WHITE PAPER

Medicare Buy-in: A High-Level Overview of Considerations

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Background

With healthcare costs on the rise in all markets, and uncertainty in ACA markets, legislators are looking for ways to make health coverage more accessible and more affordable to the general population. In the current commercial market, premiums are community rated and the younger, healthier populations are subsidizing the premium of the older, sicker population. In order to reduce premiums, one potential solution that has been proposed is to allow members between the ages of 55 and 64 to Buy-in to Medicare. Under traditional Medicare, members are eligible to receive benefits from the program beginning at age 65. This concept has been floated around political circles but specifics on how such a program would work have not been advanced yet. In this paper, we explore some ideas and unanswered questions on how Medicare Buy-In might work and some key considerations that should be fleshed out.

Goals of Medicare Buy-In

In order to set the framework for some of our discussions in this paper, it is important to establish what we believe the political goals would be of Medicare Buy-in.

1. Relieve some pressure from rising premiums in the commercial market by offering an alternative benefit plan to the near-elderly population.
2. Reduce national healthcare costs for those age 55-64 by expanding the use of Medicare fee levels paid to providers.
3. Expand coverage in a way that would not create additional burden to the Federal Government through premium subsidies.

This list is non-exhaustive but should be sufficient to give perspective on the rest of our discussion.

Note that Goal Number 3 could be resolved through increased taxes or through member premiums. We do not explore the option of increased taxes in this paper.

Key Considerations

Who Is Included In The Buy-in Population?

Above we state that a goal of Medicare Buy-in is to relieve some pressure of rising premiums in the commercial markets. In order to achieve this goal, the Buy-in population should be limited to just the near-elderly who are typically higher cost compared to their younger counterparts in the

commercial world. Depending on whether Medicare Buy-in is optional or not (discussed below), some or all of the near elderly population will move out of the commercial market which would theoretically have the effect of lowering commercial premiums.

Medicare Buy-In would have implications in the commercial, Medicare, and Medicaid markets.

Where Are The Savings?

The main reason for consideration of a Medicare Buy-In is to relieve pressure from the upward momentum of premium costs. In the commercial world, this is achieved by pulling out traditionally higher cost members, the near-elderly. Without these higher cost members in the risk pool premiums will likely decrease.

The savings in provider contracts under Medicare should more or less offset the impact of separating the near-elderly population from the younger population.

For the near-elderly, who are removed from the commercial group pool, there are several implications. First, premiums for the near-elderly could rise since there are no younger, healthier members to subsidize the premiums. Second, because this group would be considered as Medicare enrollees, they would theoretically get the benefit of Medicare's provider contracting environment which typically reflects reimbursement rates significantly lower than those of commercial coverage. So, the thought is that the savings in provider contracts should more or less offset the impact of separating the near-elderly population from the younger population.

We do recognize in the short term that Medicare Buy-in should generate premium savings for the remaining commercial population and possibly for the Buy-In population. However, this arrangement will adversely affect providers as they would get paid less on the Buy-In members for the same services since Medicare typically contracts at lower rates than private insurance. It is reasonable to assume that providers would seek to renegotiate their private contracts to recoup lost revenue on the Medicare Buy-in population. There is not universal agreement that this type of cost-shifting automatically occurs. According to a recent study published in Health Affairs, such cost-shifting does not necessarily happen and often private contracts decrease as well, at least for inpatient care[1]. If cost-shifting did occur, over time commercial premiums could rise back up and may result in premiums higher than they otherwise would have been without Medicare Buy-in.

We assume that pricing and underwriting for the new Medicare Advantage plans would follow the current law in the individual market which disallows the use of underwriting factors except for age, region and tobacco usage. Also, like current Medicare Advantage, it would be issued as individual policies and not as individual plus spouse or otherwise.

Who's Paying Premiums?

A key question for Medicare Buy-In is "who is paying"? Premiums for medical benefits are typically paid for by some combination of member, employer, and government. The table below shows how premiums are paid under the

[1] "*Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates*", Chapin White, Health Affairs Vol. 32, 935-943

current healthcare landscape for the Buy-In population.

