

# **Election 2004:**

A Guide to  
Analyzing the Issues

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**The Questions  
Candidates  
Should Answer  
About ...**

**Medicare  
Reform**



AMERICAN ACADEMY *of* ACTUARIES



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AMERICAN ACADEMY *of* ACTUARIES

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## *Election 2004: A Guide to Analyzing the Issues - The Questions Candidates Should Answer About ... Medicare Reform*

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### **Note on “Related American Academy of Actuaries Resources”**

Additional resource materials published by the Academy are listed throughout the *Guide*. These documents can be found on the Academy website at [www.actuary.org](http://www.actuary.org) in both the Publications and Health sections. You may also request a copy of these publications by calling the Academy at 202-223-8196, or by writing the Academy at:

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## Introduction

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Last year, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This Act adds a prescription drug benefit to Medicare, creates the Medicare Advantage program to replace the Medicare+Choice program, and establishes a demonstration program to test competition between Medicare and private plans. Nevertheless, many concerns regarding the Medicare program remain, and Medicare-related issues will figure prominently in the 2004 elections.

As the actuarial profession's voice on public policy issues, the members of the American Academy of Actuaries have many insights that may benefit candidates in the 2004 elections as they design their Medicare reform proposals, as well as benefit those who want to evaluate these proposals.

This guide has been written for journalists, policy-makers, and citizens to use as they evaluate the candidates' Medicare proposals. It summarizes several Medicare issues and suggests questions that should be considered when analyzing any proposed changes to the Medicare program.

### 1. Medicare Faces Long-Term Financing Problems

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**The Medicare trust funds face increasing financial pressures.** In terms of trust fund accounting, Medicare consists of two parts, each of which is financed separately. Hospital Insurance (HI) pays primarily for inpatient hospital care and Supplementary Medical Insurance (SMI) pays primarily for physician and outpatient care, as well as the new prescription drug benefit. Taxes, premiums, and other income are credited to the trust funds for each program and are used to pay benefits and administrative costs. Any unused trust fund income is invested in U.S. government securities.

- The HI program is funded primarily through earmarked payroll taxes. In the past several years, HI payroll taxes and other noninterest income have exceeded benefits paid, and the trust fund has been accumulating assets. According to the 2004 Medicare Trustees' Report, however, HI expenditures are projected to exceed HI payroll taxes beginning this year. And beginning in 2010, HI expenditures are projected to exceed all HI income, including interest. At that point, the HI trust fund will need to begin redeeming its assets in order to pay for benefits. By 2019, when trust fund

assets are projected to be depleted, payroll tax revenues would cover only about 80 percent of program costs, and the share covered by payroll taxes is projected to decrease further thereafter.

- The SMI program is financed through beneficiary premiums, which cover about one-fourth of the cost, and federal general tax revenues, which cover the remaining three-fourths. Because beneficiary premiums and general revenues allocated to the program are increased annually to meet projected future costs, the SMI trust fund is expected to remain solvent. However, SMI costs are growing faster than HI costs, meaning that continuing the current funding arrangements will result in general revenues financing increasing shares of total Medicare spending over time.

**Medicare expenditures will place increasing strains on the economy.**

Due to the rising number of beneficiaries and increases in both the use and cost of health care per beneficiary, Medicare costs will consume greater shares of total national spending. In 2003, Medicare spending amounted to 2.6 percent of Gross Domestic Product (GDP). This share is expected to increase to 3.4 percent in 2006, due in large part to the addition of the prescription drug benefit. It is expected to rise to 7.0 percent of GDP in 2030 and 10.9 percent of GDP in 2060. Considering Medicare spending in conjunction with Social Security's further highlights the strain these programs place on the economy. Combined, Medicare and Social Security expenditures equaled 7.0 percent of GDP in 2003. This share of GDP will increase considerably to a projected 13.3 percent in 2030 and 17.4 percent in 2060.

