

Raising the Medicare Eligibility Age with a Buy-In Option: Can One Stone Kill Three Birds?

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Abstract

Gradually increasing the Medicare eligibility age to 67, while allowing people age 62 to 66 to buy into the program, could potentially address three pressing public issues. This approach could reduce Medicare costs, improve insurance coverage among older adults younger than 65, and increase labor supply at older ages. However, simulations show that cost savings would be modest and, unless the buy-in option were heavily subsidized for low-income adults, many older African Americans, Hispanics, and poor adults would be left uninsured. Nonetheless, delaying eligibility would strengthen work incentives and help the nation meet the challenges of an aging population.

Introduction

As Americans live longer, we are spending more time in retirement and placing increased burdens on younger generations. Although labor supply at older ages has increased modestly in recent years, people generally retire at much younger ages today than they did 50 years ago. Retirees now collect Social Security benefits longer than ever before, and the number of workers supporting each retiree is falling steadily. Encouraging older Americans to delay retirement would ease the economic pressures of an aging population by expanding the pool of productive workers, in turn promoting economic growth and generating additional goods and services to raise living standards. Improved health and less physically demanding jobs mean that most of today's older adults can work longer than did earlier generations.

Population aging is also raising doubts about the affordability of health care promises made to older Americans, especially as health care costs continue to rise. Medicare provides subsidized health care to nearly all adults age 65 and older, but costs have been rising rapidly and are expected to soar once baby boomers begin to qualify for benefits. Unless policymakers are able to restrain the growth in Medicare spending, the program will soon lead to sharply higher taxes, unsustainably high federal budget deficits, or dramatic reductions in spending on other important federal programs.

While the federal government devotes substantial resources to Medicare, many older Americans too young to qualify for benefits lack adequate coverage. Most workers receive health benefits from their employers, but coverage options are limited for those who retire before age 65. Employer-sponsored retiree health insurance typically allows retirees to continue the coverage they had while working, although generally at higher costs. Fewer than half of full-time workers, however, are offered retiree health benefits from their employers, and employers

continue to cut back or even terminate these benefits. Some married adults receive coverage through their spouses' employer plans, but only if their spouses are working or are fortunate enough to have retiree health benefits themselves. In the absence of employer coverage, retirees too young to qualify for Medicare must generally turn to the private nongroup insurance market, where coverage is often expensive and incomplete—especially for those with health problems.

Increasing the Medicare eligibility age to 67, combined with a buy-in option for people age 62 to 66, could potentially elicit more labor supply from older adults, reduce Medicare costs, and improve insurance coverage among older adults younger than 65. Gradually increasing the eligibility age would bring it back in line with Social Security's full retirement age, which slowly began rising from 65 to 67 in 2000. Boosting the Medicare age would also reinforce other signals in society that old age does not begin until after 65; furthermore, an increase in the cost of retiring early would likely encourage older workers to remain in the labor force. Participants in a buy-in plan would gain full Medicare coverage by paying monthly premiums equal to the expected cost of their benefits. Premiums could be subsidized for low-income adults. The Clinton administration first proposed a Medicare buy-in option in 1998, and congressional Democrats have introduced similar legislation more recently; however, none of these plans has been enacted into law as yet.

This paper proposes increasing the Medicare eligibility age to 67, while allowing people age 62 to 66 to buy into the program. The analysis explores the potential impact of the proposal on coverage rates at older ages and on Medicare costs. The findings show that a buy-in plan could improve coverage for near-elderly adults, but only if the plan subsidized premiums for those with limited incomes. Moreover, unless the buy-in option were heavily subsidized for low-income adults ages 65 and 66, increasing the eligibility age would leave many poor older people

and many older African Americans and Hispanics without coverage. Costs savings would be modest because the Medicare beneficiaries who would be dropped from the program would, for the most part, be relatively healthy and, therefore, low-cost.

Medicare's Growing Cost Crisis

Health care costs have been rising steadily over time, a trend likely to continue for the next few decades. Between 1980 and 2003, health care spending increased at an average annual rate of 5.6 percent in real terms (Smith et al. 2005). The Medicare trustees predict that program costs will grow rapidly over the next 75 years, reaching nearly 7 percent of the nation's gross domestic product (GDP) in 2030 and 14 percent of GDP in 2080 (Medicare Board of Trustees 2005). In 2000, by comparison, Medicare consumed only 2 percent of GDP. Health spending tends to rise with income, as people choose to earmark part of their additional resources for better health care (Chernew, Hirth, and Cutler 2003; Reinhardt, Hussey, and Anderson 2004). Advances in medical technology, which generally lead to better but more expensive treatments, also contribute to rising spending levels (Newhouse 1993). Other explanations for high health care expenditures include increases in the prevalence of expensive medical conditions, the high administrative costs associated with a fragmented health care delivery and financing system, and the presence of a large number of highly paid medical specialists (Davis and Cooper 2003; Thorpe, Florence, and Joski 2004).

Rising health care costs, in combination with the aging of the population, will exert enormous pressure on the federal budget. The Government Accountability Office (GAO) projects that, absent reform, just three programs—Social Security, Medicare, and Medicaid—will absorb 6 percentage points more of GDP in 2030 than they did in 2004 (GAO 2005). If this

increase were financed entirely by raising taxes, the overall federal tax burden, measured as a percentage of GDP, would have to increase by roughly one-half above the average of the past 30 years (CBO 2003). In addition, that calculation unrealistically assumes that these large tax increases would not reduce economic growth. Without future tax increases, virtually all other types of noninterest spending would have to be eliminated by 2030 to prevent budget deficits from exploding.

