



Health Care Access for Older Adults

The Urgent Need for a Medicare Buy-In Option

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Executive Summary

Millions of older Americans have lost their health care coverage because they have been laid off, forced into early retirement, or because their employer has canceled coverage. Millions more Americans between the ages of 55 and 64 are denied coverage, or lack affordable coverage, or because they are self-employed, unemployed, or work at small firms not offering group health coverage. In total, more than 4 million adults ages 55 to 64 lack health insurance. And with a disproportionate number of older workers out of work or working part-time due to the economic downturn, these numbers will only increase in the near future.

Although a majority of these uninsured men and women are in the workforce, more than 80 percent are not offered employer-sponsored coverage, nor are they eligible for public coverage. Their only option is the non-group insurance market where many are denied coverage or find the

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monthly premium to be unaffordable. Denial rates for adults age 60-to-64 are three times higher than for adults 35-to-39, typically due to a pre-existing medical condition. The average premium in the non-group market is more than 20 percent of median income, for an individual, and more than 40 percent of median household income for family coverage. And while older adults who recently lost their jobs can purchase continuing coverage under COBRA, it is typically limited to 18 months and requires a payment of 102 percent of the total premium cost of the employer's plan (at an average cost of \$4,800 for individual coverage and nearly \$13,400 for a family in 2009). Despite the fact that the prevalence of chronic conditions and serious illness rises dramatically for adults over age 55, this lack of access and affordability leaves more than 10 percent uninsured and many others financially stressed.

While the health care reform bill signed into law this year would mitigate this worsening problem somewhat, it will be too little and too late. The proposed legislation will give an individual lacking access to employer-based group coverage the ability to purchase insurance through a purchasing exchange governed by critical insurance reforms: Insurers will no longer be able to deny coverage, or charge far higher rates, based on pre-existing medical conditions. However, this regulated and subsidized coverage will not be available for purchase through local exchanges until at least 2014. And, even then, insurers can charge older adults a premium that is up to *three times* the level charged to younger adults.

Today's older citizens cannot wait four years for a system that is not designed to ensure affordable coverage for the pre-Medicare population. Older Americans desperately need both a humane bridge to this new system – as well as a nationwide, guaranteed choice to buy coverage that can sustain them seamlessly into the traditional Medicare system when they turn 65. Public opinion has overwhelmingly and steadily supported expanding Medicare access to adults aged 55 to 64. Kaiser/Harvard School of Public Health polls have shown a consistent 75 percent level of support among voters between 2000 and 2008.

The most promising option is to allow adults age 55 and older to buy Medicare coverage. Opening the Medicare system as an option for older adults offers five critical benefits:

- Guaranteed access to coverage at reasonable rates
- Continuity of coverage, better outcomes and lower Medicare costs after age 64
- The efficiency of using an existing, low-cost and well-understood program
- Affordability relative to the non-group market
- Small firms could facilitate enrollment and even contribute to the cost

Access could be limited, as the Exchanges will be, to individuals without access to an employer-sponsored or other group health plan that is actuarially equivalent or superior to Medicare. Although it would be good policy to make available the same means-tested subsidies that will later apply to coverage purchased through the Exchanges (once the larger health reform bill is fully implemented), even an option to pay an unsubsidized premium would provide a beneficial option and needed alternative to the non-group insurance market.

Applying the same means-tested subsidies that will be available for coverage purchased through the Exchanges is preferable not only because it would provide access to lower-income older adults most in need of affordable coverage, but also because an unsubsidized premium (which CBO estimated to be roughly \$634 per month for individual coverage in 2011) could encourage adverse selection

and spiraling premiums over time if only the oldest and least healthy among the over-55 population enroll. Other options could help to make the premium more affordable without imposing an uncontrolled cost on taxpayers. One is varying the premiums by age and geography. Another option, first proposed by Senator Daniel Patrick Moynihan and the Clinton administration, is to recoup a share of the cost of premium subsidies over time by requiring some enrollees to add a surcharge to their much lower Medicare Part B premium beginning at age 65.

Ironically, although Medicare buy-in could be structured not to increase net Medicare spending, the status quo definitely inflates Medicare expenditures. Studies consistently show that individuals who are uninsured for prolonged periods during the years just prior to Medicare eligibility experience considerably worse health outcomes and use more services (and more expensive services) than people who were insured during the years before Medicare eligibility.

There is a large and growing population of near-elderly adults who are uninsured or spending 10 to 20 percent or more of their income on over-priced and often dangerously inadequate non-group health plans. It is unconscionable for Congress and the Administration to fail to address this need, particularly when it's clear that majorities in both the House and Senate, as well as among the American people, support opening access to Medicare at least for adults 55 and older who lack employer-based coverage.



Health Care Access for Older Adults

The Urgent Need for a Medicare Buy-In Option

I. Introduction and Background

Aside from children and the disabled, older adults not yet eligible for Medicare comprise the population most vulnerable to a lack of affordable health insurance, particularly the substantial proportion with chronic medical conditions. Millions of older Americans have lost their health care coverage because they have been laid off, forced into early retirement, or because their employer has canceled coverage. Millions more between the ages of 55 and 64 are denied coverage, or lack affordable coverage, because of pre-existing conditions, or because they are self-employed, unemployed, or work at small firms not offering group health coverage. In total, more than 4 million adults ages 55 to 64 lack health insurance.

Although a majority of these uninsured men and women are in the workforce, more than 80 percent are not offered employer-sponsored coverage, nor are they eligible for public coverage. Their only option is the non-group insurance market where many are denied coverage or find the monthly premium to be unaffordable. Denial rates for adults aged 60 to 64 are three times higher than for adults 35 to 39, typically due to a pre-existing medical condition. The average premium in the non-group market is more than 20 percent of median income, for uninsured individuals, and more than 40 percent of median household income for family coverage.

