



MARCH 2019

EXPANDING ACCESS TO PUBLIC INSURANCE PLANS



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Executive Summary

Proposals to expand access to public health insurance plans are being put forward to provide a way to supplement efforts to strengthen insurance markets under the Affordable Care Act (ACA) or to replace the ACA marketplaces and/or other health insurance programs altogether.

Goals of these proposals vary and include increasing access to affordable coverage, exerting downward pressure on provider prices, increasing plan availability, and reducing the number of uninsured. This issue paper from the American Academy of Actuaries Health Practice Council briefly outlines four approaches aiming to achieve such goals and highlights the key design elements that would need to be specified for an approach to be fully evaluated and implemented. Note that there are not clear lines demarcating these options, and particular proposals could have elements of more than one approach. In addition, different proposals often use different terminology to describe similar approaches. The nomenclature used in this paper attempts to accurately reflect each approach, and could differ from the terms used in particular proposals.

Including a government-facilitated plan in the ACA marketplaces.

Under this option, a government-facilitated or administered health plan would compete with other plans in the ACA marketplaces. The public plan would generally follow the requirements of the ACA marketplaces, including the issue, rating, and benefit coverage rules, and would be part of the single risk pool. The difference would be that the government-facilitated plan would likely use provider payment rates based on Medicare or Medicaid, or some rate between those levels and commercial payment levels.

Creating a Medicaid buy-in.

Under a Medicaid buy-in, all or certain individuals not currently eligible for Medicaid would be able to enroll directly into Medicaid and pay any applicable premiums. It would be administered by states or by private entities such as managed care organizations. Unlike a government-facilitated plan in the ACA marketplaces, it would likely operate outside of the exchange, would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans.

Creating a Medicare buy-in.

Under a Medicare buy-in, all or certain individuals not currently eligible for Medicare would be able to enroll directly into Medicare and pay any applicable premiums. It would have many similarities to a Medicaid buy-in, but rather than being administered by states it would be administered by the federal government or by private entities such as managed care organizations. It would likely operate outside of the exchange, would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans.

Medicare for more or for all.

Rather than creating a Medicare buy-in option, other approaches would more directly expand Medicare. These approaches range from extending Medicare eligibility by lowering the eligibility age (e.g., to age 55), extending Medicare eligibility to all U.S. residents, or extending Medicare eligibility to all and also restructuring the program to provide more comprehensive coverage.



When designing or evaluating a proposal to expand access to public health insurance plans, it's important for the goals of the proposal to be explicit. Regardless of the policy goal, many major and minor design elements need to be specified. These include:

- Who is the eligible population? Would the plan be available to all or would certain subgroups of the population or areas of the country be targeted? Would employers be allowed to enroll their workers in the public plan?
- Would coverage in the plan be an option among other coverage choices or the sole coverage source available?
- How would the program be funded and what entities would bear the financial risk?
- Who would administer the program?
- Would the program rely solely on public coverage (e.g., traditional Medicare) and/or include private plan choices (e.g., Medicaid managed care, Medicare Advantage (MA))?
- What benefits would be covered and what patient cost-sharing would be required?
- If other coverage options are available, would the public plan follow the same rules governing private plans competing for the same enrollees? Would the plan be part of the ACA single risk pool?
- How would provider payment rates be set? Would there be a provider network?
- How would premiums be determined and how would they vary among enrollees? Would premiums and/or cost-sharing be subsidized for low-income enrollees?
- Would the new plan be implemented all at once or phased in over time?

How these details are decided would affect the viability of the plan and the impacts it would have on coverage availability and affordability, not only of the public plan, but also of other coverage sources.

Expanding Access to Public Insurance Plans

Introduction

Proposals to expand access to public health insurance plans are being put forward as a way to supplement efforts to strengthen insurance markets under the Affordable Care Act (ACA) or to replace the ACA marketplaces and/or other health insurance programs altogether.

Rather than examining particular proposals, this issue paper examines four general approaches for incorporating or expanding public plan availability in the health insurance system—including a government-facilitated plan in the ACA marketplaces, allowing individuals to buy into Medicaid, allowing individuals to buy into Medicare, and expanding Medicare to more or to all. The terms used to describe these various options are often used interchangeably but the approaches would be structured differently and have different impacts depending on the implementation details.

To help clarify these issues, this paper from the American Academy of Actuaries Health Practice Council provides a brief overview of each general approach and identifies the key design features that would need to be specified for an approach to be fully evaluated and implemented. The nomenclature used in this paper attempts to accurately reflect each approach, and may differ from the terms used in particular proposals. Note that there are not clear lines demarcating these options, and particular proposals could have elements of more than one approach.

Designing and evaluating different proposals

When designing or evaluating a proposal to expand access to public plans, it's important for the goals of the proposal to be explicit. Such goals could include: increasing access to affordable coverage; exerting downward pressure on provider prices, especially in areas with high prices or little provider competition; increasing plan availability, especially in areas with few private insurance options; and reducing the number of uninsured.

Regardless of the policy goal, many major and minor design elements need to be specified. Among the most important is defining the eligible population. Would the plan be available to all or would certain subgroups of the population be targeted? And would coverage in the plan be an option among other choices or the sole choice available? Another primary design element is whether the program would rely solely on public coverage (e.g., traditional Medicare) or whether it would include private plan choices along the lines of Medicaid managed care or Medicare Advantage plans. Similarly, what entity bears the financial risk—the federal government, states, private plans, providers, or some combination? And of course, the funding for the program would need to be specified.