Group	Coverage	Premium Contribution
1	Medicaid	State & Fed Govt
2	Commercial Group	Employer & Employee
3	Ind On Exchange	Fed Govt & Member
4	Ind On/Off Exchange and Grandfathered	Member
5	None	None*

*Technically there is no premium but it could be argued that the costs of uncompensated care are paid for by other premium contributors through higher service unit costs.

In order for Medicare Buy-in to be a competitive option in the market and to not increase the premium burden to the Federal Government (i.e. to satisfy goals 1 and 3), provisions would need to be established to transfer non-member contributions to the purchased Medicare plan. In other words, employer contributions and government subsidies would need to be allowed for use to acquire Medicare plans. Note that this requirement of transferring non-member premium contributions (e.g. APTC and employer contributions) only applies if purchasing a Medicare plan is optional. This is discussed further in the following section.

Below we examine each sub-population separately.

Medicaid (Group 1) – For the existing Medicaid population, a Medicare Buy-in plan would not be considered unless premiums were 100% subsidized. This is not possible without creating additional burden for the federal government which would resemble more of a Medicare-For-All scenario as opposed to a Buy-in scenario. Since the focus of this paper is on Buy-in, we assume that it would not be competitive compared with existing Medicaid, and members would remain on Medicaid.

Commercial Group (Group 2) – Employers currently contribute a minimum of 50% to group plans. This contribution would need to carry over (presumably by legislative mandate) to the Medicare benefit in order for it to be competitive. Otherwise, premiums would likely be cost-prohibitive to this group.

Subsidized Individual Market (Group 3) – This case is similar to the group market since premiums are at least partially paid for by entities other than the member. In order for Medicare to be competitive with the individual market, the Advanced Premium Tax Credit[2] (APTC) would need to be made available to purchase a Medicare plan. Without it, the individual market's rating parameters with the 3:1 age curve in conjunction with APTC premium subsidies will likely be more alluring to members in this group.

Additionally, many members qualifying for APTC subsidies also qualify for cost-sharing reduction plans (CSRs) which reduces their cost-sharing compared to the standard silver benefit. Making Medicare Buy-in viable to this group may also hinge on whether benefits can compete with these CSR plans.

Unsubsidized Individual Market (Group 4) – This group currently funds their premiums on their own. Therefore Medicare premiums would need to be comparable to those in the individual market for it to be a viable option. This should generally happen as long as the savings generated from Medicare provider contracting are sufficient enough to offset the repressed premiums in the individual market from the 3:1 age curve. However, for Individuals enrolled in non-ACA compliant plans where community rating is not a limiting factor, underwriting and

[2] Advance Premium Tax Credit - A tax credit that can be taken in advance to lower monthly health insurance premium.

fewer benefits may produce premiums less than the Medicare provided rates.

No Existing Coverage (Group 5) – Individuals in this bucket either do not have coverage because they have declined it or because coverage is not available. In the former, members would likely not benefit from a Medicare Buy-In option since there would be no additional incentive to them to purchase a plan. At the time of this writing, there are issuers in every county on the exchanges so the latter would likely not come into play except perhaps in cases where the available benefits do not meet the needs of members. In these situations, Medicare could be a potential fallback option but the impact on this group should be minimal if at all.

Who's Offering/Administering Benefits and Is It Mandatory or Optional?

Under the current landscape for the population of 55-64 year olds, if we exclude Medicaid, the only options for medical insurance are generally through the private carriers in the individual market or via employer coverage.

For the Buy-in population, the number of offerings might look like one of the following scenarios:

1. Medicare FFS Only – This assumes that members are no longer eligible for their prior coverage and members are mandatorily considered as Medicare enrollees.
2. Medicare FFS and Medicare Advantage Only – The existing Medicare population can enroll in either Medicare FFS or Medicare Advantage (MA) plans from private insurers. These same plan offerings would be available to the 55-64 group enhancing consumer choice.
3. Medicare FFS, MA, or Existing Coverage – In this third and final scenario, it is optional to Buy-in to Medicare and members can choose to keep their existing coverage through their employer or the exchanges.

Scenarios (1) and (2) are similar in that it would be mandatory to be considered as a Medicare enrollee (excluding Medicaid). A mandatory Buy-in would help to reduce premiums in the commercial market since members who are near-elderly are traditionally higher cost. Without these higher cost members, premiums should decrease. Additionally, if members can only enroll in Medicare FFS, then adverse selection will be significantly reduced (it will still be an option to not get coverage). Scenario (2) has the benefit of a rich pool of Medicare plans offered by private insurers but would increase adverse selection and therefore premiums over Scenario (1).