While the health care reform legislation signed into law this year promises to mitigate this worsening problem somewhat, it will be too little and too late. Health reform will give individuals lacking access to employer-based group coverage the ability to purchase insurance through an Exchange governed by critical insurance reforms: Insurers will no longer be able to deny coverage, or charge far higher rates, based on pre-existing medical conditions. However, this regulated and subsidized coverage will not be available for purchase through local

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exchanges until at least 2014. And, even then, insurers can charge older adults a premium that is *three times* the level charged to younger adults. Moreover, while the health reform bill creates a \$5 billion Retiree Reinsurance Trust Fund to help mitigate the cost of high claims for employers that maintain coverage for early retirees, this does nothing for older adults who simply lack access to affordable coverage.

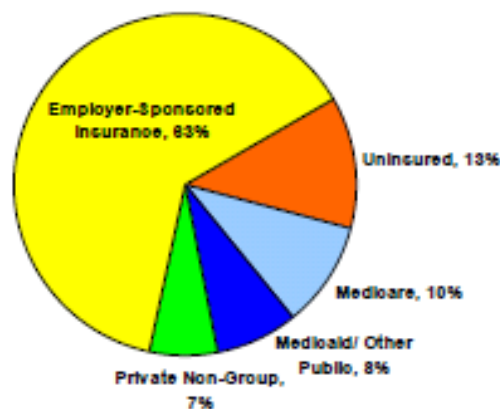
Today’s older citizens cannot wait four years for a system that is not designed to ensure affordable basic coverage for the pre-Medicare population. Older Americans desperately need both a humane bridge to this new system – as well as a nationwide, guaranteed choice to buy coverage that can sustain them seamlessly into the traditional Medicare system when they turn 65. Public opinion has overwhelmingly and steadily supported expanding Medicare access to adults aged 55 to 64. Kaiser/Harvard School of Public Health polls have shown a consistent 75 percent level of support among voters between 2000 and 2008.

The most promising option to immediately address the access and affordability crisis facing a growing number of older Americans is to allow adults age 55 and older to buy Medicare coverage. Access could be limited, as the Exchanges will be, to individuals without access to an employer-sponsored or other group health plan that is actuarially equivalent or superior to Medicare. Although it would be good policy to make available the same means-tested subsidies that would apply to coverage purchased through the Exchanges (once the larger health reform bill is fully implemented), even an option to pay an unsubsidized premium would provide a beneficial option and needed alternative to the non-group insurance market.

There is a large and growing population of near-elderly adults who are uninsured or spending 10 to 40 percent or more of their income on over-priced and often dangerously inadequate non-group health plans. It is unconscionable for Congress and the Administration to fail to address this need, particularly when it’s clear that – taken as a stand-alone issue – majorities in both the House and Senate, as well as among the American people, support opening access to Medicare at least for adults 55 and older who lack employer-based coverage.

Figure 1

Health Coverage for Adults 55-64, 2008



34.3 M Adults 55-64

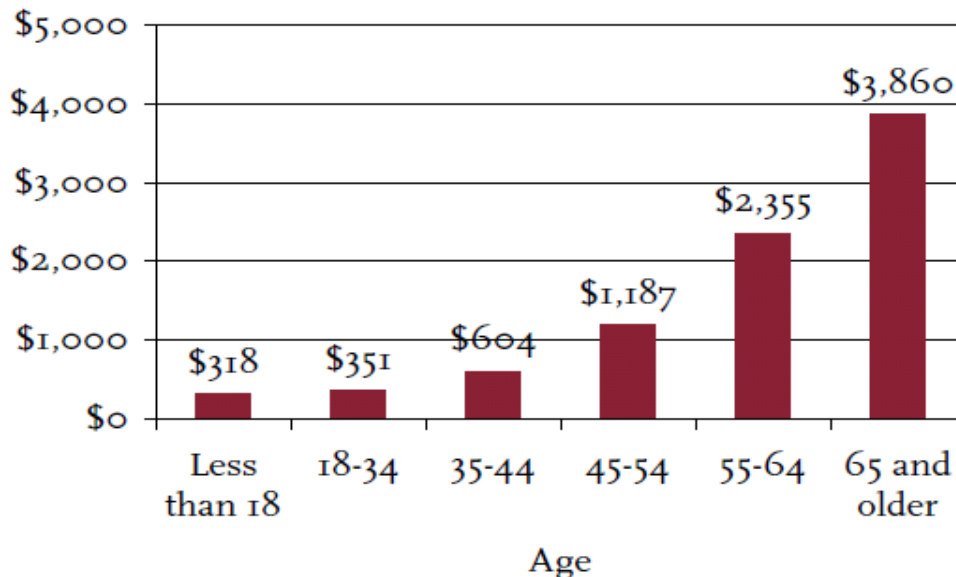
(Source: Kaiser Family Foundation (2009) from KCMU/Urban Institute analysis of 2009 ASEC Supplement to the Current Population Survey.)

II. Older Adults Lack Affordable Options for Health Coverage

Older adults present a policy paradox: Since rates of insurance increase with age, only about 13 percent of Americans age 55 to 64 lack coverage; and yet both the health and financial risks of losing group health coverage is far more acute for this age group than any other. More than one in five in this age group suffer from *two or more chronic conditions* – and are generally at far greater risk of a life-threatening or disabling illness than younger workers. This is reflected in the fact that *median annual health care costs are more than four times higher for adults 55 to 64 than at ages 35 to 44* (see Figure 2 below).¹ Older adults are also incredibly dependent on employer coverage for health insurance, with 69 percent covered through their own or their spouse’s firm. However, this means that the loss of a job, or the cancellation of early retiree health coverage, can have a devastating impact on both the health and financial security of an older worker and his or her family.

While adults over 55 are more willing to pay the higher costs associated with non-group coverage – since their need for insurance is so much greater – as a group they also face high rejection rates and increasingly unaffordable premiums and out-of-pocket costs. Just as the nation has faced up to the need to expand affordable public insurance for children and people with disabilities, there is a compelling case for a government program to ensure affordable health care access for the 55-to-64 pre-Medicare population.