Aside from these more high-level elements, the particulars of how the program would work need to be specified. These design considerations include guidelines for what services are covered and the beneficiary share of the cost of those services, what the enrollment rules are, how provider payment rates are set, how premiums are determined, and how the program is administered.

When evaluating public plan expansion proposals, it's important to assess the impacts on public plan enrollment, premiums and other funding needs, and access to providers. Equally important is to examine the impact on other remaining coverage sources (if any). For example, for proposals that would maintain the health insurance marketplaces and other private health insurance options, it's important to assess the impact of the public plan expansion on those markets: Would marketplace enrollment increase or decrease, would the risk pool profile improve or worsen, would private insurers continue to offer coverage, would employers continue to offer coverage to their workers, and how would premiums be affected?

Including a government-facilitated plan in the marketplaces

Under this approach, a government-facilitated or -administered health plan (also referred to here as a public plan) would compete with other plans in the ACA marketplaces. The primary difference between the government-facilitated plan and the participating private plans is that the government-facilitated plan would likely use provider payment rates based on Medicare or Medicaid, which can be much lower than the commercial provider payment levels, or some rate between those levels and commercial payment levels. In general, the government-facilitated plan would follow the rules of the ACA marketplaces, including the issue, rating, and benefit coverage rules, and would be part of the ACA single risk pool. To the extent that the same rules are not followed, either the public plan or the private plans could attract a disproportionate share of less-healthy individuals and find it more difficult to compete.

Key design considerations:

Where would the government-facilitated plan operate?

Government-facilitated plans could be made available in all areas or be limited to particular exchanges, depending on the goal of the program. For instance, if a goal is to serve as a fallback option, the government-facilitated plan could be targeted to areas with no or few participating private insurers. If a goal is to address high provider prices, the government-facilitated plan could be targeted to areas with high provider prices. When determining what criteria would be used to determine public plan availability, an assessment should be made as to whether particular options would encourage or discourage private plan participation.

It would also need to be determined whether the government-facilitated plan would operate solely on the ACA exchanges and/or off the exchanges.

Who would be eligible to enroll in the government-facilitated plan? Would employers be allowed to enroll their workers? Would any individuals or groups be automatically enrolled?

Presumably everyone currently eligible for ACA individual market coverage would be eligible to enroll in the government-facilitated plan, as one of the marketplace options. It's possible that in some geographic areas the public plan would be the only marketplace option available. Although this type of a proposed public plan expansion typically focuses on the individual market, it would need to be determined whether small and/or large employers would have access to the government-facilitated plan as well.

Another question is whether anyone eligible would be automatically enrolled in the public plan. Also, if any individuals more typically enrolled in other plans—such as Medicare, Medicaid, or employer-sponsored plans—would instead be targeted for individual market public plan enrollment, or automatically enrolled, the impact on each of the risk pools would need to be considered.

What entity would administer the government-facilitated plan?

A federal or state government entity could administer the public plan. Alternatively, the insurance and administrative tasks could be contracted out to a non-government entity, such as a managed care organization. Such tasks could include developing the plan design, setting premiums, premium collection, claims processing, ensuring regulatory compliance, risk adjustment processing, etc.

How would the program be funded and who would bear the financial risk?

It would need to be decided whether the program would be self-supporting through premiums (and perhaps also the federal government via ACA premium subsidies) or whether the program would have additional federal or state funding. Additional government funding solely for the government-facilitated plan compared with the private marketplace plans would affect premiums and create an unlevel playing field between the public plan and the private plans. Such advantages for the government-facilitated plan could affect marketplace participation among private plans.

Even if premiums are intended to fully fund the program, there could be a financial risk if the premiums turn out to be too low relative to plan costs (or a financial benefit if premiums exceed costs). What entity bears the risk—the federal government, states, and/or managed care organizations—depends on how the public plan is administered and whether there are risk-sharing mechanisms between the federal or state governments and participating managed care organizations.

Would the government-facilitated plan be part of the single risk pool, following the same issue, rating, and benefit coverage rules as private plans?

As long as it follows the same rules as private plans, the government-facilitated plan would most likely be part of the single risk pool. It would be required to cover the same benefits and follow the same issue and rating rules as other plans operating in the marketplaces. As a result, adverse selection concerns between the government-facilitated plan and private plans would be less as compared to having to compete under different rules. Differences in the risk profiles of the public plan and the private plans would be addressed at least partially through the risk adjustment program.

If, however, the government-facilitated plan were to compete under different rules, it could be more difficult to spread risks in the single risk pool and risk adjustment could be difficult to implement. As a result, the viability of plans attracting less-healthy individuals, whether the public plan or private plans, could be at risk.

What provider payment rates would be used in the government-facilitated plan?

Would the plan establish a provider network?

The choice of what payment rates are used in the government-facilitated plan—Medicaid, Medicare, commercial, or some level between Medicare, Medicaid, and commercial rates—would affect premiums, the willingness of providers to treat patients with public plan coverage, and the willingness of private plans to participate in the market. The broadness or narrowness of any provider networks would also affect the attractiveness of the plan and the risk profile of enrollees. These tradeoffs would need to be considered. Lower provider payment rates could result in lower premiums for the public plan, potentially offset to some extent by a lower degree of utilization control if managed care organizations don't administer the plan. But in the absence of other mechanisms to encourage provider participation (e.g., mandatory participation for providers participating in Medicare or Medicaid), provider payment rates would need to be high enough to ensure adequate access to care, which could be especially problematic in rural areas with few providers. Another question is whether lower provider payment rates in the government-facilitated plan could provide more leverage to private plans to negotiate lower payment rates. Or whether instead private plans would find it more difficult to compete, potentially leading to their exit from the market.

