MEMORANDUM April 2, 2010

To: Office of Representative Alan Grayson
Attention: Aysha Moshi

From: Mark Newsom, Analyst in Health Financing, 7-1686

Subject: **Analysis of H.R. 4789 compared to H.R. 193**

Per your request, the following memorandum briefly outlines the differences between H.R. 4789, the Medicare You Can Buy Into Act (Rep. Grayson), and H.R. 193, the AmeriCare Health Care Act of 2009 (Rep. Stark), and provides an additional analysis of the premium provision of H.R. 4789. Please note that this memorandum and your request are confidential.

Background

Under current law, individuals are eligible for Medicare if they or their spouse worked for at least 40 quarters in Medicare-covered employment, are 65 years old, and are a citizen or permanent resident of the United States.[1] Individuals less than 65 years of age, may also qualify for coverage if they have a permanent disability, have end-stage renal disease (ESRD), or have amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease).[2] Based on data from the Census Bureau's Current Population Survey (CPS), 46.3 million people not eligible for Medicare in the United States had no health insurance in 2008.[3]

Several Members of Congress have recently suggested that allowing currently ineligible persons to buy into Medicare would be an effective method of expanding access to the uninsured.[4] However, the Medicare buy-in (MBI) concept is not new. Indeed, on February 2, 1998, President William J. Clinton proposed allowing Americans between the ages of 62 and 65 to buy into Medicare coverage by paying a

[1] Refers to employment where the individual paid the Federal Insurance Contributions Act (FICA) tax. FICA is a payroll tax imposed by the federal government on both employees and employers to fund Social Security and Medicare.

[2] ESRD refers to a benefits term for the chronic stage of kidney impairment that is irreversible. Individuals of any age with ESRD who receive dialysis on a regular basis or a kidney transplant are eligible for Part A (and are deemed enrolled for Part B unless such coverage is refused) if they file an application. Entitlement usually begins after a 3-month waiting period has been served, defined as the first day of the third month after the month in which a course of regular dialysis begins. Entitlement begins before the waiting period has expired if the individual receives a transplant or participates in a self-dialysis training program during the waiting period. For a more detailed background on Medicare see CRS Report R40425, *Medicare Primer*, coordinated by Hinda Chaikind.

[3] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured in 2008*, by Chris L. Peterson.

[4] Congressman Fortney Pete Stark, "Introduction of the American Health Insurance Act of 2009," *Congressional Record*, January 6, 2009, p. e22. Congressman Alan Grayson, "Buying into Medicare," *Congressional Record*, March 9, 2010, p. H1213. Senator Max Baucus, "Call to Action: Health Reform 2009," 2009. Senator John D. Rockefeller IV, "Floor Speech on Health Reform," *Congressional Record*, December 13, 2009, p. S13820.

premium based on an actuarially fair rate for that age group.[5] The President's proposal in the Fiscal Year 1999 Budget also called for allowing displaced American workers between 55 and 62 years of age to buy Medicare coverage by paying a premium. The proposal was intended to be self-financing. The President's proposals were never enacted into law. [6]

Brief Comparison of H.R. 4789 and H.R. 193

Both H.R. 4789 and H.R. 193 (111th Congress) are similar in that they propose enacting the MBI policy concept. In other words, both bills would permit certain individuals to enroll into current law Medicare or a Medicare based system by paying a premium. The two bills, however, have several notable distinctions primarily based on the degree to which each bill is based on the current law Medicare program. With respect to H.R. 4789, enrollees would have the exact same coverage and benefits as the current Medicare program; the only substantive difference would be that their Part A premiums would be calculated on an actuarial basis separate from those eligible under current law, and without subsidies. By contrast, H.R. 193 would use the benefits and administrative structures of the current law Medicare program, but it would authorize the Secretary of HHS to develop a different enrollment system for newly eligible individuals, and would have different deductibles and cost-sharing obligations. **Table 1** summarizes the differences in major provisions between the two bills.

