Changing the Age of Medicare Eligibility:

Implications for Older Adults, Employers, and the Government

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Abstract

Growing concerns about health insurance coverage for near elderly adults have recently prompted calls to lower the age of Medicare eligibility, while increases in the normal retirement age for Social Security and concerns about Medicare's financial health, particularly as the population ages, have led others to suggest delaying it. This report reviews the available evidence on how changes to the age of Medicare eligibility might affect government costs and rates of health insurance coverage and employment for near elderly adults (ages 55 to 64) and young elderly adults (ages 65 to 66).

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Executive Summary

The age of Medicare eligibility has not changed since the program was created in 1965. For more than 35 years, Medicare has provided subsidized health insurance coverage to virtually all Americans when they turn 65. Younger adults can receive Medicare benefits only if they are disabled.

In recent years, however, numerous experts, policymakers, and advocates for the elderly have recommended changing the age of eligibility. Growing concerns about health insurance coverage for near elderly adults have prompted calls to lower the eligibility age, while increases in the normal retirement age for Social Security and concerns about Medicare's financial health, particularly as the population ages, have led others to suggest delaying it.

This report reviews the available evidence on how changes to the age of Medicare eligibility might affect government costs and rates of health insurance coverage and employment for near elderly adults (ages 55 to 64) and young elderly adults (ages 65 to 66).

Health Insurance Coverage at Older Ages Under the Current System

Like other adults, the near elderly obtain health insurance from a mix of public and private sources. These include employer-sponsored coverage received by active workers and by retirees (in the form of retiree health insurance (RHI) benefits), private nongroup coverage, Medicare for those with disabilities, and Medicaid for those with limited incomes and assets who are blind or disabled. But the relatively high risk of health problems they face limits their coverage options in the private nongroup market, where insurance is expensive and difficult to obtain at any price for those in less than perfect health. The same limited set of insurance options would exist for the young elderly if the age of Medicare eligibility were raised.

Just under 10 percent of the near elderly were uninsured in 1998. Although a larger share of younger adults are uninsured, the uninsurance rate at older ages is alarming because many of the near elderly have health problems that require medical care. Coverage rates are closely related to income, limiting the effectiveness of policies designed to increase coverage by simply encouraging adults to purchase insurance. In 1998, for example, 28 percent of near elderly adults with family incomes below the federal poverty level (FPL) were uninsured, compared with only 4 percent of those with family incomes exceeding 400 percent of FPL.

Virtually all adults ages 65 and older are covered by Medicare. Many beneficiaries supplement their Medicare coverage with additional types of insurance, including employer-sponsored health benefits (provided to active workers, retirees, or the spouses of active workers and retirees), private Medigap plans, and Medicaid coverage. But 31 percent of young elderly Medicare beneficiaries had only Medicare coverage in 1998. Because many of them have limited economic resources, young elderly adults without additional types of insurance may have special difficulty finding coverage if they lose Medicare eligibility. For example, 33 percent of those without supplemental coverage were poor or near poor, compared with only 19 percent of those with supplemental coverage.

Lowering the Age of Medicare Eligibility

Providing subsidized Medicare benefits to all adults ages 62 to 64 by lowering the age of automatic eligibility for Medicare would virtually eliminate uninsurance at ages 62 to 64. It would also improve security for those who rely on the expensive and risky individual insurance market, all of whom would instead be able to obtain less costly and more secure Medicare coverage. In addition, the expansion of Medicare coverage would reduce employer costs for retiree health benefits and both retiree and

employer costs for COBRA continuation coverage. But it would be expensive. Reducing the automatic eligibility age to 62 would cost the Medicare program about $5.4 billion per year (in 2000 dollars). The net cost to the federal government would total about $5.0 billion, because the expanded Medicare program would pick up some costs currently paid by Medicaid.

A less costly approach would be to create a buy-in plan that would allow the near elderly to purchase Medicare coverage. Buy-in plans would in effect lower the age of Medicare eligibility, although participants would pay higher premiums than older beneficiaries who qualify for automatic coverage. The Clinton administration first proposed a buy-in plan in 1998 that would charge premiums approximately equal to the cost of services it provides, and Democratic lawmakers introduced similar legislation in Congress in 2003. These proposals would have limited benefits to adults ages 62 to 64 (and displaced workers ages 55 to 61), but benefits could easily be extended to all adults as young as 55.

Studies of the impact of the Clinton buy-in proposal predict that about 37 percent of eligible adults ages 62 to 64 would participate in a plan priced at $300 per month with no supplemental payments after age 65. But participation rates would be much higher among those who would otherwise purchase private coverage than among those who would be uninsured, so the plan would not help the uninsured much. Simulations indicate that it would reduce the size of the uninsured population ages 62 to 64 by only about 6 to 12 percent.

A buy-in plan could be much more effective if it included subsidies for low-income adults. For example, uninsurance rates could fall by more than one-third if premiums were capped at 5 percent of income. And if those with family incomes below 150 percent of the federal poverty level had to pay only about $45 per month for coverage, a buy-in plan could reduce uninsurance rates for the poor by more than half. Relating premiums to income would target public benefits to those who need them most. Tying the subsidies to lifetime earnings, instead of current income, would reduce the incentive to retire early to qualify for low-cost insurance coverage.

Subsidies inevitably increase program costs, though. Costs could reach $525 million per year (in 2000) for a buy-in plan for those ages 62 to 64 that subsidized premiums for all participants by 25 percent and $2.7 billion for a plan that capped premiums at 5 percent of income. Costs would run even higher if the buy-in program were extended to those as young as 55.

Even if policymakers did not intend to subsidize benefits, they would find it almost impossible to design a cost-neutral buy-in program available to all adults ages 55 to 64 who lacked access to employer-sponsored or public insurance, because the plan would disproportionately attract participants who expect to use many services.

Extending Medicare benefits to nondisabled adults younger than 65, either by lowering the eligibility age outright or by allowing near elderly adults to buy into the Medicare program, could encourage some workers to retire early. By reducing or even eliminating the period during which early retirees without RHI benefits would need to purchase expensive private nongroup coverage to avoid becoming uninsured, extending Medicare coverage would lower the costs of retiring. Policies such as Medicare expansions that encourage retirement heighten concerns about the ability of the economy to support the growing retired population. But they would give some older workers who receive employer-sponsored health benefits on the current job the freedom to leave their job and pursue a second career in another line of work, or become self-employed, without worrying about the availability of health insurance coverage.

Recent estimates suggest that lowering the automatic age of Medicare eligibility to 62 would increase overall retirement rates by about 7 percent. Annual retirement rates among men, for example,

would rise from 6.4 percent to 6.8 percent. The introduction of a buy-in program priced at $300 per month would raise overall retirement rates for men by only about 2 percent.

Raising the Age of Medicare Eligibility to 67

Despite concerns about the number of uninsured older adults too young to qualify for Medicare, proposals to increase the age of Medicare eligibility to 67 continue to attract attention. Proponents argue that raising the eligibility age would reduce Medicare costs and improve the solvency of the Medicare trust fund. In addition, it would bring the age of Medicare eligibility in line with the normal retirement age for Social Security, and might encourage some individuals to remain at work and delay retirement, an increasingly important policy goal as the aging of the population reduces the share of adults below the traditional retirement age who can support the growing elderly population. Opponents of an increase in the eligibility age argue that it would leave many young elderly adults uninsured or with inadequate insurance.

Raising the age of Medicare eligibility to 67 would not substantially reduce coverage for most young elderly adults. More than half would receive employer-sponsored coverage from their own workplace or their spouse's workplace, and another 17 percent would receive Medicaid benefits or maintain Medicare coverage because of disabilities.

However, more than one in five young elderly adults would be forced to rely on expensive private nongroup coverage, and one-half of those could only afford policies that provided limited coverage. In addition, an increase in the age of eligibility would leave 9 percent of the young elderly uninsured.

Raising the age of eligibility would hit those with limited incomes especially hard. For example, almost one in four poor and near poor young elderly adults would lack coverage. Creating a Medicare buy-in plan for the young elderly would mitigate the adverse effects of an increase in the automatic age of eligibility, but low-income adults—who comprise a disproportionate share of the uninsured—would benefit only if the premiums they face were heavily subsidized.

An increase in the age of eligibility could generate substantial savings for Medicare. By 2022, annual savings could reach $28 billion (in 2000 dollars), compared with what the program would pay out under current rules. The reduction in the total cost of public insurance would be somewhat lower, because some of the young elderly would move from Medicare to Medicaid.

In addition, the reduction in Medicare enrollees would exceed the reduction in costs, because many of the most expensive beneficiaries—including the oldest old and those with disabilities—would remain in the program. According to one study, raising the age of eligibility would reduce Medicare enrollment by 11 percent and Medicare expenditures by 4.3 percent.

Raising the age of Medicare eligibility is likely to affect labor supply decisions by increasing the costs associated with retirement, especially for workers whose employers provide health insurance while they are employed but not after they retire. With an increase in the age of Medicare eligibility to 67, they would have to purchase expensive alternatives to employer-sponsored coverage for an additional two years if they chose to retire before age 65. Some workers might choose to avoid these additional costs by delaying retirement. One study concludes that raising the age of eligibility would reduce overall retirement rates by about 5 percent (from 21 percent over a two-year period to 20 percent), higher than some estimates of the impact of increasing the normal retirement age for Social Security.

An increase in the age of Medicare eligibility could raise insurance costs for employers who provide RHI benefits. Under the current system, employers who offer RHI benefits generally pay a

substantial share of health costs for retired workers up to age 65, when Medicare coverage begins. At that time, RHI coverage becomes the secondary payer of health care costs, picking up some Medicare cost-sharing expenses and generally paying for some services that Medicare does not cover. Raising the age of Medicare eligibility would increase the number of months of primary RHI coverage. Employers could respond to the increase in insurance costs by eliminating RHI benefits, but there is no empirical evidence to suggest the likelihood of an employer response or its size.

Making Medicare the Primary Payer for Older Workers

The large health care expenses that many older adults incur raise the costs of employing them and may reduce their employment options. Employers who provide health benefits face higher insurance costs from older workers, and age discrimination rules limit their ability to offset these costs by paying lower wages. As a result, employers may prefer younger workers, reducing the demand for older employees.

One way to lower employment costs for older workers and perhaps improve their employment opportunities would be to raise the share of health care expenses paid by Medicare. Under current rules, Medicare is the secondary payer of health care costs for most workers ages 65 and older with employer-sponsored insurance. Employer-sponsored insurance reimburses health care costs first, while Medicare pays only for Medicare-covered services that it does not cover. But the available evidence suggests that making Medicare the primary payer for older workers would not substantially improve employment options for older adults, because the savings for employers would amount to only a small share of total employment costs.

Conclusions

Setting the age for Medicare eligibility is necessarily arbitrary. Although a clear consensus exists in this country for providing universal health benefits to older adults, it is not clear when an individual becomes old. Finding the appropriate age involves difficult trade-offs. Lowering the age of Medicare eligibility would improve health and income security for some adults younger than 65, but it would raise costs and encourage some workers to retire early, exacerbating concerns about the ability of the economy to support the growing retired population. Raising the age of Medicare eligibility would reduce program costs and encourage workers to remain in the labor force, but at the expense of the health and income security of older Americans, particularly those with health problems.

Nonetheless, recent improvements in health status and increases in employment at late midlife may have reduced the need for subsidized health benefits at age 65. As the normal retirement age for Social Security benefits slowly rises to age 67 in 2022, it may make sense to increase the age of Medicare eligibility to 67, because the eligibility age always coincided with the normal retirement age (before the retirement age began increasing in 2000).

But many adults could benefit from an option to buy into the Medicare program at younger ages. Similar to the early retirement option for Social Security, the buy-in program would permit individuals to receive limited subsidized benefits before the full entitlement age. The buy-in option would be particularly important to vulnerable populations, especially if plan premiums varied with the ability to pay.

I. Introduction

The age of Medicare eligibility has not changed since the program was created in 1965. For more than 35 years, Medicare has provided subsidized health insurance coverage to virtually all Americans when they turn 65. Younger adults can receive Medicare benefits only if they are disabled. But growing concerns about health insurance coverage for near elderly adults have prompted calls to lower the eligibility age, while increases in the normal retirement age for Social Security and concerns about Medicare's financial health, particularly as the population ages, have led others to suggest delaying it. This report examines how changes to the age of Medicare eligibility might affect rates of health insurance coverage and employment for near elderly adults, defined as those ages 55 to 64, and young elderly adults, defined as those ages 65 to 66. It also describes the potential impact that changing the eligibility age would have on federal government spending.

Medicare was created to provide health benefits to aged Social Security recipients. At the time of its inception, most workers waited at least until they reached the normal retirement age of 65 to collect Social Security benefits. In 1965, only 41 percent of retired workers received Social Security income before age 65 (U.S. House of Representatives 2000). Today, however, relatively few workers wait until they reach the normal retirement age to collect Social Security. In 1999, more than three-fourths of workers elected to receive retirement benefits before age 65.[1] Given the limited (and declining) availability of retiree health benefits, many older workers lose access to employer-sponsored insurance coverage when they leave the labor force. If they are not old enough to qualify for Medicare coverage when they retire but wish to remain insured, they must turn to the private nongroup market, where coverage is usually expensive and often incomplete, especially for those with preexisting health conditions.