How would premiums be set?

Assuming no external funding of the public plan (beyond any ACA premium subsidies), premiums would be set (by the administering government entity or a managed care organization) to cover expected claims and administrative costs. As long as the government-facilitated plan follows the ACA issue and rating rules, the premium factors used for the public plan would be the same as for the private ACA plans. Private plans are subject to medical loss ratio (MLR) requirements, limiting the share of premiums available for administration and profit. It would need to be determined whether the public plan would also be subject to the MLR requirement. If plan administration is shared between the federal or a state government and a private entity, it could be difficult to track the administrative expenses and determine the public plan MLR. In addition, it would need to be determined whether other requirements that affect premiums for private insurers would also apply to the public plan, such as health insurer taxes and fees and the need to hold adequate reserves.

How would ACA premium subsidies be affected?

Premium subsidies could be used toward the government-facilitated plan in the individual market, at least for on-exchange plans. Whether or not the premium for the government-facilitated plan is included in the calculation of the benchmark premium (the second-lowest-cost silver-tier plan) could affect subsidy levels, which in turn could affect enrollment dynamics. For instance, if the public plan affects the benchmark premium and results in lower premium subsidies, enrollment could shift from private plans to the lower-premium public plan. However, lower premium subsidies could result in lower enrollment more generally, potentially leading to a worsening of the risk pool.

It would also need to be determined whether individuals not already eligible for premium subsidies (e.g., because of eligibility for Medicaid or employer-sponsored coverage) would remain ineligible for premium subsidies.

Adverse selection and an unlevel playing field

“Adverse selection” describes a situation in which an insurer (or an insurance market as a whole) attracts a disproportionate share of unhealthy individuals. It occurs because individuals with greater health care needs, when given the opportunity, are more likely to purchase health insurance and to purchase health insurance with richer benefits or broader provider networks than individuals with fewer health care needs. Adverse selection can increase premiums for everyone in a health insurance plan or market because it results in a pool of enrollees with higher-than-average health care costs. Adverse selection is a byproduct of a voluntary health insurance market in which people can choose whether to purchase coverage and what coverage to purchase, depending in part on how their anticipated health care needs compare with the insurance premium charged.

Selection can also occur between plans or insurance markets if plans competing to enroll the same participants operate under different rules, often referred to as an unlevel playing field. If one set of plans operates under rules that are more advantageous to healthy or less costly individuals, then healthy or less costly individuals will migrate to those plans; less-healthy or more costly individuals will migrate to the plans more advantageous to them. In other words, plans that have rules more amenable to higher-risk/higher-cost individuals will experience adverse selection. In the absence of an effective risk adjustment program that includes all plans, upward premium spirals could result, threatening the viability of the plans more advantageous to higher-risk individuals.

Numerous rules governing health insurance can affect selection if they differ between competing plans or markets. These include rules regarding insurance issue and rating (e.g., how premiums can vary by age, health status, and geographic area; the presence and timing of open enrollment periods; whether pre-existing conditions can be excluded from coverage); benefit coverage requirements (e.g., essential health benefit requirements; cost-sharing requirements); and health insurer rules (e.g., minimum loss ratio requirements; reserve requirements; reporting requirements).

Creating a Medicaid buy-in

Medicaid eligibility currently varies by state. In general, the federal government requires that state Medicaid programs cover low-income families (including parents, pregnant women, and children), low-income adults age 65 and older, and low-income individuals with disabilities. States also have the option to extend Medicaid eligibility to additional groups, including families and individuals above the minimum federal standards and otherwise eligible individuals with high medical expenses who have incomes exceeding the eligibility threshold (i.e., medically needy). Medicaid's benefit packages also differ by state, and within states by eligibility category. Medicaid is administered by states, but is jointly funded by the federal government and the states.

Under a Medicaid buy-in, individuals not currently eligible for Medicaid would be able to enroll directly into Medicaid and pay any applicable premiums. It would be administered by states. Unlike a government-facilitated public plan, it would operate outside of the exchange,¹ would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans. How the Medicaid buy-in rules are structured and how they compare to the rules governing ACA plans would affect the enrollment, risk profiles, and premiums in both markets.

Key design considerations:

Where would Medicaid buy-in plans be available?

A Medicaid buy-in plan could be made available on a state-by-state basis, at each state's discretion. If federal funds would be required, the buy-in program would also be subject to federal approval.

Who would be eligible to enroll in a Medicaid buy-in? Would employers be allowed to enroll their workers? Would any individuals or groups be automatically enrolled?

A Medicaid buy-in could be made available to everyone, or be limited to particular groups—for instance individuals of certain ages, individuals without access to employer coverage or ACA subsidized coverage, or individuals with limited incomes. Other eligibility questions include whether the Medicaid buy-in is an option added to current coverage choices or is instead the only source of coverage for individuals eligible, whether certain populations are automatically enrolled in the buy-in plans, and whether employers can purchase buy-in

¹ It would be possible for Medicaid buy-in plans to operate within the ACA exchanges. However, those plans would likely have to meet the ACA requirements regarding issue and rating rules, benefit requirements, etc. As a result, those plans could be similar to the government-facilitated plan option approach discussed above.

plans for their employees. The impact on other insurance markets, including the individual and employer group markets, could be larger the more expansively buy-in eligibility is defined.

