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Medicare Buy-In Proposal

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Americans at the end of their working lives are increasingly facing greater uncertainty regarding health insurance and hence access to health care. Those out of the labor force, and increasingly those still working, are finding that health insurance is not always available, even when they could afford to pay a reasonable premium. Medicare is not an option for nondisabled persons until they reach age 65, leaving large potential gaps in insurance for many who are beginning to move towards retirement in their late 50s and early 60s, or whose employers fail to offer such coverage.

In 1998, nearly one in every four persons aged 60 to 64 will either be uninsured or buying insurance in the private nongroup market. Those who lack insurance likely do so for two reasons: the absence of a viable private market serving those with health problems, and the unaffordability of insurance to persons with low incomes. Individuals with health problems who had strong labor force attachments and good group coverage are likely to have access to insurance while on the job and at least for a time afterwards through COBRA or retiree coverage. The recently passed Health Insurance Portability and Accountability Act (HIPAA) should help to some degree by extending the right to purchase insurance. But HIPAA does not assure the affordability of that insurance. Moreover, such benefits are not likely to be available at all to low income persons who likely have had periods of unemployment or jobs that do not carry insurance. For them, HIPAA and any employment-based coverage expansions are unlikely to be helpful. Premiums of $6000 to $10,000 per year price these individuals out of the market. It is this second group where the bulk of the problem of insurance most likely arises.

But even access to employer coverage is declining. The proportion of active workers covered under employer plans continues to gradually decline. In addition, there has been a fairly dramatic decrease in employers providing retiree health benefits. In 1985, 75 percent of full-time workers in medium and large firms could continue their health insurance coverage into retirement compared with only 52 percent in 1993.[1]

Thus, in seeking ways to expand coverage for this older age group, employment-based options such as COBRA extensions or subsidies would likely be poorly targeted. Instead, what is needed is access to guaranteed insurance at modest cost that does not depend upon past or present employment. Policies that force those in poor health or with other needs to remain in the labor force just to be able to obtain insurance would be unfair and likely unsuccessful. But in developing such options, it is also important to be cognizant of avoiding policies that could further discourage employer participation in an area of coverage that is already declining. In addition, while access to affordable insurance may lead to some

[1] See U.S. Department of Labor, Pension and Welfare Benefits Administration, Retirement Benefits of American Workers: New Findings from the September 1994 Current Population Survey, Washington, D.C.: U.S. GPO, 1995.

increase in the ranks of early retirees, the incentives for individuals for such behavior could be minimized. Whatever option is chosen to help this group should attempt to be relatively neutral in terms of employment status. Nonetheless, denying protection on the argument that it might allow some individuals to retire earlier would seem to be an overreaction to a legitimate problem of access to insurance.

Since nearly everyone in this age group will be eligible for Medicare once they turn age 65, an option that smooths the transition into Medicare rather than creating a whole new program makes sense both for reducing disruption to the individual and for administrative ease. As presently constituted, however, the current Medicare program is limited in terms of its benefits, leaving many older beneficiaries with the desire to also seek supplemental coverage. But there is an alternative; Medicare now offers private managed care plans to its beneficiaries -- plans that often include additional benefits. Many of the individuals in the pre-Medicare age group are already accustomed to operating in a managed care environment, so basing a coverage option on these Medicare-qualified managed care plans is a natural way to extend coverage to this population and allow them to keep the same coverage after age 65 as well. The experience in 1998 with managed care plans in Medicare raises some cautions, however, about whether these plans will continue to offer the additional benefits that bring the Medicare benefit package up to a reasonable level. If so, one of the reasons to limit the buy-in to these private plans is eliminated.

Current Proposals

In recognition of the problems that older workers and early retirees are facing in obtaining health insurance, several proposals were offered in early 1998. All of them have been quite limited in scope, however.