FIGURE 2. MEDIAN ANNUAL HEALTH CARE COSTS, BY AGE, 2004



Source: R.W. Johnson, “What Happens to Health Benefits After Retirement,” CRR (2007), author’s calculations from 2007 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

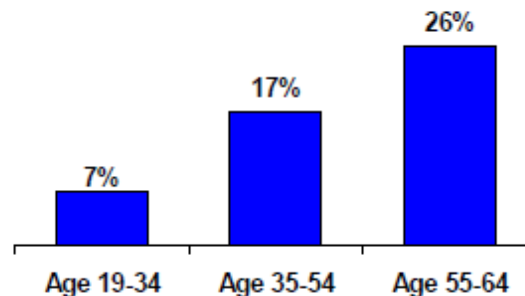
A disproportionate share of uninsured adults 55-to-64 are in poor health

Access to affordable and quality health insurance is a pressing concern for the nation's 35 million aging baby boomers. Because the prevalence of chronic medical conditions and serious illness rises steeply for individuals over age 50, older Americans incur far higher health care costs. For example, the Agency for Healthcare Research and Quality reports that average total health care expenditures for persons age 55 to 64 were more than twice as high in 2007 (\$7,400) as for persons age 25 to 44 (\$2,985).² Expenditures by the typical older adult (median) was more than twice as high (see Figure 2 above), as were average out-of-pocket expenditures.

A lack of access to affordable health insurance is a particularly serious problem for this population because the risk of serious and costly illness increases dramatically over the age of 55. According to a John Hopkins University study, 70 percent of 50- to 64-year-olds have been diagnosed with one or more chronic health conditions, with more than half suffering from two or more chronic conditions. Average total health spending for an adult with two chronic conditions is more than three-and-a-half times as high as for an adult with none. Twenty percent of pre-Medicare adults over age 50 also report limitations in one or more activities of daily living, which is also strongly associated with higher health costs and risk.³

Unsurprisingly, the uninsured among older adults report the worst health status and outcomes. Uninsured adults age 55 to 64 are more than twice as likely to be in poor or fair health than their peers with continuous employer-based or other private group-plan coverage.⁴ Among poor older adults, roughly half report poor or fair health, compared to one in five among non-poor and insured older adults. About four in ten uninsured older adults have not seen a doctor in the past 12 months and more than one in four receive no preventive care.⁵

Percent of Uninsured Adults in Fair or Poor Health by Age, 2008



Source: Kaiser Family Foundation (2009); data from KCMU/Urban Institute analysis of 2008 ASEC Supplement to Current Population Survey.

Nationally representative surveys show that uninsured adults over age 55 are at much greater risk of premature death compared to their insured peers.⁶ One major national survey by Harvard Medical School professors, published in *Health Affairs*, concluded that the number of premature deaths among older adults attributable to a lack of health insurance coverage may exceed 30,000 *per year* by 2015.⁷ The study's findings stated:

[M]ore than 105,000 excess deaths in the next eight years (more than 13,000 annually) may be attributable to the present lack of insurance coverage among the near-elderly. This estimate would place uninsurance third on a list of leading causes of death for this age group, below only heart disease and cancer. This rapidly growing age group is expected to more than double to 61.9 million (about 20 percent of the U.S. population) by 2015. Taking this growth into consideration and assuming a stable uninsurance rate (13 percent), ***the annual number of excess deaths attributable to the lack of health insurance may exceed 30,000 by 2015***, more than the combined number of deaths attributable to stroke, diabetes, and lung disease in this age group.

Medicare costs are higher among enrollees who lacked continuous coverage

Among other impacts, this uninsured and substantially less healthy cohort ultimately imposes far higher costs on the Medicare program after they turn 65 and finally have greater access to delayed care. Ironically, although a buy-in option for near-elderly adults could be structured so that it does *not* increase Medicare spending overall, the status quo *is definitely* causing higher Medicare expenditures. Studies consistently show that among the near-elderly population, those who are uninsured for prolonged periods during the years immediately prior to Medicare eligibility experience considerably worse health outcomes and use more services than those who were insured.⁸ This is well-documented among uninsured near-elderly adults with chronic conditions, particularly cardiovascular disease and diabetes. After older, uninsured adults with these conditions qualify for Medicare at age 65, they are substantially more likely to be hospitalized and to impose greater costs on the system than those who were previously insured.⁹

Among the uninsured pre-Medicare population, extended periods without coverage is not uncommon. Among uninsured 50- to 64-year-olds, four in ten have been uninsured more than three years.¹⁰ One study of 7,235 older adults by a team of Harvard Medical School researchers found substantial improvements in health outcomes after previously uninsured older adults gained access to Medicare at age 65. For example, the researchers found that for every 100 uninsured adults with heart disease or diabetes before age 65, with Medicare coverage they had 10 fewer major cardiac complications, such as heart attack or heart failure, than would be expected by age 72.¹¹

The Harvard study confirmed earlier research, published by the authors in the *New England Journal of Medicine*, which suggested that uninsured adults entering Medicare end up costing the health system more in annual medical spending after age 65, in particular from increased physician visits for untreated chronic conditions.¹² The uninsured with chronic conditions impose higher costs on Medicare not just initially, but for seven years on average until their health status becomes more like their previously insured and treated peers. "Our findings have important policy implications," the authors note in the Harvard study. "Providing earlier health insurance coverage for uninsured adults, particularly those with cardiovascular disease or diabetes, may have considerable social and economic value for the United States by improving health outcomes," as well as by reducing costs within the traditional Medicare program.

Growing numbers of Americans age 55-to-64 have no access to a group health plan

The majority of uninsured adults age 55 to 64 are still working. But because a disproportionate number of older adults work part-time, are self-employed, work for small businesses, or were pushed into early retirement without continuing coverage, just 20 percent of the uninsured have any access to group health coverage.¹³ For 80 percent, the only option is to purchase individual coverage in the non-group market.

