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# ISSUE BRIEF

## AMERICAN ACADEMY of ACTUARIES

## Actuarial Issues in Medicare Expansion

*Most Americans under the age of 65 receive their health care coverage through employment-based programs. Almost all Americans age 65 and over are covered through the Medicare program. Because of concern that those approaching age 65 are less likely than younger individuals to have access to health care coverage through employment and that, due to deteriorating health, they may be less able to purchase individual health insurance, the Clinton Administration has proposed expanding the Medicare program to allow certain individuals between the ages of 55 and 64 to participate on a voluntary "buy-in" basis. The buy-in expansion is intended to be essentially self-supporting financially when viewed over the lifetime of program participants. This issue brief discusses the actuarial aspects and potential impact of the proposal.*

*Key conclusions of this Academy brief include:*

- *The cost of the program will be strongly influenced by the health status of those who choose to participate.*
- *The reduction in the size of the uninsured population will likely be relatively small.*
- *The age 62-64 buy-in will generate losses initially, but could become essentially self-supporting over time.*
- *The amortization premium concept is innovative but unproven.*
- *Timing differences between benefit and premium payments for the age 62-64 buy-in will result in Part A trust fund balances being somewhat lower than would otherwise be expected.*
- *The age 55-61 buy-in will likely generate continuing losses.*
- *Savings from anti-fraud initiatives are intended to offset losses from the Medicare buy-in initiatives. It is unclear whether these savings will fully offset the cost of the buy-in program. We have not attempted to estimate the potential savings from the proposed anti-fraud initiatives.*

### Background and Overview

One of the motivations for the proposed expansion is a hope that it will provide coverage for some of those who are currently uninsured. Approximately

three million Americans between the ages of 55 and 64, or 13.9% of Americans in that age bracket, have no health insurance coverage. The corresponding figures for those between the ages of 18 and 54 are 27.8 million and 19.7%<sup>1</sup>. Unfortunately, many of the uninsured may be financially unable to take advantage of a buy-in program. Among those uninsured between the ages of 55 and 64 (the "near elderly"), approximately half have an income below 200% of the federal poverty level<sup>2</sup> (or approximately \$21,000 for a family of two).

Medicare eligibility currently begins at age 65. Social Security Old Age benefit eligibility is scheduled to rise from 65 to 67. Growing concern over projected future funding shortfalls in the Medicare program, particularly once the baby boom generation begins to retire, has prompted many to suggest raising the eligibility age for Medicare benefits also. This proposal

*The American Academy of Actuaries is the public policy organization for actuaries of all specialties within the United States. The Academy is nonpartisan and assists the public policy process by providing independent, actuarial information to elected officials and regulators. This issue brief is intended to bring the actuarial perspective into the public discussion of the issues and was prepared by the Academy Work Group on Medicare Expansion: Thomas F. Wildsmith, FSA, MAAA; William F. Bluhm, FCA, FSA, MAAA; Vincent L. Bodnar, ASA, MAAA; Alan D. Ford, EA, FSA, MAAA; P. Anthony Hammond, ASA, MAAA; Donna C. Novak, ASA, MAAA; John J. Schubert, ASA, FCA, MAAA; and George B. Wagoner, FSA, FCA, MAAA.*



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<sup>1</sup>Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey*, EBRI Issue Brief Number 192, Table 11, page 22, Employee Benefit Research Institute, December 1997

<sup>2</sup>Paul Fronstin, *Medicare as an Option for Americans Ages 55-64: Issues to Consider*, EBRI Notes, Vol. 19 Number 2, Employee Benefit Research Institute, February 1998

extends a buy-in privilege to those below age 65, as part of a package of Medicare proposals that are intended to be financially self-supporting.

The Clinton Administration's proposed Medicare expansion consists of two separate buy-in arrangements. The first arrangement is for individuals aged 62 to 64. Individuals in that age group would pay a "current premium" (established at a "standard risk" level) of approximately \$300 each month. Because participants in the program are expected to have higher-than-average medical expenses, they would also pay an additional monthly "amortization premium" after age 65 and up through age 84. The monthly amortization premium is anticipated to be approximately \$16 initially.

