

CRS Report for Congress

Received through the CRS Web

Medicare Expansion: President Clinton's Proposals to Allow Coverage Before Age 65

Bob Lyke, Beth C. Fuchs, and Jennifer O'Sullivan
Specialists in Social Legislation
Madeleine Smith
Consultant
Education and Public Welfare Division

Summary

President Clinton has proposed allowing people ages 62 through 64 to buy into Medicare if they do not have access to employer-sponsored or federal health insurance. Displaced workers ages 55 through 61 generally would also be allowed to buy in if they lost employer-sponsored insurance. In addition, retirees ages 55 and over whose former employers terminated or substantially reduced retiree health insurance would be permitted to extend their COBRA coverage (defined on page 6) until age 65. The proposals have been introduced as H.R. 3470 (Representative Stark) and S. 1789 (Senator Moynihan).

The President's proposals would help people in these age groups obtain health insurance. While most of them already are covered by employment-based, government, or private non-group plans, nearly one in seven is uninsured. Many without coverage find that private non-group insurance is too expensive or, if they have pre-existing medical conditions, unavailable. However, the cost of buying into Medicare (estimated to be \$300 to \$400 a month) or continuing COBRA coverage may also exceed what most uninsured can afford. Questions have been raised about whether Medicare buy-ins would result in costs to the federal government and whether Medicare should be expanded in light of the anticipated insolvency of the Part A trust fund. Some argue that legislative action should be deferred until the issue is considered by the National Bipartisan Commission on the Future of Medicare. Proponents argue that the proposal is largely self-funded and is needed now to address a growing problem.

Background

Population Characteristics. Most people ages 55 through 64 have health insurance. **Table 1** shows that in 1996 about 68% of people ages 55 through 61, and 60% of people ages 62 through 64, had employment-based insurance as their primary coverage either

directly or as a dependent spouse. Employment-based insurance includes plans for active workers, retiree health plans, and COBRA continuation coverage. About 5% of the younger group and 9% of the older group had primary coverage under Medicare (due to disability or kidney disease), while about 4% of both groups had primary coverage under Medicaid (due to disability or caring for a Medicaid-eligible child). Private, non-group insurance was primary coverage for about 9% and 11 %, respectively.

About one in seven persons in these age groups had no health insurance in 1996 (13% of those ages 55 through 61 and 16% of those ages 62 through 64). Our analysis shows that 25% of the uninsured were poor and that 35% were neither employed nor the dependent spouse of an employed person — characteristics that would make it unlikely one could pay much for insurance.

Table 1. Primary Health Insurance Coverage, 1996

Type of coverage	Ages 55-61		Ages 62-64	
	Number	Percent	Number	Percent
Employment-based: own coverage	7,991	51.0%	2,586	44.6%
Employment-based: dependent coverage	2,579	16.5%	875	15.1%
Medicare	764	4.9%	496	8.5%
Private, non-group	1,378	8.8%	624	10.8%
Medicaid	657	4.2%	216	3.7%
Veteran's, military health	232	1.5%	103	1.8%
Uninsured	2,072	13.2%	902	15.5%
Total	15,673	100.0%	5,802	100.0%

Source: CRS analysis of the March 1997 Current Population Survey (CPS). Numbers are in thousands.

However, almost half of these uninsured people had family incomes more than twice the 1996 poverty threshold (i.e., over \$16,326 for a single person and \$21,128 for two). Moreover, many had ties to the workforce. Among uninsured people ages 55 through 61, 33% were employed full time and 12% were the dependent spouse of full time workers. An additional 27% were part-time workers or the dependent spouse of a part time worker. Among uninsured people ages 62 through 64, 16% were employed full time, 19% part-time, and 14% were a dependent spouse of a worker. Among the uninsured with some labor force attachment, over half in both age groups were employed or the spouse of employees working for firms with fewer than 25 employees. Small firms generally are less likely to provide health insurance to their workers.