Overall statistics showing that only 13 percent of adults aged 55-to-64 are uninsured obscures the vulnerability of the pre-Medicare population to unwelcome changes in their employment or health status. While older adults are the age group most dependent on employer-based coverage, rates of full-time employment drop sharply from 60 percent among 55-to-61-year-olds, to 35 percent for 62-to-64-year olds.¹⁴ At the same time, as discussed further below, the share of employers offering health coverage to early retirees has dropped dramatically and steadily over the past two decades. And although a majority of uninsured 50-to-64-year-olds are employed, as they age their employment status is more likely to leave them without coverage. According to an analysis of Census data by the AARP Public Policy Institute, among the uninsured over age 50:

- More than one-third work for small employers with fewer than 25 employees.
- Roughly 26 percent work part-time or only part of the year.
- Nearly one in four are self-employed.
- By age 64, more than 40 percent report being out of the workforce and retired.¹⁵

In addition, even among older workers with full-time jobs and employer-paid benefits, the current economic downturn has made this situation far worse, as many laid-off older workers have been pushed into involuntary early retirement, or have been unable to find new full-time employment with affordable health coverage. Each of these scenarios leaves Americans 55 and older the age group most dependent upon a dysfunctional, predatory and overly-expensive non-group insurance market.

Employer-based coverage for early retirees has dropped dramatically

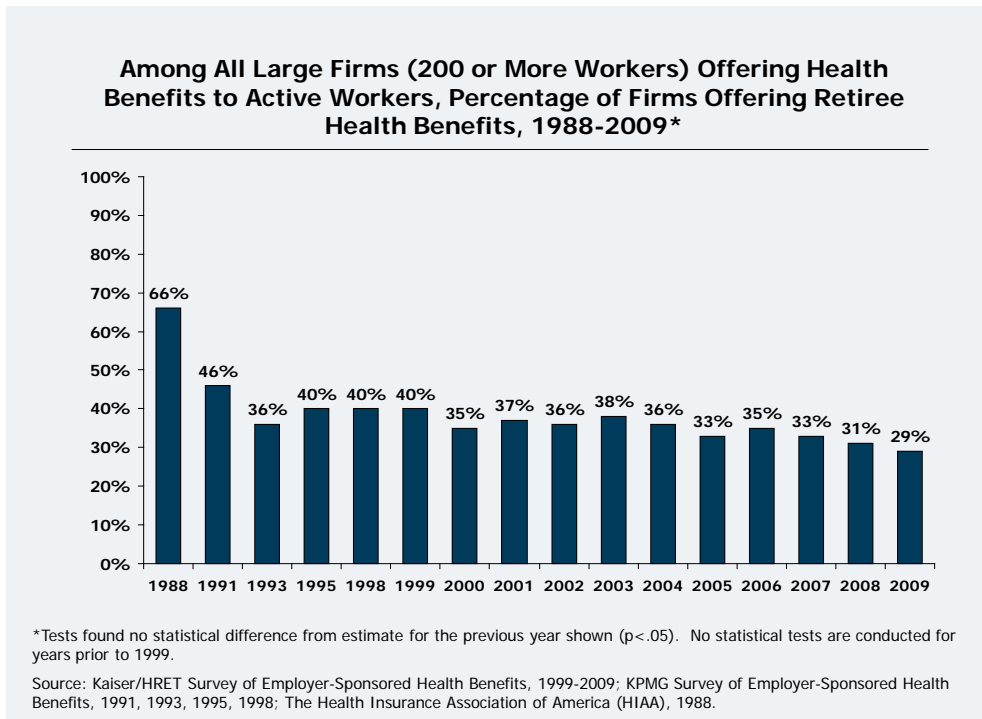
While the overall uninsured rate at ages 55 to 64 is not unusually high, it could worsen significantly if there is a renewed wave of firms dropping health coverage for early retirees. Today nearly one in five Americans in this age cohort relies on retiree health benefits from their former employer (14%), or their spouse's former employer (5%), for coverage as of 2004 (see Figure 1 above).¹⁶ While a majority of workers who retire before age 65 continue to receive employer-based coverage, the share of employers offering early retirement benefits has fallen dramatically over the past two decades, while the share of costs shifted onto the retiree has risen dramatically.

One recent report, by the Center for Retirement Research at Boston University, concluded:

Although millions of older Americans still rely on retiree health benefits from former employers to help pay their medical expenses, coverage appears to be slowly disappearing,

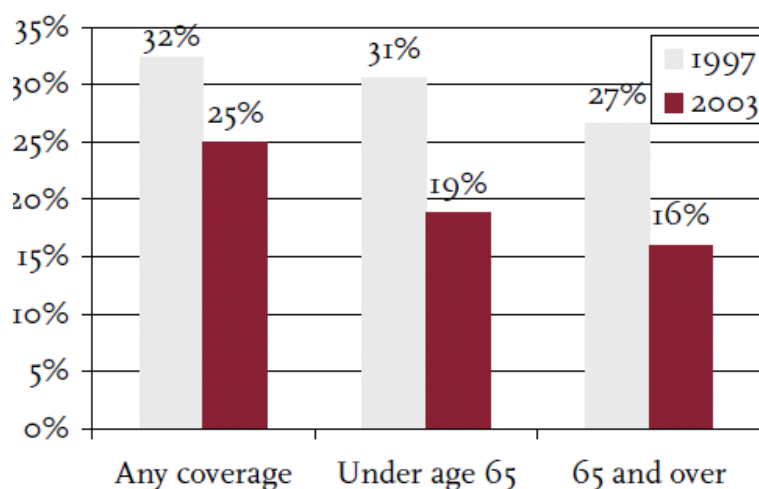
possibly jeopardizing retirement security for future generations. As health care costs rise, the workforce ages, and global competition intensifies, many employers seem to be concluding that they can no longer afford to offer subsidized health insurance to retirees.¹⁷