Receiving the most attention is a plan from the Clinton Administration's to allow certain persons between the ages of 55 and 64 to buy into the Medicare program or to buy from employers in an expanded COBRA framework. In an effort to restrict any costs to the federal government, the goal is to have participants pay fully for their own costs of insurance, although some of these costs would be spread over time. In this way, the proposal uses Medicare as the mechanism for offering expanded coverage rather than as an expansion of eligibility into the program as some have described it.

Three categories of individuals would be eligible to participate. The largest group of eligibles would be persons aged 62 through 64 who do not have access to employer-provided coverage either as workers or retirees and who are not eligible for Medicaid. Their required contributions to the costs of insurance would be divided into two pieces. Initially, they would pay a premium set to the level necessary if all persons aged 62 through 64 participated in the program. This has been estimated by the government to be about $300 per month. But since not all persons in this age group would participate in the government's program, the cost of such insurance would likely be higher in practice. This is because healthier individuals would likely have access to less expensive insurance offered by the

private sector. It is expected that Medicare would attract a sicker population, who cannot get insurance elsewhere and who are more highly motivated to purchase insurance since they are more likely to be users of medical services. To keep the program relatively budget neutral, those who sign up for coverage would be assessed a surcharge for the extra costs that result from insuring a riskier population that would be paid on a monthly basis with their Medicare premium when they reach age 65 and lasting for twenty years.

The second group of eligibles would be individuals aged 55 through 61 (and their spouses) who lose jobs through downsizing or other qualifying reasons (and who are eligible as a consequence for unemployment compensation). These individuals must not be eligible for COBRA or other federal health insurance and they must have had insurance for at least one year before losing their jobs. They would have to pay the full actuarial costs of their insurance immediately, rather than being able to spread some expenses over a twenty year period. Monthly costs of insurance for this group would thus likely be $400 or more.

The last group eligible in the Clinton plan would be persons for whom their former employer unexpectedly drops retiree coverage. For retirees aged 55 to 64 and their dependents who are in this situation, the employer would be required to offer COBRA protection until they turn age 65. The former workers would have to pay 125 percent of the costs of an active employee's premium. As a federal mandate, this piece of the plan would not raise any budget issues.

While a large number of persons would potentially be eligible under these three groups, especially the first, participation is expected to be quite low. Without subsidies either for those with low incomes or to reduce the costs of adverse selection, participants would likely be persons who both have substantial resources and for whom insurance is unavailable elsewhere. The Administration estimated that about 300,000 persons would be expected to enroll each year.

To defray the costs of the start up of this plan (and any shortfall in the contributions that individuals would make to the buy-in options), the Administration would use additional savings from fraud, waste and abuse efforts. The Congressional Budget Office initial scoring of this legislation indicates that it would add only modestly to Medicare's costs.

Critics of this proposal have fallen into two camps: those who argue that this would naturally lead to subsidies over time, thus creating new expenses for Medicare, and those who argue that it is unreasonable to set up such a system without substantial subsidies. Critics fearful of greater Medicare costs are also generally opposed to any expansion of eligibility for a public program.

To counter the Clinton Administration's plan, several other proposals -- although less well developed -- have also been suggested. Several policy makers and analysts have proposed using the Federal Employees Health Benefits Program (FEHBP) instead of Medicare as the mechanism for offering expanded coverage (Kendall 1997). The rationale seems to be that since these would be private plans,

such an offering would be less likely to lead to subsidies over time or to expansion of an entitlement to services. However, if the same adverse selection issues would apply for the FEHBP buy-in, special attention would have to be paid to pricing these policies for participants. That is, new buy-in participants could not just be folded into the current FEHBP structure without substantial across-the-board increases in premiums. Thus, many of the same issues of affordability and participation would arise under this structure.

A third type of proposal sometimes suggested is to extend the deductibility of insurance premiums to those who purchase individual policies because they are not eligible for employer-sponsored insurance (which is already extended such deductibility). House Ways and Means chairman Bill Archer, for example, has suggested this approach. Again, one of the major issues of concern is who would benefit from such a proposal. These additional tax subsidies would be poorly targeted, helping most those who can afford to buy in the current market and doing little to reduce the numbers of persons without insurance. And without further extensions of legislation to guarantee that insurers offer insurance at reasonable rates, there is no assurance that even relatively well-off individuals could purchase policies and qualify for a deduction.

