*Source: International Society of Certified Employee Benefit Specialists

Medicare in the 21st Century

by Paul Fronstin and Mark Weinstein

▶The authors provide an overview of the Medicare program in terms of how the current program operates, the current issues it faces that may shape possible options for reform, and the implications of these features and issues for employment-based health plans. *Current issues include adoption of a premium support model, changes in the eligibility age for Medicare benefits, Medigap insurance, benefits covered and customer service.*◀

Medicare is by far the largest public health care financing program, spending $213.6 billion in 1999.[1] Total Medicare benefits payments were $7.7 billion in 1970, increasing to $37.5 billion in 1980 and $111.5 billion in 1990.[2] As a percentage of spending on national health care services, Medicare has increased from 11% in 1970 to 18% in 1999. In 1999, the Medicare program covered nearly 40 million Americans, 34 million age 65 and older and five million disabled persons.[3]

In 1965, before the establishment of Medicare, only about half of the elderly in the United States had health insurance.[4] Today, 96% of the elderly are enrolled in the Medicare program.[5] Medicare's ability to provide health insurance coverage to almost all elderly may very well have contributed to the life expectancy improvements experienced in the United States over the last 40 years. For a 65-year-old woman, life expectancy increased from 15.8 years in 1960 to 19.2 years in 1998; for a 65-year-old man, it increased from 12.8 years to 15.9 years.[6] As life expectancy has increased, disability rates have declined, suggesting that these longer lives are also healthier lives.[7]

The Medicare program receives significant attention not only because of the current size of the program and the important constituency it serves, but also because it is expected to consume an ever-increasing share of U.S. resources. In 1970, 4% of the U.S. budget was devoted to Medicare. Today, 13% of the U.S. budget is devoted to Medicare, and it is expected to account for 17% by 2010, just one year before the baby boom generation starts to be eligible for Medicare. Spending on the Medicare program will be the equivalent of 3% of gross domestic product by 2010.

Medicare spending has risen dramatically for two reasons: costs and utilization. Costs were driven up in large part because health care services were paid on a fee-for-service basis by third-party payments. Beneficiaries are essentially insolated from the true cost of their care, making them less likely to actively advocate for receiving services at a lower cost. Utilization of services increased because of Medicare's willingness to pay for beneficiary health care services. As new technologies emerge, beneficia-

ries and providers naturally demand a greater number of tests and procedures.

Medicare spending will continue to increase because of U.S. demographics. There are currently 35 million Americans age 65 and older, representing 13% of the population. By 2020, the elderly population will total 54 million persons, accounting for 17% of the population.

This article discusses the Medicare program. The next section gives an overview of the current program. The following section presents current issues that may shape possible options for reform. The fourth section includes a discussion of implications for plan sponsors.

MEDICARE, 1965-2001

When Medicare (and Medicaid) was first enacted in 1965, it was seen as a first step toward universal health insurance coverage. The original developers of Medicare strongly advocated universal coverage and saw insurance coverage for the elderly as a "fallback position."[8] The elderly were the most appealing group to cover because of the high cost of their private insurance and their low rates of coverage. The concept of pooled risk appealed not only to the elderly but also to their families, who realized they might ultimately bear the high cost of their parents' health care bills.

The original Medicare program contains Parts A and B. Eligible Medicare beneficiaries in the traditional program automatically receive Medicare Part A (hospital insurance) at no premium cost and are able to supplement it with Medicare Part B (supplementary insurance) and private Medigap insurance. Persons choosing Part B services currently pay about a $50 per month premium, or approximately one-quarter of the actual cost of the coverage. In 1965, elderly persons spent on average about 19% of their income on health care. That share fell to about 11% in 1968; today, it is more than 20%.[9] In the last ten years, Medicare out-of-pocket charges to beneficiaries (including Medicare Part B premiums) have risen about 9% per year on average, a much faster rate of growth than that of income among beneficiaries.[10]

Part A covers inpatient hospital services, skilled nursing facility (SNF) benefits following a three-day hospital visit, home health visits following a hospital or SNF stay, hospice care and blood (after the member has paid for the first three pints). Hospital stays are subject to a $792 deductible for days one to 60. A $198 per day copay is required of Medicare beneficiaries for days 61-90, and it increases to $396 per day for days 91-150. Medicare beneficiaries are responsible for all costs for each day beyond 150. SNF care costs nothing during the first 20 days, after which a $99 per day copay is required until day 100, after which the beneficiary pays all costs.[11]