Among people ages 62 through 64, the uninsured rate increased from 12% to 16% between 1990 and 1996. Those without insurance were more likely to be full time employees or their dependents in 1996 than in 1990, and more had incomes at least twice the poverty level. There was no appreciable change in the uninsured rate among people ages 55 through 61. (Among all people under age 65, the uninsured rate rose from 16% in 1990 to 18% in 1996.)

Obtaining health insurance can be a serious problem for older people who are not yet eligible for Medicare. Average health care expenses of insured people in their early 60s

are twice those of people in their 40s; they are three times those of people in their early 20s. While employment-based insurance spreads these costs over all workers in the same plan, private non-group insurance premiums generally reflect the higher risk attributable to the policyholder's age and health status. (In the few states that require community rating, these costs would be spread among all individual policyholders.) Thus, it is not unusual for people in their late fifties and early sixties without group coverage to face annual premiums of \$4,000 to \$6,000. If they have not had recent insurance coverage, in most states they could be charged more or even denied coverage.

Prior Legislation. Congress has enacted legislation that provides some assistance. The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) requires that all individual policies be guaranteed renewable, regardless of the health status or claims experience of the enrollees, unless the policyholder fails to pay the premium or defrauds the insurer. It also requires that individuals who recently had group coverage be offered health insurance without restrictions for pre-existing conditions. However, the Act allows states to comply in a variety of ways. It does not limit what insurers may charge for these policies, leaving that regulatory authority to the states. Some states have established high-risk pools for people who are hard to insure, but even their premiums can be adjusted for age, and they may be as high as two times the average premium charged for individual policies outside the risk pool.

To help retirees maintain employment-based coverage, Congress has allowed COBRA eligibility upon retirement and special COBRA extensions if employers file for chapter 11 bankruptcy (see page 5). Congress has also provided tax benefits for advanced-funded retiree health plans (including 401(h) and voluntary employees' beneficiary association (VEBA) plans); however, statutory restrictions and record-keeping requirements have limited their attractiveness. Employers that do not advance fund retiree health plans can still deduct expenses as benefits are paid, just as they can deduct expenses for active workers. Nonetheless, many employers question whether they can continue the current level of benefits in the face of steadily rising health care costs and the Financial Accounting Standards Board requirement (FAS 106) that future post-retirement benefit obligations be recognized currently in financial statements.

Expanding Medicare Eligibility

Current Law. Medicare provides health insurance coverage for virtually all persons age 65 and older. In addition, it provides protection, regardless of age, for persons who receive social security disability benefits (after a 24-month waiting period) and for most who need a kidney transplant or renal dialysis. Medicare consists of two parts: the Hospital Insurance (Part A) program is paid for by payroll taxes imposed on current workers and their employers, while the Supplementary Medical Insurance Program (Part B) is financed by monthly premiums (equal to 25% of program costs for the aged) and by Federal general revenues. The 1998 monthly premium paid by Part B enrollees is \$43.80. The average per capita Part A and B cost for an aged enrollee was \$5,600 in 1997.

The President's Proposals. Under H.R. 3470/S. 1789, two groups would be allowed to buy into Medicare beginning July, 1999. First, persons ages 62 through 64 could obtain Medicare coverage if they were not eligible for employer-sponsored or federal health insurance. They would pay two monthly premiums: a **base premium** before

age 65, estimated to be about \$300 in 1999 (though subject to geographic variation); and a **deferred premium** for ages 65 through 84, estimated to be about \$10 a month in 1999 for *each year* of early participation (not subject to geographic variation).¹ Thus, a person who bought-in for three years would pay a deferred premium of about \$30 a month in addition to what they pay for their Part B premium. The base premium is not intended to cover the full cost of people who buy in; in effect, Medicare would be loaning early enrollees the difference and then obtaining repayment with interest from the deferred premium during the 20 years after they turn 65. The base premium could be adjusted yearly to reflect cost changes, but the deferred premium, made known at the time of enrollment, would be changed only for subsequent enrollees. No Medicaid assistance would be available for premiums or cost-sharing. People may enroll within two months of either turning 62 or losing federal or employer-sponsored health insurance; they would not have to elect or exhaust COBRA coverage. If they disenroll, they could not re-enroll unless they obtained and subsequently lost federal or employer-sponsored insurance *including* eligibility for COBRA coverage.