One set of proposals to help the near elderly obtain insurance coverage would allow adults as young as 55 to purchase Medicare coverage. To reduce the cost to the government of expanding Medicare, most of the proposed buy-in plans, as they are known, would charge participants substantial premiums. But many of the uninsured have only limited incomes and might not be able to afford to purchase Medicare coverage, even if it were priced lower than comparable private nongroup policies. An alternative approach would be to lower the age of full Medicare eligibility to 62, making subsidized health benefits and early Social Security retirement benefits available at the same age.

While an increasing share of older adults are choosing to receive Social Security retirement benefits before the normal retirement age, the normal retirement age itself is increasing. Beginning with workers born in 1938, it is rising above age 65, and it will gradually increase until it reaches age 67 for workers born in 1960 and later years. Retired workers will still be able to collect benefits at age 62, but they will face stiffer penalties than early retirees did in the past.[2] The increase in the normal retirement age has led to calls for an equivalent increase

[1] According to data from the Social Security Administration, 58.6 percent of adults who first began collecting Social Security retirement benefits in 1999 were age 62, and another 18.8 percent were ages 63 or 64 (U.S. House of Representatives 2000).

[2] For workers born before 1938, Social Security rules reduce monthly benefits by 20 percent if they begin collecting at age 62 instead of the normal retirement age. But workers born in 1960 or later will face monthly benefit reductions of 30 percent if they collect at age 62 instead of the normal retirement age.

in the age of Medicare eligibility. Proponents argue that raising the age of Medicare eligibility will reduce program costs and improve the solvency of the Medicare trust fund, which is currently projected to run out of funds in 2026 (Board of Trustees 2003). In addition, delaying the Medicare age might encourage some individuals to remain at work and delay retirement, an increasingly important policy goal as the aging of the population reduces the share of adults below the traditional retirement age who can support the growing elderly population.

Changing Medicare rules to designate Medicare as the primary payer for active workers with employer-sponsored coverage might also increase employment rates for older adults. Under current law, the employer's group health plan pays claims first for active workers covered by Medicare, while Medicare picks up only costs for services it covers that are not covered by the employer's plan. Because health care costs increase with age, older workers are more expensive for employers to cover than younger workers, and high health care costs may discourage firms from employing older workers. The costs of employing older workers could fall if Medicare replaced the employer's group plan as the primary payer for older workers.

Finding an appropriate age for Medicare eligibility involves trade-offs between competing objectives. For example, the Medicare program is designed to improve the health and income security of older adults, and lowering the eligibility age would extend this insurance to additional members of society. However, it would also increase the costs of the program. In addition, lowering the eligibility age might encourage some workers to retire at younger ages, exacerbating concerns about the ability of the economy to support the growing retired population. On the other hand, raising the age of Medicare eligibility might reduce programs costs and encourage workers to remain in the labor force, but perhaps at the expense of the health and income security of older Americans, particularly those with health problems.

This report examines a number of proposals to change the age of Medicare eligibility and considers how they might affect older adults, employers, and government spending. Section II describes the health security of older adults under the present system. It discusses the current health insurance options available for near elderly adults, their rates of coverage, and the characteristics of the uninsured. It also describes the types of coverage that would be available to adults ages 65 and 66 if they no longer qualified for Medicare. Section III describes proposals to extend Medicare coverage to adults younger than age 65 and how they might affect rates of uninsurance for near elderly adults, the type of coverage they have, their employment rates, and government spending. Section IV considers the impact that delaying the Medicare eligibility age to 67 would have on coverage rates, employment, and Medicare costs. Section V examines how designating Medicare as the primary payer for Medicare-covered active workers with employer-sponsored coverage might increase the demand for older workers. Section VI summarizes and presents conclusions.

II. Health Insurance Coverage at Older Ages Under the Current System

Health insurance is especially important to the health and income security of near elderly and young elderly adults. As individuals reach their late 50s and 60s, they become increasingly likely to experience serious health problems. For example, individuals ages 55 to 64 are six times as likely to have cancer than those ages 35 to 44 and five times as likely to suffer from heart disease.[3] The prevalence of health problems at older ages translates into high health care expenses and strong demand for health insurance by the near elderly. Average health care expenditures are twice as high for those between the ages of 55 and 64 as for those 35 to 44 (General Accounting Office 1998).

Numerous studies have documented the impact of health insurance status on health care access and utilization. At all ages, those without insurance are less likely to seek routine and preventive care, which can lead to a variety of preventable and potentially costly health episodes (Weissman and Epstein 1994). Among the near elderly, the uninsured are about three times more likely than those with health benefits from their employers to lack a usual source of health care, meaning that the uninsured may not receive services when needed. In addition, women without insurance are only about 70 percent as likely to receive regular breast exams as those with employer-sponsored insurance (Brennan 2000). Because the incidence of many serious health problems increases with age, forgoing routine care can be especially hazardous for the near and young elderly.

Like other adults, the near elderly (ages 55 to 64) obtain health insurance from a mix of public and private sources. However, the relatively high risk of health problems that they face limits their coverage options. The same limited set of insurance options would exist for the young elderly (ages 65 to 66) if the age of Medicare eligibility were raised.

Employer-Sponsored Coverage and Retiree Health Benefits for the Near Elderly

By the time individuals reach their early 60s, many have stopped working. At ages 62 to 64, only 49 percent of men were employed in 1998, compared with 85 percent at ages 51 to 54 (see exhibit 1). For women, the employment rate in 1998 dropped from 72 percent for those between the ages of 51 and 54 to 37 percent for those ages 62 to 64. And many men and women employed at older ages have already retired from their full-time career jobs and work at part-time jobs, which typically do not offer health benefits. Because most insurance coverage is tied to employment, retirement often leads to changes in coverage. Some firms continue to contribute toward their workers' health benefits after retirement. These benefits, known as retiree health insurance (RHI), generally continue until age 65, when Medicare coverage begins, and sometimes supplement Medicare benefits after age 65.

But most adults nearing retirement lack access to RHI benefits. Only 32 percent of full-time workers ages 55 to 62 reported in 1998 that they could continue to receive benefits from their employer-sponsored health plan until age 65 if they retired immediately, according to data from the 1998 Health and Retirement Study (HRS), a nationally representative survey of older

[3] The incidence of cancer at ages 55 to 64 is 1,052 per 100,000, compared with only 172 per 100,000 at ages 35 to 44 (Ries, Wingo, Miller, et al. 2000). The prevalence of heart disease increases from 31 per 1,000 among men under age 45 to 134 per 1,000 among men between the ages of 45 and 64 (National Center for Health Statistics 1999).

Exhibit 1. Employment Rates in 1998, by Age and Gender

	Employment Rates (%), Full-time and Part-time Work		Employment Rates (%), Full-time Work Only	
Age	**Men**	**Women**	**Men**	**Women**
51 – 54	85	72	79	56
55 – 59	79	64	69	45
60 – 61	69	52	58	34
62 – 64	49	37	35	18
65 – 66	40	26	21	11
67 – 69	33	21	14	6
70 – 74	24	13	9	4
75 and older	12	5	3	1

Note: Full-time employment is defined as 35 or more hours of paid work per week.

Source: Author's estimates from the 1998 Health and Retirement Study.

Americans conducted by the University of Michigan for the National Institute on Aging. Another 4 percent reported that they did not know whether their health benefits could continue into retirement. Among full-time workers who responded completely to the RHI questions, 34 percent reported that their employer offered RHI coverage (see exhibit 2). The share increases to 36 percent if we assume that all workers who do not know about the status of their health benefits would actually receive RHI benefits from their employers. The share of workers with access to RHI benefits may be somewhat higher than these figures suggest, though, because some workers whose employers do not offer RHI benefits may obtain coverage from their spouses' employers. Nonetheless, even among workers receiving health benefits from their employers, many would not be able to continue their benefits until age 65 if they stopped working. Among full-time workers with employer-sponsored health benefits who responded to the survey questions, only 56 percent reported that their coverage could continue until age 65 if they retired.

Even those offered RHI might not be able to afford it. RHI benefits are usually less generous and require more cost sharing than health benefits provided to active workers. In 1995, for example, large firms that offered health benefits paid an average of 77 percent of the premium costs for active workers, but those that offered RHI paid only 52 percent of the premium costs for retired workers (Foster Higgins 1996). About one in ten early retirees who are offered RHI benefits turn it down because they say it is too expensive (Loprest 1998).

Recent trends have raised concerns about the future of RHI benefits. The availability of RHI benefits has been declining steadily for more than a decade. Between 1988 and 2001, the share of large employers (those with more than 200 employees) offering RHI benefits fell from

Exhibit 2. Share of Full-Time Workers Aged 55 to 62 Eligible for Employer-Sponsored Retiree Health Benefits, 1998

	Best Guess (%)	Lower Bound (%)	Upper Bound (%)
All Full-Time Workers			
Men	34.8	32.8	37.0
Women	33.1	31.4	36.0
All	34.1	32.2	36.6
Full-Time Workers Receiving Health Benefits from Current Employer			
Men	57.9	52.6	59.3
Women	53.0	48.8	56.0
All	55.8	51.0	57.9

Note: Estimates are based on a sample of 2,888 full-time workers aged 55 to 62, 1,809 of whom were covered by employer-sponsored health insurance. The lower bound estimate assumes that none of the "don't know" responses actually have retiree health benefit offers, the upper bound estimate assumes that all of the "don't know" responses have offers, and the "best guess" estimate assumes that the "don't know" responses are equally likely to have offers as the complete responses.

Source: Author's estimates from the 1998 Health and Retirement Study.

66 percent to 34 percent, among those providing health benefits to active workers (Kaiser Family Foundation and Health Research and Educational Trust 2002).[4] When these workers retire in future years, fewer of them will be able to rely on employer-sponsored coverage than the current generation of near elderly retirees.

At the same time, employers have been shifting more of the costs of RHI plans on to participants. Among full-time workers in medium-size and large firms that offered RHI coverage, the share who would be required to make contributions upon retirement to offset at least part of the cost of their plans increased from 35 percent in 1985 to 91 percent in 1995 (Bureau of Labor Statistics 1998; Karoly and Rogowski 1998). Almost half (48 percent) of large firms offering RHI benefits reported in 2001 that they were very or somewhat likely to increase the share of premiums paid by retirees over the next two years (Kaiser Family Foundation and Health Research and Educational Trust 2002). When these workers retire, the high level of contributions required by their former employers might force many of them to decline RHI coverage. The cutbacks are generally attributed to rising health care costs and new accounting rules, introduced in 1993, requiring employers for the first time to recognize the present value of expected future retiree health care costs as liabilities on their balance sheets.

A court ruling in August 2000 could further erode the availability of RHI benefits. The Third Circuit Court of Appeals held that employers violate the Age Discrimination in Employment Act if they offer better health insurance coverage to retirees who are too young to

[4] The estimated decline in the availability of RHI offers is less dramatic in a survey of employers conducted by Hewitt Associates (1999). According to that survey, the share of firms with 1,000 or more workers offering RHI benefits to pre-65 retirees fell from 88 percent in 1991 to 76 percent in 1998.

qualify for Medicare than to Medicare-eligible retirees.[5] If adopted by other federal courts, this ruling could lead employers to reduce the generosity of health benefits they provide to early retirees or eliminate RHI benefits completely (General Accounting Office 2001b).

Most retirees who lack access to RHI can continue to receive their employer-sponsored coverage for a limited time. Under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), employers with 20 or more employees are required to provide continuation coverage to former workers for up to 18 months (or 29 months if the worker is disabled). But the cost to the beneficiary can be high because former workers assume full responsibility for 102 percent of the employer's group rate. These costs contribute to the low take-up rate for COBRA coverage (Flynn 1994). Less than 3 percent of the nonworking near elderly reported COBRA coverage in 1998, according to estimates from the HRS (see exhibit 3). Because of the limited availability of RHI coverage, the limited duration of COBRA coverage, and the relatively high costs of both types of coverage, the near elderly are significantly less likely than younger adults to have employer-sponsored coverage. According to data from the Urban Institute's National Survey of America's Families, 73 percent of persons ages 55 to 64 received coverage from an employer in 1997, compared with 76 percent of those ages 35 to 54 (Brennan 2000).

Public Sources of Coverage for the Near Elderly

Near elderly persons who lack job-related health benefits have limited insurance options. Nonelderly adults can qualify for Medicare or Medicaid benefits only if they are blind or disabled. In addition, Medicaid benefits are subject to strict income and asset tests, and Medicare benefits do not begin until at least 29 months after the onset of disability. If an increase in the age of Medicare eligibility disqualified them for Medicare coverage, some young elderly adults with

Exhibit 3. Share of Adults Aged 55 to 62 With COBRA Coverage, By Employment Status, 1998

	Best Guess (%)	Lower Bound (%)	Upper Bound (%)
All	1.0	1.0	1.4
Employed	0.5	0.5	0.5
Not Employed	2.0	1.9	2.8

Note: Estimates are based on a sample of 4,913 adults aged 55 to 62, 1,870 of whom were employed. The lower bound estimate assumes that none of the cases with missing data have COBRA coverage, the upper bound estimate assumes that all of the cases with missing data have COBRA coverage, and the "best guess" estimate assumes that the missing cases are equally likely to have COBRA coverage as the complete responses.