**The new Medicare law contains a provision intended to address Medicare's rapidly increasing costs.** In 2003, general tax revenues accounted for about 31 percent of Medicare spending. If this share increases beyond 45 percent within the next seven years, the president would be required to recommend ways to decrease it. Options would include reducing benefits, raising beneficiary premiums, or raising payroll taxes. Congress then could implement the recommendations, but would not be required to do so. This provision draws attention to the need to manage the burden Medicare places on the federal budget and sets the stage for future congressional debate about corrective action to limit the burden the program places on general tax revenues. Congressional action is not guaranteed, however, and other financing problems remain. The 2004 Medicare Trustees' report projects that the

45 percent threshold will be reached in 2012, more than seven years into the projection period. Therefore, while the requirement that the president propose reforms to reduce costs will not be triggered this year, it could be triggered as soon as two years from now.

***How does the candidate propose to strengthen Medicare's financial condition?***

- If the general revenue share of Medicare expenditures exceeds 45 percent, what strategy would the candidate recommend to decrease this share—benefit reductions, beneficiary premium increases, payroll tax increases, or some other method? Should Congress be required to implement changes to reduce the general revenue share?
- Regardless of whether the general revenue share of Medicare spending is reduced, other problems will remain. In particular, the HI trust fund will face funding shortfalls as soon as a decade from now. How does the candidate propose to meet these shortfalls—increased payroll taxes, benefit reductions, general revenue infusions, or some other method?
- Some economists estimate that raising the Medicare eligibility age would save about five percent of Medicare costs, although doing so could leave many seniors vulnerable to high health care costs. Does the candidate support raising Medicare's eligibility age to match that of Social Security?
- The recently enacted Medicare law increases Part B<sup>1</sup> premiums for higher-income beneficiaries. Does the candidate favor retaining this provision? Higher cost-sharing, in the form of higher deductibles and/or coinsurance would also improve Medicare's finances, although it would disproportionately affect those in worse health. Would the candidate prefer higher cost-sharing?
- Concern often focuses on when Medicare trust funds are predicted to run out of money. Many years before that, however, trust fund assets will begin to be drawn down. Because the trust fund is invested in U.S. government securities, if the government is experiencing budget deficits at the time the trust fund securities need to be redeemed, it will either need to levy additional taxes to fund the redemptions, or borrow additional money from the public, thereby increasing the federal debt. What course of action, if any, would the candidate pursue to delay this?

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<sup>1</sup> Medicare Part B covers primarily physician and outpatient hospital services (see page 6).

- How would the candidate's Medicare reform plan affect Medicare's long-term financing? When would the Medicare trust funds begin to be drawn down? When would they be depleted?
- Medicare premiums are currently increasing at faster rates than Social Security benefits. Does the candidate consider this problematic, and if so, how should it be addressed?

### ***Related American Academy of Actuaries Resources***

**Issue Brief:** *Medicare's Financial Condition: Beyond Actuarial Balance* (March 2004; updates a January 2004 issue brief)

**Issue Brief:** *What is the Role of the Federal Medicare Actuary?* (January 2002)

**Issue Brief:** *How is Medicare Financed?* (Fall 2001)

## **2. The Medicare Benefit Package Does Not Meet All of Seniors' Health Care Needs**

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**Traditional Medicare.** Approximately seven of eight Medicare beneficiaries enroll in the traditional fee-for-service program. Medicare Part A pays primarily for inpatient hospital care. For each hospital stay, beneficiaries must pay a deductible (\$876 in 2004) and additional copayments for hospital stays lasting beyond 60 days. Part A also pays for some skilled nursing facility and home health care. Medicare Part B covers primarily physician and outpatient hospital services. Although enrollment in Part B is voluntary, nearly all Part A enrollees also enroll in Part B, which requires an annual \$100 deductible and 20 percent cost-sharing after the deductible is met. (The deductible increases to \$110 in 2005, and is indexed thereafter.)

**Medicare Advantage Plans.** Approximately one of eight Medicare beneficiaries opt to forgo traditional Medicare in favor of private plans, previously called Medicare+Choice plans. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 replaces Medicare+Choice plans with Medicare Advantage plans. These private plans cover the same services as the traditional program, but also may provide additional benefits, such as prescription drugs and lower cost sharing requirements. However, Medicare health maintenance organizations (HMOs), the most common private Medicare plan, have more limited provider networks than the traditional program. Other private plans include preferred provider organizations (PPOs) and private fee-for-service plans.