Medicare Part B is partially financed by beneficiary premiums that originally covered 50% of the program's cost. General tax revenues finance the balance of Medicare Part B. Today, Part B is financed by beneficiary premiums that cover 25% of the program's cost. Part B covers doctors' services, outpatient care, diagnostic tests, ambulatory services, durable medical equipment, outpatient physical and occupational therapy, mental health services, clinical laboratory services, limited home health care, outpatient hospital services and blood provided on an outpatient basis. Most of these services are subject to 20% coinsurance from the Medicare beneficiary, and some services are also subject to an annual $100 deductible. Part B also now covers a number of preventive services.

Medicare Part A was originally funded by a 0.7% payroll tax, shared equally by employers and employees. The maximum taxable amount of annual earnings in 1966 was $6,600. Today,

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the Medicare payroll tax is 2.9% and all earnings, with no earnings cap, are taxable.

Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare Hospital Insurance (HI) Trust Fund (Medicare Part A)—which pays for inpatient hospital stays, skilled nursing care, hospice and certain home health services—is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays.

Annual trust fund reports show that Medicare's HI component was, on a cash basis, in the red from 1992 through 1998. In 2000, earmarked payroll taxes covered less than HI spending. Including all earmarked revenues, the fund is expected to show several billion-dollar cash deficits through 2025.[12] To finance the deficits, Medicare draws on its special issue Treasury securities acquired during the years when the program generated a cash surplus. Consequently, Medicare is a net claimant on the Treasury—a threshold that Social Security is not expected to reach until 2014.

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For Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs or reduce the projected surplus. Outlays for Medicare services covered under Supplementary Medical Insurance (SMI)—physician and outpatient hospital services, diagnostic tests and certain other medical services and supplies—are already funded largely through general revenues.

Medicare beneficiaries have been able to enroll in private health maintenance organizations (HMOs) instead of remaining in the traditional Medicare fee-for-service program since the mid-1980s. On average, however, the costs have been higher for HMO enrollees than they would have been if the same enrollees had remained in the traditional fee-for-service program. The Government Accounting Office estimates that aggregate payments to Medicare HMOs were $1.3 billion too high in 1998.[13]

As part of the 1997 Balanced Budget Act, Congress created Medicare+Choice (Part C) to increase beneficiary choice of health plan and to control rising spending for Medicare benefits. Medicare Part C built on the Medicare HMO program by expanding the types of plans beneficiaries could choose and also reformed the payment system made that applies to participating plans. These plans generally allow members to visit only health care providers that agree to treat members of the plan and often require members to get a referral to see specialists. Medicare pays a set amount of money every month to the private insurer or HMO that the Medicare beneficiary chooses. Often private insurers and HMOs provide benefits that are not covered by traditional Medicare, such as outpatient prescription drugs, and they are allowed to charge an additional monthly premium.

In December 2000, 6.3 million Medicare beneficiaries were enrolled in Medicare+Choice plans.[14] However, on January 1, 2001, about 934,000 people lost coverage from their Medicare+Choice health plans, forcing them either to seek coverage from another plan or to return to traditional fee-for-service Medicare coverage.[15] Medicare+Choice plans withdrew from more difficult-to-serve rural counties or large urban areas that the plans entered more recently or where the plans failed to attract sufficient enrollment. Problems contracting with health care providers may also have contributed to the plan withdrawals.

CURRENT ISSUES

Policy makers are currently interested in major reforms to the Medicare program. Interest in changing Medicare is strong, because the cost of providing benefits to the elderly will increase substantially once the baby boom generation

starts reaching age 65 in 2010. In essence, policy makers are examining options that they would like to use to control the cost of the Medicare program. Options for reform that we are likely to see debated during the next few years are discussed in greater detail in this section.

Premium Support Model

The adoption of a premium support system—a major overhaul of the current Medicare program that many policy analysts are suggesting—would completely change the way Medicare benefits are thought about in the policy arena. Under this system (as recommended by the National Bipartisan Commission on the Future of Medicare),[16] Medicare beneficiaries would be able to choose from among an array of private health plans, and they would also be able to choose to stay in the traditional Medicare program, much like they can do today in the Medicare+Choice program. The goal of the program is to make Medicare beneficiaries more sensitive to the cost of health care while creating stronger incentives for private plans to limit costs.