Thus, at best, the proposals now on the table would begin to address the issue of access to insurance by those who find themselves priced out of the market because of health problems. None of them begin to seriously tackle the question of making insurance affordable to this age group of the population.

Our Medicare Buy-In Proposal

Our proposal would allow older persons not yet eligible for Medicare (under age 65) to "buy into" Medicare coverage. Eligibles could buy coverage from private plans that are already providing insurance to Medicare recipients over age 65. In turn, any private plan that wants to cover regular Medicare recipients would also have to offer this buy-in coverage to all interested pre-65 eligibles. Limiting the proposal to private plans is in line with the general trend toward managed care plans, and should limit the cost of coverage. Further, it would generally allow eligibles to purchase more comprehensive coverage than Medicare's basic package allows. Our approach differs most from other options that have been proposed, however, in terms of the subsidies that we believe are necessary to meet the needs of this population.

In the rest of this section, we describe the proposal in more detail. We include a discussion of eligibility, benefits, premiums, subsidies for low-income individuals, and cost reimbursement for private plans.

Eligibility

We propose that all persons ages 62 through 64 be eligible, although one could also consider the same proposal with expanded eligibility to those age 60 through 64. The broader the eligible age range, the higher the total subsidy cost

will be. There are also implications for plan cost of including a younger group presumably in better health. This would basically be an individual plan; that is, there would be no family policy. Enrollment could occur at any time of year.

Eligibility for the Medicare buy-in would be based on age, regardless of work status.[2] Allowing current workers to buy-in would create an incentive for some people to stop working. For example, persons in ill-health and currently covered by employer-sponsored insurance might want to stop working. At present they face losing their employer coverage and fear not being able to access or afford private nongroup insurance. For this group, providing the opportunity to stop working and retain coverage could be desirable from their own perspective as well as that of society because their productivity may be low. Other workers who might be enticed to retire may pose more of a policy concern. Overall, the impact on retirement may not be large (although the exact magnitude is unknown), since buying into this plan will likely be more costly than employer-sponsored insurance for most people. Nonetheless, there would likely be opposition to this approach from those who wish to reverse the trend toward early retirement in the U.S. as a means for reducing the entitlement costs of an aging population.

Benefits, Premiums, and Partial Reimbursements

The private plans participating in this program must at a minimum offer pre-Medicare eligibles the standard Medicare-required package of benefits. They would not be required to offer any additional optional coverage but they could do so. Subsidies would be based on Medicare-covered services. This is consistent with requirements now in place for Medicare beneficiaries.

The premium would be based on a community rate set at the average actuarial cost of all persons in the relevant eligible age group regardless of actual take-up. If there is adverse selection in who buys this coverage, resulting in the average applicant having higher costs than this community rate, the proposal will result in a positive net cost to private plans, even without considering low-income subsidy and administrative costs. Keeping premiums low in this way may actually help to reduce adverse selection because it would limit the ability of other insurers to offer low rates to healthier persons and hence segment the risk pool.

Even if there is no overall adverse selection, some plans may end up with less-costly applicants than others. We hope to reduce this "creaming" issue by requiring all plans to accept all applicants. However, for many reasons, such as the uneven distribution of less healthy eligibles geographically, there may be plans whose total costs are higher than total pre-subsidy premiums. We propose that these plans could apply to the federal government for a partial cost reimbursement. We allow for only partial reimbursement because there is no way to reclaim money from plans that end up being net "winners"-- i.e., those that have lower-cost

[2] The only exception is that persons currently enrolled in Medicaid would not be eligible for this plan.

applicants on average. A total reimbursement to net "loser" plans would likely be very costly.