The second arrangement is for individuals aged 55 to 61 who become uninsured due to losing their jobs. Individuals in this age group would pay a premium that would cover their full expected medical costs. The monthly buy-in premium for this group is anticipated to be approximately \$400.

In addition, the Administration has proposed extending employer-provided COBRA continuation coverage to retirees who lose coverage due to the discontinuation of an employer-provided retiree health benefits plan. While COBRA expansion is a part of the Administration's proposal, it will not be discussed further in this issue brief.

The Administration has also linked these proposed Medicare expansions to several initiatives to reduce fraud and overpayments in the Medicare program. The savings from these anti-fraud initiatives are intended to offset the cost and initial cash outflow of the Medicare buy-in expansions. We have not attempted to estimate the potential savings from the proposed anti-fraud initiatives.

## **General Considerations for Both Medicare Buy-In Programs**

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It is important for the Medicare buy-in programs to attract as many healthy individuals as possible, in order to keep program costs at manageable levels. There are many factors that will influence individual consumers' choices about participation. One of the most fundamental is the premium they must pay in

order to participate. Those eligible for these buy-in programs will often have other health insurance coverage available to them within the private sector, and many of those eligible will find private sector options that provide equivalent coverage at a more attractive price.

Participation will require the ability to pay a significant annual buy-in premium (approximately \$3,600 per individual, or \$7,200 for a couple in the case of the age 62–64 buy-in, and approximately \$4,800 per individual, or \$9,600 per couple in the case of the age 55–61 buy-in). This would be beyond the reach of many of the uninsured. Those who can afford the premium will have to choose between the Medicare buy-in coverage and whatever private insurance may be available to them. Particularly in states where underwriting is allowed, those who are healthy may find private insurance less expensive.

A recent study of the individual health insurance market in ten states found premiums for a 60-year-old male in an intermediate cost area generally ranging from \$149 to \$535 per month (of course, rates in high cost geographic areas, or for those in poor health may be much higher)<sup>3</sup>. For example, sample rates in New York ranged from \$210 to \$264, rates in Washington State ranged from \$149 to \$331, rates in Louisiana ranged from \$233 to \$425, rates in California ranged from \$240 to \$260, and rates in Pennsylvania ranged from \$149 to \$278<sup>4</sup>. It is likely that individuals who are significantly less healthy than the average for the age group will have fewer, and less affordable, options available when purchasing private health insurance coverage and will be more likely to choose the Medicare buy-in coverage. This "self-selection" when choosing between health care coverage alternatives, operating across all those individuals aged 55 to 64 who are eligible for buy-in coverage, will be a major determinant of the cost of the Medicare buy-in program. The extent to which this participant self-selection occurs will partly depend on how potential participants perceive the costs and benefits of the program.

The majority of current Medicare beneficiaries purchase Medicare Supplement insurance (over 75% of elderly beneficiaries purchase private insurance to

<sup>3</sup>Deborah J. Chollet and Adele M. Kirk, *Understanding Individual Health Insurance Markets: Structure, Practices and Products in Ten States*, page iii, Alpha Center, March 1998

<sup>4</sup>Ibid., Table 18, page 46

supplement their Medicare benefits<sup>5</sup>). Because of the structure of the fee-for-service Medicare benefits, particularly the lack of any limit on annual out-of-pocket expenses, most beneficiaries consider a supplemental policy necessary to ensure comprehensive coverage of their medical care needs. When weighing their coverage options, consumers may view Medicare and Medicare Supplement coverage as complementary pieces of a coverage package. If they view the premium for a supplemental policy as part of the total cost of coverage under the Medicare buy-in, then the buy-in option will appear less attractive and relatively fewer healthy individuals will choose to participate.