The second group allowed to buy in includes persons ages 55 through 61 who lose their job because their firm closed, downsized, or moved or because their position was eliminated. They must meet requirements for receiving unemployment compensation and must also lose health insurance (after having at least 12 months of creditable coverage) because of this displacement and not have access to federal or employer-sponsored insurance including any COBRA coverage. The spouse of an eligible person could also buy in. Participants would be charged geographically-adjusted premiums (one for people ages 55 through 59 and another for those ages 60 and 61) that would be approximately \$400 a month in 1999. They would not pay a deferred premium after turning 65 since the \$400 monthly base premium is intended to cover their full cost. People who disenroll or obtain federal or employer-sponsored insurance could re-enroll only if they were displaced once again. If displaced workers had no federal or employer-sponsored health insurance after turning 62, they could obtain Medicare coverage under the terms described above.

Policy Issues. Coverage. The President's proposals are a response to the concern that many people ages 55 through 64 do not have access to affordable health insurance. They are targeted to several groups including individuals with pre-existing conditions who are unable to get coverage through other sources, persons who are sick, individuals with Medicare-eligible spouses who are not eligible themselves because they are not yet 65, and persons who are displaced from their jobs and lose accompanying health insurance.

Some critics of the President's plan suggest that it addresses these problems in a piecemeal fashion and only covers a portion of the target population. (A preliminary estimate by CBO is that about 410,000 persons out of the 3 million uninsured ages 55 through 64 would elect coverage under H.R. 3470/S. 1789 (including the expanded COBRA option discussed below)). There is also concern that the availability of Medicare at age 62 might encourage some people to retire earlier or to enroll in public rather than private insurance. Some suggest that employers might be further encouraged to drop all or a portion of their retiree health coverage. Others urge that the private sector should be encouraged (perhaps with use of tax incentives) to address the health insurance needs of

¹ Premium estimates in this report were made by the Congressional Budget Office (CBO).

the target population; they view this as preferable to expanding a public program which is facing long-term financial problems.

Costs. One reason that only about 13% of uninsured people ages 55 through 64 would gain coverage under H.R. 3470/S. 1789 is that many of the others could not afford the premiums. In particular, those with incomes less than twice the poverty thresholds (about half of the total) may find it difficult to pay \$300 to \$400 a month. Those with fixed incomes (including many who are not employed) may face added problems if premiums are increased to keep pace with inflation or to cover costs attributable to adverse selection.

The Administration argues that in the long run the buy-ins would be fully funded by participants' premiums and so would not incur federal costs. There would be start-up costs (which the Administration initially estimated to be about \$3.1 billion over 10 years) which would be funded by savings from proposed legislation, the Medicare Fraud and Overpayment Act of 1998 (H.R. 3471/S. 1788). The latter initiatives would be in addition to the fraud and abuse measures included in HIPAA and the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). However, some critics are concerned about the possibility that these initiatives might not actually offset the start-up costs. It is also possible that at some point in the future there would be proposals for the government to subsidize buy-in premiums for lower income individuals.