Table 1. 111th Congress: Comparison of H.R. 4789 and H.R. 193

Topic or Provision	H.R. 4789 (Grayson)	H.R. 193 (Stark)
Short Title	Public Option Act or the Medicare You Can Buy Into Act	AmeriCare Health Care Act of 2009
Introduced	3/9/2010	1/6/2009
Senate Companion Bill	None	None
CBO Cost Estimate	None	None
Committee Activity	Referral, In Committee on Ways and Means	Referral, In Committee on Energy and Commerce, Ways and Means, and Education and Labor
Eligibility	Every individual who is a resident of the United States; is either a citizen or national of the United States, or an alien lawfully admitted for permanent residence; and is not otherwise entitled to Medicare would be eligible (§2: §1818B(a) of the SSA)	Each individual who is a resident of the United States, except for residents of states that failed to make maintenance of effort payments would be eligible. These payments would be based upon payments they would have made under current law for individuals under Medicaid and CHIP. The bill would also extend eligibility to nonresidents if nationals of the United States would have similar access in the foreign state of the nonresident (§101: §§2201 and 2263 of the SSA)

[5] "Budget of the United States Government, Fiscal Year 1999," Executive Office of the President, Office of Management and Budget, February 2, 1998. Available at http://www.gpoaccess.gov/usbudget/fy99/browse.html.

[6] For more information on MBIs see CRS Report RL34596, *Health Insurance Coverage of People Aged 55 to 64: Implications for a Medicare Buy-In*, by Chris L. Peterson and Mark Newsom.

Topic or Provision	H.R. 4789 (Grayson)	H.R. 193 (Stark)
Enrollment	Would use the same procedures as under existing law for Medicare beneficiaries except that no entitlement to benefits would be effective before the first day of the first calendar year beginning after the date of the enactment (§2:§1818B(b) of the SSA)	The Secretary would develop a mechanism for enrollment and the issuance of an AmeriCare card. Enrollment would be on the basis of different classes representing an individual, a married couple without children, unmarried individuals with children, and married couples with children (§101: §2202 of the SSA)
Coverage	Would use the same benefits as under existing law for Medicare beneficiaries (§2:§1818B(b) of the SSA)	Would provide similar benefits under current law for Medicare Parts A and B, except there would be different deductibles, cost-sharing obligations, and extra benefits for certain low-income individuals. With respect to drug benefits, the bill would not utilize Medicare Part D, but would require prescription drugs and biologicals be covered in manner no less than the coverage for the standard option under FEHBP. There would also be additional specific services covered that are not covered under current law, such as eyeglasses (§101: §2221 of the SSA)
Premiums	Would amend the SSA to provide for the calculation of Medicare Part A premiums for newly eligible individuals based on an estimated monthly actuarial rate based upon costs incurred for individuals within different age cohorts defined by the bill.[a] The bill would not amend the formulas used in current law for the calculation of Medicare Part B or Part D premiums (§2:§1818B(c) of the SSA)	Would require that the Secretary of HHS calculate premiums for all benefits on the basis of the cost of coverage (determined on a state by state basis and including administrative costs) and determined separately based on the class of enrollment for the individual. On the basis of family income, certain individuals would be eligible for premium subsidies (§§201 and 202)
Dual Eligibility	Would prohibit enrollees from also claiming eligibility for programs under title XIX (Medicaid) of the SSA (§2: §1818B(d) of the SSA)	Would prohibit enrollees from also receiving benefits under title XIX (Medicaid) of the SSA, title XXI (CHIP), and chapter 89 of title 5, United States Code (FEHBP) (§101: §2264 of the SSA)

Source: CRS analysis of H.R. 4789 and H.R. 193.

Notes: This table reflects the legislative language and status of the two bills as of March 31, 2010. SSA means the Social Security Act. HHS means Health and Human Services. CHIP means the Children's Health Insurance Program. FEHBP means the Federal Employee Health Benefits Program.

a. Under current law Medicare beneficiaries generally do not pay premiums for Part A as a result of meeting their Federal Insurance Contributions Act (FICA) tax obligation. According to the Centers for Medicare and Medicaid Services, approximately 99% of Medicare beneficiaries do not pay the Part A premium as a result of having at least 40 quarters of employment paying the FICA tax. However, other seniors and certain people under age 65 with disabilities who have fewer than 30 quarters of coverage may obtain Part A coverage by paying a monthly premium of $461 per month for 2010. In addition, seniors with 30 to 39 quarters of coverage, and certain disabled persons with 30 or more quarters of coverage, pay a premium of $254 per month in 2009. www.cms.hhs.gov/apps/media/press/factsheet.asp?counter=3534.