Soaring health care costs also threaten household budgets for older Americans, limiting efforts to improve Medicare by shifting costs to consumers. Premiums for Medicare Parts B (which covers outpatient physician visits and other services) and D (which will cover prescription drugs beginning in 2006) will rise with total Medicare spending, because premiums are set to cover 25 percent of program costs. Private insurance premiums and direct payments to providers will also increase with overall health care costs. For example, average Medigap premiums increased by more than 10 percent per year between 1999 and 2001, after adjusting for overall inflation (Chollet 2003). In addition, many employers are responding to cost pressures by dropping retiree health benefits or demanding larger contributions from plan participants (Kaiser Family Foundation and Health Research and Educational Trust 2004). According to one set of projections, if current policy continues, after-tax income net of out-of-pocket health care spending for the typical older married couple will be no higher in 2030 than it was in 2000, despite 30 years of productivity growth (Johnson and Penner 2004).

Increasing the eligibility age would reduce Medicare costs by cutting some people from the Medicare rolls. The savings would probably be modest, however. People ages 65 and 66 currently account for only about 11 percent of the population age 65 and older (U.S. Census Bureau 2005). More importantly, some 65- and 66-year-olds with disabilities would remain in

the program because they receive Social Security Disability Insurance (SSDI) payments. These beneficiaries are among the heaviest users of expensive health services. In addition, low-income people could continue to receive Medicaid coverage as long as the eligibility threshold for elderly Medicaid benefits remained at age 65.

Health Insurance Coverage before Medicare Eligibility

Although important throughout life, health insurance is especially crucial to health and income security at older ages when the risk of costly medical problems is high. For example, people age 60 to 64 are more than ten times as likely to develop cancer as those age 35 to 39 (National Cancer Institute 2005), and the prevalence of heart disease more than triples for those age 45 to 64 compared with those age 18 to 44 (National Center for Health Statistics 2005). Health problems tend to increase out-of-pocket health care spending. About 8 percent of families headed by adults age 55 to 64 spend at least one-tenth of their incomes on health care, compared with 4 percent at age 25 to 54 (Merlis 2002).

Despite the importance of health insurance to older adults, substantial gaps in coverage exist among older people too young to qualify for Medicare. About 12.3 percent of adults age 62 to 64 lacked health insurance coverage in 2002 according to data from the Health and Retirement Study (HRS), a nationally representative survey of older Americans conducted by the University of Michigan for the National Institute on Aging (table 1). Coverage rates fall steadily with age from 55 to 64, as many people lose employer coverage when they stop working. For example, about 77 percent of people received coverage from current or past employers at age 55 to 58, compared with only 63 percent at age 62 to 64. Past employers account for an increasing share of employer-sponsored insurance as people age. At age 62 to 64, nearly half of adults with

Table 1. Insurance Coverage Rates among Older Adults below the Medicare Eligibility Age, by Age and Source of Coverage, 2002 (%)

Age	Own Current Employer	Own Former Employer	Spouse's Current Employer	Spouse's Former Employer	Military Benefits	Private Nongroup	Medicaid or Medicare	Uninsured
55 to 58	45.6	11.2	16.5	3.5	2.0	5.5	6.8	8.8
59 to 61	36.6	15.3	13.3	5.2	1.3	8.3	9.0	10.9
62 to 64	22.4	21.4	11.1	8.1	2.7	10.4	11.5	12.3

Source: Authors' tabulations from the Health and Retirement Study (HRS).

Notes: Estimates are based on a sample of 1,845 noninstitutionalized adults age 55 to 58, 1,979 adults age 59 to 61, and 2,199 adults age 62 to 64, and are weighted to account for the sampling design of the HRS. Coverage is determined by the following hierarchy: own current employer, own former employer, spouse's current employer, spouse's former employer, military benefits, private nongroup, and Medicaid or Medicare.

employer coverage receive benefits from their former employers or their spouses' former employers, up from about one in five adults at age 55 to 58.

Expensive nongroup insurance is generally the only source of coverage for people without employer-sponsored health benefits who do not qualify for Medicare or Medicaid. In fact, private nongroup coverage increases with age for people just under 65, but not by enough to offset the loss of employer coverage. About one in ten adults age 62 to 64 received coverage from private insurance companies in 2002, nearly double the rate at age 55 to 58. However, private nongroup coverage is generally more expensive and less comprehensive than employer coverage. In 2001, the median annual premium for 55-year-old men was \$6,120 in the nongroup market and \$2,736 in the group market (Gabel, Dhont, and Pickreign 2002). Moreover, employers typically pay some of the costs of the group health benefits they provide. Premiums are generally higher for private nongroup plans because risk pooling is more limited in the

nongroup market, administrative costs are higher, and employer subsidies are generally unavailable.

The affordability issue is compounded by the high prevalence of health problems among retirees, increasing the risk-rated premiums they face. When previously healthy individuals become sick, their premiums can rise dramatically. Because health problems are more common among the poor than among those with higher incomes, those in poverty or near poverty face substantially higher premiums on average than other individuals. Among people age 62 to 64 who describe their health as fair or poor, 22.3 percent have incomes below the federal poverty level (FPL), compared with only 4.1 percent of those in excellent or very good health (table 2). Similarly, those in excellent or very good health are more than twice as likely as those in fair or

Table 2. Distribution of Family Income at Age 62 to 64, by Overall Health Status, 2002

Household Income as Share of Federal Poverty Level	Overall Health Status (%)		
	Excellent or Very Good	Good	Fair or Poor
Less than 100%	4.1	9.5	22.3
100% to 199%	10.6	14.5	23.7
200% to 400%	28.0	31.3	30.1
More than 400%	57.3	44.8	23.9
Total	100.0	100.0	100.0

Source: Author's estimates from the Health and Retirement Study.