## **Buy-In for Ages 62–64**

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### **Premiums and Program Costs**

The age 62–64 buy-in program is intended to be self-supporting, so the question of who will choose to participate is vital. The program will need to attract as many healthy individuals as possible, in order to keep the program costs at levels that will allow the program to be financed on a basis that is self-supporting over time. A key factor determining the attractiveness of the program to healthy individuals will be the way in which premiums will be established, and especially how premiums will be adjusted when costs differ from original expectations. Even though limiting the current premium to a “standard risk” level will help mitigate the impact of participant self-selection, as could certain restrictions on eligibility and enrollment, it is still likely that individuals selecting Medicare buy-in coverage will be significantly less healthy than an average individual in this age group.

The exact impact of this self-selection by consumers is impossible to predict with certainty, however, and may well change over time. This makes the process for setting premiums particularly important. Presumably the current premium would be established annually on a prospective basis using recent Medicare claim statistics, as a part of the current process for establishing the Part B premium and reimbursement rates for risk contractors. These claim statistics should be age adjusted, because the health care utilization patterns of the near elderly, and their dependents, may be significantly different from those of the average Medicare beneficiary. Unless shortfalls were recouped in the premiums for

later years, which would make the program less attractive to healthy individuals in those years, losses would be absorbed by the Medicare system. Any such losses could be corrected with the next year’s premium increase.

The buy-in program for those aged 62 to 64 is intended to be both affordable and financially self-supporting. The program proposes to accomplish this through an affordable current premium, paid during the years in which coverage is provided, which will be supplemented by later amortization premiums paid by buy-in participants after age 65 and up to age 85. The amortization premiums are, in effect, installment payments on a loan made by the program during the coverage years. This concept is innovative but unproven. We are well aware that projecting premiums three years in advance has proven a daunting actuarial task for health insurance programs with stable participation levels and will undoubtedly be an ongoing challenge in regard to the potentially variable participation in the buy-in program. In addition, the amortization premium, which is to be paid by each cohort of participants for twenty years after their coverage ends, must be accurately estimated in advance to keep the program self-supporting over the long run. The actuarial and financial experience must be carefully monitored for current cost levels and outstanding liabilities.

To encourage participation in the program it may be necessary to provide that the monthly amortization premium will not change after an individual enters the program. Otherwise, because of the uncertain level of the future financial commitment, individuals may be wary about participating unless serious health problems give them no other option, leading to higher average costs. If the amortization premium is fixed for the cohort entering in a particular year, any underestimation in establishing the premium (due, for instance, to unexpected inflation or the impact of new medical technology) could result in a loss to the system over the lifetime of that cohort. Updated estimates would presumably be used for future cohorts when the next year’s premiums are established. However, unless shortfalls were recouped by increasing the premiums for later cohorts, which would make the program less attractive to healthy individuals, the loss would be absorbed by the Medicare system. In the event of a

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<sup>5</sup>*Medigap Insurance: Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting*, U. S. General Accounting Office, September 1996

shortfall, the amortization premium for the following cohorts would likely be higher, due to the use of updated estimates, even if it is not raised to subsidize the “loss cohort.”

The potential for a premium shortfall is a particular concern for the first few cohorts entering the system. It is likely that they will be on average less healthy than later cohorts, because many healthy individuals who would be eligible during the early years of the program will have already purchased or made plans to purchase private insurance. Recognizing this in the amortization premiums for these cohorts will reduce the attractiveness of the program, increasing the average cost and potentially damaging its acceptance among the public. Not recognizing these higher costs will result in a net loss to the Medicare system.

Because health care costs vary significantly across different regions of the country, it will be important to vary premium rates geographically. This has not been necessary in the past because the Medicare Part B premium represents a small enough portion of total costs that a national average premium is a good deal for consumers everywhere. If a national average premium is used when the consumer is paying all or most of the cost, then individuals in high-cost areas will be more likely to participate than those living in low-cost areas, driving up the overall average cost. To ensure equity between participants in different areas of the country it may well be necessary to vary both the current and amortization premiums geographically.