The initial sharp drop in retiree health coverage occurred in the early 1990s and is largely attributed to an accounting rule change requiring firms to show the full future cost of promised retiree health benefits as liabilities on their balance sheets.¹⁸ Among private firms with 200 or more employees, the share offering any retiree health insurance fell from 66 percent in 1988 to 29 percent in 2009, according to Kaiser Family Foundation surveys (see chart below).¹⁹ The Mercer survey of employer-sponsored health plans charts a similarly steep drop off, from 46 percent in 1993 to 27 percent and falling in 2008.²⁰ Only 4 percent of firms with fewer than 200 employees offer retiree health coverage.²¹



The drop-off in firms offering continuing coverage has substantially increased the share of early retirees with no access to group health coverage. Between 1997 and 2003, the share of private sector workers employed at firms offering health benefits to early retirees (under age 65) dropped more than a third, from 31 to 19 percent.²² Although many of those losing coverage decide not to retire early as a result, the continuing erosion of employer-based coverage for those who cannot sustain full-time employment until age 65 leaves more individuals and families subject to the non-group market. While it appears that the one-third share of early retirees without access to coverage from their former employer has remained fairly stable in recent years, the overall number of uninsured retirees increased to 913,000 in 2007 and is higher today.²³

PERCENT OF PRIVATE SECTOR WORKERS AT FIRMS OFFERING
RETIREE HEALTH BENEFITS BY COVERED AGE GROUP: 1997, 2003



Source: Center for Retirement Research (2007)²⁴

These trends, combined with the greater dependence of older workers on employer-based group coverage, take on added significance in light of the large numbers of workers who report being pushed involuntarily into retirement (or part-time work) far sooner than they had planned. According to the comprehensive the latest (2009) *Retirement Confidence Survey* conducted each year by the Employee Benefit Research Institute, there is a huge disparity between the planned and actual retirement age of older workers.²⁵ While only 26 percent of older workers in EBRI's Survey said they planned to retire from full-time work before age 65, in fact 72 percent actually retired before age 65 (35 percent before age 60). The Survey report concluded:

The *Retirement Confidence Survey* has consistently found that a large proportion of retirees leave the work force earlier than planned (47 percent in 2009). Many retirees who retired early cite negative reasons for leaving the work force before they expected, including health problems or disability (42 percent), changes at their company, such as downsizing or closure (34 Percent), and having to care for a spouse or another family member (18 percent). Others say ... outdated skills (13 percent) played a role. ... but just 10 percent offer only positive reasons.

The consequence of an unplanned early retirement can be heavy. Retirees who retire earlier than planned are more likely ... to say they are *not* confident about having enough money for basic expenses in retirement.²⁶

Of course, a major factor in this sense of retirement insecurity among a majority of older Americans forced to leave full-time employment before age 65 is the high and unpredictable availability and cost of health care coverage until they reach the rather arbitrary but 'golden' age of 65 – and Medicare eligibility.

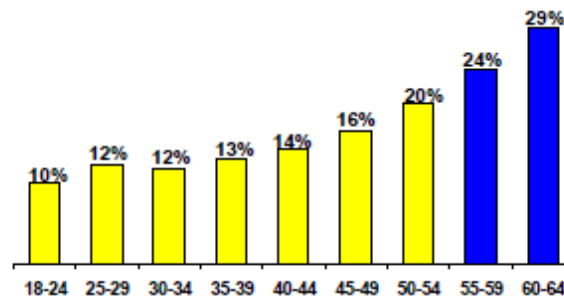
Rejection Rates and Unaffordable Premiums limit access to the non-group market

While the vast majority of older workers and early retirees today retain access to employer-based plans, those who do not – and who don't qualify by financial hardship or disability for public plans – must rely on the individual market for insurance coverage. However, as the Senate Finance Committee stated in its 2009 paper outlining options to expand health coverage, the market for individual health coverage has failed to meet the special and growing needs of the vulnerable older adult population:

In the individual market, many people who have health problems are denied coverage or are offered policies that exclude coverage for preexisting conditions. Because older people are sicker, people ages 55 to 64 tend to have greater difficulty obtaining insurance in the individual market than their younger counterparts do. Additionally, many private employers face high legacy costs associated with providing health insurance to early retirees. However, these companies are forced to continue to provide retiree coverage as the non-group market is not a viable option.²⁷

The non-group market is particularly problematic for workers and early retirees over 55 because in most states insurance companies can refuse to provide coverage to individuals with chronic and other pre-existing medical conditions, or can charge premium rates far higher than employers pay in group markets. According to the insurance industry's own survey, denial rates in 2006 were three times greater for those 60 to 64 years old (29%) than for those age 35 to 39 (10%).²⁸ As the chart just below indicates, denial rates for non-group coverage by age worsen dramatically over age 50, with more than one-fourth of all 55-to-65 year olds who seek coverage denied access.²⁹ Many who are not outright denied coverage must purchase insurance subject to an "elimination rider" that requires them to pay all of the costs for pre-existing conditions (such as diabetes or high blood pressure) out of pocket. AHIP reports that 10 percent of non-group plans offered to adults 55 and over were subject to such a rider.