Notes: Estimates are based on a sample of 2,199 noninstitutionalized adults age 62 to 64, and are weighted to account for the sampling design of the HRS.

poor health to report incomes exceeding 400 percent of the FPL. Thus, the poor are doubly disadvantaged in their efforts to acquire coverage in the private market because they lack sufficient resources to purchase health insurance and they face particularly high prices. Even when near-elderly Americans are able to afford nongroup policies, insurers sometimes deny them coverage, even for relatively minor ailments (Chollet and Kirk 1998; Pollitz, Sorian, and Thomas 2001). Related to the high price of private nongroup coverage is the problem of limited benefits. Many private nongroup plans do not provide comprehensive benefits to policyholders. Because of the high cost of comprehensive coverage, many who purchase nongroup policies opt for plans that offer only limited coverage and come with high deductibles and high cost-sharing requirements. Moreover, insurers are often reluctant to offer low-deductible comprehensive coverage because these policies generally attract persons with health problems who use many services. This adverse selection problem drives up premiums and discourages all but the heaviest users of health services from purchasing coverage, causing the market for these policies to break down. Many insurers also exclude coverage for preexisting health conditions. HRS data indicate that about 14 percent of Americans age 55 to 64 with private nongroup coverage have restrictions on their policies because of preexisting conditions. Consequently, many near-elderly persons with nongroup coverage may be underinsured, leaving them vulnerable to high out-of-pocket costs if they become seriously ill.

In part because of underwriting practices in the private nongroup market, many uninsured older people not yet eligible for Medicare report low incomes and health problems. In 2002, 27.4 percent of adults age 62 to 64 with incomes below the FPL and 18.9 percent of those with incomes between 100 percent and 199 percent of the FPL were uninsured, compared with only 5.8 percent of those with incomes in excess of 400 percent of the FPL (table 3). About 15 percent

of those in fair or poor health lacked coverage, compared with 10.6 percent of those in excellent or very good health. A Medicare buy-in plan could improve insurance options for people with health problems, but it would not provide much help to low-income adults unless heavily subsidized.

Table 3. Share of Adults without Health Insurance, by Health Status, Income, and Age, 2002 (%)

	55 to 58	59 to 61	62 to 64
All	8.8	10.9	12.3
Health Status			
Excellent/Very Good	5.7	7.0	10.6
Good	10.1	14.2	12.5
Fair/Poor	14.6	15.3	15.2
Household Income as Share of Federal Poverty Level			
Less than 100%	23.9	23.0	27.4
100% to 199%	17.0	25.0	18.9
200% to 400%	14.0	12.8	13.6
More than 400%	3.7	4.7	5.8

Source: Authors' tabulations from the Health and Retirement Study (HRS).

Notes: Estimates are based on a sample of 1,845 noninstitutionalized adults age 55 to 58, 1,979 adults age 59 to 61, and 2,199 adults age 62 to 64, and are weighted to account for the sampling design of the HRS.

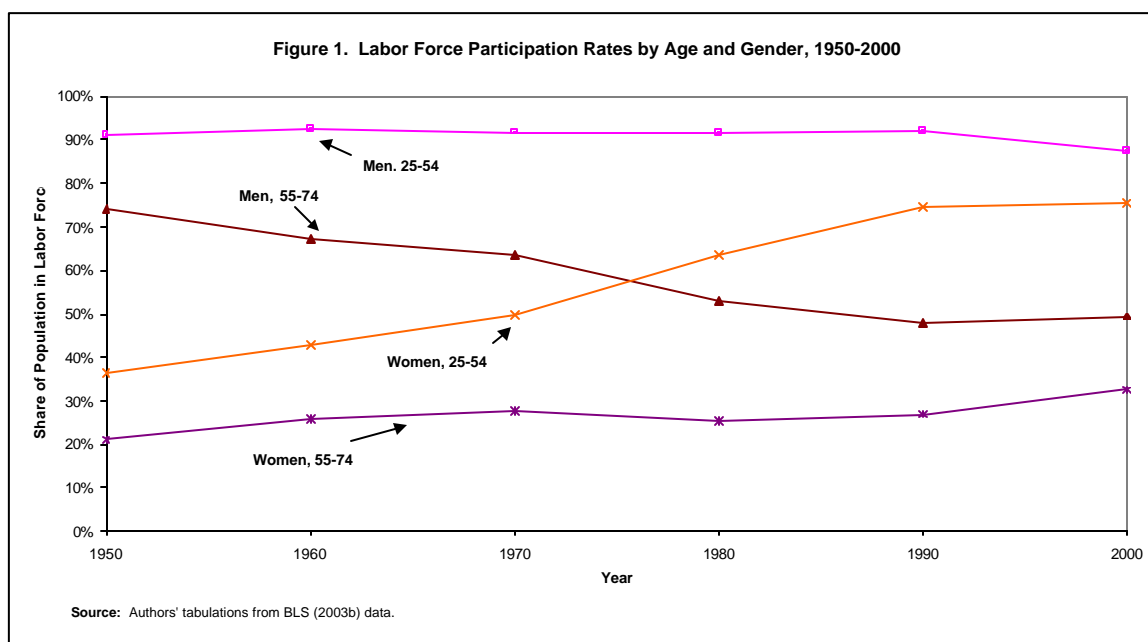
The Need to Increase Work Incentives at Older Ages

The population is growing older as people now live longer and have fewer children than in the past. Between 1950 and 2000, the share of the adult population age 65 and older increased 5 percentage points, to 17 percent (U.S. Census Bureau 2002b). This long-term trend will accelerate over the next 50 years with the aging of the baby boom cohort, the unusually large generation of Americans born between 1946 and 1964. With baby boomers reaching old age in the coming decades, the total number of adults under the age of 55 (who have traditionally dominated the nation's workforce) will remain virtually unchanged between now and 2020, even

though the overall population will grow by 44 million (U.S. Census Bureau 2002a, 2002b). The U.S. Census Bureau projects that about 27 percent of the adult population will be at least 65 years old in 2050.