Alternatively, premiums could be set at the average actuarial cost of beneficiaries in the eligible age group who actually buy this coverage (or an estimate of this with some adjustments over time). This would presumably be a higher level premium because less healthy people are more likely to want to buy into Medicare. In theory, this higher premium would mean total premiums (without taking into account subsidies) would equal total costs. In reality, a premium set at this level would still need to be combined with a partial reimbursement scheme to plans, since some plans could still be potential losers even with a higher average premium.

Subsidies

Because of the high cost of Medicare coverage and the fact that those with greatest need for this coverage may not be able to afford it, premium subsidies would be available for individuals based on their incomes. The subsidy would be on a sliding scale from a total subsidy for those whose income is below 100% of the poverty guidelines (about $8000 in 1998), phasing out to no subsidy for those whose incomes are at or above 200% of poverty. Thus, someone at 150 percent of poverty would receive a fifty percent subsidy towards the cost of the insurance premium.

Subsidies would also be available to persons with own-employer-sponsored insurance who meet the income guidelines outlined above. These individuals would be eligible for a subsidy based on the minimum Medicare benefit package up to the lower of their actual employee contribution or the total allowed subsidy for their income level. This subsidy would decrease the incentive for employees, and to some extent employers, to drop employer-sponsored coverage. The subsidy could also be applied to COBRA coverage, but not to private nongroup coverage.

For those with family coverage, if the covered employee is age eligible but the spouse is not, the subsidy is the lower of the employee contribution for an individual plan or the total allowed subsidy for their income level. If both the covered employee and the spouse are age eligible, the combined subsidy of both spouses is the lower of the total employee contribution for dual coverage or the total combined subsidy of both spouses allowed for their income level. If the covered employee is not age eligible and the spouse is, no subsidy would be available through the employer.

Subsidy administration

Applicants would apply for subsidies through the private plans. These private plans would do an initial income-eligibility intake. The Social Security Administration (SSA), building on their role in income determination for the Supplemental Security Income (SSI) program, would process and verify income eligibility. Additional resources would, however, be needed as this would add to

SSA's administrative costs. The subsidy would then be provided directly to private plans for eligible individuals. Based on the initial intake, private plans could give a temporary qualification status to eligibles for a short time (possibly 2 months) until SSA certifies the person is eligible for the subsidy.

Those in employer-sponsored plans eligible for the subsidy would apply for it through their employer, who would be responsible for having the forms and instructions available and sending them on to the Social Security Administration.

The subsidy would be provided directly to the employer who must use it to reduce the employee's contribution.

Likely Participation and Costs of the Plan

Participation in this plan is difficult to determine; it will depend upon the costs of the insurance offered through Medicare, the alternatives that individuals face in terms of nongroup coverage and the characteristics of their employer-sponsored plans, and whether there are behavioral responses such as early retirement that would cause some to leave employer-sponsored plans. In addition, we do not know how affordable even the subsidized premiums will look to low income individuals. To obtain a sense of the likely impact of such a proposal, we look at projected premium levels and the numbers of potential eligibles to develop a range of possible participation rates and resulting costs.

Table 1 offers a basis to begin to consider the numbers of persons between the ages of 62 and 64 who might sign up for a Medicare buy-in. This table indicates the numbers of persons eligible by current insurance status and income as a percent of the poverty guidelines.[3] Certainly a large share of those eligible will not enroll. For example, many of those with employer-sponsored insurance who are still in the labor force would not benefit from this proposal and hence likely would not participate even though they are technically eligible. We need to look further to begin to develop estimates of take up rates.

An actuarially fair premium for enrollment in a Medicare managed care plan is expected to be about $3202. This is the premium that each individual above 200 percent of poverty would face if they chose to buy-in to the Medicare program. The employee's premium contribution for employer-sponsored insurance is likely to be substantially lower than this amount. For example, the average employee contribution for *family* coverage was $1,685 for active employees and $2,340 for retirees in 1995 (GAO, 1998). Thus, we generally would assume that only those who wish to retire early and do not have access to subsidized insurance would take up this offer. In some cases, employers -- particularly those with large numbers of older workers -- might decide to drop their own insurance and encourage workers to sign up for the Medicare buy-in. We expect this number to be small, however, since

[3]The numbers for persons aged 60 to 64 break out in a relatively similar pattern, although the total would be about twice as large.

most employers would not make changes for their workers of all ages just because of this option. And even for retirees, many of whom would receive no federal subsidies, employers may well view their retiree health programs as an important benefit for attracting and retaining workers.

