



Rationalizing a Medicare Buy-In Policy for Adults Ages 50 to 64 That Builds on the ACA

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Medicare buy-in policies gained prominence as potential incremental health reforms in the mid-1990s, after the Clinton administration's more ambitious health reform plan failed (Johnson, Moon, and Davidoff 2002). Such proposals from that era would have created a guaranteed source of health insurance adults ages 55 to 64 could buy, before becoming eligible for Medicare at age 65.¹ At a time when individually purchased coverage was not always available (insurers could deny coverage based on preexisting conditions) and premiums were generally linked to health status, the ability to buy into Medicare would have produced a reliable new source of health coverage for older adults.

With the implementation of the Affordable Care Act (ACA), coverage options for older adults changed significantly. Medicaid coverage is now generally available for all individuals with incomes below 138 percent of the federal poverty level (FPL) in states that adopted the ACA's Medicaid expansions. Many older adults who do not have access to affordable employer-based coverage may purchase coverage in the ACA's Marketplaces, regardless of health status. Government subsidies, in the form of income-based tax credits, are now available that partially or fully offset the costs of health insurance premiums. By making coverage more broadly available—without regard for health status and possibly with a subsidy—the ACA has substantially obviated some key rationales of earlier Medicare buy-in proposals.

Even with the ACA, some coverage gaps remain. In the 12 states that have not expanded Medicaid, subsidized coverage is unavailable to those with incomes below the FPL. And ACA subsidies are not available for people with incomes over 400 percent of FPL, who may face very high health insurance premiums, even with age-rating rules that limit premiums for older enrollees to no more than three times what enrollees in their early 20s are charged.

Two recent Medicare buy-in proposals, the Medicare at 50 Act (S. 470), sponsored by Senator Deborah Stabenow, and the Medicare Buy-in and Health Care Stabilization Act of 2019 (H.R. 1346), sponsored by Representative Brian Higgins, are designed to build on the ACA. These proposals aim to produce a competing Medicare-like insurance product for the population ages 50 to 64 (called "older adults" hereafter). By taking advantage of Medicare payment rates for providers, potentially offering broader provider networks, and lowering cost sharing, these proposals intend to benefit older adults.

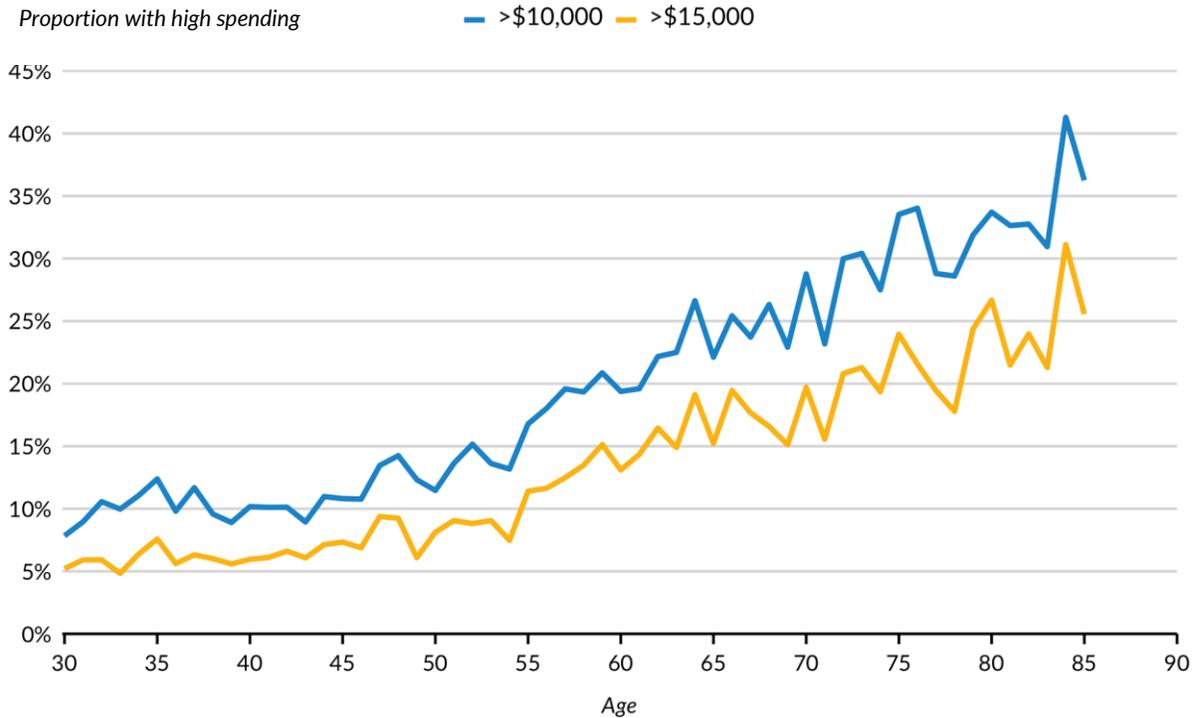
In this brief, we discuss the potential merits of a Medicare buy-in policy that coexists with the ACA. We first show how older adults are at substantial risk of high health care spending, making health insurance coverage critical to their financial security. We then show how uninsurance rates have varied with age before and after ACA implementation. We also highlight some main findings from a recent report that estimated the health insurance coverage and spending effects of Medicare buy-in policies (Garrett et al. 2020) and discuss what buy-in policies could achieve if they were implemented alongside the ACA.