A standard benefits package would be specified by law and would consist of all health care services covered under the existing Medicare program. However, health plans would be able to offer additional benefits beyond the standard package. In addition, cost-sharing arrangements, such as deductibles, coinsurances and copay levels, could also vary. All private plans and the government-run traditional Medicare program would be required to offer a high-option health plan that includes outpatient prescription drug benefits.

Under the Bipartisan Commission's plan, Medicare beneficiaries would be required to pay an average of 12% of the total cost of a standard option plan. There would be no contribution from the Medicare beneficiary if the costs of the plan chosen were less than 85% of the national weighted average plan price. Medicare beneficiaries would pay the additional premiums if they chose plans that were above the national weighted average premium price. Such a general rate structure would likely be a burden for low-income Medicare beneficiaries. As a result, low-income Medicare beneficiaries would likely be driven into plans that were less than 85% of the national weighted average plan price, if one was available in their geographic region. The Medicare contribution could also vary by a person's age, gender, geographic region and health status. Premium contributions could also be means tested.

As with the employment-based health care system, a small portion of Medicare beneficiaries account for a disproportionately higher share of total program costs. In the Medicare population, however, the very high medical costs associated with serious acute and chronic illness among elderly and disabled persons are more likely to be protracted. In order for the premium support system to operate most efficiently, adjustments in premiums paid to such plans would need to be made for extensive patient health care needs. However, this risk has not been randomly distributed among sectors of the Medicare market. For example, on average, individuals enrolled in Medicare+Choice health plans are healthier than those beneficiaries enrolled in the fee-for-service plan.[17] Determining how to compensate plans enrolling people who are, or may become, high-cost users of the health care system is critically important to providing the competition necessary to offer better health care plans to beneficiaries and to improving the fee-for-service program.

Unless health plans are compensated more for higher users of health services, plans would encounter significant financial incentives to avoid enrolling beneficiaries with significant health care needs, and to stint on care for beneficiaries already enrolled. A risk adjustment system would need to be developed in order to determine the appropriate premium to be paid to health care plans based on the makeup of the enrolled beneficiary population. Compensating for adverse selection in plan enrollment (not paying plans with healthier enrollees too much) and adjusting for the health risks of individual beneficiaries (making higher payments to plans for sicker enrollees) will require particular attention and continuous study and adaptation.

Allowing more types of health plans in the Medicare program gives Medicare beneficiaries more choice of plans. A competitive process could emerge among plans to enroll more Medicare beneficiaries, allowing beneficiaries to enroll in plans that best match their needs while potentially having lower cost-sharing expenses.

Health plans' ability to realize savings for Medicare beneficiaries is open to debate. Medicare has by far the lowest administrative expenses of any health insurance or health care payer. Medicare accomplishes this because it does not need to market its product or make profits, and because Medicare spends less on customer service than typical private health insurance plans.

Private health plans may not be able to control administrative expenses, as they will need to market their product to demonstrate the value that their plan offers as compared to other plans. In order for health plans to be competitive under a premium support system, they would have to become efficient and very innovative in their delivery of health care.

A majority of the members on the National Bipartisan Commission on the Future of Medicare voted to establish a board to take over many of the Center for Medicare and Medicaid Services (CMS—formerly the Health Care Financing Administration) marketing functions and management of private plans. The Institute of Medicine's Committee on Choice and Managed Care in 1996 reached a similar conclusion. The function of this new board would be to organize the market of competing plans, including the traditional fee-for-service plan, and to provide Medicare beneficiaries with the information that they need to make health plan choices. Both groups suggest CMS should not be primarily responsible for both operating the traditional fee-for-service plan and the marketing and management of private health plans.[18]

According to James Morrison, a career civil servant who ran the Federal Employees Health Benefit Plan (FEHBP) during the 1980s, there is a profound difference in the way CMS deals with the private sector intermediary in the Medicare program and the way in which the Office of Personnel Management (OPM), responsible for operating FEHBP, deals with the private sector plans in FEHBP. This difference derives, in large measure, from the statutory difference between the two programs.[19] For example, OPM operates a market with dozens of competing health insurance plans for federal workers, but does not run a plan itself.

Eligibility Age

The National Bipartisan Commission on the Future of Medicare recommended that the eligibility age for Medicare benefits be tied to the eligibility age for full Social Security benefits, which is scheduled to increase for persons born after 1938.[20] One reason for recommending that the eligibility age for Medicare benefits be increased is because life expectancy is increasing. Another reason to increase the eligibility age is to reduce spending on the Medicare program. Tying the eligibility age of Medicare to the increased age for Social Security may encourage workers to remain in the labor market.