Premiums in H.R. 4789

Medicare Part A premiums in H.R. 4789 would be based on the estimate of the monthly actuarial rate under section 1818(d) based upon costs incurred for individuals within the following age cohorts: (A) individuals under 19 years of age; (B) individuals at least 19 years of age but not more than 25 years of age; (C) individuals at least 26 years of age and not more than 35 years of age; (D) individuals at least 36 years of age and not more than 45 years of age; (E) individuals at least 46 years of age and not more than 55 years of age; and (F) individuals at least 56 years of age and not more than 64 years of age. The bill would not amend the current law formulas for calculating premiums for Medicare Parts B and D.[7]

The Congressional Budget Office (CBO) has not provided a cost estimate for this bill, but they did previously estimate that the annual premium for the 62 to 64 age group in a MBI would be about $7,600 in 2011 (this includes the costs of Medicare Parts A, B, and D).[8] The CBO estimate did not examine younger age cohorts, *but absent a significant skewing effect over time from adverse selection*, it would be reasonable to expect that the premiums would be lower for the younger age cohorts.[9]

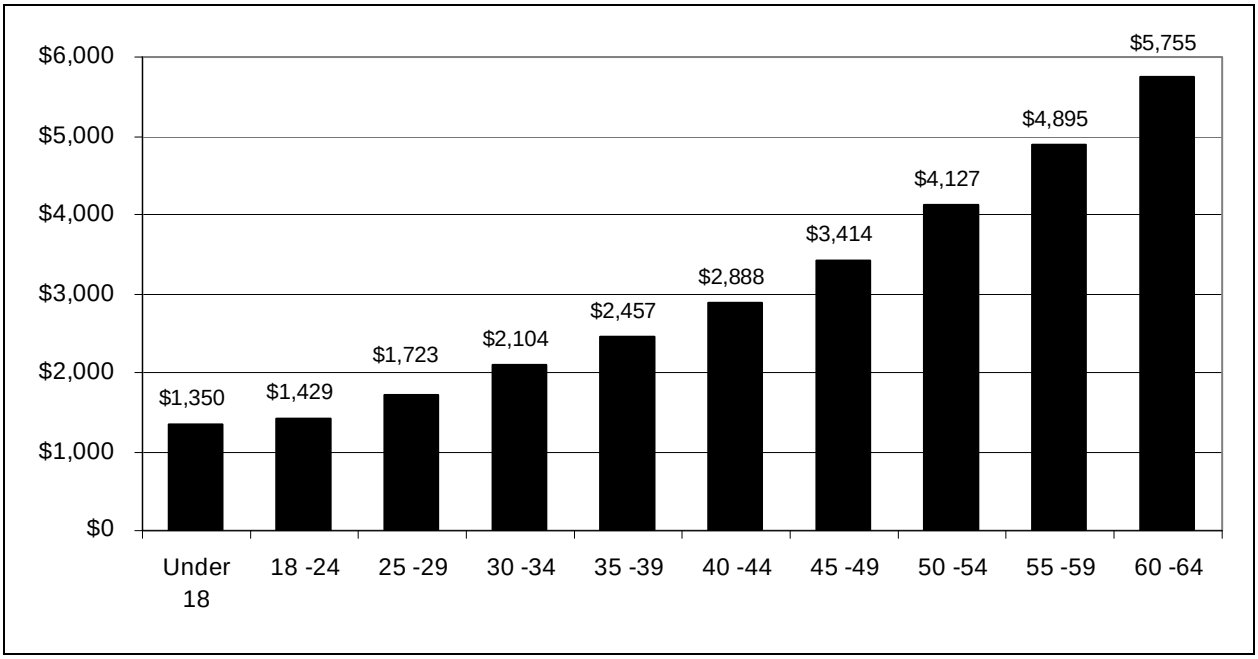
Enrollees in the MBI would generally come from those currently in the individual market. Thus, examining individual insurance market data by age cohort may provide a general estimate of where total MBI premiums might be. Please note that available data do not perfectly match the age cohorts that would be established by H.R. 4789. As illustrated in **Figure 1**, annual premiums in 2009 ranged from $5,755 in the 60-64 age cohort to $1,350 in the under 18 age cohort.

