THE PRESIDENT'S FRAMEWORK FOR MEDICARE: HOW IT WORKS IN THE BUDGET, DRAFT: April 14, 1999

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ISSUES WITH RAISING THE AGE ELIGIBILITY FOR MEDICARE

April 13, 1999

PROPOSAL: The Breaux-Thomas proposal increases the Medicare age eligibility from 65 to 67, one month per year, parallel to Social Security. Some proposals include an unsubsidized Medicare buy-in proposal, similar to what the President has proposed for certain people ages 55 to 65.

ISSUES:

- **The availability and affordability of health insurance for people in their early 60s has not improved -- and in fact has deteriorated.**

  - **People ages 55 to 65 are the fastest growing group of uninsured.** The number of uninsured ages 55 to 65 increased by nearly 7 percent in 1998 -- as fast as people ages 35 to 45 and faster than all other age groups.

  - **Fewer have employer-based health insurance.** Compared to younger adults, people approaching retirement are less likely to have employer-sponsored health insurance -- which is the least expensive type of insurance. For example, about 73 percent of people ages 45 to 55 have employer-based health insurance, but this drops to 64 percent for all people ages 55 to 65 -- and only 54 percent of 64 year olds. In part, this reflects changes in employment as workers retire, cut down on hours, or take "bridge" jobs (e.g., consulting, new careers), forfeiting health insurance. It also results from younger spouses losing their health coverage when their older spouses retire and goes on Medicare.

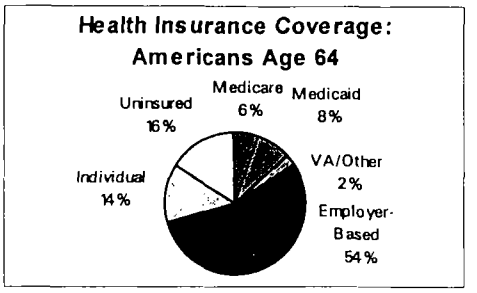
  - **More are forced to turn to expensive individual insurance or have no options at all.** People ages 55 to 65 are twice as likely as younger people to purchase individual private health insurance -- despite the fact that, in virtually all states, it is the most expensive and inaccessible insurance option for older Americans. In 1998, 36 states allowed insurers to deny people individual insurance outright and many more allow insurers to charge more for older and/or sicker people.

- **Different than Social Security because it is more difficult to postpone health care needs than retirement.** Unlike preparation for income security in retirement, illness and disability are rarely foreseeable. People ages 55 to 65 are twice as likely to experience health problems such as heart disease, emphysema, heart attack, stroke and cancer than those ages 45 to 55. The likelihood of developing health problems is even greater at ages 65 and 66. Thus, raising Medicare's eligibility age would affect people with the greatest risk of health problems and lowest probability of finding affordable private health insurance.

- **Breaux-Thomas proposal does not conform to Social Security.** Even under current law, Social Security provides the option for a partial benefit at age 62. In contrast, the Breaux-Thomas proposal provides for no such option for people at age 62. Thus, it does not accurately conform to Social Security policy.

- **Raising Medicare's age eligibility could have serious consequences.** Although the Federal government and Medicare Trust Fund would save from raising Medicare's eligibility age, it could create other costs and problems.

  - **Increase the uninsured.** Nearly one in ten Medicare beneficiaries today is either age 65 or 66. In 1998, 16 percent of people age 64 were uninsured. If the 3.7 million people age 65 and 66 were to lose Medicare, it could be assumed that 16 percent of this group would also be uninsured -- nearly 600,000. This would likely be higher since more people in this age group have health problems and would be unable to access or afford private individual health insurance.



  - **Cost shift to employers.** About half of people age 64 have insurance through their employers. If Medicare's eligibility age were raised, these employers would have to continue coverage if these older people continue to work. Costs would result not only from covering workers longer, but from higher premiums for all workers since this older group would raise the average costs of all employees. The few firms that offer retiree coverage would pay more as well, since their insurance would be the primary source of coverage, not a wrap-around to Medicare. This could accelerate the trend of dropping retiree coverage. Finally, the Federal government would lose revenue as employers deduct additional cost of premiums.