Source: Author's estimates from the 1998 Health and Retirement Study.

[5] *Erie County Retirees Association v. County of Erie*, 220 F.3d 193 (3d Cir. 2000) cert. denied, 69 U.S.L.W. 3409 (U.S. Mar. 5, 2001) (No. 00-906).

limited income and assets could receive Medicaid benefits even if they were not blind or disabled, as long as Medicaid rules did not change in response to the increase in Medicare.

Private Nongroup Coverage for the Near Elderly

Given these constraints, many near elderly persons without coverage from employers turn to the private nongroup market. Indeed, private nongroup coverage rates are almost twice as high at ages 55 to 64 as at ages 35 to 54 (Brennan 2000). However, there are a number of important drawbacks to relying on the private nongroup market at older ages. A primary concern is the affordability of nongroup coverage. Compared with premiums for group policies, premiums are generally higher for private nongroup plans because risk pooling is more limited, administrative costs are higher, and employer subsidies are generally unavailable. According to one recent study, in 2001 the median annual nongroup premium faced by 55-year-old men was $6,120 (Gabel et al. 2002). By comparison, the median of annual group premiums was only $2,736, and employers typically pay at least part of those costs.

The affordability issue is compounded by the health problems that many retirees have when they enter the nongroup market, 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 those with higher incomes, those in poverty face substantially higher premiums on average than other individuals. Exhibit 4 reports the distribution of family income by overall health status, for adults ages 55 to 64. Among those who described their health as fair or poor, 23 percent had incomes below the federal poverty level, compared with only 4 percent of those with excellent or very good health. Similarly, those with excellent or very good health were more than twice as likely as those with fair or poor health to report incomes exceeding 400 percent of the poverty level. 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 because they face particularly high prices.

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, with high deductibles, high cost-sharing requirements, and limited benefits. 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 ages 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.

Exhibit 4. Distribution of Family Income at Ages 55 to 64, by Overall Health Status, 1998

Family Income	Overall Health Status (%)		
	Excellent or Very Good	Good	Fair or Poor
Less than 100% of the Poverty Line	4.0	8.0	22.7
100% - 200% of the Poverty Line	7.2	10.7	20.2
200% - 400% of the Poverty Line	19.8	27.7	27.2
More than 400% of the Poverty Line	68.9	53.6	29.9
Total	100.0	100.0	100.0

Source: Author's estimates from the 1998 Health and Retirement Study.

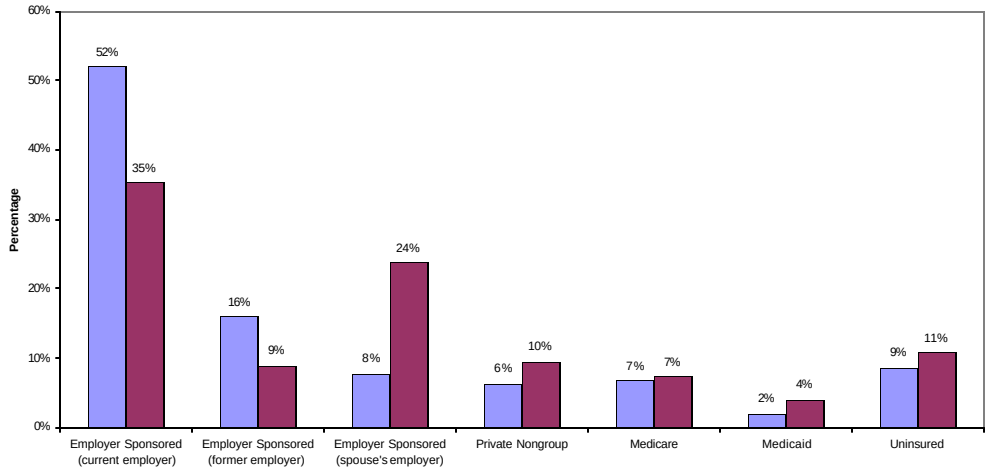
Even when near elderly Americans are able to afford the high cost of private nongroup coverage, insurers may deny them coverage. According to a recent study of the nongroup health insurance market in 10 states, insurers often deny coverage for such health problems as rheumatoid arthritis, chronic headaches, kidney stones, angina, heart disease, and stroke (Chollet and Kirk 1998).

A number of laws and regulations at both the federal and state levels have been enacted recently to address problems with the private nongroup market, but it is not yet clear how effective these initiatives will be in improving access to nongroup coverage for near elderly Americans. With the passage of the Health Insurance Portability and Accountability Act in 1996, federal law now requires insurers to offer policies to retirees who have exhausted COBRA coverage. But there are no restrictions on the premiums they can charge, so this legislation does not address concerns about the affordability of nongroup coverage. Some states now limit the variation in the price that private insurers can charge across different age or health groups, which could lower premium costs for the near elderly, but these restrictions are not present in every state. Moreover, restrictions on premium variation without other market reforms could raise health insurance premiums for healthy adults in the private nongroup market.

Coverage Rates for Near Elderly Adults in 1998

Exhibit 5 reports the distribution of health insurance coverage in 1998 for men and women between the ages of 55 and 64, based on estimates from the HRS. Overall, for men and women combined, about 44 percent of near elderly Americans were covered by their own current employers. Another 12 percent received coverage from former employers, and 16 percent received coverage through their spouses' employers. In all, 72 percent of the near elderly had workplace coverage. About 8 percent purchased private nongroup coverage and 10 percent

Exhibit 5
Health Insurance Coverage at Ages 55 to 64, 1998



Source: Author's estimates from the 1998 Health and Retirement Study

Note: Coverage is determined by the following hierarchy: employer-sponsored (current, former, spouse), private nongroup, Medicare, and Medicaid

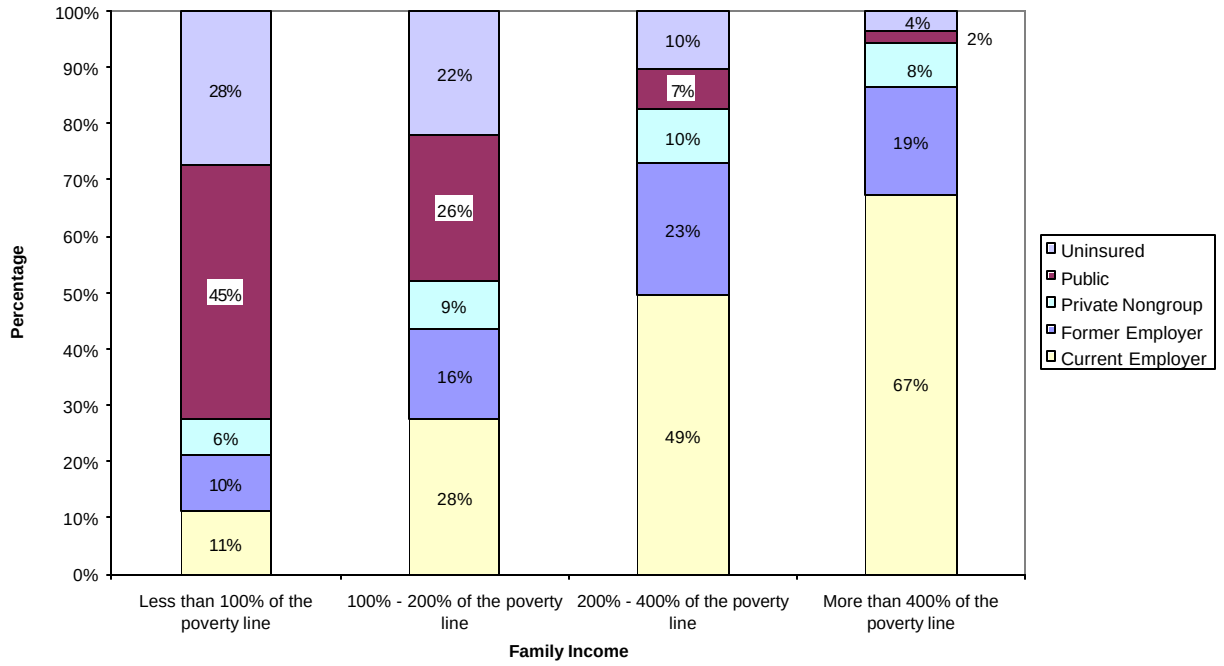
received public benefits through the Medicare or Medicaid programs. Just under 10 percent of the near elderly were uninsured in 1998.[6]

The uninsurance rate for near elderly adults is somewhat lower than estimates of the rate of uninsurance for all nonelderly adults. Estimated rates of uninsurance differ across surveys, but virtually all surveys agree that the near elderly are no more likely to lack coverage than other nonelderly adults. For example, in the Urban Institute's National Survey of American Families, 13.4 percent of respondents ages 35 to 54 lacked coverage in 1997, compared with 9.5 percent of those ages 55 to 64 (Brennan 2000). Concern about lack of coverage among near elderly adults arises not because they are more likely to be uninsured than other age groups, but because the lack of coverage can have especially serious consequences at older ages.

There are important differences in coverage between men and women in their 50s and early 60s. As reported in exhibit 5, women are much less likely than men to receive coverage through their own employment, either as active workers or as retirees. Conversely, they are much more likely than men to receive coverage from their spouses' employers. As a result, divorcees and widows stand to lose their insurance coverage. Women are also more likely than men to purchase private nongroup coverage and are more likely to be uninsured (10.8 percent vs. 8.7 percent).

[6] This estimate of the uninsurance rate is substantially lower than estimates derived from the Current Population Survey (CPS), which are widely cited. For example, Shea, Short, and Powell (2001) report that 14 percent of CPS respondents ages 50 to 64 lacked coverage in 1998. Estimates may be higher in the CPS than the HRS because the CPS asks about coverage during the previous calendar year, while the HRS measures insurance coverage at the time of the survey. In addition, the CPS asks a series of questions about insurance coverage and then assumes that any person not designated as being covered through any type of insurance is uninsured. The HRS adds a question that verifies whether respondents who appear not to have coverage are, in fact, uninsured. HRS estimates are consistent with those from other sources, including the National Survey of American Families.

Exhibit 6
Health Insurance Coverage at Ages 55 to 64,
by Family Income Relative to the Poverty Line, 1998

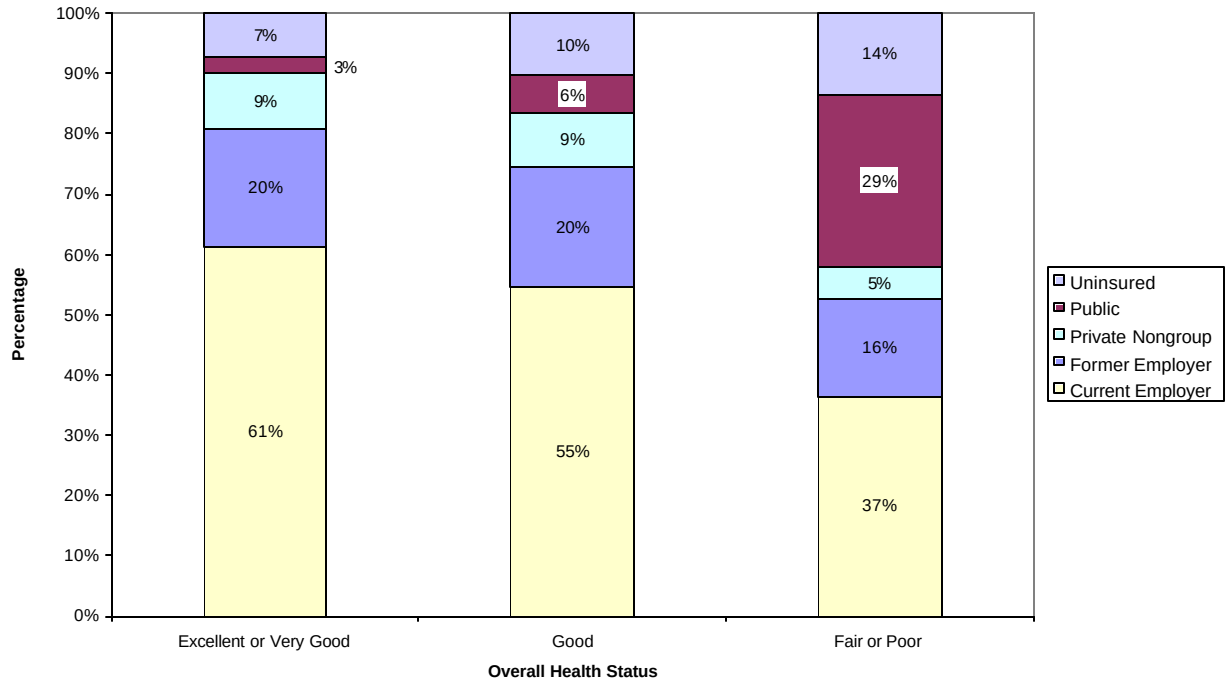


Source: Author's estimates from the 1998 Health and Retirement Study.