Changes in population tell only part of the story, however. What really matters for total economic output, and the burden of supporting the older population, is the number of workers in the economy relative to those who will be supported—which in turn depends on individual decisions about work.

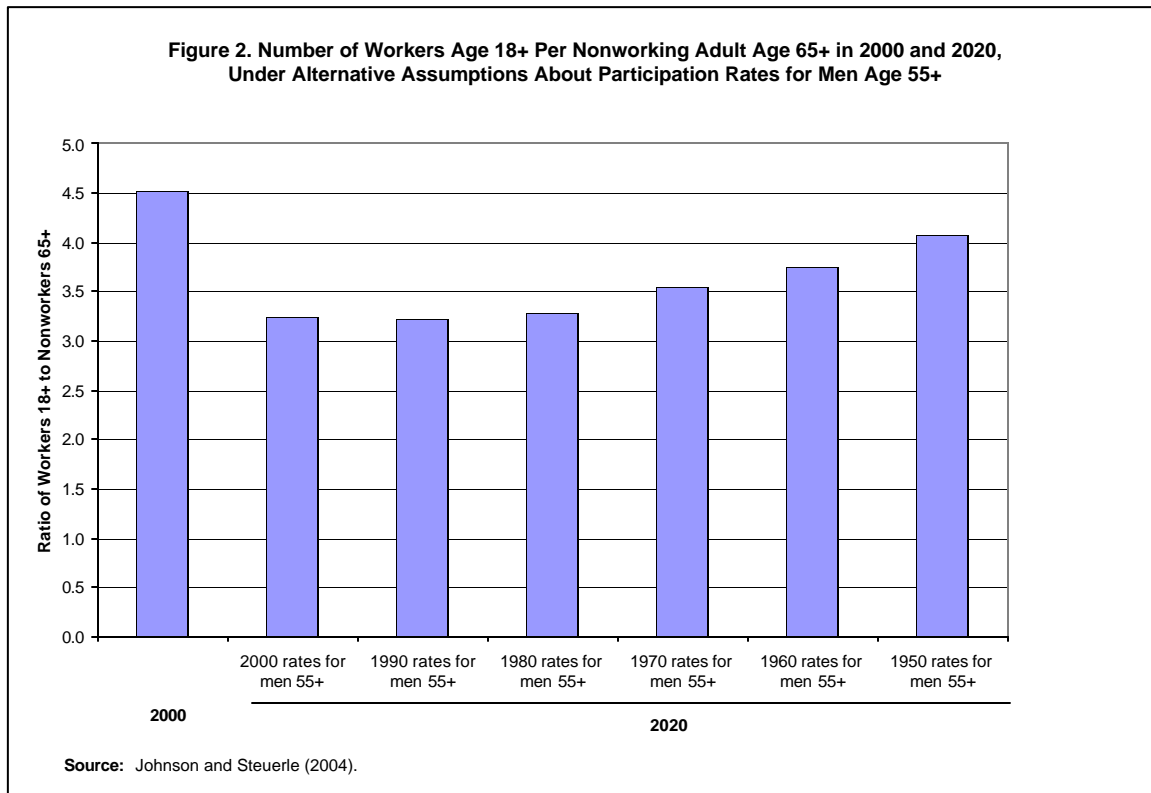
Until recently, labor force participation rates for men had been declining steadily, particularly at older ages (figure 1). Almost three-quarters of men age 55 to 74 worked in 1950, compared with just under half in 2000. Nonetheless, there are encouraging signs that the decline in participation rates has ended and may have even reversed. For example, between 1995 and 2003, employment rates among men ages 62 to 64 increased from 45 percent to 50 percent, although employment rates among men ages 55 to 61 did not increase (Federal Interagency Forum on Aging Related Statistics 2004).



Labor supply patterns differ for women, who entered the labor force in large numbers over the past 50 years. Female participation rates at age 25 to 54 more than doubled between 1950 and 2000, to 76 percent, and women in this age group are now almost as likely to work as men. The movement of women into the labor force has offset the decline in male participation and maintained the overall size of the labor pool. Labor force participation rates among all adults increased in almost every non-recession year since 1950 (Steuerle and Carasso 2001; BLS 2003a). But it is unlikely that participation rates among young and middle-aged women will rise much higher in coming years, since women generally shoulder more child care responsibilities than men. Participation rates among older women will probably increase in the near term, however, as later generations of women accustomed to paid employment grow older and replace earlier generations who worked less outside the home. In fact, between 1995 and 2003, employment among women age 55 to 61 rose from 56 percent to 63 percent (Federal Interagency Forum on Aging Related Statistics 2004).