Older Adults Are at Substantially Higher Risk of High Health Care Costs

Expected health care spending increases steadily with age, as does the risk of incurring very high health care costs. Using data from the three pooled years of the Medical Expenditure Panel Survey (2014–16), figure 1 shows how the share of people with high total health care spending (exceeding \$10,000 or \$15,000 in total spending annually), including insured and out-of-pocket costs, increases with age. The share of people with such spending exceeding \$10,000 is less than 10 percent until around age 50. Around age 64, more than 20 percent of people have health spending exceeding \$10,000, and more than 15 percent have health spending exceeding \$15,000. Thus, older adults face substantial risk of high health care costs. Without the financial protection of health insurance, many older adults would be unable to pay such high costs for care.

FIGURE 1

People with High Health Care Expenditures, by Age, 2014–16



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Source: Medical Expenditure Panel Survey, 2014–16.

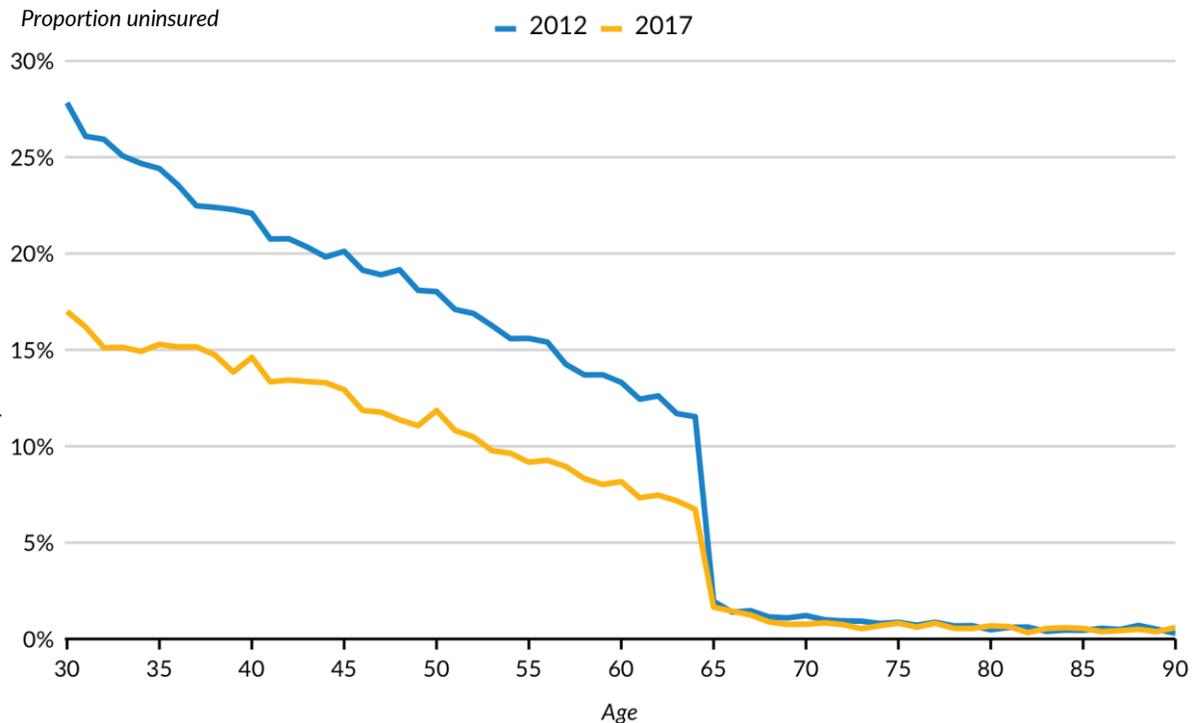
Health insurance plans available in the ACA Marketplaces feature out-of-pocket maximums that provide financial protection for enrollees, limiting the amount they must pay in cost-sharing obligations. Depending on their design, Medicare buy-in plans may also include such out-of-pocket maximums. If Medicare buy-in plans provide these maximums, they may be lower than those in a typical ACA silver plan. But in any case, the ACA already provides such protection for Marketplace enrollees.

The ACA Greatly Increased Insurance Coverage Rates for Adults under Age 65

An estimated 20 million Americans gained health insurance coverage under the ACA (CBPP 2016). Figure 2 shows how uninsurance rates varied with age in 2012, before implementation of the ACA's main coverage provisions, and in 2017, after full ACA implementation. In both years, the share of people lacking insurance fell with age. From