Coverage rates are closely related to income, limiting the effectiveness of policies designed to increase coverage by simply encouraging adults to purchase insurance. As reported in exhibit 6, 28 percent of near elderly adults with family incomes below the federal poverty level were uninsured in 1998, compared with only 4 percent of those with family incomes exceeding 400 percent of the poverty level. Only 21 percent of adults in poverty and only 44 percent of the near poor (with incomes between 100 percent and 200 percent of the poverty level) reported employer-sponsored coverage in their own names or their spouses' names. By contrast, 86 percent of near elderly adults with incomes above 400 percent of the poverty level received benefits from their own current or former employers or their spouses' employers. Rates of coverage by public insurance, in the form of Medicare and Medicaid benefits, are much higher among the poor than those with substantial incomes, but not high enough to offset the low rates of employer-sponsored coverage for those with limited incomes.

Despite the importance of health insurance to those in poor health, many near elderly adults with health problems are uninsured. Fully 14 percent of those who described their health as fair or poor were uninsured in 1998, compared with only 7 percent of those in excellent or very good health (see exhibit 7). Much of the shortfall in coverage for those in fair or poor health is due to their low rates of employer-sponsored coverage. Only 53 percent received health benefits through current or former employers, compared with 81 percent for those in excellent or very good health. Although many near elderly adults with health problems receive Medicare and Medicaid benefits, strict eligibility criteria and lengthy waiting periods leave others without publicly provided health benefits. Adults in poor health without access to employer-sponsored

Exhibit 7
Health Insurance Coverage at Ages 55 to 64, by Overall Health Status, 1998

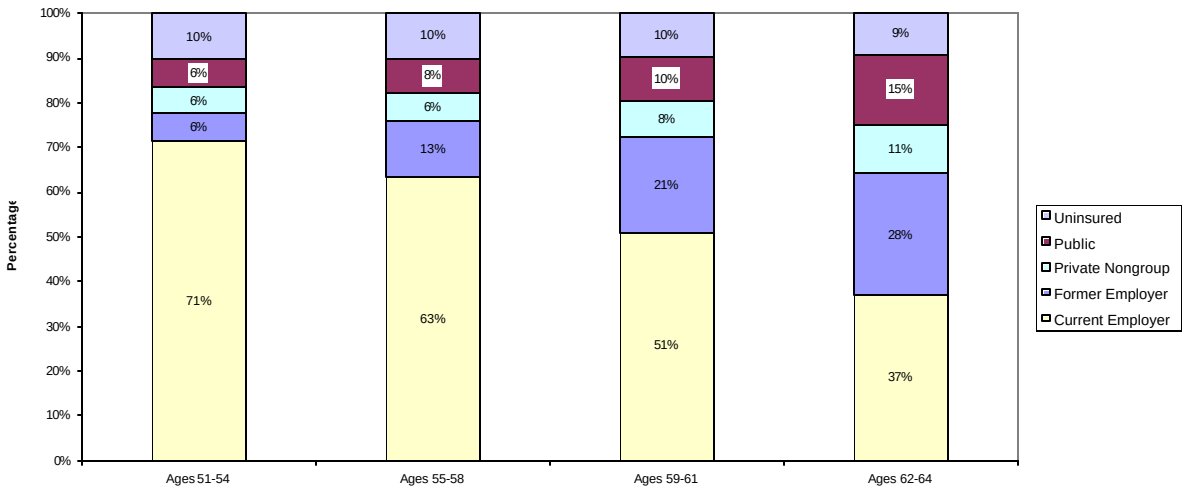


Source: Author's estimates from the 1998 Health and Retirement Study.

coverage have difficulty obtaining coverage in the private nongroup market, where they face unaffordable premiums or are unable to purchase insurance at any price. In fact, only 5 percent of those in fair or poor health had private nongroup coverage, compared with 9 percent of those in better health. Thus, more comprehensive public sources of insurance may be critical to improve coverage rates for those with serious health problems.

Although rates of uninsurance remain fairly stable as near elderly adults approach the age of Medicare eligibility, the type of coverage individuals receive often changes as they age from their early 50s into their 60s. As reported in exhibit 8, the likelihood that individuals receive health benefits from current employers steadily falls during this decade of life, while the likelihood of receiving coverage from former employers, private nongroup plans, and the public sector steadily rises. For example, at ages 51 to 54, some 71 percent of Americans reported coverage from current employers. The comparable figure was only 37 percent for ages 62 to 64. Coverage rates from former employers were 28 percent at ages 62 to 64 – far higher than the 6 percent rate for Americans at ages 51 to 54. Even so, coverage from current employers drops off so precipitously for older groups that overall employer-sponsored coverage was 12 percentage points lower at ages 62 to 64 than at ages 51 to 54 (65 percent vs. 77 percent). What does offset the shortfall in employer-sponsored coverage at older ages is sharp increases in private nongroup coverage and public coverage. Almost all of this rise in public coverage comes from an increase in disability-related Medicare coverage.

Exhibit 8
Health Insurance Coverage by Age, 1998



Source: Authors estimates from the 1998 Health and Retirement Study.

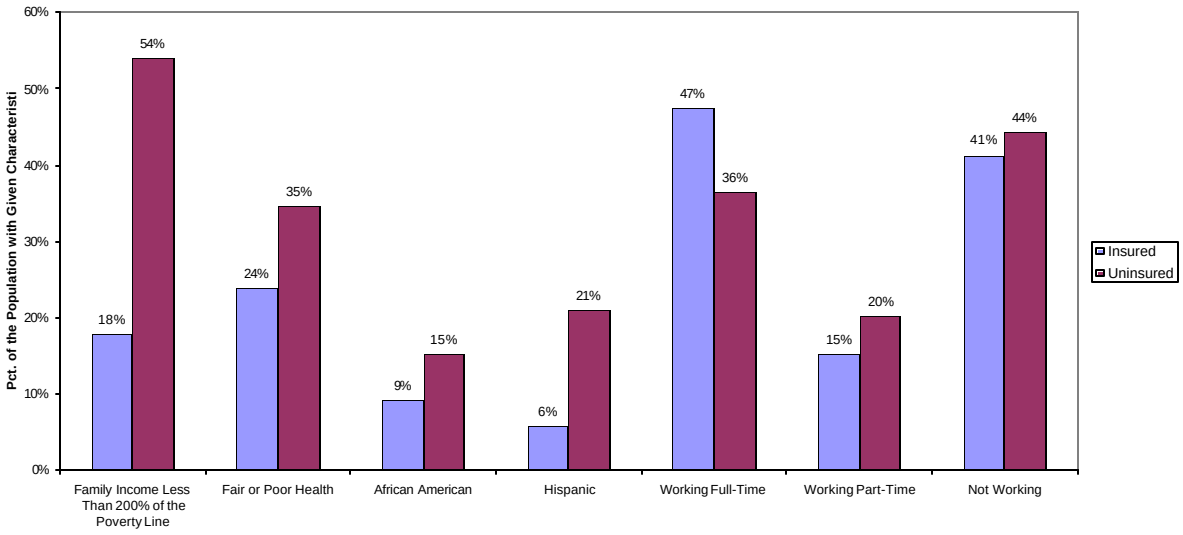
The insured and uninsured near elderly populations differ in ways that have important implications for efforts to increase coverage rates. As shown in exhibit 9, disproportionate shares of the uninsured have low incomes and health problems. In 1998, just over half (54 percent) of the uninsured were poor or near poor, with family incomes below 200 percent of the federal poverty level, compared with only 18 percent of the insured population. In addition, just over one-third of near elderly adults without insurance reported fair or poor health, compared with slightly less than one-quarter of those with coverage. Moreover, 22 percent of the uninsured had both limited income and health problems. As a result, initiatives such as tax credits that aim to increase coverage by encouraging older adults to purchase private insurance are likely to be ineffective unless they include substantial subsidies. Otherwise, private insurance options will remain unaffordable for many uninsured near elderly adults.

Although the uninsured are less likely to be employed than those with insurance, few near elderly uninsured appear to have lost coverage when they retired. The majority of near elderly adults without coverage were employed in 1998 (although one-third of those with jobs were working only part time). Among those who were not employed in 1998, only 23 percent reported working with employer-sponsored coverage in 1994 or 1996. In other words, only one out of ten uninsured near elderly adults had employer-sponsored coverage that they lost when they retired.

Health Insurance Coverage for the Young Elderly

Virtually all adults ages 65 and older are covered by Medicare, a federal health insurance program for older and disabled adults that pays part of the costs of inpatient hospital care (through the program's Hospital Insurance component, also known as Part A) and physicians' services (through the Supplementary Medical Insurance component, also known as Part B), among other services. Many beneficiaries supplement their Medicare coverage with additional types of insurance, which generally pay at least part of the deductibles, copayments, and

Exhibit 9
Composition of the Insured and Uninsured Population Aged 55 to 64, 1998



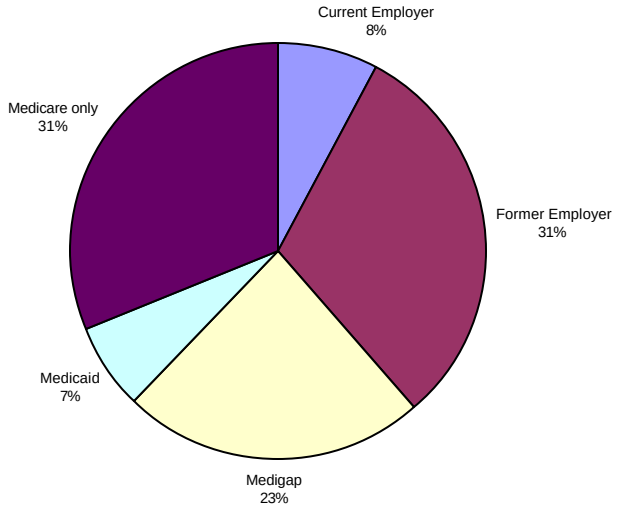
Source: Author's estimates from the 1998 Health and Retirement Study.

premiums that Medicare charges beneficiaries and sometimes cover services not covered by Medicare, such as prescription drugs and long-term care. Medicare supplements include employer-sponsored health benefits (provided to active workers, retirees, or the spouses of active workers and retirees), private Medigap plans, and Medicaid coverage. While those with supplemental coverage under the current system might easily replace their Medicare coverage if the age of eligibility were increased to 67, those without supplemental coverage may have difficulty finding alternatives to Medicare.[7]

Exhibit 10 reports the distribution of health insurance coverage for Medicare beneficiaries ages 65 to 66 in 1998, based on HRS data. Almost one-third received RHI benefits from former employers (either their own or their spouses'), and another 8 percent received coverage from their current employers or their spouses' current employers. Workers with coverage from their own employers would be largely unaffected by an increase in the age of Medicare eligibility, because under the current system Medicare pays claims only if the worker's employment benefits do not pay all of the costs of Medicare-covered services and most employer-sponsored health plans provide coverage at least as comprehensive as that provided by Medicare. Thus, for young elderly adults who are employed and receive job-related health benefits, employer-sponsored insurance covers their health care needs regardless of any changes to the age of Medicare eligibility.

[7] Beneficiaries can also supplement traditional Medicare coverage by participating in the Medicare+Choice program and joining Medicare managed care plans, which frequently provide benefits not offered by Medicare. In 2002, 13 percent of Medicare beneficiaries belonged to managed care plans (Centers for Medicare and Medicaid Services 2002). The analysis in this section does not distinguish those in Medicare managed care plans from those in the traditional fee-for-service plan with no supplemental coverage, because young elderly adults would lose access to the Medicare+Choice program if the age of eligibility were raised.

Exhibit 10
Health Insurance Coverage for Medicare Beneficiaries Aged 65 to 66, 1998



Source: Author's tabulations from the 1998 Health and Retirement Study.
Note: Coverage is determined by the following hierarchy: current employer, former employer, Medigap, and Medicaid.

The impact of an increase in the age of Medicare eligibility would be more significant for retirees with RHI coverage. Under current Medicare rules, RHI is the second payer after Medicare when beneficiaries are no longer working, meaning that employer-sponsored coverage pays only some Medicare cost-sharing expenses and provides coverage for some services not covered by Medicare, such as prescription drugs. With an increase in the age of Medicare eligibility, RHI would be the first (and generally only) payer for covered young elderly adults who are no longer working. This would increase insurance costs for employers, possibly leading some to cut back on post-retirement coverage or to increase the amount of cost-sharing they require from participants. Even if employers do not drop retiree health coverage in response to an increase in the eligibility age, fewer young elderly adults may have access to this important insurance option in the future because many employers are already cutting back on retiree health benefits (McCormack et al. 2002).