Raising the eligibility age does not come without controversy. Some of the people who had been paying Medicare payroll taxes would likely become uninsured. Furthermore, it is unrealistic to expect many workers to extend their work lives when many are already choosing to retire before age 65. Many workers may be unable to continue working past age 65 (or earlier) because they are already in poor health. Finally, savings from raising the Medicare eligibility age will be modest, at best. CMS projected that raising the Medicare eligibility age to coincide with the eligibility age for full Social Security benefits would reduce Medicare spending by 1.7% through 2030.[21]

Some of the issues surrounding an increase in the eligibility age for Medicare benefits could be alleviated if persons not yet eligible for Medicare benefits were allowed to buy in to the Medicare program. Allowing persons ages 65 to 66 to buy in to Medicare, as proposed by the Bipartisan Commission, may alleviate some of the issues surrounding increasing the eligibility age, but persons ages 65 to 66 may not be able to afford to buy Medicare benefits.

The Clinton administration proposed allowing individuals to buy into the Medicare program at even younger ages—age 55 for individuals laid off or displaced from a job, and age 62 for all individuals.The age 62 provision would have effectively brought consistency to the Medicare and Social Security programs in that both would have provided for early retirement benefits before age 65 and full retirement benefits at age 65. While the population ages 55 to 64 is one of the least likely age groups to be unin-

sured, this age cohort may have more difficulty obtaining health insurance coverage because of their age and health status.

On March 28, 2001 a group of legislators in the House and Senate introduced legislation (S 623, HR 1255) that would provide a 50% tax credit for individuals 55 through 64 to help pay for this new Medicare buy-in opportunity and COBRA, but not for any employment-based coverage premiums. The Medicare Early Access and Tax Credit Act would require companies that have discontinued or substantially cut a company retiree health plan, but have continued to provide coverage for active employees, to provide access for retirees to the company health plan at 125% of the cost until the employee becomes eligible for Medicare. The program would be divided into two tiers for those ages 55 to 61 and 62 to 64.

Those ages 62 to 64 without health insurance, who had earned enough quarters of coverage to be eligible for Medicare at 65, would be able to purchase Medicare coverage, whether or not they had exhausted any employer COBRA eligibility. They would pay a base premium of approximately $326 monthly, adjusted for inflation, and varied based on geographic differences in the cost of health care. An additional premium of about $4 monthly would be taken from the covered person's Social Security check after retirement for a 20-year period during which the individual would be covered under Medicare. The coverage could continue even if the individual later became eligible for an employer group health plan or public plan.

Those ages 55 to 61 and their uninsured spouses could purchase the full range of Medicare benefits if they had earned enough quarters of coverage to be eligible for Medicare at age 65; were eligible for unemployment insurance; had a year-plus of employment-based health insurance coverage before layoff; or were not eligible for COBRA or other coverage as a result of unemployment. Such coverage would cost approximately $460 monthly, adjusted for inflation. There would be no additional premium at age 65, because the base cost was set to include the likely enrollment of sicker-than-average people.

Medigap

It is often suggested that the Medicare benefit package is inadequate because it leaves beneficiaries liable for nearly half of the cost of their acute care. As mentioned above, the current deductible for hospitalization is $792, and beneficiaries must pay 20% of their physicians' fees, with no annual cap on that amount. Because of these potentially high out-of-pocket expenses, about seven in ten beneficiaries have supplemental insurance: 34% through an employment-based plan, 29% through a private insurer and 8% through the Medicaid program.[22] Premiums charged to beneficiaries for these supplemental plans increased by 35% between 1994 and 1998, and monthly premiums can easily range from $150 to $400 per month.[23]

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A 1998 study that compared Medicare with a sample of 250 employer plans offering indemnity health insurance benefits concluded that 82% of those plans offered more comprehensive benefits than Medicare.[24] Medicare's benefit structure lags behind current notions of good insurance, as indicated by the study, because it fails to provide adequate financial protection when enrollees require extensive health care. This creates a strong demand for Medigap coverage.

Even if Congress provided Medicare beneficiaries with a generous outpatient prescription drug benefit, it is likely that beneficiaries will continue to have a demand for supplemental insurance. If Congress were to establish an upper limit on cost sharing and reduce the deductible for hospital services in addition to a prescription drug benefit, then the demand for

supplemental insurance coverage would be markedly less.