Aside from eligibility, any enrollment rules would need to be determined. For instance, would there be limited open enrollment periods (and if so, would those coincide with ACA enrollment periods) or could individuals move into and out of the buy-in at any time? The latter could increase adverse selection effects between the buy-in program and other insurance markets.

Would the buy-in include traditional Medicaid coverage and/or coverage through a Medicaid managed care organization (MCO)?

Many states allow or require segments of their Medicaid beneficiaries to enroll in a managed care plan, and in 2016, about two-thirds of Medicaid enrollees were in a comprehensive managed care plan.² Such coverage is provided by risk-bearing Medicaid MCOs, which receive capitated rates to cover the costs of Medicaid benefits and associated administrative costs and profit. Would buy-in enrollees have the same options or requirements?

The buy-in population could be very different from the current Medicaid population in terms of their health care needs. Private insurers with expertise in the current Medicaid population, or a particular segment thereof, might not necessarily have expertise in a broader buy-in population. If enrollment in a Medicaid managed care plan is allowed or required in a Medicaid buy-in program, plans for currently eligible Medicaid beneficiaries might need to be distinct from plans for the buy-in population. Would MCOs be allowed to offer managed care plans to the buy-in population but not the currently eligible population, or vice versa?

How would the Medicaid buy-in program be funded?

It would need to be decided whether the program would be self-supporting through buy-in premiums (and perhaps also the federal government via ACA premium subsidies) or whether the program would have additional state or federal funding.

² Medicaid and CHIP Access Commission, *MACStats: Medicaid and CHIP Data Book*, December 2018. Medicaid managed care enrollment is generally highest among non-disabled children and adults, and lower for disabled and aged beneficiaries.

How would the Medicaid buy-in be administered?

States would administer the program, but could contract with private MCOs to perform insurance and administrative tasks.

What benefits would be covered?

Federal rules require that Medicaid cover a broad range of benefits, including inpatient and outpatient hospital services and physician services, but states are allowed the option to cover additional benefits. As a result, Medicaid benefits vary considerably among states and also vary within states by Medicaid eligibility category. Medicaid mandated benefits include some services not considered part of ACA essential health benefits, and exclude some benefits that are. For instance, prescription drugs and physical therapy are not mandated Medicaid benefits but can be covered as optional benefits. States must offer nursing facility and home health care benefits, and can offer other long-term care services on an optional basis. Long-term care services are not typically covered by private health insurance plans. Because Medicaid is targeted to a low-income population, patient cost-sharing is usually held to a minimum.

It would need to be determined what benefits a Medicaid buy-in would cover. Would they reflect benefits the state currently uses for one or more of its eligibility categories, the ACA essential health benefits, or some other set of benefits? Also, would cost-sharing requirements change from the state's current requirements, which could be lower than those under ACA plans?

How benefits and cost-sharing are defined under a Medicaid buy-in plan and how they compare to those in ACA coverage could affect selection between the Medicaid buy-in plan and ACA coverage.

What would provider payment rates be under a Medicaid buy-in plan?

Provider payment rates would affect buy-in premiums as well as provider willingness to treat buy-in enrollees. Medicaid provider payment rates are often low compared with Medicare and commercial payment rates. If payment rates were set higher than current Medicaid rates, providers could be more willing to participate, but premiums would be higher. Payment rates for any new services covered would also need to be determined. A question is whether lower provider payment rates in the Medicaid buy-in plan could provide more leverage to individual and group market plans to negotiate lower payment rates. Or instead would private plans find it more difficult to compete with the buy-in, potentially leading to their exit from the individual or group market.

How would Medicaid buy-in premiums be set?

A key question is whether Medicaid buy-in premiums would be self-supporting or whether they would be subsidized by the state or federal government (aside from any premium subsidies provided to low-income enrollees through the buy-in program or through ACA premium subsidies, if applicable). If premiums are to be self-supporting, they would need to reflect the expected claims plus administrative costs for the buy-in population; any premiums for current Medicaid beneficiaries likely would be unaffected unless other changes are also made to the current Medicaid program. Even if premiums are intended to fully fund the program, there could be a financial risk if the premiums turn out to be too low relative to plan costs (or a financial benefit if premiums exceed costs). What entity bears the risk—the federal government, states, and/or managed care organizations—depends on how the buy-in plan is administered and whether there are risk-sharing mechanisms between the federal or state governments and participating MCOs.

It would also need to be determined whether and how buy-in premiums would be allowed to vary by individual characteristics, such as age or geographic area. If allowable premium rating factors differ from those in ACA plans, there could be selection effects between buy-in plans and ACA plans. Depending on the buy-in rules, lower-cost people could be better off purchasing buy-in coverage compared with ACA plans or other coverage choices, or vice versa. The buy-in plans would likely not be included in the ACA single risk pool, so there wouldn't be risk adjustment between buy-in plans and ACA plans. Even if it were desired to include buy-in plans in ACA risk adjustment, it could be difficult to do so, especially if the buy-in plans have different benefits and rating rules.