The premium estimates assume that the proposals would result in some adverse selection, that is, that the people who buy in early would have higher than average health care costs. (Otherwise, they would find private insurance less expensive.) But actuarial estimates sometimes are not borne out by subsequent events. While premiums would be adjusted for *future* participants, based upon the experience of the earlier enrollees, there still could be temporary unanticipated gains or losses. If the buy-in is attractive mostly to higher-cost people, premiums would rise as they obtain coverage and use health care they previously could not afford. Over time, healthier individuals would find other insurance to be less expensive or would forgo coverage entirely, further increasing the buy-in premiums. Unless the premiums were subsidized, costs would increase to the point that either few people would be served or the early buy-in could not pay for itself. This phenomenon is sometimes referred to as the adverse selection spiral.

Effect on Future of Medicare. Some observers argue that Medicare should not be expanded until the problems facing the existing program are addressed. BBA 97 established a National Bipartisan Commission on the Future of Medicare to review the long-term financial condition of the program and to analyze potential solutions. The Commission's report, due March, 1999, is required to include recommendations on a number of items including "the feasibility of allowing individuals between the age of 62 and the Medicare eligibility age to buy into the Medicare program." The Commission is also required to consider gradually *increasing* the eligibility age to 67 to match the increase slated to occur under the social security program. A provision increasing the Medicare eligibility age was included in the Senate-passed version of the BBA 97; however, it was dropped in conference. At that time, some persons suggested that if the eligibility age were increased, persons age 65 and 66 should be allowed to buy into the program. The Administration argues that its buy-in proposal can be treated as a separate issue since it would not add to Medicare costs.

Extending COBRA Coverage

Current Law. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), most employers with 20 or more employees that provide group health insurance must offer employees and their families the option of continuing the insurance at group rates when faced with loss of coverage because of certain events. One qualifying event is retirement or other termination of employment (except for gross misconduct), for which 18 months of continued coverage is allowed. If employers have filed for chapter 11 bankruptcy, retirees may continue coverage for life and their families for 36 months. Other qualifying events (such as death, divorce, or entitlement to Medicare) allow 36 months of coverage for the worker's beneficiary. Generally, employers may not charge employees or family members more than 102% of the otherwise applicable premium. (See CRS Issue Brief 87182, *Health Insurance Coverage under COBRA*, by Beth C. Fuchs.)

The President's Proposal. Under H.R. 3470/S. 1789, retirees 55 years and older whose employers terminate or substantially reduce retiree health insurance would be allowed to extend COBRA coverage until the Medicare eligibility age of 65. (A substantial reduction is at least 50% of the total average actuarial value of the benefits, including premiums in excess of 150% of the initial premium.) The retiree's spouse could also extend coverage to age 65, while other dependents could do so for 36 months. Employers could charge no more than 125% of the applicable premium. Advance notice of terminations and reductions would be required.

Policy Issues. This proposal may help retired individuals whose former employer terminates or sharply reduces health insurance that they had expected to continue at least until age 65. Retiree health plan terminations can occur with little notice and leave early retirees with difficult financial choices. Requirements for greater cost-sharing—higher premiums, larger deductibles and coinsurance, and caps on total employer liability—may happen more gradually but can also cause financial difficulty. Enrollment in managed care plans sometimes reduces effective choice of doctors and other health care providers.

However, whether most early retirees could afford extended COBRA coverage is questionable. For 1997, we estimate that the average cost of a COBRA policy was about \$2,000 for an individual and \$5,600 for a family; if employers could charge 125% of the applicable premium, as proposed, the average cost for early retirees might then be \$2,500 and \$7,000, respectively. These sums may be prohibitively expensive for all but higher income retirees. Thus, the option might be attractive mainly to people with pre-existing conditions who could not obtain comparable coverage in the private individual market.

COBRA enrollees on average use more health care than active workers. Among people who are eligible, those who need care are more likely to elect coverage, while those in good health tend to purchase individual policies or forgo insurance. Some estimate the average enrollee cost to be 150% of that for other plan participants. Employers might argue that the higher costs of a further extension would not be covered by the 125% premium rate and thus would unfairly add to the insurance costs of active workers. Whether the increase would be significant, however, would depend on the ratio of enrollees to the number of active workers.