The amortization premium essentially represents a long-term loan that is forgiven at death. The premium required and the financial impact on the Medicare program depend on many factors, including the interest rate used and the mortality of program participants. If the interest rate equals the rate that would otherwise be earned by the Medicare trust funds, then there would be no investment loss to the program. Using a lower interest rate would reduce the amortization premium, but would result in a net loss to the Medicare program. A higher interest rate would produce a gain to the Medicare program, but would make the buy-in option less attractive.

The required premium level also depends on how long participants live past age 65. The longer the average life expectancy of buy-in participants, the longer amortization premiums will be received on

average (resulting in a larger total amount paid), and the lower each premium payment can be. Since participants will tend to be less healthy than average for their age group, it seems reasonable to expect them to experience higher-than-average mortality rates. This will shorten the amortization period and thus increase the amortization premium needed.

## **Program Administration**

If area specific premiums are used it will significantly complicate the administration of the program. Actual residence must be tracked, not just eligibility and mailing address. To equitably allocate costs, the amortization premium should be determined based on residence during the period of coverage, and should “follow” an individual through subsequent moves. An enrollee who changes residence several times from age 62 to 65 could have a final amortization premium based on multiple different geographic rates. Automatically deducting the amortization premium from Social Security Old Age benefits (as with the current Part B premium) will avoid the necessity for a separate billing process, but will not make it easier to determine the correct amount to collect.

It will also be necessary to identify and notify eligible individuals. This will be complicated if eligibility is extended only to those who do not have other federal or private group insurance coverage available, because the availability of such coverage must be recorded and tracked. Other provisions that might be considered to reduce consumer self-selection, such as allowing enrollment only when a person first becomes eligible or restricting participants’ ability to leave the program and reenter it at a later time, would tend to further complicate the administration.

## **Other Considerations**

Existing public and private insurance programs typically provide either for premiums that are payable during the period of coverage, such as private health insurance and term life insurance, or for advance funding of benefits, such as pension, annuity, and long-term care programs. The proposed amortization premiums will be payable for twenty years after benefits have ceased. The presence of a “premium” payment without any current or future benefit may cause some dissatisfaction, leading to pressure to reduce or forgive the amortization premiums. Explicitly describing the arrangement as a loan

might improve understanding and forestall such pressures, but might also reduce participation if individuals see it as entailing a significant debt.

The type of “loan” proposed is also somewhat unusual. Because liability ends at death it is essentially a reverse annuity, rather than a simple amortized payment. Those who live longer than average will pay more over their lifetime than those who die earlier. Unless sex-distinct amortization premiums are established, because of their generally lower death rates, women will, on average, pay more than men.

## **Buy-In for Ages 55–61**

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### **Premiums and Program Costs**

Because healthy individuals will have a choice between the Medicare buy-in program and individually purchased private insurance, with no mandate to enter the Medicare program or subsidy to lower its direct cost, it is unlikely that a self-supporting premium can be established for this portion of the program. Many healthy individuals can be expected to purchase private insurance whenever it is less expensive than the Medicare buy-in premium. Increasing the buy-in premium will not solve the problem, because it will make private coverage attractive to even more consumers, resulting in even higher average costs among the buy-in program participants.

The financial dynamics of this buy-in proposal are fundamentally different from those of COBRA continuation coverage, where the employer plan provides a significant subsidy, and from those of a more traditional guaranteed-issue market where healthy individuals must participate in the same rating pool as the unhealthy if they want coverage at all. The Administration’s proposal is analogous to group conversion coverage, or to a state high-risk pool. In the latter two cases, stable premium rates are achieved only because some level of subsidy is ultimately provided.

### **Program Administration**

Significant regional differences in medical costs make area-specific premiums as important for the age 55 to 61 buy-in program as they are for the age 62 to 64 buy-in. Because there is no amortization premium, the premium administration will be less complex, however.