If more than one MCO were to participate in the buy-in program, there may need to be risk adjustment among participating organizations to reflect the risk profiles of different MCOs and reduce incentives for MCOs to avoid high-cost enrollees.

Could individuals use ACA premium subsidies toward a Medicaid buy-in plan?

It would need to be determined whether ACA premium subsidies could be used toward Medicaid buy-in premiums, and if so, whether and how buy-in premiums are used when determining the ACA benchmark plan. The latter could be complicated if buy-in plans cover different benefits or have different actuarial values than ACA plans. Allowing ACA premium subsidies to be used for Medicaid buy-in coverage could reduce enrollment in ACA plans, potentially reducing the viability of the ACA marketplaces. It could also reduce overall enrollment if the buy-in premium was used to determine the ACA benchmark premium and lower ACA premiums subsidies resulted.

Creating a Medicare buy-in

Medicare eligibility is currently limited to individuals aged 65 and older and individuals younger than 65 meeting certain disability criteria. Under a Medicare buy-in, individuals not currently eligible for Medicare would be able to enroll directly into Medicare and would pay any applicable premiums. It would have many similarities to a Medicaid buy-in, but rather than being administered by states it would be administered by the federal government. It would operate outside of the exchange,³ would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans. How the Medicare buy-in rules are structured and how they compare to the rules governing ACA plans would affect the enrollment, risk profiles, and premiums in both markets. A Medicare buy-in could also affect the employer group health insurance market if coverage is extended to individuals who would be otherwise covered by employer plans.

Key design considerations:

Where would Medicare buy-in plans be available?

A Medicare buy-in plan could be made available nationwide. The federal nature of the program could make it more difficult to limit a buy-in to particular areas, perhaps unless done as a demonstration project.

Who would be eligible to enroll in a Medicare buy-in? Would employers be allowed to enroll their workers? Would any individuals or groups be automatically enrolled?

A Medicare buy-in could be made available to everyone, or be limited to particular groups, for instance individuals of certain ages (e.g., ages 55-64) or individuals without access to employer coverage. Other eligibility questions include whether the Medicare buy-in would be an option added to current coverage choices or would instead be the only available source of coverage for individuals eligible, whether certain populations would be automatically enrolled in the buy-in plans, and whether employers could purchase buy-in plans for their employees. The impact on other insurance markets, including the individual and employer group markets, could be larger the more expansively buy-in eligibility is defined.

³ It would be possible for Medicare buy-in plans to operate within the ACA exchanges. However, those plans would likely have to meet the ACA requirements regarding issue and rating rules, benefit requirements, etc. As a result, those plans could be similar to the government-facilitated plan approach discussed above.

Aside from eligibility, any enrollment rules would need to be determined. For instance, would there be limited open enrollment periods (and if so, would those coincide with ACA or Medicare enrollment periods) or could individuals move into and out of the buy-in at any time? The latter could increase any selection effects between the buy-in program and other insurance markets.

Would the buy-in include traditional Medicare coverage and/or Medicare Advantage coverage?

Current Medicare beneficiaries have the option of enrolling in traditional Medicare or in a Medicare Advantage plan. Would buy-in enrollees have the same options? Under traditional Medicare, the federal government bears the financial risk, although providers can sometimes share in that risk, for instance through bundled payments or accountable care organizations. Under Medicare Advantage, private plans bear the financial risk, although again, that risk can be shifted to or shared with providers depending on the provider payment arrangement. Under Part D prescription drug plans, private plans and the federal government bear the financial risk, with the latter shouldering much of the catastrophic costs of high-cost beneficiaries through a reinsurance program.

The buy-in population could be very different from the current Medicare population in terms of their health care needs. Private insurers with expertise in the current Medicare population may not necessarily have expertise in the buy-in population. If Medicare Advantage plans are included in the buy-in program, would plans for currently eligible Medicare beneficiaries be distinct from plans for the buy-in population? Would insurers be allowed to offer MA plans to the buy-in population but not the currently eligible population, or vice versa?

How would the program be funded?

It would need to be decided whether the program would be self-supporting through buy-in premiums (and perhaps also the federal government via ACA premium subsidies) or whether the program would have additional federal funding. As long as the buy-in premiums are fully self-supporting, there would be no net impact on the Medicare trust funds. However, state Medicaid budgets could be affected, depending on any changes in state funding responsibility for beneficiaries dually eligible for Medicare and Medicaid.

What entity would administer the buy-in program?

The federal government would administer the buy-in. As with the current Medicare program, some insurance and administrative tasks could be contracted out to private entities, through Medicare Advantage plans or other private contractors.

What is the current Medicare benefit structure?

Under traditional Medicare, benefits are covered by three separate parts. Medicare Part A covers inpatient hospital and post-acute services; Part B covers physician and outpatient hospital services; Part D covers prescription drugs. Each part is subject to different deductibles and coinsurance requirements. Eligible individuals automatically have Part A coverage, but parts B and D are optional. Private MA plans are more integrated and cover all of the services covered by the traditional Medicare program. MA plans (also known as Medicare Part C) can also provide benefits beyond those in traditional Medicare and are available both with and without prescription drug coverage.

Medicare benefits do not cover all of the ACA-required essential health benefits. For instance newborn care and prescription drug coverage is not required. And although MA plans have out-of-pocket limits, traditional Medicare coverage does not. Individuals with traditional Medicare can have supplemental coverage, in the form of an individually purchased Medigap plan or retiree benefits provided from a former employer. And low-income Medicare beneficiaries can have additional benefits and cost-sharing protections through Medicaid and Part D low-income subsidies.