**Medicare prescription drug coverage.** Prior to the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare did not cover outpatient prescription drugs. The new law creates a new prescription drug benefit, available to Medicare beneficiaries on a voluntary basis through private plans, beginning in 2006. Until then, beneficiaries can enroll in a prescription drug discount card program. For 2006, the standard prescription drug plan will have a deductible of \$250, 25 percent coinsurance up to the initial coverage limit (\$2,250 in total spending), then no coverage until the beneficiary meets an out-of-pocket maximum of \$3,600 (\$5,100 total spending). After meeting this maximum, all drug costs are covered, with nominal cost sharing.

**Medicare leaves beneficiaries with a sizeable share of health care costs.** Medicare beneficiaries must bear some of their health care costs not only because Medicare imposes cost sharing, but also because some products and services are not covered. For instance, although Medicare does cover skilled nursing care to some extent, it does not cover custodial nursing care, which makes up the bulk of long-term care spending. Moreover, Medicare does not cap beneficiary out-of-pocket costs. And although outpatient prescription drug coverage will be available beginning in 2006, the benefit is expected to cover only about one quarter of total prescription drug spending among the elderly over the next 10 years.

**Most Medicare beneficiaries have supplemental coverage to fill in the gaps.** To fill in the gaps in Medicare's coverage, one-third of Medicare beneficiaries have supplemental coverage through an employer and one-fourth have coverage through a Medigap plan. Almost another one-third has coverage through Medicaid, a Medicare+Choice plan, or through another public plan. Only about one in eight Medicare beneficiaries has traditional Medicare only, without any supplemental coverage. Even those with supplemental coverage could bear significant out-of-pocket costs, because supplemental coverage often limits prescription drug benefits and excludes long-term care. On the other hand, supplemental coverage can result in almost first-dollar<sup>2</sup> coverage for Part A and Part B services, thus reducing the effectiveness of these cost control incentives.

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<sup>2</sup> "First dollar" coverage provides insurance without a deductible or other cost-sharing requirements.

## ***How does the candidate propose to modernize the Medicare benefit package?***

- Some policy-makers have expressed concern that the coverage gap in the prescription drug benefit is not only confusing to beneficiaries, but also could cause financial hardship. Does the candidate advocate closing this gap, and if so, how should the enhanced benefit be financed?
- As a practical matter, enrollees in the traditional fee-for-service Medicare plan have supplemental coverage, whether through an employer, an individually purchased Medicare supplement, or through Medicaid. Is this appropriate? Should the base Medicare plan — whatever that may be in the future — provide a more comprehensive set of benefits, or should supplemental coverage continue to be necessary?
- During the past several years, policy-makers have focused on Medicare's lack of prescription drug coverage. Medicare also lacks a long-term care benefit. Does the candidate consider this problematic, and if so, how should it be addressed and financed?
- The current cost-sharing mechanisms for traditional Medicare are somewhat skewed toward nondiscretionary care. In particular, inpatient care requires higher cost sharing than outpatient care. Beginning in 2005, the outpatient deductible will be indexed, but a large disparity between inpatient and outpatient cost-sharing requirements will remain. Does the candidate favor further changes to Medicare's cost-sharing requirements?
- Does the candidate favor adding specific benefits to the existing Medicare benefit package as needed, or is a more substantial overhaul to the benefit package needed, perhaps combining Parts A and B as in Medicare Advantage plans?
- The new Medicare prescription drug program will institute an out-of-pocket maximum for drug benefits. Does the candidate favor instituting an out-of-pocket maximum for non-prescription drug spending by Medicare beneficiaries as well?

### **3. Medicare Supplements**

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**Medicare Supplement insurance fills Medicare's benefit gaps.** The traditional Medicare benefit package covers only about one-half of a beneficiary's health care costs. Medicare supplement policies are private insurance policies designed to cover some or all of the expenses that

traditional Medicare does not cover. This may include the Medicare Part A and Part B deductibles and co-payments, provider charges that exceed the Medicare approved amount, preventive care, and prescription drugs. Coverage may be provided through an employer or purchased individually. Individually purchased Medicare supplements are often called Medigap policies because they are designed to fill in the “gaps” in Medicare. Ten standard Medigap plans – A through J – were established for individually purchased policies. They differ in which of the Medicare deductibles and co-payments they cover and what additional benefits they provide. Only three – H, I, and J – provide coverage for prescription drugs. Plan A provides the most limited benefits; Plan J provides the most extensive coverage.