Work decisions will influence how the aging of the population affects the size of the future labor force. If current rates of labor force participation by age and sex continue into the future, the number of workers per nonworking adult age 65 and older will fall from 4.5 to 3.3 between 2000 and 2020. However, if men age 55 and older participate at the same rate as they did in 1950 (when jobs were more physically demanding and health problems more prevalent), and women and other men participate at their 2000 rates, then the ratio would fall only to 4.1 in 2020 (figure 2). Although this improvement alone would not solve the old-age crisis, it would make the problem significantly more manageable.

Increasing the Medicare eligibility age would strengthen work incentives at older ages. This strategy would raise the cost of retirement for workers with employer-sponsored health



insurance but without retiree health insurance offers, by increasing the length of time during which they would need to purchase expensive continuation coverage or nongroup coverage in order to remain insured.

A Proposal to Raise the Medicare Age to 67, With a Buy-In Option

Raising the Medicare eligibility age to 67 with a buy-in option for people between the ages of 62 and 66 could potentially increase labor supply at older ages, modestly reduce Medicare costs, and improve insurance coverage among older adults below the age of 65. Congress could gradually raise the Medicare eligibility age to keep pace with the scheduled increase in Social Security's full retirement age, which will reach age 67 for those born after 1959. The new eligibility age, then, would be fully implemented in 2027. The terms of Medicare participation would not change: Beneficiaries would have to pay Part B premiums in order to

receive Part B benefits, but they would not have to pay any premiums for Part A benefits. The proposal would also allow those below the eligibility age to buy into Medicare once they qualify for early Social Security benefits at age 62. People age 62 to 64 could purchase Medicare coverage from the federal government at actuarially fair prices. Beginning at age 65, the premiums would fall steadily each month until they disappear at the Medicare eligibility age. A system of subsidies would be created for those age 62 to 66 with limited incomes.

This proposal's effectiveness depends on how many people retain publicly subsidized health insurance after the Medicare age increases and how people respond to new work incentives and insurance opportunities. Some of the heaviest users of health services will continue to qualify for Medicare at ages 65 and 66 because they receive SSDI payments. Some low-income adults will receive Medicaid benefits as long as the Medicaid age does not rise in tandem with the Medicare age. People who remain on subsidized government insurance rolls reduce the cost savings realized from an increase in the Medicare age.

Participation in the buy-in option, which would improve coverage rates, will depend on how people respond to the program's low premiums relative to those available in the private nongroup market. The extent to which the buy-in option disproportionately attracts high-cost users will influence the program's cost. Responses to the plan's work incentives depend on workers' choices between leisure and the consumption of additional goods and services. Whether employers respond by dropping their own retiree health plans or raising the premiums and cost sharing required of participants in these plans will also crucially affect the program's effectiveness.

As is often the case, the devil is in the details. Particular parameters of the program will determine how much savings it generates and how it affects coverage rates at older ages. For

example, what is the definition of actuarial fairness used to set the price of the buy-in? Should the calculations try to account for adverse selection into the plan, or should they be based on the entire age cohort, excluding those with SSDI? How generous will the low-income subsidies be? Will the definition of disability be liberalized for those age 65 and older? What will happen to the upper Medicaid-eligibility age, currently set at 65? Would employers be allowed to buy into Medicare for their older workers or their retirees?

Overview of the Empirical Approach

To get some sense of the possible effects of increasing the Medicare eligibility age to 67, in combination with a Medicare buy-in option at ages 62 to 66, this analysis draws on results from an earlier series of studies about changes in the Medicare eligibility age (Davidoff and Johnson 2003; Johnson 2002; Johnson, Davidoff, and Perese 2003; Johnson, Moon, and Davidoff 2002). These earlier studies, based primarily on 1998 HRS data, show how coverage would change. The estimates reported here are based on updated cost figures, but assume that people will respond to various incentives in the ways elaborated in the earlier research. Although insurance markets have changed since 1998, this exercise still provides some insights into the proposed policy's likely impact.

Although an increase in the Medicare eligibility age may leave some people ages 65 and 66 without any health insurance, many may be able to secure coverage from alternative sources. For example, workers with employer-sponsored insurance but without access to retiree health benefits may choose to delay retirement in order to maintain their health coverage. Some may choose to purchase nongroup coverage. Others may become eligible for Medicaid because of their low incomes or for Medicare because of disabilities. Still others may obtain coverage from

their spouses' employer-sponsored health plans. Finally, some may choose to purchase Medicare coverage through the buy-in option. To predict the effects on coverage and on the costs of a delay in the Medicare eligibility age, one needs to consider the impact on retirement behavior, disability coverage, Medicaid coverage, spousal coverage, the demand for nongroup insurance, and participation in the Medicare buy-in plan.

Estimating Effects on Retirement Decisions

The first step in the model is to estimate the effect of delaying Medicare eligibility on retirement. An increase in the eligibility age would influence labor supply through its effect on the health insurance premium cost associated with retirement (Johnson et al. 2003). Many individuals who leave the labor force before qualifying for Medicare benefits face higher premiums after they retire than they faced while working. The premium cost of retirement (PCR) is especially high for workers with employer-sponsored insurance that does not continue after retirement, since these workers generally have to replace employer coverage with expensive nongroup coverage to remain insured. A delay in the Medicare eligibility age would raise PCR for workers with employer coverage but not retiree health insurance by increasing the number of months during which they would need to purchase expensive, private nongroup coverage to replace the job-related health benefits lost at retirement. The increase in PCR would be smaller if a buy-in plan were offered in combination with a delay in the eligibility age, as long as the premiums and cost sharing for the buy-in plan were lower than those associated with private insurance plans.