What benefits would be covered?

Many decisions about benefits under a Medicare buy-in would need to be made, including:

- For a traditional Medicare buy-in option, would individuals have to choose both parts A and B? Would Part D coverage also be mandatory under either a traditional Medicare or Medicare Advantage buy-in option?
- Would buy-in benefits be supplemented in order to meet ACA essential health benefit requirements and the needs of a broader eligible population?
- What cost-sharing requirements and/or protections would be included?
- Would supplemental coverage, such as Medigap coverage, be available to buy-in enrollees?
- Would Medicare Advantage special needs plans (SNPs)—which tailor coverage to particular groups, such as those with specific conditions or dually eligible for Medicaid—be available to the buy-in population?

How benefits are defined under a Medicare buy-in plan and how they compare to benefits in ACA coverage could affect selection between the Medicare buy-in plan and ACA coverage. Estimates of the actuarial value of the traditional Medicare program range from 80 percent⁴ to 84 percent.⁵ These findings suggest that Medicare coverage is in the range of an ACA gold metal tier plan, although differences in underlying benefits can affect such comparisons.

What would provider payment rates be under a Medicare buy-in plan?

Provider payment rates would affect buy-in premiums as well as provider willingness to treat buy-in enrollees. If payment rates were set higher than current Medicare rates, providers could be more willing to participate, but premiums would be higher. Payment rates for any new services would also need to be determined. A question is whether lower provider payment rates in the Medicare buy-in plan compared to commercial coverage could provide more leverage to individual and group market plans to negotiate lower payment rates. Or instead would private plans find it more difficult to compete with the buy-in, potentially leading to their exit from the individual or group markets.

How would Medicare buy-in premiums be set?

A key question is whether Medicare buy-in premiums would be self-supporting or whether they would be subsidized by the federal government or states (aside from any premium subsidies provided to low-income enrollees through the buy-in program or through ACA premium subsidies, if applicable). If premiums are to be self-supporting, they would need to reflect the expected claims plus administrative costs for the buy-in population. Unless there were a specific policy goal to have cross subsidies between the current Medicare population and the buy-in population (or other changes made to the current Medicare program), premiums for current Medicare beneficiaries likely would be unaffected.

The federal government would be at risk if buy-in premiums for traditional Medicare were set too low relative to plan costs (and could benefit if premiums exceed costs). If MA plans are included as a buy-in choice, they would be at financial risk if those premiums were set too low. If a Medicare buy-in program is federally subsidized, there would need to be a structure to allocate the government subsidy, especially if MA buy-in plans are available. Additional subsidies for buy-in plans compared with individual or group market coverage would affect premiums and enrollment, potentially affecting the availability of individual and group market plans.

⁴ Frank McArdle, Ian Stark, Zachary Levinson, and Tricia Neuman, "[How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans? A 2012 Update](#)," Kaiser Family Foundation issue brief, April 2002. The Medicare actuarial value estimate includes prescription drug coverage.

⁵ Daniel W. Bailey, "[Actuarial Value and the Actuarial Value of Original A/B Medicare](#)," *In the Public Interest*, Issue 9, January 2014. The Medicare actuarial value estimate reflects parts A and B only and does not include prescription drug coverage.

It would also need to be determined whether and how buy-in premiums would be allowed to vary by individual characteristics, such as age or geographic area. If allowable premium rating factors differ from those in ACA plans, there could be selection effects between buy-in plans and ACA plans. Depending on the buy-in rules, higher-cost people could be better off purchasing buy-in coverage than other available coverage, or vice versa. In addition, setting a uniform national buy-in premium could result in high buy-in enrollment in areas with higher ACA premiums and lower enrollment in areas with lower ACA premiums. The buy-in plans would likely not be included in the ACA single risk pool, so there wouldn't be risk adjustment between buy-in plans and ACA plans. Even if it were desired to include buy-in plans in ACA risk adjustment, it could be difficult to do so, especially if the buy-in plans have different benefits and rating rules.

Aside from any risk adjustment between ACA plans and buy-in plans, if private plans participate in the program, there might need to be risk adjustment among buy-in plans to reflect the risk profiles of different buy-in plans and to reduce incentives for plans to avoid high-cost enrollees.

Could individuals use ACA premium subsidies toward a Medicare buy-in plan?

It would need to be determined whether ACA premium subsidies could be used toward Medicare buy-in premiums, and if so, whether and how buy-in premiums are used when determining the ACA benchmark plan. The latter could be complicated if buy-in plans cover different benefits or have different actuarial values than ACA plans. Allowing ACA premium subsidies to be used for Medicare buy-in coverage could reduce enrollment in ACA plans, potentially reducing the viability of the ACA marketplaces. It could also reduce overall enrollment if the buy-in premium was used to determine the ACA benchmark premium and lower ACA premiums subsidies resulted.

Medicare for more or for all

Rather than creating a Medicare buy-in option, other approaches would more directly expand Medicare. These approaches range from extending Medicare eligibility by lowering the eligibility age (e.g., to age 55), extending Medicare eligibility to all U.S. residents, or extending Medicare eligibility to all and also restructuring the program to provide more comprehensive coverage. The latter two approaches are often referred to as “Medicare for All” or “single payer,” and they would replace most or all other sources of coverage. However, the design details of particular proposals could be different and have different implications.