While Scenario (3) is most beneficial to the member in terms of options, it would limit the intended effect of the Buy-in on commercial premiums and possibly even lead to increased premiums. In general members are going to pick the plans that are most advantageous to them; therefore, adverse selection would be highest under this scenario since it has the most options available. Additionally, any leverage MA plans had to negotiate rates on the Buy-in population with providers would be eroded since the market would be split between existing coverages and Medicare. Said another way, insurers with more Medicare Buy-in members are assumed to be able to negotiate lower rates with providers.

In terms of achieving the goals laid out at the beginning of this paper, we see Scenarios (1) and (2) as best able to deliver on them. Premiums for the younger population will be reduced from where they otherwise would be and premiums for the Medicare Buy-in population could be well below current levels

depending on differences in Medicare and Commercial provider contracting.

In general, members are going to pick the plans that are most advantageous to them therefore adverse selection would be highest under Scenario (3).

There are other conceivable scenarios such as only allowing a portion of the 55-64 population to buy in based on health status or excluding MA from Scenario (3), but we believe that the discussion above can be extrapolated to such scenarios.

How Will This Affect Various Areas Of The Health Insurance Industry?

The impact of Medicare Buy-in will vary by major line of business: Medicaid, Medicare, and Commercial. For traditional Medicare and MA plans, there would not be any change to the existing landscape. All of these members have already qualified for Medicare through age or disability. Members would continue to enroll in traditional Medicare or Medicare Advantage as they always have. Medicare would need to be split into the legacy block and the Buy-in block and care would need to be taken in future years to price these separately

Many individuals on Medicaid would also become eligible for Medicare through the Buy-in. However, these individuals would likely not be able to afford the premiums needed to purchase the coverage effectively pricing them out of the option. If the Buy-in is "mandatory," then this group would need to be carved out of the mandate in order to maintain their coverage as federal dollars would not be available for premium assistance. We note that there is potential to treat these members in a similar manner as dual-eligible members under the current Medicare infrastructure like Medicaid currently funds Part A and Part B premiums; however, we would expect the premiums for the buy-in population to be substantially higher than those under traditional Medicare which would require higher premium contributions from the Medicaid programs and/or individuals on Medicaid. Individuals likely would not be able to afford the remaining premium balance after the regular contribution and states may push back significantly on legislation that requires them to contribute more. It is possible that states could end up funding the entire premium amount but it is not clear if a solution is possible that would satisfy goal number 3 especially considering that Medicare provider reimbursements are generally higher than Medicaid. Therefore, as a simplifying assumption, we assume that Medicaid dollars would not be able to be transferred to Buy-in premiums.

The commercial environment will see the most impact. We first consider the individual market.

Individuals generally receive coverage on ACA compliant plans (either on or off the exchanges) or non-ACA compliant plans (such as grandfathered plans, grandmother plans, or short-term duration plans). The latter non-ACA compliant plans currently make up a smaller percentage[3] of individual insurance policies. Members enrolling in these plans are likely healthier or may not be able to afford higher premiums and a Medicare plan would be cost prohibitive. Protections could be added for these members allowing them to keep their existing

[3] According to an article posted by Modern Healthcare in early 2017, "it is estimated that fewer than one million people currently remain in grandmothered individual-market plans in the three dozen or so states that still allow them". This compares to over 11 million members who had signed up in the exchanges for 2017.

plans but that would almost guarantee an increase in the morbidity (and therefore premiums) of the Medicare Buy-in population. The off exchange enrollees currently fund their premiums without government premium assistance. This group would not be burdened with transferring subsidies from one market to another, making the process of switching more seamless. Their counterparts, the on exchange enrollees, might be in a similar situation where they fully fund their premiums or they may receive subsidies in the form of premium assistance and/or cost-sharing assistance through Cost-Sharing Reduction[4] (CSR) plans. In order to be consistent with the goals of the Medicare Buy-In, the premium subsidies would need to be made available for purchasing Medicare plans as well. While the CSR funding could potentially carry-over into Medicare, there are significant administrative and political barriers that would need to be overcome. In the event that CSR funding does not carry-over, members in CSR plans would see increases in their cost-sharing that might make purchasing a Medicare plan prohibitive.