Identification and notification of eligible individuals may be difficult. In addition to age, it will be necessary to verify prior health insurance coverage and that the loss of coverage resulted from job loss due to layoff or job displacement. Verifying the reason for job loss will be critical, but difficult. Employers will have no direct interest in distinguishing between voluntary early retirees and those who are displaced. In many cases the nature of a termination is unclear, with employees resigning or retiring in order to avoid involuntary termination.

Multiple periods of eligibility are possible as individuals reenter the labor market. If there are eligibility restrictions designed to reduce the effects of selection, it will become important to distinguish between those who truly reenter the labor force and suffer another displacement and those who try to game the system by creating the appearance of a second qualifying event. It is not clear who will be responsible for verifying ongoing eligibility, including any change in employment status. It also is not clear whether obtaining a new job terminates eligibility for buy-in coverage. If not, it is possible that some employers might encourage new hires with Medicare buy-in coverage to maintain it rather than enroll in any employer-provided health plan.

### **Other Considerations**

With potential participants as young as age 55, the questions of dependent coverage and maternity coverage become more important than they would be for an aged population. Some individuals in this age group will have younger spouses. Many will have dependent children. To provide financial protection to the family group, both maternity coverage and coverage for dependent children may be needed. If they are not provided, the program may be considerably less attractive to those individuals with families.

## **Potential Impact**

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### **On the Uninsured**

The proposed buy-in expansions of Medicare are unlikely to have a significant impact on the number of Americans without health insurance. Many of the uninsured will be unable to pay the required premiums. Others will not meet the eligibility criteria. The Congressional Budget Office estimates that approximately 320,000 people will buy in to

Medicare. Of those, roughly two-thirds are already covered through private health insurance.

### **On the Problem of “Job-Lock”**

The proposed buy-in expansions of Medicare will have relatively little effect on workers moving from one job with health benefits to another, but may be of more assistance to workers who leave the labor force entirely or move to jobs that do not provide health benefits. Because eligibility for the age 55 to 61 buy-in program is limited to those who have lost employer-sponsored coverage due to involuntary job loss, if it is effectively administered it should not facilitate voluntary job movement. This eligibility restriction does not apply to the age 62 to 64 buy-in program.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides significant protection to workers moving directly from one employee benefit plan to another. COBRA continuation coverage also provides significant short-term protection to individuals leaving employers with twenty or more employees. HIPAA also mandates long-term protection for those leaving covered employment, but the cost of that protection varies significantly from state to state. Many, but not all, states provided some form of long-term protection for the uninsurable even before the advent of HIPAA, typically through high-risk pools or some form of guaranteed issue requirement.

In states where underwriting is allowed, healthy individuals most likely already find private coverage that is less expensive than the Medicare buy-in option. COBRA continuation coverage, when available, will often be less expensive than the Medicare buy-in for employees aged 62 to 64, and almost always be less expensive for those ages 55 to 61. In a recent survey of midsize to large employers, average monthly premiums for single coverage were \$192 for conventional coverage, \$160 for HMO coverage, \$169 for PPO coverage and \$168 for POS coverage<sup>6</sup> (enrollee premiums for COBRA continuation coverage are limited to 102% of the premium for active employees). The relationship between the Medicare buy-in option and HIPAA individual portability coverage will vary by state, with the Medicare buy-in

option premium rates being more attractive in some states and HIPAA individual portability being less expensive in others. Perhaps the one group that will benefit most will be individuals who lost covered employment before the advent of HIPAA in those states that did not already provide some form of long-term protection.

### **On Employee Benefit Plans**

The proposed buy-in expansions of Medicare should have little if any impact on health benefits for active employees. The potential impact is greater for post-retirement health benefits. The 1990s have seen a general trend of employers limiting or eliminating their post-retirement medical benefits in the wake of FAS 106. One recent survey of employer-sponsored health plans found that 38% of employers provide health coverage to retirees under age 65, and only 31% provide coverage to Medicare-eligible employees<sup>7</sup>. Post-retirement packages for Medicare-eligible retirees focus on benefits that supplement Medicare. More comprehensive “bridge” benefits are offered to retirees under age 65 to encourage early retirement by ensuring the availability of health insurance until Medicare benefits become available.