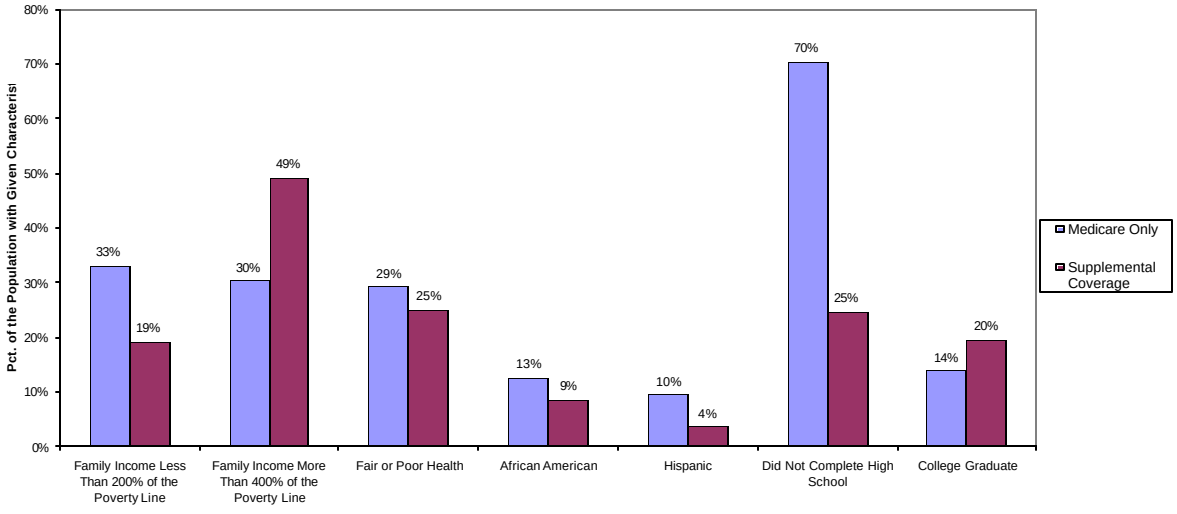
Nongroup Medigap policies are also fairly common among young elderly Medicare beneficiaries. About 23 percent of Medicare beneficiaries ages 65 to 66 reported supplemental Medigap coverage in 1998. These policies are generally more expensive and cover fewer services than employer-sponsored retiree coverage. In 1995, for example, elderly Medicare beneficiaries with employer-sponsored supplemental insurance contributed on average $606 per year for their RHI coverage, while those with Medigap policies averaged $1,007 in annual premiums (Crystal et al. 2000). Despite their relatively high premiums, few Medigap policies cover pharmaceutical costs. In 1999, only about 25 percent of Medicare beneficiaries with Medigap policies had drug coverage, compared with about 86 percent of those with employer-sponsored supplemental insurance (Murray and Eppig 2002b). Those Medigap policies with drug coverage have high premiums, a $250 deductible, a 50-percent coinsurance payment, and low benefit caps (General Accounting Office 2001a). The rise in Medigap prices over the past few years (Weiss Ratings Inc. 2002), combined with the growth in Medicare managed care plans,

which provide better benefits at lower prices, has been eroding Medigap coverage, which fell by 28 percent from 1994 to 1999 (Murray and Eppig 2002a).

Many young elderly adults who currently hold Medigap policies would probably have purchased nongroup coverage if an increase in the eligibility age disqualified them for Medicare. But primary nongroup coverage may be more difficult to obtain than supplemental private coverage, because federal law guarantees access to Medigap policies during an initial six-month open enrollment period, beginning when the individual turns 65 and is enrolled in Medicare Part B. During the open enrollment period, insurers cannot deny Medigap coverage to eligible adults, place conditions on the policies, or charge higher prices because of past or present health conditions. These restrictions do not apply to primary nongroup coverage, except in selected states. Private nongroup coverage may also be a less desirable alternative to Medicare if premiums continue to rise rapidly, as they have done in recent years (Levit et al. 2002).

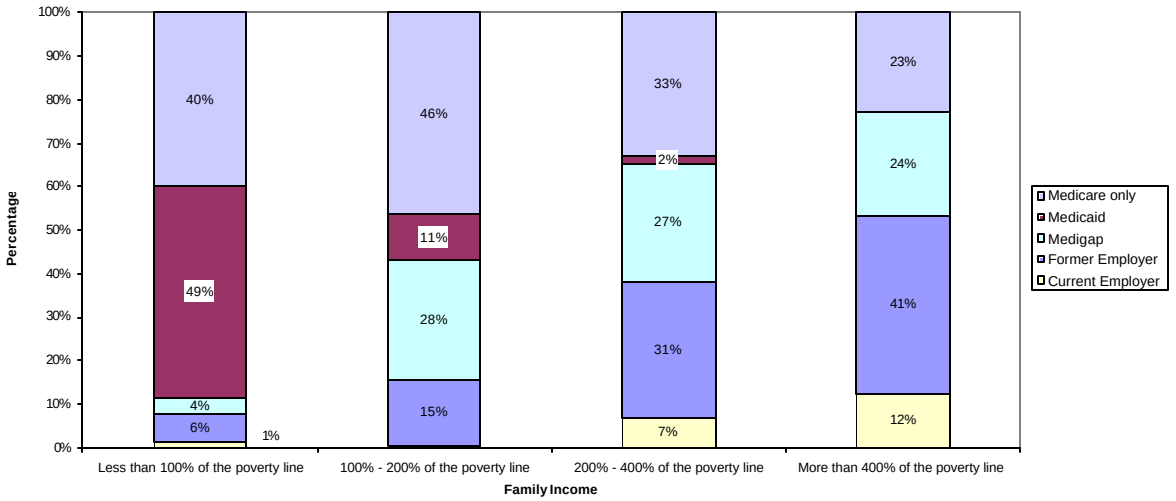
About 7 percent of young elderly Medicare beneficiaries with low incomes and assets also enrolled in Medicaid, which generally requires no cost sharing and covers more services than Medicare, including prescription drugs and extended nursing home care. Those with incomes too high to qualify for full Medicaid benefits may be eligible for Medicare Savings Programs, such as the Qualified Medicare Beneficiary (QMB) program or the Specified Low-Income Medicare Beneficiary (SLMB) program, which cover the cost of Medicare premiums and sometimes deductibles and copayments through state Medicaid programs. With an increase in the age of Medicare eligibility, Medicaid would become the primary source of coverage for some young elderly adults. In fact, raising the Medicare eligibility age might boost Medicaid coverage rates, because individuals have stronger incentives to enroll in Medicaid when the alternative is being uninsured, instead of being underinsured through the Medicare program. Under the current system, about one quarter of eligible Medicare beneficiaries do not enroll in Medicaid (Moon, Brennan, and Segal 1998). However, low-income young elderly adults would

Exhibit 11
Composition of the Population of Medicare Beneficiaries Aged 65 to 66 With and Without Supplemental Coverage, 1998



Source: Author's estimates from the 1998 Health and Retirement Study.

Exhibit 12
Health Insurance Coverage of Medicare Beneficiaries Aged 65 to 66, by Family Income Relative to the Poverty Line, 1998



Source: Author's tabulations from the 1998 Health and Retirement Study.

lose access to the Medicare Savings Programs if the Medicare eligibility age were raised, because these programs are available only to Medicare beneficiaries.

The remaining 31 percent of young elderly Medicare beneficiaries had only Medicare coverage in 1998, although some of them belonged to managed care plans, which often cover more services than the traditional fee-for-service Medicare program. Young elderly adults without additional types of insurance may have difficulty finding coverage if they lose Medicare eligibility, especially because many of those without supplemental coverage have limited economic resources (Pourat et al. 2000). For example, among Medicare beneficiaries ages 65 to 66 in 1998, 33 percent of those without supplemental coverage were poor or near poor, with family incomes below 200 percent of the federal poverty level (see exhibit 11). The comparable figure is only 19 percent for those with supplemental coverage. Only 30 percent of young elderly beneficiaries who relied solely on Medicare had incomes exceeding 400 percent of the poverty level, compared with 49 percent of those with supplemental coverage. Thus, many young elderly beneficiaries may be unable to afford private alternatives to Medicare. High school dropouts, African Americans, Hispanics, and those in fair or poor health also make up disproportionate shares of the young elderly population without supplemental health insurance coverage.

Exhibit 12 reports how insurance coverage for Medicare beneficiaries ages 65 to 66 varied by income in 1998. Only 23 percent of those with family incomes exceeding 400 percent of the federal poverty level relied solely on Medicare, compared with 46 percent of the near poor (with family incomes between 100 percent and 200 percent of the poverty level). The entire shortfall in supplemental coverage among the near poor was due to their low rates of employer-sponsored coverage. Among poor beneficiaries, only 11 percent had private supplemental coverage, but nearly half of them received Medicaid benefits. As a result, only two in five poor beneficiaries relied solely on Medicare coverage.

III. Lowering the Age of Medicare Eligibility

The creation of a buy-in plan that would allow the near elderly to purchase Medicare coverage has been proposed to improve health insurance coverage for adults not old enough to qualify for automatic Medicare coverage. Buy-in plans would in effect lower the age of Medicare eligibility, although participants would pay higher premiums than older beneficiaries who qualify for automatic coverage. The Clinton administration first proposed a buy-in plan in 1998, and Democratic lawmakers have introduced legislation in Congress over the past two years to allow near elderly Americans to purchase Medicare coverage. A number of advocacy groups have also endorsed buy-in plans for the near elderly, including the National Council of Senior Citizens (1998), AARP (2002), and Consumers Union (1998). This section describes how different buy-in plans might work, examines their possible impact on coverage and employment, and considers how much they might cost the federal government.

Extending Medicare Benefits to All Adults at Age 62

Uninsurance at ages 62 to 64 could be virtually eliminated at all income levels if Congress lowered the age of automatic eligibility for Medicare to 62. Most impoverished adults could receive help with their Part B premiums through Medicare Savings Programs, such as QMB and SLMB, administered by state Medicaid offices. Lowering the automatic eligibility age would also improve security for those who rely on the expensive and risky individual insurance market, all of whom would instead be able to obtain less costly and more secure Medicare coverage. In addition, the expansion of Medicare coverage would reduce employer costs for retiree health benefits and both retiree and employer costs for COBRA continuation coverage. Because COBRA beneficiaries tend to use more health services than active workers, they are expensive for employers to insure, even though they pay the full group rate themselves (Fronstin 2001).

However, lowering the automatic eligibility age would do nothing to improve coverage for near elderly adults younger than 62. And it would be expensive. Reducing the automatic eligibility age to 62 would cost the Medicare program about $5.4 billion per year (in 2000 dollars), assuming that beneficiaries ages 62 to 64 pay the same Part B premiums as older beneficiaries and they do not increase their utilization of health services in response to the expansion of insurance coverage. The net cost to the federal government would be about $5.0 billion, because the expanded Medicare program would pick up some costs currently paid by Medicaid.[8] These costs have generated interest in Medicare buy-in plans, which would provide benefits only to eligible adults willing to pay for them.

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[8] The cost estimate assumes that near elderly beneficiaries would use the same amount of services they used before the reduction in the eligibility age and that Medicare would cover the same proportion of costs at ages 62 to 64 as at older ages. According to data from the Medical Expenditure Panel Survey (MEPS), total health care costs for adults ages 62 to 64 not covered by Medicare averaged $3,319 in 1998, the most recent year available (Agency for Healthcare Research and Quality 2001). Medicare paid 58 percent of health care costs incurred by elderly beneficiaries in MEPS. Applying that rate to the near elderly implies per capita Medicare costs of $1,914 for beneficiaries ages 62 to 64 in 1998. Per capita benefit payments by Medicare grew by 1.8 percent from 1998 to 2000 (Social Security Administration 2001).

However, MEPS does not capture all health care costs (Selden, Levit, Cohen, et al. 2001). Comparing average per capita Medicare costs reported in MEPS with actual per capita Medicare reimbursements for aged

The Clinton Medicare Buy-In Plan

In 1998 the Clinton administration first proposed a Medicare buy-in option that would allow adults ages 62 to 64 without access to employer-sponsored health insurance or federal insurance to purchase Medicare coverage. In addition, those as young as age 55 could participate if they were laid off from jobs that provided health insurance and had exhausted their COBRA coverage.[9] Buy-in participants would receive the same package of benefits as elderly Medicare beneficiaries. The plan was designed to be cost-neutral, with premiums paid by participants equaling the cost of the services received.

One of the difficulties in achieving cost-neutrality in an insurance program is that it disproportionately attracts participants who especially value its benefits. Thus, a Medicare buy-in plan will tend to attract participants with health problems and high rates of health services use. Raising premiums to cover the cost of providing services to heavy users further discourages relatively healthy individuals from participating, increasing the share of heavy users in the participant pool and leading to further premium increases. This adverse selection problem, as economists call it, can undermine private insurance markets.

The Clinton plan included an unusual pricing structure to circumvent the adverse selection problem. At ages 62 to 64, participants would pay premiums equal to the average cost of services used by the pool of adults eligible for the buy in. In addition, they would pay supplemental Medicare premiums from ages 65 to 84 if the average cost of the benefits received by buy-in participants in their birth cohort exceeded the average premiums they paid from ages 62 to 64. Adverse selection would not drive relatively healthy individuals out of the program, because any increase in premiums would not materialize until after participants had left the program. The Congressional Budget Office (CBO) (1999) estimated that a cost-neutral buy-in plan would charge participants $324 per month at ages 62 to 64 in 2001, plus monthly surcharges of about $23 from ages 65 to 84. Spreading the premium costs over 23 years would also help make the plan more affordable for many near elderly adults.