**Medigap open enrollment guarantees availability of coverage.**

When beneficiaries first enroll in Medicare Part B after becoming age 65, they have a six-month Medigap “open enrollment” period. During that six-month period, they can apply for a Medigap policy and the insurer cannot deny them coverage, place special restrictions on the policy, or charge them more because of poor health. In addition, any waiting period for pre-existing conditions is shortened if they had health coverage before enrolling in Medicare.

**Medigap enrollment.** About one of four Medicare beneficiaries has a Medigap plan. Of the two-thirds of those who purchase standardized Medigap plans, two-thirds opt for Plan C or Plan F, which cover both the Medicare Part A and Part B deductibles, and skilled nursing coinsurance. Fewer than 10 percent of Medigap purchasers opt for Plans H, I, or J – the plans that include prescription drug coverage. Because drug costs are fairly predictable, only people who knew they were likely to need a lot of prescribed drugs bought those plans. As a result of this adverse selection<sup>3</sup>, these plans tend to be very expensive.

**The new Medicare law will limit the use of Medigap plans that cover prescription drugs.** When Medicare Part D prescription drug coverage becomes available in 2006, individuals enrolling in Part D will be prohibited from purchasing or renewing Medigap prescription drug coverage, but they will be allowed to convert to a Medigap plan

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<sup>3</sup>Insurance spreads risks among a pool of people. In health insurance, this means that there should be a balance between the number of healthy and less healthy people in the pool. “Adverse selection” occurs when relatively fewer healthy people enroll in a health insurance plan, thereby reducing the positive effects of spreading the risk among a pool of people. As a result, adverse selection increases plan costs per participant.

without prescription drug coverage. Although non-Part D enrollees can renew Medigap prescription drug coverage, non-Part D enrollees cannot purchase new Medigap prescription drug coverage.

**Two new Medigap packages will be offered.** The new Medicare law directs the National Association of Insurance Commissioners (NAIC)<sup>4</sup> to define two new Medigap packages that would provide partial coverage of Medicare Part A and Part B cost-sharing and also would limit annual out-of-pocket costs. The plans would not cover the Part B deductible, thereby partially addressing concerns that by providing first-dollar coverage, Medigap plans give beneficiaries little incentive to be cost conscious when making their health care decisions. The NAIC also is charged with reviewing and revising the standards for all Medigap benefit packages.

### ***How does the candidate view the role of Medicare supplement policies?***

- Should all of the standard Medicare packages be revised to eliminate first-dollar coverage for Part B services, which are typically more discretionary than Part A services?
- What other changes, if any, should be made to the current set of standard Medicare supplement packages?
- If the candidate proposes more fundamental changes to Medicare's cost-sharing requirements, how would these changes affect Medigap plans? Would individuals still be allowed to continue purchasing Medigap plans?

#### **🔗 Related American Academy of Actuaries Resources**

*Report on Medicare Supplement Experience, 1996-2000 (February 2003)*

## **4. Using Private Plans in Medicare**

Few Medicare beneficiaries currently enroll in private Medicare plans. The Medicare + Choice (M+C) program, now renamed the Medicare Advantage program, was a significant attempt to provide Medicare benefits through private health plans. M+C plans include HMO, PPO, and private fee for service plans and typically cover the same services as the traditional Medicare program, but also may provide additional benefits, such as prescription drugs and lower cost-sharing requirements.

<sup>4</sup> The NAIC is an organization of state insurance commissioners that performs research and analysis and develops model legislation and regulations.

Enrollment in M+C plans grew rapidly during the 1990s, but has since dropped off significantly as the number of private plans offering coverage has declined. By 2002, 5.0 million (12 percent) Medicare enrollees will be enrolled in an M+C plan, down from a high of 6.3 million (16 percent) in 2000. The withdrawal of private plans from the program, due in large part to plans' concerns of insufficient payments, means that fewer Medicare beneficiaries will have access to an M+C plan. In 1998 nearly three-quarters of Medicare beneficiaries had access to a M+C plan, but this share declined to three-fifths by 2002.