age 65 on, the uninsurance rate was close to zero, because most of this population qualifies for Medicare. In 2012, about 18 percent of 50-year-old adults were uninsured, with higher uninsurance rates for those under age 50. With the ACA in place, the share of 50-year-old adults lacking coverage dropped to about 12 percent in 2017. Adults under

age 50 were more likely to be uninsured even after the ACA. A Medicare buy-in policy would prioritize expanding coverage or making coverage more affordable to those ages 50 to 64, who are less likely to be uninsured than those under age 50 but have a higher risk of high health care spending.

FIGURE 2
Uninsurance Rates Before and After Affordable Care Act Implementation, by Age, 2012 and 2017



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Source: American Community Survey.

Medicare Buy-In Policies That Build on the ACA Have Limited Ability to Expand Older Adults' Health Insurance Coverage

In a recent Urban Institute report (Garrett et al. 2020), we estimated the effects of a base Medicare buy-in policy targeting older adults and modeled on core features of recent legislative proposals, as well as several policy variations. In the base buy-in policy, adults ages 50 to 64 can purchase a plan like traditional fee-for-service Medicare that covers hospital care (Part A), physician and outpatient services (Part B), and prescription drugs (Part D). The plan would have an actuarial value of 85 percent, which is comparable with that for fee-for-service Medicare. The plan would reimburse providers at Medicare payment rates, which are typically lower than payment rates in the current nongroup market. Enrollees in this plan would form their own risk pool and the plan would be self-supporting. All

buy-in enrollees within a rating area would pay the same premium, and enrollees would be eligible for the same subsidy structure used in the ACA Marketplaces (premium tax credits and cost-sharing reductions). The report provides more detail on the policies modeled and methods.²