  - **Unfunded mandate to states.** State Medicaid programs would incur significant new costs from raising Medicare's eligibility age. Not only would states continue to be the primary payer for the 8 percent of the 64 year olds on Medicaid who turn 65, but Medicaid would become primary payer for the additional elderly who become eligible for Supplemental Security Income (SSI) at age 65.

- **No viable policy has been offered to prevent the elderly uninsured from increasing.**

  - **Medicare buy-in cannot replace Medicare.** Some proponents of raising the age eligibility of Medicare have suggested that the President's Medicare buy-in proposal as a health insurance alternative for people ages 66 and 67. It is true that, relative to the coverage options facing people ages 55 to 65, it is an affordable, attractive option, even without a subsidy. However, it is not designed to be a substitute for Medicare. According to the Congressional Budget Office, about 9 percent of the uninsured and 5 percent of the total eligible population ages 62 to 65 would participate in the buy-in. If similar take-up rates occurred in the 65 to 66 year old population, only a small number of those who would lose Medicare would opt for coverage through the buy-in.

  - **Costs of subsidies for buy-in would reduce savings.** The Medicare buy-in proposal could be subsidized to encourage low-income people to participate. However, since about over half of people ages 65 and 66 have income below 300 percent of poverty (about $27,000 for a single), the cost of subsidies would be high, lowering savings.

Sent to Judy Ann - want to feel ok about it b/f circulating. What do you think?

DRAFT: COORDINATING CARE FOR DUAL ELIGIBLES

Issue: About 30 percent of Medicare spending and 35 percent of Medicaid spending is attributable to beneficiaries who are fully eligible for Medicare and Medicaid (check). These beneficiaries typically have low income and greater health care needs. The cost of and management of their care, however, is split between Medicare and Medicaid. This can result not only in conflicting incentives, as providers seek the better payer, but care that is not in the best interest of the beneficiary.

Policy: A number of policies would be enacted to improve the coordination of care for dual eligibles. These policies are primarily intended to assure that beneficiaries' services are not adversely affected by the different programmatic funding. They include:

- **Timely notification of enrollment and disenrollment of dual eligibles in Medicaid.** Today, a provider only knows that a beneficiary is a dual eligible if they beneficiary has both a Medicare and Medicaid card. There is no central way for Medicare to know that the beneficiary is dually eligible. This lack of information impedes effective management of Medicare services. Under this policy, states would be required to notify Medicare of enrollment and disenrollment of beneficiaries in Medicaid in a timefly fashion. This information will be kept in the beneficiary's file to ensure that Medicare providers are aware of this status.

- **Single managed care plans for dual eligibles**: Beneficiaries identified as dual eligibles could not be enrolled in a mandatory Medicaid managed care plan if that plan is different than the Medicare managed care plan that the beneficiary has chosen. Although rare, this situation occurs under current law and leads to strong incentives for the Medicare plan to shift cost to the Medicaid managed care plan, and vice versa. Additionally, states could not limit their cost sharing protections for poor beneficiaries (qualified Medicare beneficiaries or QMBs) to providers in the Medicaid managed care plan.

- **New state waiver option to coordinate care:** States would be given a new option to encourage them to work with Medicare to coordinate care and costs. This waiver, similar to 1915(c) authority, would allow states to apply for a budget-neutral, substate waiver to assign a physician care coordinator to all eligible dual eligibles in the area. These coordinators, who also must also be Medicare participating providers, would receive an extra Medicare payment to monitor all Medicare and Medicaid service use. Budget neutrality would be calculated on a combined Medicare-Medicaid per capita basis, but the Medicare payment would be limited to the risk-adjusted managed care payment, discounted for the costs of the care coordinator. Any savings that occur within the combined amount would be returned to the beneficiary in the form of extra benefits – either for Medicaid or Medicare services.

  This waiver option would be limited to 5 years and would be extended only if evaluators suggest that it has been effective at reduce costs and coordinating care.

ISSUES WITH RAISING THE AGE ELIGIBILITY FOR MEDICARE
April 13, 1999

PROPOSAL: The Breaux-Thomas proposal increases the Medicare age eligibility from 65 to 67, one month per year, parallel to Social Security. Some proposals include an unsubsidized Medicare buy-in proposal, similar to what the President has proposed for certain people ages 55 to 65.