The availability of a Medicare buy-in, in conjunction with HIPAA portability and COBRA continuation coverage, may make employers less likely to offer comprehensive health insurance benefits to early retirees. The availability of multiple coverage options may reduce the sense of social obligation on the part of employers, and reduce the need to provide the benefits to facilitate employees’ ability and willingness to leave employment. Employer alternatives to offering comprehensive health coverage could include extending to early retirees the same Medicare supplementary benefits available to retirees over age sixty-five or increasing monthly pension or lump-sum severance benefits to offset buy-in premiums. Some employers could encourage early retirees to enroll in Medicare, with the employer paying some or all of the buy-in premium, as an attractive way to limit the cost of post-retirement medical benefits. Employers with less healthy groups are especially likely to follow this route, resulting in a disproport-

<sup>6</sup>*Health Benefits in 1997*, KPMG Peat Marwick LLP, June 1997, Figure 11, page 9

<sup>7</sup>*Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 1997*, William M. Mercer, March 1998, page 6

tionate number of less healthy lives enrolling in the buy-in program.

### **On the Medicare Part A Trust Fund**

The amortization premium charged after age 65 for coverage from ages 62 to 64 represents a long-term, low-interest loan from the Medicare program to the insured individual. The result will be a net cash outflow during the early years of the program. This outflow will be reduced over time as participants reach age 65 and begin paying amortization premiums. If the pricing assumptions are relatively accurate and enrollment levels are stable, then the age 62–64 buy-in portion of the system should reach a steady state balance in approximately 20 to 24 years, with cash inflows roughly balancing cash outflows. The net cash outflow over this period of time will result in trust fund balances somewhat lower than would otherwise be expected. If enrollment in the buy-in program rises over time, for economic or demographic reasons (such as the retirement of the baby-boom generation), outflows may persist. Nevertheless, if the buy-in program were at some point to be discontinued, the loan to participants would be paid back over the next 20 to 24 years, ultimately making the trust fund whole.

Assuming the buy-in program is not discontinued, the trust fund balance will remain lower than would otherwise be expected. To the extent that the amortization premiums balance the additional cost arising from the age 62 to 64 buy-in, there should be no net effect on the long-term actuarial balance of the program. However, due to the reduced cash balance, exhaustion of the trust fund will be somewhat accelerated.

The trust fund will also experience gains or losses as actual experience differs from the assumptions used in establishing the current premiums for the buy-in program. For participants ages 62 through 64, the annual premium recalculation should correct any estimation errors, and the net effect over time should be negligible. Unless some form of subsidy is provided, it is likely that the age 55 to 61 buy-in program will generate continuing losses. However, if premium levels are set relatively high, they are likely to keep enrollment low, making the aggregate loss to the program smaller than it might otherwise be.

### **On the Federal Budget**

The budget should see the same pattern of gains and losses as mentioned above for the Part A trust fund, assuming that both the current premiums and the amortization premiums are allocated to Medicare Parts A and B based on program costs. Because the Part B program is funded primarily through general revenues, gains and losses essentially flow through to the federal budget. The amortization premium portion of the program will generate a net cash outflow during the early years of the program that should gradually diminish over time, with cash inflows eventually roughly balancing cash outflows. The current premium for the age 62 through 64 buy-in may produce short-term gains or losses, but the net effect over time should be negligible. The age 55 to 61 buy-in program will likely generate continuing losses. The size of these losses will depend on a number of factors, the most important of which will likely be the number of program participants. Savings from efforts to reduce fraud and overpayments in the Medicare program are intended to offset the cost of the buy-in programs, primarily the age 55–61 buy-in, but also the initial cash outflow from the age 62–64 buy-in. This could be seen as using reduced overpayments in the overall Medicare program to indirectly contribute to financing the buy-in options for the near elderly.