**Denial Rates for Non-Group Coverage
by Age Group, 2008**

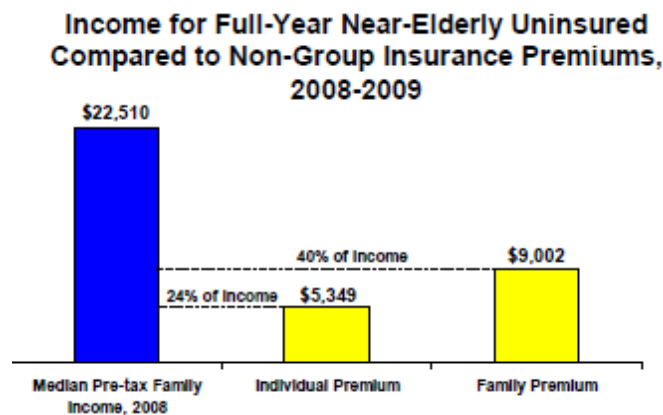


Source: Kaiser Family Foundation (2009), based on survey data from America's Health Insurance Plans (AHIP)³⁰

Even when access is not denied, non-group coverage is unaffordable for far too many older individuals and families. According to the AHIP survey noted above, the average annual premium for an individual 55 to 64 (\$4,800 in 2007) is more than double the cost of the same coverage purchased by an adult under age 55 (\$2,600).³¹ Based on AHIP’s premium data, the Kaiser Family Foundation estimates that individual non-group premiums would consume nearly a quarter (23%) of average pre-tax family income, while family coverage would consume 40 percent.³² Because insurers can charge far higher premiums based on both age and health, studies have found that the same insurance product can be 14- to 17-times as expensive. For example, one study by the Commonwealth Fund found that while a healthy 25-year-old male could buy a \$2,500-deductible policy for \$624 per year, an unhealthy 63-year-old eligible for coverage through the high-risk pool would pay \$10,800 for similar benefits (with an \$1,800 deductible).³³

On top of high premiums, the higher deductibles and other out-of-pocket costs associated with non-group plans take a far higher and often unsustainable percentage of family income for older adults than for any other group. Average out-of-pocket spending on health care is more than twice as high among older Americans buying coverage in the individual market compared to those with employer coverage. According to a study by AARP’s Public Policy Institute, two-thirds of adults over age 50 purchasing coverage in the non-group market spent at least 10 percent of their disposable family income on health, three times as much as those with employer-based coverage.³⁴ And since more than half of uninsured adults age 55 to 64 live in households with incomes below 200 percent of the federal poverty line (about \$28,000 for a couple in 2008), a majority are priced out of the non-group market from the start.

The number of older Americans facing catastrophic health care costs – and often bankruptcy – is rising sharply and most common among those with non-group insurance coverage. For example, the share of adults age 55 to 64 spending more than one-third of their income on health care increased from 6 percent in 1998 to 9 percent in 2002.³⁵



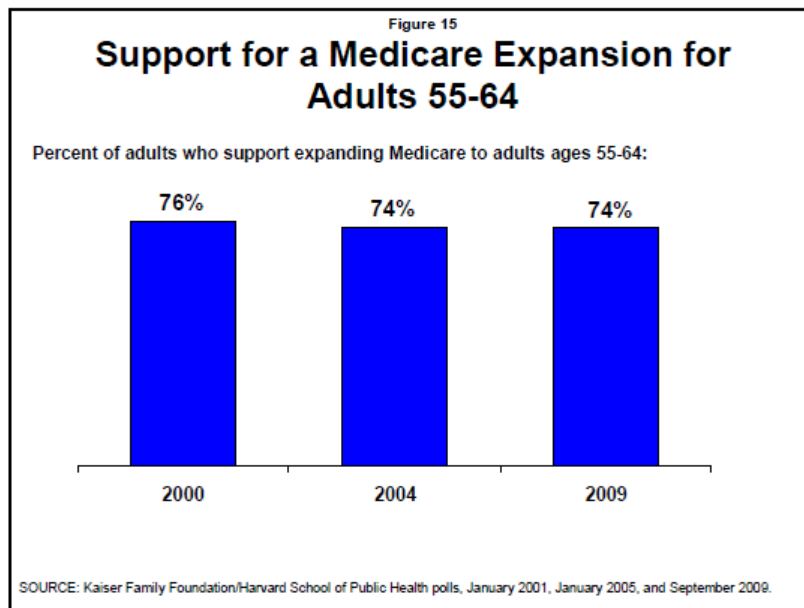
Source: Kaiser Family Foundation, using premiums from AHIP 2009 Survey of Premiums, Availability and Benefits³⁶

COBRA is not an affordable or long-term option

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) required employers with health plans and more than 20 employees to continue covering laid-off workers on a temporary, non-subsidized basis. While older adults who recently lost their jobs can purchase continuing coverage under COBRA, coverage is typically limited to 18 months and requires a payment of 102 percent of the total premium cost of the employer's plan. The average cost of continuing coverage under an employer-sponsored plan in 2009 was \$4,800 for individual coverage and nearly \$13,400 for a family, according to a Kaiser Family Foundation survey.³⁷ As part of the recent economic stimulus, the American Recovery and Reinvestment Act of 2009 provided a temporary 65 percent subsidy on these premium costs for laid-off workers, but that nine-month program ended after 2009.

III. Medicare Buy-In Proposals

Opening Medicare as a voluntary option for older, uninsured Americans is by no means a new idea. For over a decade the public has overwhelmingly supported expanding Medicare access to adults aged 55 to 64. Kaiser/Harvard School of Public Health polls have shown a consistent 75 percent level of support among voters between 2000 and 2008 (see chart just below). This is undoubtedly one reason why many different proposals and bills in Congress to expand Medicare for this age group, either on a subsidized or on a budget-neutral basis, have been put forward by senior members of Congress, as well as by leading health policy experts and advocacy groups. Senators Max Baucus and Jay Rockefeller, who respectively chair the Senate Finance Committee and its Subcommittee on Health Care, have supported buy-in as an interim measure, until health insurance purchasing exchanges are available (Baucus), or introduced legislation to enact Medicare buy-in apart from the overall health reform effort (Rockefeller). Senior House Democrats have also endorsed the approach, none more so than Rep. Pete Stark, Chairman of the health subcommittee of the House Ways & Means Committee, who introduced his Medicare Early Access Act beginning in the 105th Congress and has been a leading proponent since.



Even if the health reform bills passed by the House and Senate in late 2009 ultimately become law, it will be another three or four years or more before state health insurance purchasing Exchanges

offer group coverage to uninsured older adults. And, even then, under the Senate bill insurers can charge older adults a premium that is *three times* the level charged to younger adults. Today's 55-to-64-year-old population cannot wait four years for a system that is not even designed to ensure affordable coverage. Older Americans desperately need both a humane bridge to this new system – as well as a nationwide, guaranteed choice to buy coverage that can sustain them seamlessly into the traditional Medicare system when they turn 65.