Studies show that beneficiaries with supplemental insurance have higher service utilization and higher Medicare costs. According to the Physician Payment Review Commission, Medicare expenditures for beneficiaries with Medigap coverage were 29.2% higher than expenditures for beneficiaries without supplemental insurance, and spending for beneficiaries with employer-sponsored insurance was 11.1% higher. The Congressional Budget Office has documented similar findings. These findings mean that beneficiaries with Medigap cost Medicare $5,400 in 1996. Beneficiaries with employment-based coverage cost Medicare $4,900, and beneficiaries with no supplemental coverage cost Medicare $4,000.[25]

The fact that Medigap policies increase health care costs is rather expected given that all policies cover the 20% copayment for Part B services, and nearly all cover the $768 Part A deductible. This concept is known as moral hazard—meaning individuals demand a greater quantity of health care services when health insurance pays for at least part of the cost of receiving care. Findings from the RAND Health Insurance Experiment indicate that as coinsurance rates increased, utilization and expenditures for health care services declined.[26]

More than almost any other type of insurance, Medigap policies have been subject to a great deal of federal regulation. Congress enacted the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) to require all Medigap policies sold after July 1992 to conform to one of the standardized sets of benefits that the National Association of Insurance Commissioners developed as model policies. In 1997, 5.8 million beneficiaries were enrolled in standardized plans, while 6.1 million remained in the nonstandardized plans in which they had enrolled before July 1992.[27]

OBRA '90 reforms alleviated some problems of consumer fraud and abuse in the Medigap market. A current problem involves adverse selection. Healthier beneficiaries tend to join Medicare managed care plans. In this situation; low- and moderate-income beneficiaries whose incomes are too high to qualify for assistance through Medicaid may have to go without any supplemental coverage.[28]

Medicare beneficiaries are able to choose from among ten different Medigap products. Three of those products include prescription drug benefits. The low prescription drug coverage plan in the standardized Medigap market has a $250 annual deductible, 50% coinsurance and a maximum annual benefit of $1,250; the high coverage plan has a $3,000 maximum annual benefit. This coverage for prescription drugs provides insight as to why Congress now considers such a benefit for Medicare beneficiaries with and without Medigap coverage. Medicare beneficiaries often exceed the maximum annual benefit, and the 50% coinsurance rate often leaves many prescription drugs unaffordable.

Any structural reform of the Medicare program would likely include an examination of the supplemental insurance market. If Medicare+Choice or a new Premium Support Model, as discussed above, become dominant vehicles in the Medicare system, the Medigap coverage will likely adapt. Perhaps within this new model that has catastrophic and outpatient prescription drug coverage, Medigap may become more of an "option" for future Medicare beneficiaries.

Benefits Covered

When Medicare was created in 1965, its benefits package was based on the prevailing Blue Cross/Blue Shield package for working Americans in large firms. However, since its inception, Medicare has fallen behind benefits offered through most employment-based health care plans. For example, whereas most employment-based health plans offer an outpatient drug benefit, Medicare does not offer one.

The reason that the Medicare benefits package may lag behind employment-based health care plans is that a change to Medicare benefits requires an act of Congress. The task of addressing Medicare benefits becomes entangled in the political process. Congress micromanages the benefits package offered by Medicare.

Instead of setting specific benefits in legislation, Congress may consider confining itself to describing the broad categories of benefits (e.g., outpatient pharmaceutical benefits) that Medi-

care should provide. This is the approach that Congress takes with FEHBP.

Congress could create a Benefits Board whose recommendations would be subject to an up-or-down vote without amendment. This would both reduce political pressures on Congress's benefit decisions and take lawmakers out of the process of making detailed medical decisions. Yet, Congress would have the final say in any benefit changes. This same methodology was used to create the Base Closing Commission in the 1980s.

Public financing of long-term care remains limited to the Medicaid program. Beneficiaries covered under Medicare must be eligible for Medicaid in order to receive publicly financed long-term care. Washington's legislative agenda seems to have shifted away from a public long-term care entitlement and toward legislation that establishes tax deductibility of private long-term care insurance. Congress has passed legislation that allows the purchase of long-term care insurance under employer cafeteria plans and flexible spending arrangements. Federal workers and their families may purchase long-term care insurance through FEHBP. The outlook for long-term care becoming an entitlement under Medicare appears to be stymied by a more seriously perceived need to address the coverage of prescription drugs under Medicare.