In our base policy, about 2.1 million people ages 50 to 64 would enroll in the Medicare buy-in plan. Most of these enrollees (1.9 million) would shift from current ACA Marketplace or nongroup coverage. Of the estimated 5.6 million adults ages 50 to 64 uninsured under current law in 2020, very few (176,000) would opt to purchase coverage under the base buy-in policy. Because an estimated 110,000 people under age 50 would lose coverage, only 67,000 people would gain coverage on net. In none of the alternative policies we modeled would buy-in enrollment exceed 3 million people. Under the most expansive policy, which substantially increases the generosity of the premium tax credits available in the ACA Marketplaces and the buy-in plan, the number of uninsured adults ages 50 to 64 would fall by 700,000.

Our finding that Medicare buy-in policies have limited potential to expand health insurance coverage is similar to earlier work. RAND estimated the effects of a range of Medicare buy-in policies and found that total health insurance enrollment would increase by 400,000 to 1.6 million people over age 50 and decline by 100,000 to 800,000 people under age 50 (depending on the scenario), leading to net changes in coverage of 1 million or fewer people (Eibner et al. 2019). Though the range of effects RAND estimated tend to be somewhat larger than what we have estimated, both studies show modest changes in net coverage and that most older adults who are uninsured under current law would remain uninsured with the buy-in. A recent National Academy of Social Insurance review of potential options for expanding coverage to older adults also concluded that Medicare buy-in policies would have limited impact on the uninsured (Docteur et al. 2020).

Given their high expected health care costs and risks of incurring significant health care expenses, older adults should highly value health insurance coverage. Indeed, they are much more likely than younger adults to have coverage, as shown in figure 2. But older adults who remain uninsured under the ACA are likely hard to cover through a voluntary buy-in policy alone. They typically have low incomes and have either already declined insurance options available under the ACA or were ineligible for subsidized coverage (e.g., noncitizens or people with incomes below the FPL living in a state that did not expand Medicaid).

Medicare Buy-In Policies Are Likely to Increase Premiums Somewhat in the ACA Marketplace Plans, Rather Than Reduce Them

One possible benefit of a Medicare buy-in policy is that it could lower premiums in the ACA Marketplaces for people under age 50 (Neuman, Pollitz, and Tolbert 2018). By attracting older adults with higher health care costs away from Marketplace plans, Marketplace risk pools might become less costly, possibly leading to lower premiums. However, a Milliman study found the opposite, that

premium rates would likely increase in the ACA Marketplaces as older adults shift to the buy-in (Kotecki and Westrom 2020). This finding is counterintuitive because average health care spending increases with age, but the study found that the higher premiums charged to older adults exceed their claims costs, whereas younger adults' claims costs exceed their plan's premiums. With the older population effectively subsidizing the younger one, shifts of older adults to the buy-in plan would lead to higher premiums for those remaining in the Marketplaces. The RAND and Urban studies similarly found that Medicare buy-in policies for older adults would lead to somewhat higher premiums in the Marketplaces. By drawing away market share and raising premiums, the buy-in policy could be a destabilizing force in the Marketplaces, likely contrary to buy-in proponents' aims.

Buy-In Policies Can Lower Out-of-Pocket Health Care Spending for Older Adults, Particularly Those Not Qualifying for Premium Tax Credits in the ACA Marketplaces

In the base buy-in policy we modeled, out-of-pocket premiums would decrease for some Marketplace enrollees switching to the buy-in and increase for others. However, because buy-in coverage would be more generous, all groups switching to the buy-in would pay less in out-of-pocket cost sharing. Overall, we estimate out-of-pocket health spending among those who switch from Marketplace coverage to the base buy-in plan would fall from \$3,414 to \$1,528, because of the buy-in's higher actuarial value, and their out-of-pocket premiums would fall from \$6,430 to \$6,230. Thus, buy-in enrollees would pay less out of pocket overall than they would in the current nongroup market. Most older adults with Marketplace coverage under current law would not switch to the buy-in plan and would experience little change in spending (66 percent).