Would this premium be a better rate than that faced by those enrolling in nongroup plans? This is a more difficult question to answer since some plans that carefully select only healthy individuals are likely to be able to provide comparable insurance for less. (This is one reason why it is important to keep this buy-in option priced competitively.) Moreover, the comprehensiveness of the benefit package may make comparisons difficult since Medicare offers a package of benefits that is more restricted than many other insurance policies, particularly in the managed care area. At least some of the nongroup market would readily be attracted to this buy-in if they are currently in poor health and face very high underwritten premiums. Our estimates of the costs of insurance for those with nongroup plans indicates that at least 40 percent of those with such insurance paid more than $2500 in 1994 (Loprest and Uccello, 1997). That number would likely be considerably higher in 1998.

The uninsured with incomes above 200 percent of poverty are perhaps the most likely group of participants who would be willing to pay the $3200 premium. At least some of those with reasonable levels of income who currently lack insurance are likely to be unable to buy it in the current market except at exorbitant prices because of health conditions. Others may find the buy-in only modestly less expensive but the differential may be enough to entice them to purchase. Even in this group of the population, however, are those who do not value such protection and who will choose to do without.

What about low income persons eligible for a subsidy? There are relatively few persons in Table 1 whose incomes are low enough (and who are not eligible for Medicaid) to allow no premium (about 50,000 people). Nonetheless, take up should be quite high for this group if the information can be made available to them. For persons with incomes in the range of 100 to 200 percent of poverty -- particularly those who lack employer-sponsored protections -- the issue is likely to be the perceived generosity of the subsidy. For example, an individual at 150 percent of the poverty guidelines -- with an income of about $12,000 in 1998 -- would have to pay a premium of about $1600. This would constitute over 13 percent of that individual's income. Is the subsidy generous enough to attract this individual? The answer may well depend upon the person's health status and fears about the costs of health care.

Table 1 Status of Persons Aged 62 through 64 Eligible for Medicare Buy-In Proposal (in Thousands)				
Current Insurance Status	**Income as a Percent of Poverty**			**Total**
	<100%	**100-200%**	**200+%**	
Uninsured	40	280	160	480
Nongroup Insurance	*	140	200	350
Employee-Sponsored	*	360	1,620	1,990
TOTAL	50	780	1,990	2,720

(* Less than 10,000 persons)
Source: Urban Institute's TRIM model using Current Population Survey 1996.

To give a sense of what might happen to take up, we offer in Table 2 two sets of assumptions that would likely provide bounds on the numbers of persons who would choose to participate. We present both a high and low take-up scenario. Our assumptions are based on a variety of guidelines. First, we assume that, even in a high take-up scenario, not more than 80 percent of those who would save money by buying into Medicare relative to their current health spending will choose to participate. There are several reasons individuals may not buy into Medicare. Not everyone who is eligible may be aware of the program or their eligibility; some uninsured individuals may place a low personal value for health insurance; those with employer family coverage where only one spouse is eligible may not wish to lose eligibility for an ineligible spouse; and there is some cost to switching plans that might dissuade those who would receive only minimal savings over their current costs. Second, we assume take up within each current coverage category falls as income increases because individuals are eligible for a smaller (or no) subsidy. Third, we assume that those already buying nongroup coverage are signaling a greater likelihood of participation in the Medicare buy in than those without insurance.