We begin by estimating a retirement model for a sample of workers age 57 to 64 and measuring the impact of PCR on the retirement decision. We then recompute PCR assuming a delay in the eligibility age, with and without a buy-in plan, and use the parameters from our

estimated model to predict employment status at ages 65 and 66. We assume that those whom we predict would work 20 or more hours per week after the increase in the eligibility age would maintain any employer benefits they had reported earlier in the survey. Based on predicted employment status and an equation for hours of work, we simulate income for each of the members of the sample.

Estimating Disability-Related Coverage

The next stage of the model simulates disability-related Medicare coverage at ages 65 and 66 by first estimating a model of Medicare coverage under current rules for those age 62 to 64 who qualify for benefits only if they are disabled. The model is estimated as a function of health, education, and demographic characteristics. We then apply the estimated parameters from the model to the sample of adults ages 65 and 66 to predict the likelihood of disability coverage if Medicare eligibility were delayed to age 67.

Estimating Medicaid Coverage

Medicaid benefits, which are available to older adults with limited income and assets, are likely to become an important source of insurance coverage for low-income people ages 65 and 66 if the Medicare eligibility is raised to age 67. We simulate Medicaid coverage under an increase in the Medicare eligibility age by first determining eligibility for Medicaid and then identifying which eligible members of the sample would participate. We assume that anyone who meets the income and asset criteria for receipt of cash assistance (such as Supplemental Security Income [SSI] or state supplementary payments) would be eligible for Medicaid. We also assume that some elderly people with high medical expenses relative to income would newly qualify for Medicaid through medically needy programs upon the loss of Medicare coverage. The model assumes that 80 percent of eligible people participate (the upper end of the

range of estimated Medicaid participation rates among the elderly [Moon, Brennan, and Segal 1998]), with those with higher medical spending more likely to participate. We assume that people ages 65 and 66 would not qualify for the Medicare Savings Program, which is linked to Medicare eligibility.

Estimating Employer Coverage

The model assigns employer coverage from one's own employer or a spouse's employer if the respondent reported coverage at the time of the survey under the current system, unless the model already assigned the respondent Medicare disability coverage or Medicaid coverage. Retirees from firms that provide retiree health benefits only until Medicare coverage begins would not report retiree coverage at ages 65 or 66 under the current system, but they would probably be covered if the Medicare eligibility age were raised. To account for these cases, the model assigns employer coverage to those who had retiree coverage before age 65 or who retired at age 65 from jobs offering retiree benefits. The model also assigns employer coverage to those who would be eligible for continuation coverage under provisions of the Consolidated Omnibus Reconciliation Act (COBRA).

Simulating Private Nongroup Coverage

The model simulates purchase of nongroup insurance coverage among those not already assigned disability-related Medicare, Medicaid, or employer coverage. We use results from a multivariate regression that estimates the effects of premium price, health status, income, and other characteristics on purchase decisions. Premium prices were obtained from an insurance web site for a standard preferred provider organization (PPO) plan with a \$500 deductible and a 20 percent coinsurance rate for in-plan expenses; premiums varied by age, sex, smoking behavior, and the presence of chronic medical conditions. Monthly 1998 nongroup premiums in

the model for people ages 65 and 66 vary from a low of \$273 for women with no serious health problems who do not smoke to a high of \$915 for male smokers with at least two serious medical conditions.¹

The model indicates that health status is an important predictor of insurance purchase. Because many adults with poor health status have limited incomes, the model predicts that some low-income persons would spend unrealistically large shares of their income on health insurance. We assume that those who the model predicts would spend more than 20 percent of their income on health insurance would buy less expensive, limited nongroup coverage instead of standard nongroup policies.²

Participation in the Medicare Buy-In Plan

Introduction of a Medicare buy-in at age 62 to 67 may provide a less expensive alternative for standard insurance coverage for those not eligible for public or employer coverage. The model selects the lower of the Medicare buy-in premium and the imputed nongroup premium, and uses it to simulate the purchase decision and assign coverage (Medicare, standard nongroup, or limited nongroup). We examine two different pricing schemes for the buy-in program: flat monthly premiums of \$300 for all participants, and an income-related scheme whereby those with incomes below 150 percent of the FPL would pay just the monthly Medicare Part B premium each month (equal to \$43.80 in 1998), while those with higher incomes would pay the full \$300 premium each month. None of the plans we model charge supplemental premiums after age 66. The flat \$300 monthly premium is similar to the level set by the

¹ We collected insurance quotes for people age 57 to 64, but were unable to collect insurance quotes for older people, nearly all of whom are now covered by Medicare. We estimated prices at ages 65 and 66 by computing the linear growth rate in premiums between age 60 to 62 and age 63 to 64, and applying the growth rate to premiums for age 63 to 64.

² Health insurance costs exceed 20 percent of total household expenditures in only 2 percent of households, according to estimates from the 1998 Consumer Expenditure Survey.

Congressional Budget Office when it priced the cost-neutral buy-in plan proposed by the Clinton administration for adults age 62 to 64.

Impact of Medicare Buy-In Option on Coverage Rates at Age 62 to 64

The introduction of a buy-in option would reduce uninsurance rates among those individuals age 62 to 64, but the effects would be small unless the plan was heavily subsidized (table 4). If the buy-in premiums were set at a flat monthly rate of \$300 per month, uninsurance rates would fall to 9 percent, from 10 percent under current law. Overall, 8 percent of adults age 62 to 64 would participate in the Medicare buy-in plan, and 5 percent would purchase private nongroup coverage. Participants in the buy-in program would far outnumber the newly insured, because most buy-in participants would have purchased private coverage if they were unable to

Table 4. Simulated Uninsurance Rates at Ages 62 to 64, Under Current Law and Alternative Buy-in Options, 1998 (%)

	Current Law	\$300 Plan	\$300 Plan with Subsidies for Low-Income Adults
All	10	9	6
Household Income as Share of Federal Poverty Level			
Less than 100%	28	28	12
100% to 199%	22	22	12
200% to 400%	9	8	8
More than 400%	3	1	1
Number of Serious Health Problems			
None	10	10	7
One	9	8	5
Two or more	9	6	3

Source: Johnson, Moon, and Davidoff (2002), based primarily on the 1998 Health and Retirement Study.