[7] §1839 (Part B premiums) and §1860D-13 (Part D premiums) of the Social Security Act.

[8] Congressional Budget Office, "Budget Options, Volume 1: Health Care," December 2008.

[9] Adverse selection refers to the phenomenon of enrollees in a particular health insurance plan using significantly more health services, on average, than those who do not enroll. High-cost individuals may find Medicare particularly attractive since it does not have a restrictive provider network and generally does not utilize managed care techniques such as prior authorization. Adverse selection has been a concern with MBI proposals. John Sheils and Ying-Jun Chen, "Medicare Buy-In Options: Estimating Coverage and Cost," February 2001. Available at: www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2001/Feb/Medicare%20Buy%20In%20Options%20%20Estimating%20Coverage%20and%20Costs/sheils_buy%20inoptions_441%20pdf.pdf.

Figure 1. Annual Average Premiums for Individual Non-Group Coverage, by Age, 2009



Source: America's Health Insurance Plans (AHIP) survey of nongroup insurers, described in "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits," AHIP Center for Policy and Research, October 2009, available at http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.

Even if the MBI does not have adverse selection, these average private plan premiums likely represent a actuarial floor for MBI premiums because unlike the private plans, Medicare generally does not utilize various managed care techniques, such as prior authorization, high cost-sharing and deductibles, and closed provider networks. Without these cost controls Medicare premiums, for the same risk pool, would likely be higher. Specifically, annual premiums for MBI enrollees could be higher because Medicare:

- would enroll anyone who is entitled that wanted to enroll, whereas these non-group plans had coverage denial rates as high as 29.2% for the 60-64 age group;[10]
- would generally cover more services with less restrictions than private non-group plans;
- would generally have lower deductibles. In 2009, the deductibles were $1,068 for Part A hospital and $135 for Part B compared to an average of $2,456 for the most popular individual product type (representing nearly 83% of policies);[11]
- does not have a restrictive provider network, whereas private plans can restrict access to high cost providers; and

[10] "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits," AHIP Center for Policy and Research, October 2009, available at http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.

[11] "CMS announces Medicare Premiums and Deductibles for 2009" available at http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3272. "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits," AHIP Center for Policy and Research, October 2009, available at http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.

- has lower co-insurance, generally 20% compared to an average, depending on the product type, ranging from 25.8% to 26.6% in the private plans.[12]

The expected increased costs from unmanaged health utilization would be partially offset by the lower Medicare provider payment rates relative to private plans.[13] With respect to out-of-pocket premium costs for the MBI enrollees, it is worth noting that both Part B and Part D premiums are subsidized under current law, but these premiums are actuarially calculated based on the 65 and older population for Part B and for the expected risk pool for Part D enrollees.[14] Thus, the bill would grant eligibility to Part B and Part D with premiums that are subsidized, but actuarially calculated on older and more costly risk pools than would normally be experienced in the non-group private insurance market.

[12] Less controlled products, like loosely managed preferred provide organizations (PPOs), often increase cost-sharing relative to more restrictive plan product types (e.g. health maintenance organizations) in order to manage costs.

[13] Glenn A. Melnick and Katya Fonkych, "Hospital Pricing And The Uninsured: Do The Uninsured Pay Higher Prices?," *Health Affairs*, 27 no. 2 (2008): w116–w122. Direct Research, LLC for the Medicare Payment Advisory Commission, "Medicare Physician Payment Rates Compared to Rates Paid by the Average Private Insurer, 1999-2001," August 2003.

[14] CRS Report R40082, *Medicare: Part B Premiums*, by Jim Hahn. CRS Report R40611, *Medicare Part D Prescription Drug Benefit*, by Patricia A. Davis.