The ACA's Marketplace subsidies (premium tax credits and cost-sharing reductions), available under current law, shield enrollees with lower incomes from high out-of-pocket costs.³ The buy-in plan would disproportionately attract people with higher incomes, because the financial gains of switching to the buy-in would be greater for people who do not qualify for the ACA's premium tax credits. As such, one rationale for a buy-in policy alongside the ACA is that it can reduce financial burdens for older adults by offering more generous insurance at a lower or similar cost to enrollees as Marketplace coverage.

By Paying Providers at Typically Lower Medicare Payment Rates, Buy-In Policies Can Reduce Overall Health Care Spending at a Modest Cost to the Federal Government

The base buy-in policy we examined would reduce aggregate health care spending by about \$1.8 billion (about 0.1 percent) on net. This reflects a net decrease in spending of \$2.8 billion (-0.3 percent) for older adults, enabled by the lower payment rates, and an increase in spending of about \$1.1 billion (0.1 percent) for people under age 50, given the modest increase in Marketplace premiums. The net decline in health care spending for adults ages 50 to 64 would be primarily driven by reduced household out-of-pocket health care spending. Though such spending for households would decline by \$3.6 billion (-2.9 percent) because buy-in coverage is more generous, total premium spending would increase by \$1.4 billion (1.2 percent) because 176,000 people would gain coverage. Federal spending would change very little (by \$95 million, or a less than 0.1 percent increase), because increased spending on buy-in tax credits would be almost fully offset by reduced spending on Marketplace tax credits. Thus, though of limited scope, the buy-in policy is one approach for reducing overall health care spending.

Conclusion

The rationale for creating a Medicare-like health care plan adults ages 50 to 64 can buy into was more compelling before ACA implementation. Older adults face substantial risk of high health care spending, but coverage was often unavailable or unaffordable before the ACA. The ACA greatly expanded health insurance coverage among older adults through Medicaid expansion and guaranteed availability of Marketplace plans, which may be subsidized for those with lower incomes. With the ACA in place, fewer older adults remain uninsured, and analyses find buy-in policies have limited potential to expand coverage further. What Medicare buy-in policies can mainly do, by building on the ACA, is take advantage of lower provider payment rates, which can increase the value of coverage and reduce out-of-pocket spending for beneficiaries, particularly those who do not qualify for premium tax credits. With modest additional federal spending, buy-in policies can also result in savings in national health spending.

Notes

- ¹ John M. Broder, “Clinton Proposes Opening Medicare to Those 55 to 65,” *New York Times*, January 7, 1998, <https://www.nytimes.com/1998/01/07/us/clinton-proposes-opening-medicare-to-those-55-to-65.html>.
- ² We estimate the implications of the base buy-in policy and seven policy variations on health insurance coverage and health care spending using the Urban Institute’s Health Insurance Policy Simulation Model.
- ³ People who switch to the buy-in would experience financial gains, even though the Marketplace plans have an out-of-pocket maximum and the base buy-in plan would not. However, coverage changes and overall savings were similar in an alternative buy-in policy that added an out-of-pocket maximum and dental, vision, and hearing benefits at the same 85 percent actuarial value. This suggests people are not very sensitive to the specifics of the design of the buy-in policy so long as it produces higher value overall.

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Bowen Garrett is a senior fellow in the Health Policy Center at the Urban Institute. His work focuses on health reform and health policy, with recent research examining the labor market effects of the Affordable Care Act, the design of Medicare’s payment systems for postacute care, and the effects of a unified cost-sharing design for Medicare. He leads the development of MCARE-SIM, a microsimulation model of policy reforms affecting Medicare beneficiaries. Garrett received his PhD in economics from Columbia University and was a postdoctoral research fellow in the Robert Wood Johnson Foundation’s Scholars in Health Policy Research Program at the University of California, Berkeley, and UCSF.

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