Legislation to establish Medicare buy-in plans for near elderly adults has not progressed far in Congress. The last Clinton proposal (H.R. 4938, S. 2918) died in committee in the 106th Congress, without ever coming up for a vote. Sen. Rockefeller (D-W.Va.) and Reps. Pallone (D-N.J.) and Stark (D-Calif.) introduced similar bills in 2001 and 2002 in the 107th Congress (H.R. 1255, H.R. 4684, S. 623), but they did not come any closer to being enacted into law.

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enrollees published by the Social Security Administration indicates that MEPS accounts for only about 80 percent of total Medicare costs. These two adjustments imply that per capita Medicare costs for the near elderly would equal $2,427 in 2000, and total costs (including administrative charges of 2.1 percent) would reach $6.9 billion, excluding the 10 percent of adults ages 62 to 64 who are already covered by Medicare, according to MEPS estimates. If all participants paid monthly Part B premiums of $45.50, the price faced by elderly beneficiaries in 2000, then the net annual cost to Medicare of lowering the age of automatic eligibility would be $5.4 billion. MEPS data indicate that 6.63 percent of adults ages 62 to 64 without Medicare coverage received Medicaid benefits in 1998. Excluding these cases from the estimates lowers the net cost to the federal government of reducing the age of Medicare eligibility to $5.0 billion. State Medicaid outlays would fall by about $0.3 billion.

[9] The proposal would also require employers who dropped previously promised RHI benefits to make COBRA continuation coverage available up to age 65 for early retirees ages 55 and older.

Potential Effects of the Clinton Medicare Buy-In Plan on Coverage

A Medicare buy-in plan would allow near elderly adults without access to employer-sponsored health insurance to obtain coverage at prices below what many face in the private nongroup market. It would appeal to the uninsured and to those with private nongroup coverage, which could be replaced with less expensive (and perhaps more comprehensive) Medicare coverage. By denying access to those who could obtain health benefits from employers, the proposals aim to avoid crowding out employer-sponsored coverage and to target public benefits to those who need them most. However, if the government subsidizes the buy-in by charging premiums below the average cost of providing coverage, high participation rates by those with private nongroup coverage would raise the costs of the program without reducing the number of near elderly adults who lack insurance coverage.

While most near elderly adults with private nongroup coverage would probably switch to the buy-in as long as it cost them less than their nongroup policies, it is more difficult to predict how many of the uninsured would elect to participate. This is a critical issue, because the key goal of a buy-in plan is to reduce uninsurance rates. Participation by those who would not otherwise purchase nongroup coverage will depend on the difference between the buy-in premium and premiums in the nongroup market, the responsiveness of the participation decision to the premium price, and the affordability of the buy-in plan.

There have been two major studies that predict participation in hypothetical Medicare buy-in plans. Johnson, Moon, and Davidoff (2002), hereafter referred to as JMD, simulated participation for a sample of 1998 HRS respondents, and Sheils and Chen (2001), hereafter referred to as SC, simulated participation for a sample of respondents in the 1996 and 1997 waves of the Current Population Survey (CPS). Despite differences in their methods and data, both studies concluded that the introduction of a buy-in plan similar to the one proposed by the Clinton administration would only modestly improve coverage rates at ages 62 to 64, because few uninsured could afford to purchase unsubsidized Medicare coverage. However, both studies found that a buy-in plan that subsidized coverage for those with limited incomes could substantially reduce uninsurance rates. Most of the conclusions from these studies can be generalized to the population ages 55 to 64.

The price that near elderly adults face in the nongroup market is a critical factor in simulations of a Medicare buy-in plan. JMD estimated average nongroup premiums by collecting nongroup quotes through an online service from leading insurance providers across the country. They collected premium data for random respondents from the 1998 HRS and used them to impute premiums for the entire sample. The quotes varied by age, sex, medical history, state of residence, height and weight, and tobacco use. SC estimated nongroup premiums examining a sample of adults with nongroup coverage in the 1987 National Medical Expenditures Survey. They regressed premiums on self-reported health status, age, sex, and plan characteristics and used the results to impute premiums to their CSP sample.[10]

[10] Both of these approaches have potentially important limitations. SC did not account for selection in the nongroup market. They ignored the possibility that those who purchase nongroup coverage may face lower premiums than those who do not purchase coverage, perhaps because of health differences between the two groups that are not measured by the survey. Assigning premiums reported by purchasers to similar nonpurchasers may understate the

Both studies found that the average monthly premium in the nongroup market for adults ages 62 to 64 exceeds the amount the government would likely charge participants to buy into Medicare. SC estimated an average nongroup premium of $370 per month in 2000, ranging from $339 for those in excellent and very good overall health to $483 for those in poor health. JMD estimated that the mean nongroup premium in 1998 faced by adults ages 62 to 64 without access to employer-sponsored or public insurance was $446. They found large differences in premiums by health and tobacco use. Average premiums at ages 63 to 64 ranged from a low of $270 for women with no chronic conditions who did not smoke to a high of $908 for men with two or more chronic conditions who did smoke. These results underscore the value of the buy-in plan for near elderly adults with health problems.

By reducing the price of insurance coverage for many near elderly adults, the creation of a Medicare buy-in plan would lead at least some uninsured near elderly adults to acquire coverage. The number of uninsured adults who would participate in the program depends primarily on the sensitivity of the purchase decision to the price of insurance. However, little is known about the demand for insurance coverage by older adults, and there is no consensus in the literature about how insurance coverage for other populations responds to variations in price, because existing studies have been based on data that is incomplete or obsolete.

JMD simulated participation in a Medicare buy-in plan by estimating a regression model of private nongroup insurance coverage for adults ages 57 to 64 without access to employer-sponsored coverage or public insurance. The regression model estimated the effects of premium prices, income, health status, and demographic characteristics on nongroup insurance demand. The study found that premiums strongly influence the probability of purchasing coverage: A 1 percent reduction in premiums increases coverage rates by 0.88 percent. This estimate of the price elasticity of demand, as it is known, is substantially higher (in absolute value) than many other studies have found, because JMD's model was based on premiums that increased with health problems. Persons with health problems have stronger demand for insurance coverage, but also face higher prices than those in better health. Studies such as Marquis and Long (1995) based on premiums that do not vary by health status understate the impact of premiums on coverage because they confound the positive effect of health problems on coverage rates with the negative effect of premium levels.[11]

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true price in the nongroup market. In addition, overall health status may not be a very reliable predictor of nongroup premiums, because it is not closely correlated with chronic medical conditions, which insurers use in the underwriting process. For example, in the 1999 National Health Insurance Survey, only 18 percent of those with chronic conditions reported fair or poor health.

Although JMD attempted to avoid the selection problem by collecting premium prices faced by those with and without nongroup coverage, the online service they used often indicated that no quotes were available when potential purchasers reported serious health problems. As a result, they were able to generate quotes for only a small percentage of respondents in poor health. If those with quotes face lower prices than those without quotes, their premium estimates will understate the true price that those with health problems face in the nongroup market.

[11] Marquis and Long (1995) estimated that the price elasticity of demand for nongroup insurance was between –0.3 and –0.4, for working families. Other studies estimated even smaller elasticities (Holmer 1984; Taylor and Wilensky 1983). Gruber and Poterba (1994), however, concluded that coverage rates are quite sensitive to price, with a 1 percent reduction in the price of insurance raising the probability of coverage by 1.8 percent for self-employed workers.

JMD also found that adults are more likely to purchase coverage (either through the Medicare buy-in or through private insurers) as their health declines or their income rises. Because many near elderly adults in poor health have limited incomes, the model sometimes predicted that an individual would purchase coverage even though the premium costs would consume a large fraction of total income. If the model assigned them coverage but they could not afford the premiums for standard polices, JMD assigned them to limited private nongroup plans that provide little more than catastrophic health insurance coverage. The model assumed that premium costs for an individual could not exceed 10 percent of family income for a married person or 20 percent of family income for a single person.

The responsiveness of nongroup demand to price was lower in the SC simulations than in the JMD simulations. SC assumed that each 1 percent reduction in premiums increased coverage rates by 0.2 percent on average, and they assumed the impact fell with income. For example, their simulations assumed that a 1 percent reduction in premiums would raise coverage rates by 0.34 percent for those with $10,000 in income, but by only 0.04 percent for those with $100,000 in income.

Despite these differences, both studies predicted that about 9 percent of adults ages 62 to 64 would participate in a buy-in plan priced at $300 per month with no supplemental payments after age 65. This represents about 37 percent of adults eligible for the buy-in plan, because only those without access to other types of public insurance or employer-sponsored health benefits would qualify for the buy-in plan (see exhibit 13). However, participation rates would be much higher among those who would otherwise purchase private coverage than among those who would be uninsured. For example, SC estimated that only 6.3 percent of uninsured adults would participate in the buy-in plan, compared with 86.6 percent of those with private nongroup coverage. JMD also found large, but less dramatic, differences in participation rates. Thus, the introduction of a buy-in plan would have only a modest impact on uninsurance rates among the near elderly.[12]

The impact of a buy-in plan on uninsurance rates would be even lower if it were structured in the same way as the Clinton plan, which would charge supplemental premiums from ages 65 to 84 to recoup any program costs that exceeded premium payments. SC estimated that if the plan charged $300 per month at ages 62 to 64, plus an additional $10 per month from ages 65 to 84 for each year of buy-in participation, only 11.5 percent of eligible adults would participate. In addition, only 1.2 percent of the uninsured would buy into Medicare.[13]

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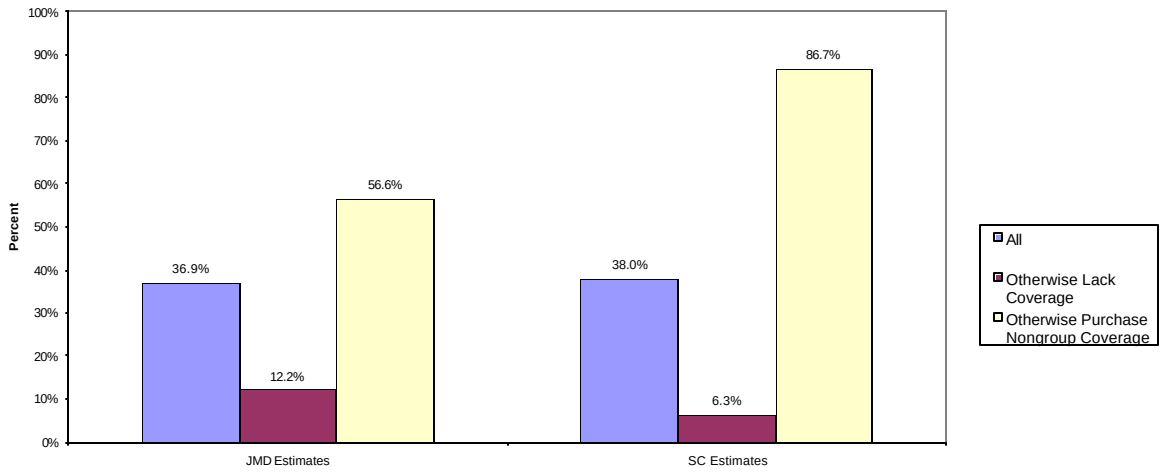
[12] It would, however, improve the quality of coverage for some near elderly adults. JMD estimated that the share of adults ages 62 to 64 with only limited insurance that provides little more than catastrophic coverage would fall from 4.5 percent under the current system to 1.9 percent after the introduction of a $300 per month buy-in plan.

[13] However, the presence of supplemental premiums reduces the reliability of the participation estimates. The government would not set the supplemental payments until after participants reached age 65 and left the buy-in program, so they would not know the total cost of buying into Medicare at the time they were deciding whether to participate. It is not known how this uncertainty would affect the participation decision, although it presumably would have an impact. In addition, participants would probably give less weight to these costs than to current premiums in the buy-in decision, because they do not bear the costs until sometime in the future. Again, however, it is not clear how much they would discount the supplemental payments. SC assumed a 6 percent discount factor in their simulations of the supplemental premiums. Other studies suggest that individuals discount the future at much higher rates (e.g., Warner and Pleeter 2001).

Exhibit 13
Simulated Participation Rates in a $300 Buy-In Plan, Among Eligible Adults Aged 62 to 64



Note: Only adults aged 62 to 64 without access to employer-sponsored insurance or public insurance could participate in the buy-in program. The plans modeled here would not charge supplemental premiums after age 65.

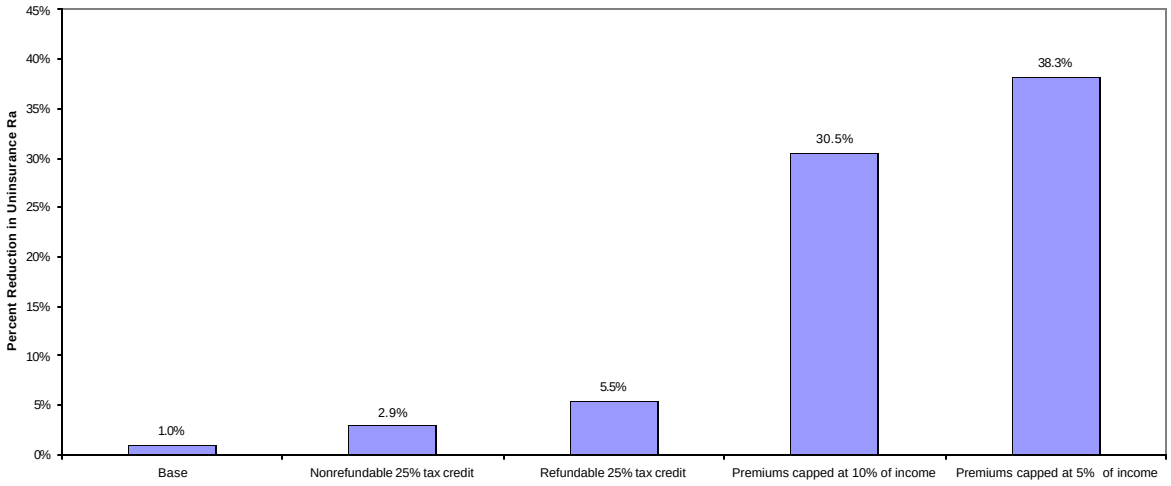
Source: Johnson, Moon, and Davidoff (2002); Sheils and Chen (2001).