Notes: Under the income -related option, enrollees with incomes below 150 percent of the federal poverty level would pay just the monthly Medicare Part B premium, while those with higher incomes would pay the full \$300 monthly premium.

buy into Medicare. However, the buy-in option would raise the overall quality of coverage, with many participants replacing limited private nongroup coverage with more comprehensive Medicare benefits. As a result, a moderately priced buy-in option would reduce the share of the near-elderly population lacking standard coverage by 3 percentage points, to 11 percent.

Because many uninsured individuals have limited resources, the effect of the buy-in option on coverage rates would be larger if monthly premiums were related to income. A buy-in plan with income-related premiums would reduce overall uninsurance rates for the near elderly to 6 percent. The effect would be even more pronounced among the near-elderly poor, whose uninsurance rates would fall from 28 percent to 12 percent.

If premiums were not related to income, coverage rates for those with limited incomes would not improve significantly. A buy-in plan that ties premiums to income better targets benefits to those who need them most than does a plan charging everyone the same premium.

Even without special targeting, the introduction of a Medicare buy-in plan would substantially reduce uninsurance rates for those with health problems, who face especially high premiums in the private nongroup market. A plan priced at a flat rate of \$300 per month would reduce uninsurance rates for those with two or more serious health problems from 9 percent to 6 percent. Uninsurance rates would fall even further if premiums were related to income, to 3 percent among those with two or more serious health problems.

Impact of Increase in Eligibility Age on Coverage Rates at Ages 65 and 66

With a delay in Medicare eligibility to age 67, 91 percent of adults ages 65 and 66 would remain insured, even if the government did not create a buy-in plan. More than half would receive employer-sponsored benefits, based mostly on their own employment. About 14 percent would receive disability-related Medicare benefits (sometimes with Medicaid benefits), and

about 3 percent would receive only Medicaid benefits. Another 22 percent would purchase private nongroup coverage if they were no longer eligible for Medicare. Only 9 percent of adults ages 65 and 66 would lack coverage if the Medicare eligibility age were raised to 67.

However, a raise in the Medicare eligibility age would greatly increase rates of uninsurance among African Americans, Hispanics, and those with family incomes below 200 percent of the FPL (table 5). For example, 33.5 percent of Hispanics and 25.8 percent of African Americans ages 65 and 66 would become uninsured, compared with only 6.3 percent of non-

Table 5. Simulated Uninsurance Rates at Ages 65 and 66, Assuming an Increase in the Medicare Eligibility Age to 67, Under Alternative Buy-in Options (%)

	No Buy-In Option	\$300 Plan	\$300 Plan with Subsidies for Low-Income Adults
All	9.1	7.4	4.7
Household Income as Share of Federal Poverty Level			
Less than 100%	22.6	22.6	8.9
100% to 199%	24.6	24.6	12.7
200% to 400%	11.1	8.6	8.6
More than 400%	2.5	0.4	0.4
Number of Serious Health Problems			
None	9.1	8.2	5.6
One	10.6	8.1	5.1
Two or more	6.6	3.6	1.4
Race and Ethnicity			
African American	25.8	23.8	17.6
Hispanic	33.5	32.4	27.3
White and other	6.3	4.5	2.3

Source: Davidoff and Johnson (2003), based primarily on the 1998 Health and Retirement Study

Notes: Under the income-related option, enrollees with incomes below 150 percent of the federal poverty level would pay just the monthly Medicare Part B premium, while those with higher incomes would pay the full \$300 monthly premium.

Hispanic whites. Income differentials in coverage are also striking. We estimate that 22.6 percent of the poor ages 65 and 66 would lack coverage, compared with only 2.5 percent of those with family incomes above 400 percent of the FPL.

Vulnerable populations, such as racial minorities and the poor, would benefit greatly from the introduction of a Medicare buy-in option only if premiums were related to income. For example, with a buy-in premium of \$300 per month, the rate of uninsurance among Hispanics would decrease by only about 1 percentage point. Under the income-related premium plan, the uninsurance rate would fall by about 6 percentage points for Hispanics, 8 percentage points for African Americans, and 4 percentage points for whites, relative to the scenario with no buy-in option.

Relating premiums for the Medicare buy-in plan to income would especially increase rates of coverage for people with limited incomes. If Medicare eligibility were delayed, the introduction of a flat \$300-per-month plan would not reduce uninsurance rates at all for those in poverty, but it would reduce uninsurance for those with incomes above 400 percent of the FPL—from 2.5 percent to 0.4 percent. However, if premiums were instead related to income, uninsurance rates would fall to 8.9 percent for those in poverty and remain at 0.4 percent for those with incomes about 400 percent of the FPL.