The advantages of giving adults age 55 to 64 the ability to buy into Medicare are clear considering the negatives of the current system summarized above. The most obvious benefits include:

Guaranteed access to coverage at reasonable rates: Unlike the non-group market, the uninsured 55 and older would be guaranteed coverage without discrimination or limitations due to pre-existing medical conditions. While premium costs would need to reflect the average cost of care for people in this age category, they would be as low as they could be considering the Medicare system's very low administrative costs (as a percent of claims) and lack of marketing expense. For example, a current Medicare buy-in option available to individuals 65 and older who don't qualify because of work history costs about \$550 a month, which would not be affordable for the poor or near-poor, but which is still considerably less costly than the private individual market, especially for individuals with pre-existing medical conditions. Partial subsidies from current or former employers, states, or federal sources could reduce this further while still taking advantage of Medicare's relatively low overall cost basis.

Continuity of coverage, better outcomes and lower Medicare costs: As noted above, adults over 55 who experience long periods without health insurance generally end up in poor health and impose higher costs on the traditional Medicare system once they enroll at age 65. This is particularly true for the roughly half of uninsured older adults who live with two or more chronic medical conditions. A lack of preventive and ongoing care for this population also imposes other costs on families and on society as a whole, as it leads to reduced work hours and productivity, earlier retirements and more people desperate to qualify for other public programs (Medicare and Medicaid) based on disabilities and bankruptcies that could have been avoided through more affordable and continuing coverage.

The efficiency of using an existing, low-cost and well-understood program: Uninsured older Americans can be given almost immediate access to relatively affordable and seamless coverage without the creation or administration of a new public program. The marginal administrative costs of adding additional age cohorts would be relatively small and may even bring down the per participant cost for the overall system. Likewise, doctors, hospitals, pharmacies and other health providers would not need to implement any new or costly administrative procedures to participate.

Senator Baucus summarized well the broader, often-overlooked benefits to society and to the Medicare system in his November 2008 white paper on health reform, "A Call to Action: Health Reform 2009":

Providing immediate assistance to the Americans aged 55 to 64 would benefit not only individuals in this age group, but the Medicare program overall. An option for those 55 to 64 to buy into Medicare could enable individuals to remain healthy and continue working, prevent disabling conditions, and provide protection from catastrophic medical costs. It

would also help to ensure that individuals would not experience a break in coverage during this age period, which could lead to improved health status upon Medicare eligibility at age 65. The Medicare program might also benefit through reduced costs for this population relative to what might have been spent³⁸

While public and Congressional support for the concept is solid, a number of important issues concerning the program's cost and design remain to be addressed.

Affordability: A Medicare buy-in policy could be subsidized to ensure affordability for the lower-income uninsured, or it could be "budget neutral" by charging a premium actuarially estimated to cover actual cost. As noted, a current Medicare buy-in option available to individuals 65 and older who do not qualify because of work history costs about \$550 a month; and CBO has estimated that a budget-neutral buy-in for the oldest pre-Medicare population (age 62 to 64) would be approximately \$630 a month in 2011 (including the cost of drug coverage through Medicare Part D).³⁹ Although \$7,600 in annual premium would be a welcome option for many early retirees and others age 55 to 64 who face even higher costs for comparable coverage in the individual insurance market (if they can get it at all), it would be unaffordable for at least the half of the uninsured population this age who live in households with income below 200 percent of the federal poverty line. Financing a Buy-in option is discussed further below.

Eligibility: Most recent proposals by Congressional leaders (including Baucus, Rockefeller and Stark) would offer the buy-in option to individuals aged 55 to 64 who currently do not have access to either an employer-sponsored or public sector group plan. Some proposals require that individuals first exhaust their COBRA coverage, although the high cost of paying 102 percent of the employer's cost could amount to an 18-month insurance gap for a substantial portion of workers 55 and older who are laid off or forced into early retirement without employer-subsidized coverage. A more difficult issue is whether to provide access as well for a spouse younger than 55 who also lost coverage and lacks access to group plan coverage. Medicare itself is strictly based on individual eligibility (based on age and work history), although the rationale is that eligibility is based on individual workers contributing 2.7 percent of wages up to age 65 via the Medicare payroll tax. A spouse who paid 100 percent of his or her actuarial cost would not be subsidized.

Employer Access: Most proposals would prohibit either individuals or firms with employer-sponsored plans from buying into Medicare in order to reduce costs. The rationale is two-fold: that this could undermine employer-sponsored insurance and, particularly if Medicare buy-in is subsidized for lower-income people who need coverage, companies could shift costs onto the federal government, making the program substantially more expensive. While this reasoning holds for employers already offering health care to their older employees and/or early retirees, small businesses not currently offering coverage present a different balance. Since any contribution from those firms toward the cost of coverage would not 'crowd out' group plan coverage, it would make sense to encourage smaller employers to facilitate enrollment and even contribute to the cost (perhaps through a partial matching tax credit to the firm, as this would leverage private sector contributions toward more affordable coverage).

Financing a Medicare Buy-In Option

As noted above, while the option to buy into Medicare would benefit Americans age 55 to 64 in general, access without regard to affordability will only address a fraction of the problem. Applying the same means-tested subsidies that will be available for coverage purchased through the Exchanges is preferable not only because it would provide access to lower-income older adults most in need of affordable coverage, but also because an unsubsidized premium (which CBO estimated to be roughly \$630 per month for individuals age 62 to 64 in 2011) could encourage adverse selection and spiraling premiums over time if only the oldest and least healthy portions of the over-55 population enroll. This will be even more important if, as it should, Medicare buy-in includes the same annual and out-of-pocket catastrophic cost limits that will apply to private insurance sold through the exchanges. At a minimum, enrollees could face the additional cost of supplemental ‘medigap’ insurance, just as a majority of Medicare recipients who lack employer-provided retiree health benefits do today.