The Clinton plan would also allow adults ages 55 to 61 to buy into Medicare if they lost their health insurance when they were laid off from their jobs (or were married to displaced workers who lost their insurance), did not have access to federal health insurance, and exhausted their COBRA coverage. They must also have received employer-sponsored coverage for at least 12 months before they lost their jobs in order to buy into Medicare. Relatively few individuals meet these criteria. CBO (1998) estimated that only 190,000 adults ages 55 to 61, or about 1 percent of the population in that age group, would qualify for the Clinton buy-in plan in a typical year. Although about 1 million adults ages 55 to 61 receive unemployment insurance each year, many would be ineligible for the buy-in because they have access to other types of coverage, they lacked sufficient coverage on their previous jobs, or they did not purchase COBRA coverage for the full 18 months. Among those who do qualify, SC estimated that only 2.5 percent would participate in the buy-in plan, assuming premiums of $400 per month. Among eligible uninsured adults, only 0.4 percent would buy into Medicare.

Potential Participation in Alternative Medicare Buy-In Plans

Although the original Clinton plan would not substantially reduce uninsurance rates, a Medicare buy-in plan could significantly improve coverage for near elderly adults if it were subsidized, particularly for those with limited incomes. In 2000, the Clinton administration modified its plan to include a 25 percent tax credit for premiums paid by participants. If the credits were refundable, so that all participants would receive the full value of the tax credit even when it exceeded their total tax liabilities, the effective price of the buy-in plan would fall to 25 percent below the average cost of services provided for all prospective participants. If the tax credits were not refundable, they would have little effect on after-tax premiums for those with limited incomes who pay little federal taxes.

Exhibit 14
Predicted Impact on Uninsurance Rates of Alternative Medicare Buy-in Plans Priced at $300 per Month, for All Adults Aged 62 to 64 and Displaced Workers Aged 55 to 61



Note: Participants would also pay supplemental premiums of $30 per month from ages 65 to 84.

Source: Sheils and Chen (2001).

One drawback of the tax credit approach in the Clinton plan is that it does not target subsidies to those who need them most. Low-income participants would not receive larger subsidies than high-income participants, and in fact would receive lower subsidies if the tax credit were nonrefundable.[14] SC proposed two alternative plans that would relate premiums to income. They suggested capping the buy-in premium so that it did not exceed 5 percent or 10 percent of income. These plans would substantially reduce premiums for those with limited incomes and would eliminate subsidies for high-income participants.

SC estimated participation rates in these alternative plans for the two groups eligible for the Clinton plan combined—all adults ages 62 to 64 without access to employer-sponsored or public insurance and all displaced workers ages 55 to 61 who lost their coverage when they were laid off. They found that the introduction of a $300 buy-in plan (with supplemental premiums of $300 at ages 65 to 84) combined with a 25 percent refundable tax credit for premium costs would reduce uninsurance rates among eligible adults by 5.5 percent, compared with 2.9 percent for a buy-in plan with nonrefundable tax credits and 1 percent for a buy-in plan with no tax credits (see exhibit 14). Structuring the buy-in plan so that premiums do not exceed a given share of income would substantially reduce the number of uninsured adults. Uninsurance rates would fall by 31 percent if premiums were capped at 10 percent of income, and by 38 percent if they were capped at 5 percent of income. Relating premiums to income would also target benefits to those who would otherwise be uninsured. In the plan with refundable tax credits, only 9 percent of participants would lack coverage if the buy-in plan were not available, compared with one-third of participants in the plan that capped premiums at 5 percent of income.

Health policy experts have proposed alternative buy-in plans that would target benefits to low-income adults. Loprest and Moon (1999) suggested creating a buy-in plan at ages 62 to 64

[14] The tax credits could be structured so that they are available only to those with limited incomes, however.

that fully subsidizes premiums for those with incomes below the federal poverty level. The subsidy would gradually fall as income rises, disappearing completely for those with incomes above 200 percent of the poverty level. Their plan would also set premiums at the community rate that would prevail if all adults ages 62 to 64 enrolled, which they estimate would be about $270 per month. This pricing scheme would reduce adverse selection problems, by attracting moderate health care users, but it would raise program costs for the government. Short, Shea, and Powell (2001) recently proposed an extension of the Loprest-Moon proposal. They would provide low-income adults with subsidized vouchers that could be used to buy into the Medicare program. The plan would base eligibility for the vouchers on lifetime earnings, not current income, reducing the incentive to cut back on work hours at older ages to qualify for low-cost health insurance. They would also create a tax-deferred saving program in which the middle class could accumulate funds to purchase Medicare coverage when they reach age 62. The vouchers and savings accounts could also be used to purchase private nongroup coverage or to participate in employer-sponsored plans.

Relating buy-in premiums to income could substantially improve coverage rates for those with low incomes. JMD compared the impact of a buy-in plan that charged a flat premium of $300 per month for all participants to a plan priced at $43.80 per month (the monthly Medicare Part B premium in 1998) for those with family incomes below 150 percent of the poverty level and $300 per month for everyone else.[15] They found that the flat pricing scheme would have no effect on uninsurance rates for the poor or near poor (with incomes between 100 percent and 200 percent of the poverty level). However, a buy-in plan with subsidies for low-income adults would reduce uninsurance rates from 28 percent to 12 percent for poor near elderly adults and from 22 percent to 12 percent for near poor adults (see exhibit 15).

Costs of Medicare Buy-In Plans to the Federal Government

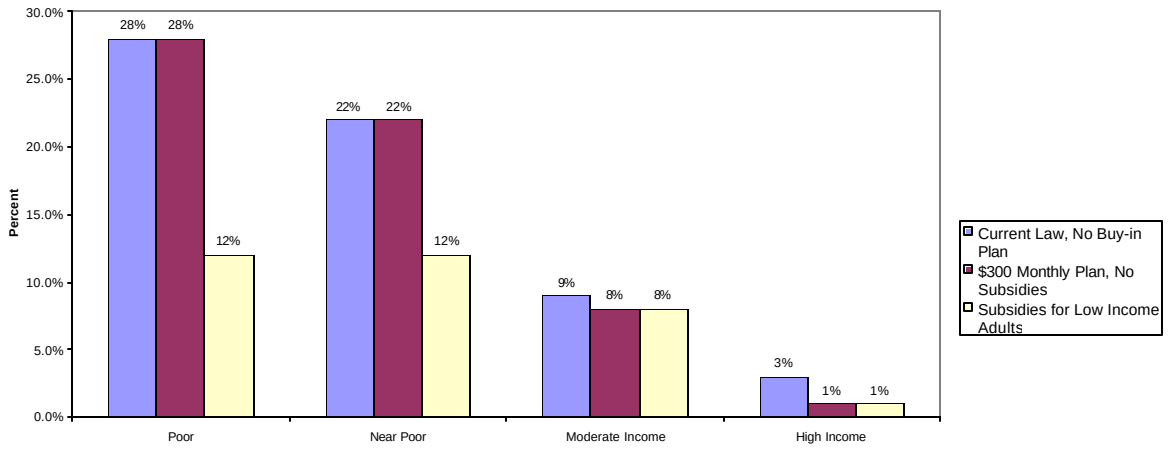
The Medicare buy-in plan originally proposed by the Clinton administration was designed to be cost-neutral, with total premiums (those paid at ages 62 to 64 plus those paid after age 65) set to cover the total cost of providing services to participants. However, the plan would still raise net costs for Medicare in any given year, because some premiums would not be received until long after services were provided. CBO (1998) estimated that the original Clinton buy-in plan for adults ages 62 to 64 would cost Medicare about $300 million per year, about 0.5 percent of the government's current contribution to Medicare.[16] Even though premiums paid by displaced workers ages 55 to 61 would not be designed to cover the costs of their participation, that part of the Clinton buy-in program would cost less than the buy-in at ages 62 to 64 because it would enroll fewer participants. According to CBO estimates, the Clinton buy-in plan for displaced workers would cost Medicare $20 million in 2000.

Costs could rise substantially if the government subsidized the buy-in plan. According to SC estimates, premium subsidies would cost $373 million in 2000 for the buy-in with a 25

[15] This plan imposes a large tax on those with incomes just above 150 percent of the federal poverty level, leaving them potentially worse off than others with less income and creating powerful work disincentives for those with incomes near that level. A better plan design would be to phase out subsidies gradually as income rises.

[16] In 2000 the government contributed $65.9 billion to Medicare Part B (Supplementary Medical Insurance), which pays physician services (Social Security Administration 2001). The government does not contribute to Part A, which is financed through the Hospital Insurance trust fund.

Exhibit 15
Simulated Uninsurance Rates at Ages 62 to 64
Under Current Law and Alternative Buy-In Plans, by Income



Note: The subsidized plan sets premiums at $43.80 per month for those for those with incomes below 150 percent of the poverty level and at $300 per month for everyone else. Plans do not charge supplemental premiums after age 65. Individuals are classifed as poor if family income falls below the poverty level, as near poor if it falls between 100% and 200% of the poverty level, as moderate income if it falls between 200% and 400% of the poverty level, and as high income if it exceeds 400% of the poverty level.
Source: Johnson, Moon, and Davidoff (2002).

percent nonrefundable tax credit and $525 million for a plan with a 25 percent refundable tax credit. If premiums were capped at 5 percent of income, annual subsidies would reach $2.7 billion. Loprest and Moon (1999) estimate that their plan would cost the government between $660 million and $790 million, depending on participation rates. The costs result primarily from providing subsidies to low-income participants. However, some costs arise from risk selection, because the plan would set premiums equal to the average cost of services used by the entire age-eligible population, below the average cost of services that buy-in participants are likely to use.

The projected costs of funding a subsidized Medicare buy-in plan at age 62 are only a small share of current government contributions to Medicare, and substantially less than the likely cost of subsidizing coverage for adults as young as 55. Even if they did not intend to subsidize benefits, policymakers would find it almost impossible to design a cost-neutral buy-in program available to all adults ages 55 to 64 who lack access to employer-sponsored or public insurance, because the plan would disproportionately attract participants who expect to use many services. JMD estimated that participation rates in a buy-in plan priced at $300 per month (with no post-65 supplements) for those ages 62 to 64 would be higher among those with health problems than those in good health. For example, 29 percent of participants would be in fair or poor health, compared with 24 percent of the eligible population. Moreover, adverse selection intensifies as the premium rises. If priced at $400 per month, 41 percent of buy-in participants would be in fair or poor health. McDevitt (1998) estimated that to account for adverse selection, a buy-in plan at ages 62 to 64 would have to charge premiums of $380 per month (in 1997), not $300 per month, to cover fully the costs of participation.

The Clinton plan attempted to solve the adverse selection problem by imposing supplemental premiums beginning at age 65, when eligibility for the program ends. This scheme prevents high-cost users from driving low-cost users out of the program and driving up average costs, because the full price of the program does not become evident to low-cost users until it is

too late to withdraw. (However, the approach is less effective if low-cost users are able to anticipate accurately the full price of the program and make participation decisions based on that price.) This pricing structure is difficult to implement for a program that lasts for 10 years, instead of three years. Supplemental premiums in a 10-year program might be quite large, raising serious political and ethical questions about a government program that ultimately charges participants more than they expected.

Potential Effects on Retirement Decisions

Economic theory predicts that workers weigh the costs of lost labor market compensation against the benefits of increased leisure time when making retirement decisions. The loss of job-related health benefits can be an important cost of retiring before age 65. Some retirees receive RHI benefits from their employers or get coverage through their spouses, giving them access to subsidized insurance until Medicare benefits begin. Other workers, however, lose subsidized health benefits when they retire, and must purchase COBRA continuation coverage or private nongroup insurance to avoid becoming uninsured. These alternatives are generally much more expensive than participating in an employer's health plan.

Extending Medicare benefits to nondisabled adults younger than 65, either by lowering the eligibility age outright or by allowing near elderly adults to buy into the Medicare program, could encourage some workers to retire early. By reducing or even eliminating the period during which early retirees without RHI benefits would need to purchase expensive continuation or private nongroup coverage to avoid becoming uninsured, extending Medicare coverage would lower the costs of retiring. Policies such as Medicare expansions that encourage retirement heighten concerns about the ability of the economy to support the growing retired population. But they would give some older workers who receive employer-sponsored health benefits on the current job the freedom to leave their job and pursue a second career in another line of work, or become self-employed, without worrying about the availability of health insurance coverage.