**The new Medicare law will increase the program's reliance on private plans.** The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 will expand the use of private plans in the Medicare program. New prescription drug benefits will be available through private stand-alone prescription drug plans or through Medicare Advantage plans. In addition, Medicare Advantage plan payments will increase to encourage more private plan participation. Regional PPO options will also be established as part of the Medicare Advantage program.

**The new Medicare law moves toward competition between traditional Medicare and private plans.** The new Medicare law establishes a six year demonstration program beginning in 2010 that will introduce competition between private plans and traditional fee for service Medicare. In up to six metropolitan areas, Medicare enrollees will be given a choice between private plans and the traditional program. If traditional Medicare can provide benefits at a lower cost than private plans, traditional plan premiums will be lower than those for the private plans, and vice versa.

**Demonstration projects could be first step toward a more defined contribution approach to Medicare.** Medicare is a defined benefit program, because Congress defines the Medicare benefits and the funding required as determined by the cost of providing those promised benefits to Medicare beneficiaries. Once the required premiums and payroll taxes are paid, Medicare enrollees have a statutory right to the benefits promised by the Medicare program. Introducing more competition, potentially as part of a defined contribution approach, has been suggested as a way to help control future Medicare costs. Proposals to move to a system similar to the Federal Employees Health Benefits Program, or a system of premium support, are examples of ways to move to a defined contribution approach.

The essential change would be that Congress would define the level of Medicare funding provided to Medicare beneficiaries rather than to define the level of benefits provided. Conceptually, it would shift the program's focus away from guaranteeing enrollees a defined set of benefits (with the Medicare trust funds and federal government responsible for any funding shortfall) toward providing a fixed government contribution that enrollees could apply toward purchasing health care coverage (with the enrollees responsible for making up the difference between the government contribution and the cost of the benefits they select). Typically, proposals for such an approach would make the traditional fee-for-service Medicare one of the options available.

Medicare Advantage plans already incorporate several defined contribution elements; Congress has defined the contribution the federal government will make on behalf of any beneficiary for a minimum standard Medicare benefit enhanced with additional benefits, with an optional additional cost to the beneficiary. Such plans also have defined benefit features — most notably, the benefits provided are required to be at least as great as those provided under the Medicare fee-for-service program.

**Potential implications of a defined contribution approach to Medicare.** A defined contribution approach could make future federal outlays for Medicare more predictable and controllable — this is often cited as a primary advantage. On the other hand, a pure defined contribution approach would not guarantee that government contributions would keep pace with increases in the cost of coverage. Beneficiaries are unlikely to be satisfied if the contribution made on their behalf is not sufficient to buy meaningful coverage.

A defined contribution approach would allow greater emphasis to be placed on cost management through the contribution side of Medicare (with or without including continued or additional limits on allowed provider reimbursement levels). It would also facilitate a transition to increased control by individual Medicare beneficiaries over the benefits they receive, and greater personal involvement in the cost of their coverage and the health care they receive. Greater personal responsibility for health care buying decisions could reduce the overall level of spending on health care as beneficiaries become better consumers of health care services, and ultimately help control the long-term cost of providing coverage to seniors. On the other hand, beneficiaries might see this as placing a significant financial burden on

their shoulders and creating barriers that would prevent them from seeking needed care.

Individual selection of coverage adds a dimension to Medicare that many seniors, particularly older ones, may find difficult to manage effectively. As more choices are made available, it becomes increasingly important and difficult to compare the different options and select the most appropriate one for any particular individual. This concern, and perceived market problems that appeared to support it, motivated the standardization of Medicare supplement policies. Offering individual enrollees a choice between multiple coverage options, particularly when cost and benefit levels vary significantly between them, also creates the potential that some options will receive a disproportionate share of high-cost enrollees. Some way of adjusting payments will be required to ensure that all of the options remain financially viable.