### **On the OASDI Trust Fund**

The proposed Medicare buy-in expansions may also have an indirect effect on the OASDI trust fund. To the extent that early retirement is encouraged, OASDI payroll taxes will be reduced and benefit payment levels increased. Because OAS benefits are actuarially reduced for early retirement, there should be no net effect on the long-term actuarial balance of the program. However, the onset of a net cash outflow for that individual is accelerated. For the program as a whole, the effect of this acceleration should be relatively small.

### **On the Medicare Supplement Market**

The presence of a buy-in option will lead to a demand among early retirees for supplemental policies. An inability to qualify for private Medicare sup-

plement policies may make the buy-in program less attractive to high-risk individuals under age 65. Guaranteed-issue requirements on private insurance, however, would increase the cost of the policies for all seniors.

### **On Medicare+Choice Plans**

Allowing Medicare buy-in participants to participate in Medicare+Choice plans would likely reduce the cost of coverage while providing more comprehensive benefits than are available under the Medicare fee-for-service program. Equitable payment to the Medicare+Choice plans would require a payment rate that reflects the relatively poor health of buy-in enrollees. While encouraging Medicare+Choice participation may be desirable, it is unclear how attractive these plans would be to buy-in participants. Individuals in poor health often prefer fee-for-service benefits to managed care programs.

### **On Providers**

For those buy-in enrollees choosing fee-for-service Medicare benefits rather than participation in a Medicare+Choice plan, provider reimbursements will be limited by the Medicare allowable charges. This reimbursement level may often be lower than that provided by many private plans. The impact of reduced reimbursement levels should be limited by the relatively low number of expected buy-in participants. While provider revenues may be reduced in the case of individuals who would otherwise purchase private coverage, they may actually rise in the case of individuals who would otherwise be uninsured. Furthermore, providers will tend to increase charges for individuals covered under private plans in order to offset the reduced revenue on buy-in program participants.

### **On Seniors**

The proposed Medicare buy-in expansion should have little direct effect on current Medicare beneficiaries. Indirect effects could arise if guaranteed-issue requirements are placed on Medicare Supplement insurance that raise the cost of coverage, or if Medicare+Choice reimbursement rates do not reflect the true cost of buy-in enrollees. The effect on the overall financing of the program should be relatively small.

The most direct impact on future seniors will be the post-65 amortization premium. Based on the Administration's statements, an individual enrolling at age 62 would have a monthly amortization premium after age 65 roughly equal to the current Part B premium. This could be significant for seniors with fixed incomes and declining assets. While deducting the amortization premium directly from Social Security Old Age benefits can ensure that it is always collectable, there may be a desire to avoid reducing the Social Security payments of very-low-income seniors. If reducing the Social Security payments of low-income seniors is to be avoided, it will require raising the amortization premium, requiring Medicaid or some other third party to pay the premium, or simply allowing the Medicare program to absorb the loss.

## **Actuarial Standards**

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A key factor in the success of the proposed expansions is attracting a broad range of participating individuals, including healthy individuals as well as those with significant medical expenses. This in turn depends on the direct cost of the program to consumers. Because of the sensitivity of both enrollment and financing adequacy to changes in premium levels, it is vital that the premiums be established in accordance with sound actuarial principles. If such Medicare buy-in options are established, we strongly recommend (as we do for all other aspects of the Medicare system) that premiums and reimbursement rates for them be established by a qualified actuary in accordance with the actuarial standards of practice promulgated by the Actuarial Standards Board, in particular Actuarial Standard of Practice (ASOP) No. 32, "Social Insurance" and with reference to those standards that address long-term health-care valuations, such as ASOP No. 6, "Measuring and Allocating Actuarial Present Values of Retiree Health Care and Death Benefits" and ASOP No. 18, "Long-term Care Insurance." To ensure public accountability, we recommend that a formal actuarial statement opinion be required for the premiums established each year, certifying that, in the appointed actuary's opinion, premiums and reimbursement rates for the program have been developed in accordance with all applicable actuarial standards of practice and relevant legal requirements.