA:** Consolidated Omnibus Reconciliation Act: offers workers and their families who lose their health benefits the option to continue group health benefits from their group health plan for limited time periods in certain cases including job loss, work hour reduction, job transition, death, divorce, and other life events. Qualified individuals could be required to pay the entire premium for coverage up to 102% of the plan's cost. COBRA usually requires group health plans sponsored by employers with 20 or more employees in the prior year to offer employees and their families the chance for a temporary extension of health coverage (continuation coverage) when the plan's coverage would otherwise end. COBRA outlines how employees and family members may elect continuation coverage (employers and plans must provide notice).

**Confounding Variable:** A factor associated with both a variable and its outcome; results in a distortion in the relationship between the variable and its outcome.

**FICA:** The Federal Insurance Contribution Act (FICA) requires employees to withhold two separate taxes from their checks: a social security tax and a Medicare tax. In addition, FICA requires that the employer pay an amount that matches their employees' portion of these taxes (unless the employees receive tips). The social security tax rate for employees was 6.2 percent and the Medicare tax rate was 1.45 percent for 2004.

**FFS:** Fee-for-service: refers to traditional Medicare indemnity coverage for beneficiary health expenses.

**HHS:** Health and Human Services: the principal United States government agency responsible for healthcare.

**HMO:** Health Maintenance Organization: organized health care systems that are responsible for both the financing (risk-bearing elements) and the delivery of a broad range of comprehensive health services to an enrolled population.  
**Medicare Part A:** The Medicare component – funded by the Federal Hospital Insurance Trust Fund – covering inpatient hospital, home health, skilled nursing facility, psychiatric hospital, and hospice care services.

**Medicare Part B:** The Medicare component – funded by the Federal Supplementary Medical Insurance Trust Fund – covering physician visits, outpatient services, some mental health services, durable medical equipment, some preventive services, and home health visits not covered under Part A.



**Medicare Part C:** The Medicare component – formerly known as Medicare + Choice and now Medicare Advantage – that offers expanded benefits through private health plans such as health maintenance organizations and preferred provider organizations (beneficiary must first have Parts A and B).

**Medicare Part D:** The Medicare component – funded through the Federal Supplementary Medical Insurance Trust Fund – covering outpatient prescription drugs (not covered under Parts A and B).

**MedPAC:** Medicare Payment Advisory Commission: an independent committee responsible for advising Congress on Medicare payment issues.

**MMA:** The Medicare Modernization Act (The Medicare Prescription Drug Improvement and Modernization Act of 2003; Public Law 108-173).

**MEPS:** The Medical Expenditure Panel Survey: is a national survey on the financing and utilization of medical care conducted in the United States (performed by the Agency for Healthcare Research and Quality).

**MA:** Medicare Advantage (see Medicare Part C).

**PPO:** Preferred Provider Organization: organizations that employer health plans and health insurance carriers use for purchasing health care services for beneficiaries from a selected network of participating providers.

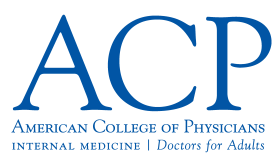
**Price Elasticity of Demand:** How much a consumer will want a product given a change in the product's price ( $\text{Percent Change in Demand} / \text{Percent Change in Price}$ ).

**SHIP:** State Health Insurance Programs: a network of programs – in all 50 states, DC, Guam, Puerto Rico, and the Virgin Islands – providing information, counseling, and assistance to Medicare beneficiaries.

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