Table 2 Potential High for a Medicare Buy-In and Low Take-Up Scenarios			
Current Insurance Status	**Percent of Poverty**		
	<100% (high/low)	**100-200%** (high/low)	**200%+** (high/low)
Uninsured	75% / 60%	65% / 50%	25% / 20%
Nongroup Insurance	80% / 65%	70% / 55%	30% / 25%
Employer-Sponsored	40% / 30%	20% / 15%	5% / 4%

The absolute take-up percentages are estimates within these guidelines. We assume that of those who currently have employer coverage and would receive a subsidy under this plan (those under 100 percent of poverty), all whose employer pays no part of the employer premium as well as half of those whose employer pays only part of the premium would participate. This comes to roughly 40 percent of all those in the employer-provided insurance category. Also, we assume that the approximately 30 percent of those with nongroup coverage paying over $3000 annually in premiums would participate in this program, even without a subsidy. Our low take-up scenario assumptions are roughly 85 percent of our high take-up assumptions.

A major cost of this proposal would be in the form of subsidies for persons with low incomes. The per capita cost will depend upon the number of those who participate who qualify for subsidies and their income levels (which will determine the subsidy amounts). For

purposes of simplicity, we assume a 50% subsidy for all those who take up the buy-in and whose incomes are less than 200 percent of poverty.

To translate participation rates into costs, we put the various pieces together as shown in Table 3. Our estimate of participation ranges from 448,000 to 570,000 persons -- considerably more than the approximately 300,000 persons anticipated in the Clinton administration's proposal that lacked low income subsidies. These numbers then translate into low income subsidies of between $528 and $677 million. To this is added the subsidy for risk adjustment; this is an arbitrary amount shown here to illustrate that if more people participate, the costs per person could well be lower and translate into higher costs for the low take-up scenario. We assumed that costs would be about 10 percent higher under the low take-up scenario and less if more people participated in the program. The total costs of the

program are then estimated as being between $662 million and $791 million if fully implemented in 1998. These estimates are offered as rough guidelines of the costs of the proposal and not as firm projections; considerable additional work would be needed to achieve a more precise set of estimates.

Table 3
Estimated Plan Participants and Subsidy Amounts for High and Low Take-Up Scenarios

	Take-Up Scenario	
	High	**Low**
Participants	570,000	448,000
Low-Income Subsidy[1]	$677 million	$528 million
Risk Adjustment Subsidy[2]	$114 million	$134 million
Total Subsidy Cost	$791 million	$662 million

Notes:
1 Low-income subsidy calculated at $3,202 for those with incomes less than 100% poverty and an average half subsidy for those between 100% and 200% of poverty.
2 Risk adjustment subsidy is calculated at $300 per person in low take-up scenario and $200 per person in high take-up scenario.

Discussion

The success of the option described here would particularly depend upon whether the insurance premiums would be affordable to the eligible uninsured. In turn, this depends upon the costs of the basic premium and the generosity of the subsidies. Both of these factors are technically under the control of the federal government as we have laid out the initial option.

If is our intention that the basic premium could be set at the actuarial costs if everyone in the covered age group participated, rather than on the specific pool that might enroll. If, as we expect, this option attracts individuals at greater risk and the premium were set to reflect that group, the premiums could be unaffordable even to those well above the low-income subsidy level. This would create a vicious circle in which the costs would be high so only those who have no other recourse would enroll, driving up the costs further over time as the risk group becomes more and more skewed. Subsidizing the basic premium to keep costs lower could mitigate this spiral and help to attract healthier enrollees, which would in turn hold down the level of subsidy necessary for the overall program. This point was illustrated in Table 3 which indicated a lower risk adjustment subsidy for the high participation scenario. There still would be a cost to the federal government, however, to offering this basic insurance in this way.

One dilemma of this approach then is the fact that if the first subsidy (available to everyone) is high, then it becomes more difficult to offer generous low-income subsidies without creating very high overall costs of this program. But the low income subsidies are also essential since, as Loprest and Uccello (1998) have shown, many of the uninsured have low incomes. Since even a premium set at the actuarial costs for all 62 year olds would be relatively high, enrollment in this incremental plan would depend upon how generous the low income subsidies can be.