Key design considerations:

Where would Medicare eligibility be extended?

A reduction in the Medicare eligibility age would be made available nationwide. The federal nature of the program would make it more difficult to extend eligibility only to particular geographic areas.

How would Medicare eligibility be extended?

Medicare eligibility could be extended to all regardless of age, or the Medicare eligibility age could be lowered, for instance to age 55. Unlike a buy-in approach, in which Medicare could be one of many insurance coverage options, under a Medicare eligibility change, Medicare would become the primary source of coverage for those eligible, replacing other sources of coverage. Other coverage could potentially be available to supplement Medicare coverage.

Would the Medicare expansion include traditional Medicare coverage and/or Medicare Advantage coverage?

Presumably a change in the Medicare eligibility age would result in newly eligible Medicare beneficiaries having the same choices as current Medicare beneficiaries. That is, they would have a choice of enrolling in traditional Medicare (in which the federal government bears the financial risk) or in a risk-bearing Medicare Advantage plan and/or Part D plan. However, a policy to increase Medicare eligibility to more or to all could also include more structural changes to the Medicare coverage options, including the extent to which private plans remain available and how they compete with traditional Medicare.

The newly eligible population could be very different from the current Medicare population in terms of their health care needs. Private insurers with expertise in the current Medicare population might not necessarily have expertise in the newly eligible population or could evaluate the relative health management opportunities differently for the newly eligible population. But unlike a Medicare buy-in approach, it might be more administratively difficult for Medicare Advantage plans to have separate plans for the currently eligible Medicare beneficiaries and the newly eligible beneficiaries.

How would the program be funded?

Medicare is currently funded by a combination of federal payroll taxes, beneficiary premiums, and general tax revenues. An expansion of Medicare would require additional funding, especially as the current Medicare program is already facing serious financial challenges. Non-Medicare health spending is financed by a range of payers, including individual premiums and out-of-pocket costs, employer premium contributions, and state and federal governments, via taxpayer funds. Financing needs for non-Medicare spending would decline if more of the population becomes covered by Medicare. Therefore, it is important to determine how Medicare would be financed and also the net effect on total health care financing.

To the extent that Medicare would continue to be at least partially financed by beneficiary premiums, it would need to be determined whether and how premiums would vary among enrollees (e.g., by age or income).

What entity would administer the expansion program?

The federal government would administer the expansion. As with the current Medicare program, some insurance and administrative tasks could be contracted out to private entities, through Medicare Advantage plans or other private contractors.

How Medicare is currently financed

Medicare benefits are financed through two trust funds. The Hospital Insurance (HI) trust fund supports Medicare Part A, which covers inpatient hospital care and post-acute care services such as skilled nursing facility care and home health care services. The Supplementary Medical Insurance (SMI) trust fund supports Medicare Part B—hospital outpatient care, doctor visits, lab tests, and medical supplies—and Part D prescription drug coverage. Medicare Advantage plans are paid out of both funds, in applicable proportions.

HI Trust Fund. According to the 2018 Medicare trustees report, payroll taxes comprise 87 percent of HI trust fund revenues. The payroll tax rate is 1.45 percent for both workers and employers; self-employed workers pay 2.9 percent. Workers with incomes exceeding \$200,000 (\$250,000 for married couples) pay an additional 0.9 percent payroll tax on income exceeding the threshold. Other sources of HI income include a portion of the federal taxes on Social Security benefits, premiums from voluntary enrollees not eligible for premium-free Part A, and interest on trust fund assets. The HI trust fund had built up a surplus of \$202 billion at the end of 2017 but is projected to be depleted in 2026. At that time, tax revenues are projected to cover only 91 percent of program costs, with the share declining to 79 percent in 2050.

No current provision exists for general fund transfers to cover HI expenditures in excess of dedicated revenues, so additional revenues would need to be raised, benefits cut, or some combination of the two. Eliminating the HI deficit over the next 75 years would require an immediate 28 percent increase in payroll taxes, an immediate 17 percent reduction in expenditures, or some combination of both. Deferring action would require larger increases in payroll taxes or larger reductions in expenditures to attain long-term trust fund solvency.

SMI Trust Fund. Medicare's SMI trust fund receives nearly three-quarters of its funding from federal general tax revenues. Standard per beneficiary premiums for parts B (\$135.50 per month in 2019) and D (\$33 per month in 2019) are set to equal one-quarter of coverage costs; high-income beneficiaries pay a larger share of costs. Low-income Part D beneficiaries receive federal premium assistance and pay lower premiums. As a result, beneficiary premiums account for 26 percent of Part B costs and 17 percent of Part D costs. Part D receives 13 percent of its funding from states to reflect the federal assumption of prescription drug costs for dually eligible beneficiaries. Aside from interest on the trust funds, the remaining funding comes from general revenues—72 percent for Part B and 70 percent for Part D.

The SMI trust fund is expected to remain solvent because its financing is reset each year to meet projected future costs. But increases in SMI costs will require increases in beneficiary premiums and federal tax dollars, which will add pressure to the federal budget. SMI general revenue funding is scheduled to increase from 1.6 percent of gross domestic product (GDP) in 2017 to 2.8 percent in 2092.

