The Daily Dish

Don’t Buy the Buy-Ins

DOUGLAS HOLTZ-EAKIN | FEBRUARY 15, 2019

Eakinomics: Don’t Buy the Buy-Ins

The unease of some on the left with the overreaching “Medicare For All” proposal has spawned a plethora of alternatives. This week was seemingly “buy-in” week. The first to arrive was Medicare at 50. Although it sounds like simply dropping the Medicare eligibility age to 50, in fact the proposal is to allow people to buy into Medicare. The key elements are that: (1) Premiums would be based on the estimated average per capita cost for benefits and administration for individuals enrolled under the buy-in (and not the Medicare population as a whole), (2) Subsidies would be available for enrollees equal to the amounts they would be eligible for through the Affordable Care Act (ACA) exchanges, (3) $500 million each year for three years would be allotted to outreach and enrollment, and (4) … wait for it … The government would have the authority to negotiate drug prices!

There are a host of unanswered questions along the lines of “what happens if premiums are estimated too low? Will the money be taken from the rest of Medicare?” But the threshold issue is this: Isn’t this the problem that the ACA was supposed to have already fixed? Presumably the target audience is the fewer than 7 million people who are below Medicare eligibility age and not insured. But why are they uninsured? If they chose not to buy ACA policies (which have protections against high premiums for older people), why will they be willing to pay to join the older-worker only club that is Medicare buy-in? (One possibility is that Medicare price-fixing yields lower-price providers, but the net impact is not obvious.)

At any rate, it sure looks like a solution in search of a problem.

Next in line is the State Public Option, essentially a Medicaid-based public option plus gobs of taxpayer money to induce the remaining states to expand Medicaid. In this case the key points are that: (1) Anyone not otherwise eligible for Medicaid could buy into it on the ACA exchange — the state would be the issuer, (2) Any ACA subsidies the individuals would

otherwise be eligible for could be applied to the purchase, (3) Primary care providers would have to be paid as well as they are paid under Medicare (true of Medicaid in general), and (4) … wait for it … Any state still considering expansion would get three years when 100 percent of the tab is picked up by the federal taxpayer PLUS $100 billion in grant monies for additional assistance available to any state.

This proposal raises the same threshold questions, but at least in this case there is the fig leaf of trying to fix the ACA. Once again, however, one has to wonder just how many individuals would be covered by the option. If they were not eligible for Medicaid to begin with, they probably made too much money, which means they were already eligible for the ACA and perhaps ACA subsidies. Will the public option be a cheaper plan that attracts them? If not, why put the cash on the counter to induce states to expand Medicaid and create public options?

In short, the buy-ins to Medicare and Medicaid are not substitutes for Medicare for All. They are simply intended as slower journeys to the same single-payer destination.