Impact of Increase in Eligibility Age on Medicare Costs

Increasing the Medicare eligibility age to 67 without a buy-in option would reduce program costs, but these costs would fall by a smaller percentage than the number of Medicare beneficiaries. If the Medicare eligibility had been raised in 2004, the number of Part A beneficiaries would have fallen 3.4 million below actual enrollment levels. This loss represents

86 percent of Medicare beneficiaries ages 65 and 66 in 2004. The remaining 14 percent would have retained Medicare coverage through SSDI benefits. An increase in the eligibility age would have reduced 2004 program costs net of Part B premiums about \$11.6 billion below actual levels, a savings of about 4.2 percent of Medicare expenditures net of Part B premiums across all beneficiaries, or about 5.0 percent of net expenditures across all aged beneficiaries (table 6).

Delaying the Medicare eligibility age, however, would also increase Medicaid expenditures. Medicaid would pick up the tab for much of the Medicare services received by people who would be dually eligible if the Medicare age had not changed. Medicaid expenditures would have increased by \$1.0 billion above actual 2004 levels if Medicaid had covered the entire cost of the services this group would have received from Medicare. Medicare savings from delaying the eligibility age, net of the increase in Medicaid expenditures, therefore would have totaled \$10.6 billion in 2004, or 3.9 percent of all Medicare expenditures net of Part B premiums. Cost savings would be even lower if the government offered a Medicare buy-in option with subsidies for low-income adults in conjunction with an increase in the eligibility age.

The cost savings from an increase in the Medicare eligibility age are modest because many relatively expensive users of Medicare services would remain in the program. Among beneficiaries ages 65 and 66, average annual Medicare expenditures are about 217 percent as high for those who enter the program through the disability rolls as for all beneficiaries ages 65 and 66, and about 174 percent as large for those who qualified for Medicaid before turning 65. (Waidmann 1998). By contrast, average Medicare expenditures for 65- and 66-year-olds who were not on Medicaid or SSDI amount to only 83 percent of the overall average for the age group. Additionally, beneficiaries ages 65 and 66 incur lower costs than older beneficiaries. Average annual expenditures for beneficiaries age 65 to 69 are only 56 percent as high as the

Table 6. Cost Savings From Increasing the Medicare Eligibility Age to 67, 2004

	All Medicare Beneficiaries	Medicare Beneficiaries Age 65+	Adults Age 65-66 After Increase in Medicare Eligibility Age to 67				Total
			Disability-Related Medicare Only	Dual Eligibles	Medicaid Only	Lose Public Insurance	
Share of Population Age 65-66 (%)			11.8	2.0	3.1	83.1	
No. of Enrollees (thousands)							
Part A	41,320	34,994	466	79	122	3283	
part B	38,810	33,330	427	72	112	3006	
Per Capita Annual Medicare Expenditures (\$)							
Part A Enrollees	4,064	4,117	4,900	4,900	3,939	1,892	
Part B Enrollees	3,478	3,421	5,799	5,799	4,661	2,239	
Per Enrollee Annual Part B Premiums (\$)			793	0	0	793	
Total Annual Medicare Expenditures (\$ millions)	302,906	258,067	4,759	807	1,005	12,943	
Total Part B Premium Revenue (\$ millions)	30,341	25,873	338	0	0	2,384	
Total Annual Medicare Expenditures Net of Part B Premiums (\$ millions)	272,565	232,194	4,420	807	1,005	10,559	
Medicare Savings (\$ millions)			0	0	1,005	10,559	11,564
Savings As Share of Total Medicare Costs (%)							
All Medicare Beneficiaries							4.2
Medicare Beneficiaries Age 65+							5.0
Additional Medicaid Costs (\$ millions)			0	0	1,005	0	1,005
Medicare Savings Net of Medicaid (\$ millions)			0	0	0	10,559	10,559
Net Savings As Share of Total Medicare Costs (%)							
All Medicare Beneficiaries							3.9
Medicare Beneficiaries Age 65+							4.5

Source: Authors' calculations based on Waidmann (1998), Medicare Board of Trustees (2005), and private correspondence with Medicare actuaries. See text for more details.

average among all Medicare beneficiaries for Part A costs and only 77 percent as high for Part B costs.³

Conclusions

An increase in the Medicare eligibility age will increase the size of the uninsured older population at least somewhat, and the increase could be substantial if the delay in eligibility is not combined with a well-designed buy-in option. Without a subsidized buy-in option, raising the eligibility age could leave one-quarter of poor and near-poor people ages 65 and 66 without health insurance coverage. A buy-in option for people as young as age 62 could improve coverage for the near elderly, but only if premiums are subsidized for low-income adults.

Raising the Medicare age will also affect employers. More retirees will likely purchase COBRA continuation coverage from their former employers, increasing costs for businesses. Although employers can charge premiums equal to average costs among all enrollees, retirees who purchase continuation coverage tend to incur higher-than-average costs. In addition, many employers may respond to an increase in the Medicare eligibility age by dropping their retiree health benefits to avoid the additional costs of providing coverage at ages 65 and 66.

Increasing the Medicare eligibility age to 67 will not solve the program's growing cost crisis. Eliminating 65- and 66-year-olds without disabilities from the Medicare rolls will not save very much money because they do not tend to be particularly heavy users of Medicare services. Moreover, it will be almost impossible to design a cost-neutral buy-in option. The buy-in plan will disproportionately attract people with health problems who are expensive to insure. And to be effective, the option must include some subsidies.

³ Private communication from Medicare actuaries.

Nonetheless, policymakers looking for ways to strengthen work incentives at older ages may reasonably view an increase in the Medicare eligibility age as an attractive option. The current eligibility age sends a powerful signal that retirement starts at age 65, despite the increase in Social Security's full retirement age. With proper protections for vulnerable groups, possibly including liberalized disability criteria at older ages, raising the Medicare age could help the nation meet the challenges of an aging population.

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