SMI premium increases similarly will place pressure on beneficiaries, especially when considered in conjunction with increasing beneficiary cost-sharing expenses. The average beneficiary expenses (premiums and cost-sharing) for parts B and D combined currently equal 24 percent of the average Social Security benefit. These expenses are projected to 34 percent of the average Social Security benefit by 2092.

What benefits would be covered?

Many decisions about benefits would need to be made, including:

- Would Medicare benefits be supplemented to meet the needs of a broader eligible population, including benefits covered by Medicaid and employer plans?
- Would traditional Medicare retain its separate parts A, B, and D component structure, or would the benefit design be more integrated, consistent with other types of coverage such as ACA individual market plans and employer coverage?
- What cost-sharing requirements and/or protections would be included?
- Would supplemental coverage, such as Medigap coverage, continue to be available to Medicare enrollees?
- Would Medicaid continue to provide additional benefits and cost-sharing protections to low-income beneficiaries?

Would other coverage options be available?

As noted above, aside from the potential availability of supplemental plans, Medicare would replace other sources of coverage for those eligible for Medicare. As a result, there would not be selection concerns between Medicare and other plans. However, there would be disruption as individuals shift from their existing source of coverage to Medicare. Whether individuals are better off under current coverage sources or Medicare depends on any differences in benefits and cost-sharing requirements, provider networks, premiums, and taxes.

If Medicare extends eligibility only to certain age groups, the risk pools of other sources of coverage would shrink, with premiums reflecting the risk pool composition of the remaining enrollees. To the extent that other coverage sources continue, there might need to be coordination between Medicare and other coverage sources. For instance, if the Medicare eligibility age is lowered (as opposed to being extended to all) it would need to be determined how Medicare would coordinate with active and retired workers with employer coverage. Also, what would happen to coverage for dependents if older workers became eligible for Medicare but the dependents are not yet eligible?

What is a single payer health insurance system?

In general, “single payer” means the health insurance system covers the health care spending for all of a specified population and is financed by the government, typically from tax revenues. Although the term describes how the system is financed, it does not define who employs the health care providers. The term “socialized medicine” differs from “single payer” in that the former refers to a system in which the government not only pays for the medical spending, but also owns the health care facilities and employs the physicians and other health care workers.

The Medicare program is often referred to as a single payer system. Medicare is currently financed through payroll taxes, beneficiary premiums, as well as federal income taxes. Medicare covers medical services for eligible beneficiaries, and care is received from private health care providers. Medicare is not operated completely by the government, however. Private insurers participate through Medicare Advantage and the Part D prescription drug program. About one-third of Medicare beneficiaries were enrolled in MA plans in 2018, and all Medicare Part D coverage is offered by private insurers. In addition, beneficiaries participating in the traditional Medicare program can choose to purchase private Medigap plans that supplement Medicare coverage.

What would provider payment rates be under Medicare?

Under a Medicare for all expansion, it would need to be determined whether payment rates would continue at current Medicare rates. If so, for those beneficiaries currently covered by Medicaid, providers would generally be paid more than under the current system, and for commercially insured patients, provider payments would decrease. Even if on average provider rates remain unchanged, individual providers could be better or worse off, depending on their patient mix. Because total Medicare spending reflects not just provider payment rates but also utilization, one consideration is whether any reduction in provider payment rates would be offset by less utilization control. Payment rates for any new services would also need to be determined. If MA plans continue to be available, it would also need to be determined whether the MA requirement that out-of-network providers are paid Medicare fee-for-service rates would be retained.

In the long run, provider payment rates reflect not only where they were set initially, but also how they grow over time. For most Medicare services, Congress determines how Medicare provider payment rates are increased from year to year, although the secretary of Health and Human Services sets the updates for particular service categories. These updates reflect in part a determination of whether payments cover providers' costs and whether Medicare beneficiaries have adequate access to high-quality providers, as well as a goal of spending Medicare funds efficiently. Setting Medicare payments low can help put pressure on providers to lower their costs and provide care more efficiently. However, if low payments result in reduced access to care or provider financial losses, there could be pressure on Congress to increase rates more rapidly.

How would Medicare expansion premiums be set?

As noted above, standard Medicare parts B and D premiums are set equal to 25 percent of program costs. Higher-income beneficiaries pay higher premiums for parts B and D, and lower-income beneficiaries pay lower premiums for Part D. (Low-income beneficiaries can also have Part B premiums paid by Medicaid.) Premiums can differ for particular MA and Part D plans but are otherwise uniform, with no variation by age, gender, health status, or other factors. Aside from setting overall premiums to meet program financing goals, it would need to be determined whether and how any premiums would vary among beneficiaries. This question becomes more important the lower the Medicare age is set.

Would the transition to an expanded Medicare program be done all at once or phased in?

If an expanded Medicare program is to be phased in rather than implemented all at once, transition rules would be required.

Conclusion

Many approaches to expanding access to public health insurance plans are being explored as potential ways to increase access to affordable health insurance. To fully evaluate or to implement any of these proposals, many design features would need to be specified. These include: defining where the plan would operate and who would be eligible, whether the public plan would be an optional choice or the sole coverage source available, whether the program would rely solely on public coverage or would also incorporate private plans such as Medicare Advantage plans, what benefits would be covered and what cost-sharing would be required, what providers would be paid, how premiums and other financing would be set, and any transition rules. How these features are decided would affect the viability of the plan and the impacts it would have on coverage availability and affordability—not only of the public plan, but also of other coverage sources.



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