Although fiscal realities may necessitate no or low subsidies, at least initially, it is also useful to consider that employer-provided health insurance is heavily subsidized through the tax code. A premium reduction equal to the average tax subsidy paid today by the federal government for employer-based health care would reduce the cost of Medicare buy-in by 30 to 50 percent – and by more if the subsidy was limited to eligible enrollees earning less than 200 percent of poverty. Because employer payments for health insurance premiums and related benefits (such as cafeteria plans) are not taxable as income, the federal subsidy alone is as high as 55 percent (for an individual or family in the top tax bracket). Not only is health compensation free of federal (and typically state) income tax, but it also escapes the 15.2 percent payroll tax (FICA) that is assessed on all other wage income – including 401(k) plan deposits – to finance Medicare and Social Security. These “tax expenditures” to subsidize employer-based and self-employed health coverage cost the federal government alone \$232 billion in 2008 (\$138.5 billion in lost income taxes and \$93.5 billion in lost payroll taxes).⁴⁰

It would take only a tiny fraction of this cost to make a Medicare buy-in substantially more affordable on a means-tested basis. The best approach would likely be the same sliding-scale tax credit adopted in the House or Senate health reform bills to ensure that premium costs for coverage sold through the Exchanges do not exceed a certain percentage (roughly 10 percent) of an individual’s or family’s income. Under the option outlined by the Senate Finance Committee last year, the tax credit would be available for individuals (single or joint filers) with modified adjusted gross income (“MAGI”) between 100 and 400 percent of the federal poverty level (FPL). The tax credit would be in the form of a “premium subsidy” that would help offset the cost of purchasing health insurance. It would be paid directly from the Treasury to the Medicare program, provided that the individual paid his or her share as well.

There are other options that could help to make a Medicare buy-in premium more affordable without imposing a new and unpredictably costly entitlement cost on taxpayers. Some legislative proposals would vary Medicare buy-in premiums by age and geography, which might at least make a budget-neutral approach correspond more accurately to the actual distribution of costs. A more promising option, first proposed by Senator Daniel Patrick Moynihan and the Clinton administration, is to recoup a share of the cost of premium subsidies over time by requiring

enrollees above a specified income level to add a surcharge to their much lower Medicare Part B premium beginning at age 65.

IV. Recommendation and Conclusion

More than two-thirds of workers and early retirees aged 55 to 64 have access to employer-provided health insurance coverage. But millions of other older Americans without access to group health coverage are denied insurance, or lack affordable coverage, because of pre-existing conditions, or because they are self-employed, unemployed, or work at small firms not offering health benefits. Increasing numbers of early retirees, who counted on promises of continued company coverage, have lost it. In total, more than 4 million adults ages 55 to 64 lack health insurance. Their only option is the non-group insurance market where many are denied coverage or find the monthly premium to be unaffordable.

A Medicare ‘buy-in’ option for the uninsured age 55 and older is a modest, incremental and low-cost way to address this growing problem. It does not create a new public program, but gives an almost equally vulnerable group the option to participate in the very cost-effective Medicare system that is already in operation. The concept can be shaped to accommodate different fiscal and health reform scenarios. A Medicare buy-in can be budget-neutral – requiring participants to pay a premium equal to the expected average cost of benefits – or it can provide subsidies on a means-tested basis, which would make it affordable to a far larger share of the uninsured pre-Medicare population. It can be enacted either on a temporary basis, until a similarly guaranteed and affordable option is available, or as a permanent option for the pre-Medicare population, which would promote seamless coverage into old age. It can be limited to only those without access to a group plan – whether through an employer, former employer or the public sector – or it could be opened to small-to-medium sized employer plan groups as well.

While the health care reform bill that is now law would mitigate the dilemma faced by uninsured older Americans, the regulated and subsidized coverage available for purchase through state Exchanges would not be available until at least 2014. Today’s older citizens cannot wait years longer for a system that is not designed to ensure affordable coverage for the pre-Medicare population. Older Americans desperately need both a humane bridge to this new system – as well as a nationwide, guaranteed choice to buy coverage that can sustain them seamlessly into the traditional Medicare system when they turn 65. Public opinion has overwhelmingly and steadily supported expanding Medicare access to adults aged 55 to 64.

The NRLN strongly urges Congress and the Administration to immediately address this access and affordability crisis for a growing number of older Americans by allowing adults age 55 and older to buy Medicare coverage. Access could be limited, as the Exchanges will be, to individuals without access to an employer-sponsored or other group health plan that is actuarially equivalent or superior to Medicare. Although it would be good policy to provide the same means-tested subsidies that would apply to coverage purchased through the proposed state insurance Exchanges, even an option to pay an unsubsidized premium would provide a beneficial option and needed alternative to the non-group insurance market.

Applying the same means-tested subsidies that will be available for coverage purchased through the Exchanges is preferable not only because it would provide access to lower-income older adults most in need of affordable coverage, but also because an unsubsidized premium (which CBO estimated to be roughly \$634 per month) could encourage adverse selection and spiraling premiums over time if only the oldest and least healthy portions of the over-55 population enroll. This will be even more important if, as it should, Medicare buy-in includes the same annual and out-of-pocket catastrophic cost limits that will apply to private insurance sold through the exchanges.

It is unconscionable for Congress and the Administration to fail to address this need, particularly when it's clear that – taken as a stand-alone issue – majorities in both the House and Senate, as well as among the American people, support opening access to Medicare at least for adults 55 and older who lack employer-based or other group plan coverage. The Medicare system is in place; there is no reason not to open this option to older Americans no later than next January 2011.

ENDNOTES

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¹³ G. Jacobsen, K. Schwartz and T. Neuman, "Health insurance Coverage for Older Adults: Implications of a Medicare Buy-In," Kaiser Family Foundation, Focus on Health Reform series (December 2009), at p. 7.

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