Customer Service

Currently the administrative costs for Medicare are less than 1% of benefit dollars, significantly less than the rate of most efficient private insurers.[29] Medicare cannot be expected to provide competitive customer service when its funding level for such tasks remain well below the amount targeted for such activities in the private marketplace.

Medicare offers several places for beneficiaries to find information. Significant ongoing improvements continue to be made to the Medicare Handbook, the Beneficiary Hot Line and the Medicare Internet site www.Medicare.gov. Despite these varied resources, beneficiaries remain confused, and many rely on family members to handle their dealings with Medicare. Nearly one in four Medicare beneficiaries faces challenges navigating the health care system because of cognitive impairments.[30]

The many plan choices that beneficiaries now face only compound Medicare's customer service challenge. The State Health Insurance Assistance Program (SHIP) does provide individual assistance with making health plan choices. This program is thought to be severely underfunded.[31] SHIP is staffed largely with volunteers and located only in some large cities. There are multiple hot lines where beneficiaries can receive assistance regarding plan choices. However, assuming beneficiaries know the hot lines exist in the first place, information is often available only through multiple lines, and beneficiaries must call several hot lines to get complete information.

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Many times a beneficiary does not know whether or not Medicare will pay for a service until after it has been received. This becomes especially relevant for home health care services and particular items of durable medical equipment. The fact that beneficiaries cannot appeal an adverse benefit determination unless they have received, and paid for, the service causes additional hardship for low-income elderly. Employment-based health plans typically make these types of decisions for plan participants before the service or equipment is received.

The Explanation of Benefits (EOB) form is being replaced with a more streamlined Medicare Summary Notice. This new document incorporates Part A and Part B payment sum-

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mary information on one convenient form and replaces the benefit denial letters issued in the past. This new means of communicating with Medicare beneficiaries should facilitate a better understanding of benefits covered.

Most statutory changes to Medicare as of late directly affect providers. CMS requires appropriate funds to adequately educate providers regarding these massive changes. Providers are expected to learn about all these new changes on their own. Economists theorize that this additional expense to providers, not directly reimbursed by Medicare, gets allocated to the providers' other books of business.

As with Medicare beneficiaries, providers have no one place to go for comprehensive information on a particular topic. For example, there exists no one place to find out everything about wheelchairs. Which are covered? When and for how long? What is the payment amount and what are the payment rules? How do wheelchair providers get certified to sell them in Medicare? What do beneficiaries need to do to get one? The Internet Web site could be enhanced to provide this type of information in one place.

IMPLICATIONS FOR PLAN SPONSORS

Changes to the Medicare program are likely to have significant effects on employment-based health plans. Potential changes could affect benefits for both retirees and active workers and may have an impact beyond the health plan. For example, raising the Medicare eligibility age from 65 to 67 would undoubtedly affect other benefit plans. First, workers would have an added incentive to remain employed until age 67 (the increase in the eligibility age for full Social Security benefits is already expected to influence retirement behavior) in order to keep health benefits, unless they had another source for health insurance.

If employees remained in the labor market past age 65, the cost of providing health benefits would increase. Since health care use increases with age, average costs would increase. Employers offering retiree health benefits to early retirees would also see their costs increase, as they would not be able to move retirees to the Medicare supplement benefit until age 67. Also, unfunded liabilities for retiree health benefits that are now reported on financial statements would also increase, affecting earnings levels.

Plan sponsors would also likely experience an increase in labor costs if the Medicare eligibility age were increased to 67. Older workers typically have higher earnings than younger workers, as older workers are often compensated for skills associated with job tenure.

Implementation of a premium support model may also have consequences for employment-based health plans. Employers offering retiree health benefits to Medicare-eligible retirees may be able to switch to a defined contribution approach, where the employer provides a defined contribution that allows retirees to choose from the available health plans in their geographic region. The employer contribution could be set at an amount that would allow the average retiree to pay the difference between the government's contribution and the full cost of the retiree's chosen plan.

Finally, regardless of what shape Medicare may eventually take, employers will likely have to increase their educational efforts aimed at explaining any change to their benefits package. ◀

Editor's note: Any views expressed in this article are those of the author and should not be ascribed to the officers, trustees, members or other sponsors of EBRI, EBRI-ERF or their staffs.

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