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LOSS OF MEDICARE BUY-IN NOT THE MAJOR SETBACK SOME ASSUME

Strong Insurance Market Reforms Would Be More Effective in Promoting Competition

By Paul N. Van de Water

A recent proposal to allow people aged 55 to 64 to “buy in” to Medicare would have done relatively little to increase competition in the market for health insurance, and health reformers should not greatly mourn its removal from the legislation that the Senate is considering. In the absence of a robust public health insurance plan, legislators should instead focus on establishing strong market reforms, or “rules of the road,” to assure that insurers compete to lower prices and improve the quality of health care.

The pending health reform legislation would create a system of health insurance marketplaces, called exchanges, that would offer a range of competing private health insurance plans to individuals who lack access to employer-sponsored insurance as well as to small businesses. Plans would not be allowed to turn people away, charge higher rates because of their health status, or deny coverage for pre-existing conditions. Plans would have to meet certain minimum benefit standards, including a limit on the maximum out-of-pocket charges that an enrollee would have to pay in any year. Low-income people would receive a tax credit that would allow them to purchase a plan at an affordable price and cost-sharing subsidies to hold down their out-of-pocket costs.

In contrast, Medicare is the only game in town for most Americans age 65 and over. People earn Hospital Insurance coverage under Medicare by paying a payroll tax on their earnings during their working years. Medicare beneficiaries must pay premiums for physician and drug coverage, with the premiums covering about one-quarter of the cost and the rest being financed through general tax revenues. Most eligible people choose to participate in these voluntary parts of Medicare, because they are paying only a fraction of the cost of the benefit.

Medicare has been a great success and is highly popular among its beneficiaries.¹ Thanks to Medicare, health insurance coverage is almost universal for older Americans, the only major group in the population for which this is the case. The vast majority of health care providers participate in Medicare, which helps ensure that all beneficiaries have access to services. Over the years, Medicare

¹ Mark Blumenthal, “Who’s Afraid of Public Insurance? Health Care Consumers Give Medicare Higher Marks Than Private Plans,” *National Journal*, June 29, 2009.

has led the private sector in adopting new payment mechanisms to contain the growth of costs — including the prospective payment system for hospitals and fee schedules for physicians.² The independent Medicare Payment Advisory Commission (MedPAC) reviews the program’s payment rates to assure that they are adequate to cover the costs of efficient providers.³ Traditional Medicare also incurs lower administrative costs than other forms of health insurance.⁴

In the absence of broader reforms to extend coverage to the uninsured, allowing older people to purchase (or “buy into”) Medicare coverage has much to recommend it as an incremental improvement. It would provide the value of group coverage through Medicare to older adults, particularly those who cannot obtain affordable, comprehensive coverage on their own in the flawed individual market. For example, in its budget for fiscal year 2001, the Clinton Administration proposed to allow two groups of older workers to buy into Medicare: people aged 62 to 65 who do not have employment-based or public health insurance, and a limited number of unemployed workers aged 55 to 61. The benefits would have been fully financed by premium payments, but participants would have been eligible for a tax credit equal to 25 percent of their premium costs.⁵

In the context of comprehensive health reform, however, as one option within the exchange, a Medicare buy-in *loses much of its attraction*. Under the proposals now before Congress, people aged 55 to 64 would have guaranteed access to health insurance through an exchange, in which they would be pooled with younger people, or through Medicaid, which would be expanded to cover most everyone with income below 133 or 150 percent of the poverty level.⁶ Older enrollees in the exchange could be charged no more than three times as much as the youngest enrollees (no more than two times as much under the House bill), a much lower ratio than is typically charged in insurance markets today. In addition, if they have low or moderate incomes, they would be eligible for the same subsidies as other low- and moderate-income participants in the exchange.⁷

Issues in Designing a Medicare Buy-In in a Health Insurance Exchange

Recently, Senate Democratic leaders considered making Medicare an option for people aged 55 to 64 within the health insurance exchanges, an idea they have now dropped. The proposal was never fully fleshed out, but integrating Medicare into the health insurance exchanges would have posed many difficult issues.

² Rick Mayes and Robert A. Berenson, *Prospective Payment and the Shaping of U.S. Health Care* (Baltimore: Johns Hopkins University Press, 2006).

³ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2009, pp. 35-41.

⁴ *Administrative Solutions in Health Reform*, National Academy of Social Insurance and National Academy of Public Administration, July 2009, pp. 64-5.

⁵ Paul N. Van de Water, “Improving Health Coverage Before Medicare,” in Randall W. Eberts and Richard A. Hobbie (eds.), *Older and Out of Work: Jobs and Social Insurance for a Changing Economy* (Kalamazoo, MI: W.E. Upjohn Institute for Employment Research, 2008).