***How does the candidate view the role of private plans in Medicare?***

- Would the candidate like private plans to play a greater role in providing Medicare benefits in the future? If so, what is the primary reason for using private plans in Medicare — to help control costs; to give enrollees more options; or to modernize benefits?
- If greater involvement of private plans in Medicare is preferred, what incentives would the candidate propose to encourage private plan participation? Are those incentives stronger than those under the Medicare+Choice program?
- Does the candidate believe the competition demonstration project should proceed as scheduled beginning in 2010?
- Does the candidate view the Medicare+Choice program as a success or a failure? Why?
- Does the candidate prefer a premium-support type of system that would provide enrollees with a fixed amount of money with which to buy the best coverage they can find, or should Medicare always provide a minimum basic level of benefits?
- There are concerns that private plans would enroll healthier beneficiaries, leaving the less healthy in the traditional fee for service program. As a result, premiums could increase for those remaining in the traditional Medicare program. What steps would the candidate take to ensure a level playing field between private plans and the traditional fee-for-service program?

## *Related American Academy of Actuaries Resources*

**Issue Brief:** *Applying the Defined Contribution Approach to Medicare: A Primer (July 2002)*

**Monograph:** *Medicare Reform: Using Private Sector Competition Strategies (April 2000)*

### **5. Some Have Suggested Expanding Medicare to Cover Uninsured Individuals Ages 55 to 64**

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**Those who are not yet eligible for Medicare are particularly vulnerable to lacking health insurance.** According to the U.S. Census Bureau, approximately 13 percent of adults age 55 to 64 lack health insurance. Although uninsured rates for these pre-Medicare eligibles are lower than those for younger adults, being uninsured can be particularly problematic for this group because health problems tend to increase with age.

**Declines in retiree health insurance coverage could exacerbate the problem.** Early retirees, that is workers who retire prior to age 65 (the Medicare eligibility age), often rely on retiree health insurance coverage from a former employer for their health insurance needs. However, access to retiree health coverage has declined dramatically in recent years. For instance, Hewitt Associates found that the share of large employers offering health insurance coverage to their pre-Medicare retirees declined from 88 percent in 1991 to 76 percent in 1999. Moreover, employers who continue to offer coverage have been increasing the premiums and/or cost sharing requirements, forcing some retirees to forgo coverage.

**The new Medicare law provides incentives to encourage employers to retain retiree health insurance.** In an attempt to stem the decline in retiree health coverage, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 would provide subsidies to employers who offer retiree coverage. However, these subsidies apply only to retirees who are eligible for Medicare. They do not apply to coverage for pre-Medicare retirees.

**Reducing the costs of coverage is key to addressing the decline in retiree health insurance.** A key problem with retiree health insurance is the rapidly escalating costs. Without stemming this growth in costs, firms will continue to reduce or eliminate coverage. Providing tax incentives to employers for prefunding retiree health insurance is one way to reduce the decline in coverage. Although this approach might



help a little, employers might be wary of the reduced flexibility that would likely accompany such subsidies.

**Some policy-makers propose allowing those not yet eligible to enroll in Medicare the opportunity to “buy into” (i.e. purchase) Medicare coverage.** Because of concerns that those approaching age 65 are less likely than younger adults to have access to health coverage through employment and that, due to deteriorating health, they may be less able to purchase individual health insurance, some policy-makers have proposed expanding the Medicare program to allow certain individuals between the ages of 55 and 64 to participate on a voluntary “buy in” basis. General considerations for Medicare buy-in programs include:

- The costs of such a program would be strongly influenced by the health status of those who choose to participate. To keep per-enrollee costs at manageable levels, it is important to attract as many healthy individuals as possible.
- Even with provisions designed to attract healthy individuals, some degree of adverse selection is inevitable. An innovative, but unproven, way to recapture increased costs due to adverse selection is to increase Medicare premiums from age 65 to 85 for buy-in participants.
- Although subsidizing premiums could increase participation, this would increase the costs of the program to taxpayers.

***How does the candidate propose to address the lack of insurance among those not yet eligible for Medicare?***

- What methods, if any, does the candidate propose to encourage employers to continue offering retiree health insurance coverage?
- Does the candidate support a Medicare buy-in program for pre-Medicare eligibles to increase their access to health insurance coverage?
- How would a Medicare buy-in affect the long-term financing of the program?
- Under a buy-in program, Medicare would be directly competing with private insurers. Is that an appropriate role for Medicare?
- How should any increased costs in a Medicare buy-in program that are due to adverse selection be paid?

🔗 ***Related American Academy of Actuaries Resources***

**Issue Brief:** *Actuarial Issues in Medicare Expansion (Spring 1998)*



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