The impact of Medicare Buy-in will vary by major line of business: Medicaid, Medicare, and Commercial

The commercial group market will also need to be considered when creating a Medicare Buy-in Option. Under the current landscape, large groups are fully underwritten and small groups purchase ACA compliant health insurance from issuers. Large and small groups alike will have some composite of younger and near-elderly members. There are a couple of ways that Medicare Buy-in might work for groups:

1. The younger employees continue to purchase coverage as they normally have. The group offers a Medicare plan to members eligible for the Buy-in.
2. The younger employees continue to purchase coverage as they normally have. The group provides a defined contribution amount that Buy-in members could use to purchase a Medicare product of their choosing.

In either event, for Medicare to be competitive, employer contributions would need to be made available to purchase Medicare products. There is also an additional challenge of determining what happens to dependents. For example, consider a family of five where the member is eligible for Medicare and the other members are not. Under the current law, if the member switched to Medicare, the dependents would need to find alternative forms of coverage such as COBRA or from the individual exchange. Since Medicare Buy-in is not considered an entitlement and because a significant amount of the population could be affected in this way, it is reasonable to assume that provisions could be established to continue coverage for the dependents under the traditional employer group coverage. The legislation, coupled with the administrative task of pricing and managing these cases, will be challenging.

How Will Federal Subsidy Programs Work?

In the exchanges, low-income members between 133% and 400% of the federal poverty level (FPL) qualify for subsidies. There are some Federal subsidies to members at this range of

[4] Cost-Sharing Reduction plans offer lower cost-sharing to low income members who qualify. This program behaves similarly to the Medicare Part D LICS program where LIS members receive lower Part D cost-sharing and the Federal Government assumes the risk for the difference in cost-sharing.

FPL under Medicare but they are not as comprehensive as those offered on the exchange. In order to make Medicare a viable option (assuming Medicare Buy-in is optional) then current premium subsidizations would need to be made available for purchasing Medicare plans. This means APTC dollars in the Exchanges could flow freely to be used to purchase Medicare plans as well.

CSR plans are currently reserved for the on-exchange, individual market. These plans allow for lower income members to purchase plans with reduced cost-sharing at the price of a silver benefit. Historically, the insurer would be reimbursed the difference of the lower cost-sharing and the silver cost-sharing from the Federal Government, though in October 2017 those federal payments were discontinued. Legislatively, there could be a comparable program set up under Medicare Buy-in. Having CSRs available under Medicare would help to ease the transition for members currently receiving this benefit but would be less essential than the premium subsidies as those relieve guaranteed costs to members.

Under Medicare Part D, there are shared risk programs (Federal Reinsurance, Risk Corridor) as well as cost-sharing subsidy programs (Low-Income Cost Sharing, and Coverage Gap Discount Program) that CMS participates in with insurers. It is unclear how expanding these programs to the Buy-in population might impact the burden to the federal government (Goal 3). If these programs are considered, care should be taken to ensure that Goal 3 is not infringed upon especially if other subsidy programs are carried over for the Buy-in population.

Other Considerations

The discussion above is not exhaustive in terms of all the considerations that must be made if a Medicare Buy-In program is pursued, but it includes key issues that must be considered. Below is a list of further questions that should be answered by stakeholders and legislators under Medicare Buy-in:

1. Will benefits for the Medicare FFS Buy-In option be the same as existing Medicare?
2. What other services would need to be included (e.g. maternity services)?
3. Will the concept of essential health benefits transfer from the exchange?
4. Will any populations not be eligible?
5. What underwriting restrictions will be in place, if any?
6. Will it be age-rated or community rated?
7. Will the program be risk adjusted?
8. How many contract tiers will there be? Individuals only? Individual plus dependents?
9. How will dependents be affected? (This could be a particularly difficult question for the group market).
10. How do Medicare and MA network impact competitiveness relative to existing commercial options?
11. How will pharmacy coverage be handled if the Buy-in population is considered eligible for Medicare Part D?

Follow-ups

This whitepaper is intended to be part one in a two part discussion. The second part, to be released at a later date, will focus on a particular scenario and quantify the impact to various stakeholders.

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