How did we choose the low income subsidy formula? We proposed to ask individuals above 100% of the poverty line to begin paying a modest premium in order to maintain some consistency with the Medicare program. With some exceptions, beneficiaries of Medicare with incomes below 135 percent of poverty are eligible for subsidies of the Part B premium. Above that level, they are implicitly paying nearly 10 percent of the costs of Medicare. By our schedule, eligible persons with incomes above 135 percent of poverty would pay at least 35 percent of the costs of their insurance -- guaranteeing that subsidies for persons age 65 and over are more generous that in this plan. The upper bound for subsidies is set at 200 percent of poverty. We would have liked to set a higher bound, but to keep the costs of the program down, we phase out the subsidy entirely at that level. This may generate hardships for people with incomes of just $16,000 who would have to pay the full $3202 costs of health insurance.

One of the major advantages of this approach is the ease of transition onto Medicare that it would allow, both from the perspective of beneficiaries and administration of the program. People leaving jobs and obtaining several years of "fill-in" insurance coverage would not be forced to once again change plans and providers of care. Instead, if they wished, they could move onto Medicare with no change in their policy. Oversight of plans and other administrative activities could be overseen for this incremental option by the Medicare program. Finally, the ability to attract customers who would stick with a managed care plan for many years should be attractive to HMOs and other plan organizers who might otherwise be reluctant to offer coverage for just a short period of time. Participation in this plan and some competition among plans might thus be enhanced by building on links to Medicare. This might, in turn, help reduce the premiums charged.

Another advantage of this option is that it provides a framework for filling in gaps for persons above age 65 should the age of eligibility for Medicare be raised. It is not likely to be feasible to increase eligibility age without providing some guaranteed access to insurance for those disenfranchised. Thus, an option that starts on a relatively small scale for those in their early 60s could serve as a model if this type of policy change were implemented in Medicare.

One obvious disadvantage of this type of approach is that it could be quite expensive, particularly if employers cut back further on their offerings both to retirees and to current workers. This trend is already in place, so to some extent

offering an alternative is important to fill in gaps that already exist. But if this option exacerbates such changes, the pool of individuals needing coverage would likely rise. And if the cutbacks by employers are selective -- i.e. employers with lower income or sicker employees drop coverage -- the burdens on a public program could be high over time.

Because of concern over the current costs and financing of the Medicare program, it might be essential to consider a separate financing mechanism for this buy-in, walling it off from the rest of Medicare. One possible source of financing could be an assessment on private plans that write individual policies in the market and skim off the good risks, implicitly raising the costs of a buy-in proposal such as that described here. Insurance companies could avoid any tax by following a set of guidelines that would offer individuals reasonable access to policies. For insurers who choose to underwrite policies and seek to select only good risks, a tax could be assessed on each policy. This could achieve two goals: first, raising some revenues to offset the problems of adverse risk selection for the buy-in program, and secondly to help to level the playing field so that it becomes more difficult for insurers to skim off the low cost individuals. By itself, this would not pay for the subsidies to low income individuals, however, so other revenue sources should be considered. Special aid to low income individuals is usually provided through general revenues, although dedicated taxes might also be considered. Whatever the strategy, it is likely unwise and politically unpalatable to expect that the costs of this new program could simply be absorbed by Medicare.

Unfortunately, it is difficult to imagine how more modest proposals could go very far in solving the problems of uninsurance for this group. So many of the older uninsured are low-income, lack strong labor force attachment, or lack employer-sponsored coverage while working. Therefore, proposals to extend employer coverage into retirement, including expansions of COBRA continuation coverage or subsidies for retiree health coverage, are not likely to be the answer. And because this age group has higher medical care costs than younger age groups, subsidies for each uninsured individual will be relatively expensive.

However, without changes in the current health financing system, the number of uninsured older Americans are likely to increase. As fewer employers offer retiree health benefits and even coverage for current workers declines, older persons not yet eligible for Medicare, particularly those with low incomes, are going to become more vulnerable to being without health insurance. Our proposed Medicare buy-in is one way to meet the needs of this age group.

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