⁶ The Medicaid expansion would not cover people over age 65 or those receiving Medicare on account of a disability.

⁷ Edwin Park, *House Health Reform Bill Would Help Ensure Affordable, Quality Coverage for Older Adults Aged 55-64*, Center on Budget and Policy Priorities, November 2, 2009.

In its simplest form, a Medicare buy-in would give people aged 55 to 64 the choice of purchasing Medicare at a price that would cover the full cost of the coverage. By some estimates, that price might amount to about \$7,500 a year, including drug coverage. Unlike regular Medicare, the price of the Medicare buy-in would presumably vary regionally, as would the prices of other plans in the health insurance exchanges.

Medicare likely would cost *more* for people aged 55 to 64 than other plans offered in the exchanges because it would cover *only* people age 55 and over — *its risk pool would not include younger people, who tend to be healthier and less costly*. Medicare’s lower administrative expenses and lower payment rates to health care providers would offset some, but probably not all, of the higher costs stemming from its older, less healthy risk pool. A buy-in proposal could include some mechanism to eliminate that competitive disadvantage by transferring money from other insurance plans in the exchange to Medicare. Doing so, however, would invite charges that private plans were being forced to subsidize Medicare and probably could not survive politically.

Even if a way were found to offset Medicare’s likely price disadvantage, a *Medicare buy-in likely would have difficulty competing with other insurance plans because of limitations in its benefit package*. In particular, Medicare lacks “catastrophic” coverage: it places no limit on a beneficiary’s annual out-of-pocket expenses. Many beneficiaries consequently purchase supplemental private coverage, known as “Medigap,” to supplement their Medicare coverage.⁸ In contrast, plans offered through the exchange would be required to include out-of-pocket limits, which both the Senate and House health bills would establish.

Fitting Medicare into the system of health insurance exchanges would raise many smaller issues as well. People aged 55-64 who have children or spouses *below* age 55 would be unlikely to participate in the buy-in, since Medicare would not cover the entire family. Also, consumers could find it difficult to make an informed choice among insurance plans, since the Medicare benefit package would not be comparable to that of other plans in the exchange. In addition, since Medicare offers many different drug plans whereas other plans in the exchange would each have a unique drug benefit, it might be necessary to designate a particular Medicare drug plan as the standard for the 55- to 64-year-old age group. Finally, since the Medicare buy-in would be available only to older adults, it would fragment the risk pool in the exchange and place greater pressure on the exchange’s risk-adjustment system, which is designed to assure that health insurance plans do not benefit from efforts to attract healthier enrollees and deter sicker ones.

With enough time, it might have been possible to resolve all these issues and design a Medicare buy-in that could compete effectively with private plans in the health insurance exchanges. More likely, however, a Medicare buy-in for the 55- to 64-year-old age group would have labored under handicaps that would have prevented it from attracting enough enrollees to provide an effective check on private insurers.

⁸ Medicare’s prescription drug benefit does provide coverage against catastrophic drug costs, but only after a beneficiary has incurred \$4,550 in out-of-pocket drug costs (in 2010).

The Importance of Proper Regulation of the Exchange

Even with a Medicare buy-in or other robust public option, effective health reform requires adequate rules and regulations for the health insurance exchanges along with reforms of the health insurance market. The absence of a public option makes strong exchange rules and market reforms even more essential. Consumers must have guaranteed access to stable, adequate health benefits, and insurers must be spurred to compete on the basis of the price and quality of their products, not on their ability to attract healthier enrollees and deter sicker ones.⁹ The rules and regulations in the exchange are far more critical to achieving these goals than the presence or absence of a Medicare buy-in.

As health policy expert and Pulitzer Prize-winner Paul Starr has recently written, “Giving the exchanges the necessary authority to regulate private insurers could solve many of the problems that motivated the public option in the first place.”¹⁰ The House bill is substantially superior to the Senate bill in these respects because it would create the needed, strong standards for health plans and apply them broadly to help protect consumers and ensure that insurers treat people fairly. A new report by the Committee for Economic Development makes a number of useful recommendations for improving the health insurance exchanges in the Senate bill.¹¹

⁹ Sarah Lueck, *Rules of the Road: How an Insurance Exchange Can Pool Risk and Protect Enrollees*, Center on Budget and Policy Priorities, March 31, 2009; Lueck, *Designing Benefit Standards for a Health Insurance Exchange*, May 21, 2009.

¹⁰ Paul Starr, “Fighting the Wrong Health Care Battle,” *New York Times*, November 29, 2009.

¹¹ Alain Enthoven and others, *Making Exchanges Work in Health-Care Reform*, Committee for Economic Development, December 16, 2009.