ISSUES:

- **The availability and affordability of health insurance for people in their early 60s has not improved -- and in fact has deteriorated.**

  - **People ages 55 to 65 are the fastest growing group of uninsured.** The number of uninsured ages 55 to 65 increased by nearly 7 percent in 1998 -- as fast as people ages 35 to 45 and faster than all other age groups.

  - **Fewer have employer-based health insurance**. Compared to younger adults, people approaching retirement are less likely to have employer-sponsored health insurance -- which is the least expensive type of insurance. For example, about 73 percent of people ages 45 to 55 have employer-based health insurance, but this drops to 64 percent for all people ages 55 to 65 -- and only 54 percent of 64 year olds. In part, this reflects changes in employment as workers retire, cut down on hours, or take "bridge" jobs (e.g., consulting, new careers), forfeiting health insurance. It also results from younger spouses losing their health coverage when their older spouses retire and goes on Medicare.

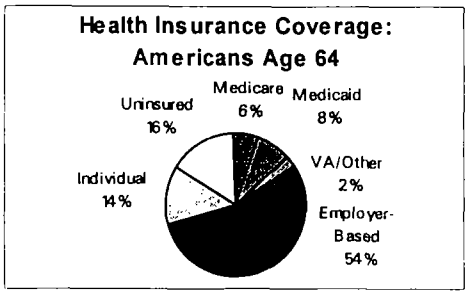
  - **More are forced to turn to expensive individual insurance or have no options at all.** People ages 55 to 65 are twice as likely as younger people to purchase individual private health insurance -- despite the fact that, in virtually all states, it is the most expensive and inaccessible insurance option for older Americans. In 1998, 36 states allowed insurers to deny people individual insurance outright and many more allow insurers to charge more for older and/or sicker people.

- **Different than Social Security because it is more difficult to postpone health care needs than retirement**. Unlike preparation for income security in retirement, illness and disability are rarely foreseeable. People ages 55 to 65 are twice as likely to experience health problems such as heart disease, emphysema, heart attack, stroke and cancer than those ages 45 to 55. The likelihood of developing health problems is even greater at ages 65 and 66. Thus, raising Medicare's eligibility age would affect people with the greatest risk of health problems and lowest probability of finding affordable private health insurance.

- **Breaux-Thomas proposal does not conform to Social Security**. Even under current law, Social Security provides the option for a partial benefit at age 62. In contrast, the Breaux-Thomas proposal provides for no such option for people at age 62. Thus, it does not accurately conform to Social Security policy.

- **Raising Medicare's age eligibility could have serious consequences.** Although the Federal government and Medicare Trust Fund would save from raising Medicare's eligibility age, it could create other costs and problems.

  - **Increase the uninsured.** Nearly one in ten Medicare beneficiaries today is either age 65 or 66. In 1998, 16 percent of people age 64 were uninsured. If the 3.7 million people age 65 and 66 were to lose Medicare, it could be assumed that 16 percent of this group would also be uninsured -- nearly 600,000. This would likely be higher since more people in this age group have health problems and would be unable to access or afford private individual health insurance.



  - **Cost shift to employers.** About half of people age 64 have insurance through their employers. If Medicare's eligibility age were raised, these employers would have to continue coverage if these older people continue to work. Costs would result not only from covering workers longer, but from higher premiums for all workers since this older group would raise the average costs of all employees. The few firms that offer retiree coverage would pay more as well, since their insurance would be the primary source of coverage, not a wrap-around to Medicare. This could accelerate the trend of dropping retiree coverage. Finally, the Federal government would lose revenue as employers deduct additional cost of premiums.

  - **Unfunded mandate to states.** State Medicaid programs would incur significant new costs from raising Medicare's eligibility age. Not only would states continue to be the primary payer for the 8 percent of the 64 year olds on Medicaid who turn 65, but Medicaid would become primary payer for the additional elderly who become eligible for Supplemental Security Income (SSI) at age 65.

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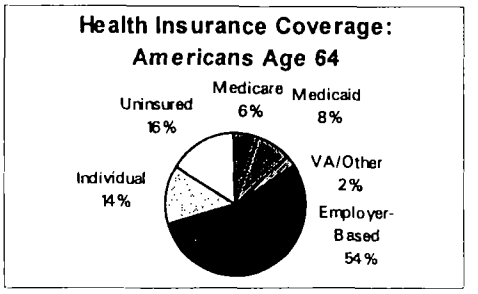

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