A number of studies have shown that the availability of health insurance after retirement encourages workers to withdraw from the labor force. For example, workers at jobs that offer retiree health insurance are substantially more likely to retire than those with subsidized employer-sponsored coverage that does not continue after retirement (Blau and Gilleskie 2001; Karoly and Rogowski 1994; Rogowski and Karoly 2000), and workers who forfeit employer-sponsored insurance when they retire often wait until they qualify for Medicare before withdrawing from the labor force (Rust and Phelan 1997).[17] Madrian and Beaulieu (1998) found that retirement rates among married men ages 55 to 69 are higher for those with Medicare-eligible spouses than for those whose spouses had not yet reached age 65, perhaps because of the expense of purchasing health insurance for spouses not yet old enough to qualify for Medicare benefits. Government mandates that require employers to continue insurance coverage for a certain period of time after workers leave the firm appear to encourage retirement as well. According to one estimate, continuation-of-coverage mandates increase retirement rates by 32 percent (Gruber and Madrian 1995).

[17] Gustman and Steinmeier (1994), however, found that the effects of post-retirement health benefits were small, accelerating retirement for men by only 1.3 months.

Johnson, Davidoff, and Perese (2003) estimated the labor supply effects of expanding Medicare to near elderly adults by computing the health insurance cost of retirement and examining how it affects decisions to withdraw from the labor force. They measured the insurance cost of retirement as the increase in premium costs that workers would pay if they retire, compared with what they would pay if they remain at work. For example, consider a 60-year-old worker whose employer provides subsidized health insurance coverage but does not offer RHI benefits. If he remains at work until age 65, he contributes toward part of the cost of his employer-sponsored coverage for five years, and then receives subsidized Medicare coverage. If he instead retires at age 60, he pays the entire cost of group coverage (plus a small additional share to cover administrative costs) for 18 months, until COBRA benefits run out, and then must purchase coverage in the nongroup market for three and a half years before becoming eligible for subsidized Medicare benefits. The health insurance cost of retiring is the present discounted value of the difference between these two streams of payments. This cost is lower for workers with RHI offers from their employers, because RHI coverage is generally much less expensive than COBRA or nongroup coverage.

Reducing the age of Medicare eligibility would lower the health insurance cost of retirement for some workers. Lowering the automatic age of eligibility to 62 would reduce the number of months during which retirees without RHI benefits would need to purchase expensive COBRA benefits or private nongroup coverage to remain insured. Creating a buy-in program would reduce retirement costs for workers with employer-sponsored coverage who do not have access to RHI benefits. However, the impact would be modest unless premiums were much less expensive for the buy-in program than private nongroup policies. Extending Medicare to the near elderly would not reduce the health insurance costs associated with retirement for workers without employer-sponsored coverage, because they face the same insurance options and costs whether or not they remain at work. Thus the creation of a buy-in plan would reduce the cost of retirement only for workers with employer-sponsored coverage whose employers do not offer RHI benefits and whose health problems raise the prices they face in the private nongroup market.

Using longitudinal data from the HRS, Johnson, Davidoff, and Perese (2003) found that post-retirement increases in premium costs significantly reduce retirement probabilities. Policy simulations indicate that lowering the automatic age of Medicare eligibility to 62 would increase the probability of retiring during a two-year period by 16 percent (from 7.4 percent to 8.6 percent) for men with employer-sponsored coverage whose employers do not offer RHI benefits and by 18 percent (from 11.1 percent to 13.1 percent) for women (see exhibit 16). Overall, however, lowering the eligibility age to 62 would raise retirement rates by only 7 percent, because only about one in five full-time workers nearing retirement age have employer-sponsored coverage but no access to RHI benefits. The creation of a buy-in plan would have more modest effects on retirement decisions. A buy-in program priced at $300 per month (without any post-65 supplemental charges) would increase retirement rates by almost 10 percent for men with employer-sponsored coverage whose employers do not offer RHI benefits, but by only about 2 percent for men overall.

The analysis by Johnson, Davidoff, and Perese did not model all of the possible ways in which a reduction in the age of Medicare eligibility might affect retirement decisions. For

Exhibit 16
Estimated Retirement Effects of Extending Medicare Coverage to Adults Aged 62 to 64

Proposed Reform	Workers with Employer Coverage, Without RHI Offers		Full Sample of Workers	
	Predicted 2-Yr. Probability of Retirement	Pct. Change in Retirement Probability	Predicted 2-Yr. Probability of Retirement	Pct. Change in Retirement Probability
MEN				
Current System	7.4%	…	12.8%	…
Extending Subsidized Medicare Coverage to Age 62	8.6	16.2%	13.6	6.5%
$300 Medicare Buy-In Plan	8.1	9.5	13.1	2.3
WOMEN				
Current System	11.1	…	15.3	…
Extension of Subsidized Medicare Coverage to Age 62	13.1	18.0	16.3	6.5
$300 Medicare Buy-In Plan	12.0	8.1	15.6	2.0

Notes: The buy-in plan modeled here would not charge supplemental premiums after age 64. The sample is restricted to full-time wage and salary workers ages 51 to 61 in 1992. Workers with public insurance and those who did not know whether they had RHI are excluded. Workers are considered to be retired if they reported working fewer than 20 hours per week and were not actively seeking work at the 1994 interview.

Source: Johnson, Davidoff, and Perese (2003).

example, the analysis failed to account for risk aversion. Workers not offered RHI coverage by their employers may be concerned about their access to the nongroup insurance market after retirement. Risk-averse workers may worry that their nongroup premiums will become unaffordable if they develop health problems during retirement. The availability of Medicare benefits at age 62 may be quite appealing to these workers and may lead them to accelerate substantially their retirement plans. The analysis also ignored income effects associated with a change in the age of Medicare eligibility. Expanding Medicare reduces health insurance costs and increases consumption possibilities for virtually all near elderly adults, even if it does not change the costs associated with retirement. Some adults who remained at work so they could afford to pay nongroup premiums may respond by retiring early. These effects are not captured by the model. Despite these caveats, their analysis provides strong evidence that the labor supply effects of changes in the Medicare eligibility age are likely to be modest.

IV. Raising the Age of Medicare Eligibility to 67

Despite concerns about the number of uninsured older adults too young to qualify for Medicare, proposals to increase the age of Medicare eligibility continue to attract attention. In 1999, for example, a majority of the members of the National Bipartisan Commission on the Future of Medicare (1999), mandated by Congress to suggest reforms to improve Medicare's financial outlook, recommended gradually raising the age of eligibility to 67, so that it would be consistent with the legislated increase in the Social Security normal retirement age. Two years earlier the U.S. Senate approved an increase in the Medicare eligibility age to 67 as part of the 1997 Balanced Budget Act (S. 947, Section 5611), but this provision was dropped from the bill before it became law. The Bipartisan Commission on Entitlement and Tax Reform (1995) also proposed delaying the eligibility age. Although the commission's final report included a number of different reform initiatives, the principal proposal by Sens. Bob Kerrey (D-Neb.) and John Danforth (R-Mo.) would have increased both the age of Medicare eligibility and the normal retirement age for Social Security to 70, after a 30-year transition period.

Proposed increases in the age of Medicare eligibility are designed to promote two goals. Proponents argue that raising the eligibility age would reduce Medicare costs and improve the solvency of the Medicare trust fund, which is currently projected to run out of funds in 2026 (Board of Trustees 2003). In addition, delaying the Medicare age might encourage some individuals to remain at work and delay retirement, an increasingly important policy goal as the aging of the population reduces the share of adults below the traditional retirement age who can support the growing elderly population.

Opponents of an increase in the eligibility age argue that it would leave many young elderly adults uninsured or with inadequate insurance. Those with health problems or limited incomes might have special difficulty finding adequate alternatives to Medicare coverage. Persons with health problems may not be physically able to continue working to maintain their employer-sponsored coverage, and they may not be able to afford the high premiums they would face in the private nongroup market. Some proposals to increase the eligibility age, such as those put forth by the 1995 and 1999 bipartisan commissions, attempt to address these concerns by offering Medicare buy-in plans for young elderly adults who would no longer qualify for Medicare coverage. Under these plans, older adults ineligible for automatic Medicare coverage could purchase unsubsidized insurance through the Medicare program.

This section of the report describes how raising the age of Medicare eligibility to 67 might affect coverage and employment rates for young elderly adults and total Medicare costs. It also considers the potential impact of combining an increase in the eligibility age with the introduction of a Medicare buy-in plan.

Potential Effects on Coverage

The effects of an increase in the age of Medicare eligibility depend on the prevalence of supplemental coverage and the capacity and inclination of young elderly adults without supplemental coverage to find alternatives to Medicare. As discussed in Section II, many young elderly adults currently supplement their Medicare coverage with private nongroup insurance, Medicaid, or employer-sponsored retiree health insurance (either from their own employers or

from their spouses' employers), and for many adults these supplemental forms of insurance could provide adequate primary coverage in the absence of Medicare.

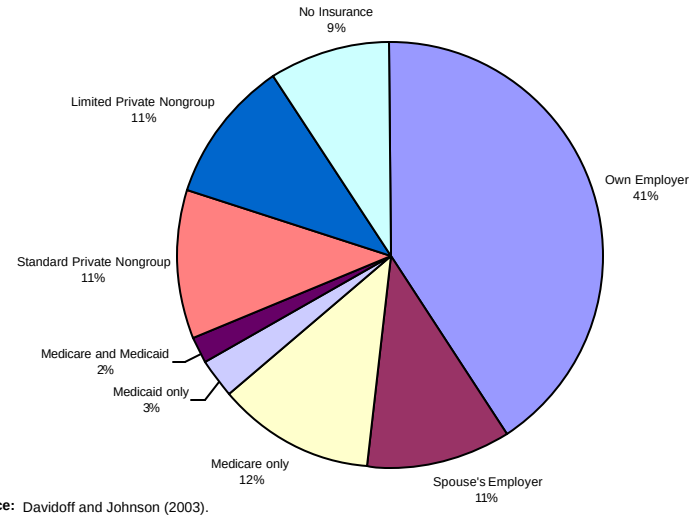
However, an increase in the age of eligibility for Medicare could change the cost and availability of these alternatives, while raising the incentives to obtain them. For example, primary nongroup coverage will be more expensive than supplemental Medigap coverage, and some young elderly adults who could afford Medigap premiums may not be able to afford premiums for primary nongroup policies. However, they may be more likely to make the financial sacrifices necessary to purchase nongroup coverage when the alternative is being uninsured, instead of being underinsured through the Medicare program. Young elderly adults eligible for Medicaid, about a quarter of whom do not currently participate when covered by Medicare (Moon, Brennan, and Segal 1998), face stronger incentives to enroll if they no longer qualify for Medicare.

In addition, some young elderly adults with disabilities would continue to qualify for Medicare benefits if the age of eligibility were increased to 67. The number of young elderly adults with disabilities receiving Medicare benefits after an increase in the eligibility age would exceed the number of near elderly adults with Medicare coverage because the prevalence of health problems increases with age.[18] Others without access to RHI benefits could remain at work to receive employer-sponsored health benefits, and those with working spouses could receive coverage from their spouses' employers. Young elderly adults without access to employer-sponsored coverage, disability-related Medicare benefits, or Medicaid must turn to the nongroup market if lawmakers increase the age of Medicare eligibility. The number with adequate coverage depends on whether they can afford nongroup coverage and are willing to purchase it.

To estimate the impact of an increase in the age of Medicare eligibility on coverage, Davidoff and Johnson (2003) developed a detailed microsimulation model based on data primarily from the 1998 HRS that accounted for all of these factors. They estimated that 91 percent of young elderly adults would maintain some type of insurance coverage if the age of Medicare eligibility were raised to 67 (see exhibit 17). More than half (52 percent) would receive employer-sponsored benefits, based mostly on their own employment. Only about one-fifth of those with employer-sponsored coverage would receive health benefits from their spouses' current or former employers. Another 22 percent of the young elderly population would purchase private nongroup coverage. Public insurance would also be an important source of coverage. About 3 percent would receive Medicaid benefits only, 12 percent would receive disability-related Medicare benefits only, and 2 percent would have dual coverage, according to their estimates. Only 9 percent of the young elderly population, or 356,000 adults ages 65 to 66, would have lacked coverage in 1998 if the age of Medicare eligibility had increased to 67.

[18] Non-aged adults who receive Social Security Disability Insurance (SSDI) payments qualify for Medicare, but they must wait two years after payments begin before they can receive coverage. (Individuals with end-stage renal disease also qualify for Medicare, but this is small group.) In addition, there is a five-month waiting period after the onset of a disability before SSDI payments begin. Thus, those with disabilities must wait at least 29 months after the onset of the disability before they can receive Medicare benefits. Under the current system, adults who develop disabilities at age 62 or 63 probably would not qualify for Medicare before age 65, when virtually all adults qualify, but they probably would qualify before age 67.

Exhibit 17
Simulated Coverage Rates at Ages 65 and 66 if the Age of Medicare Eligibility Were 67, With No Medicare Buy-In Plan, 1998



Source: Davidoff and Johnson (2003).

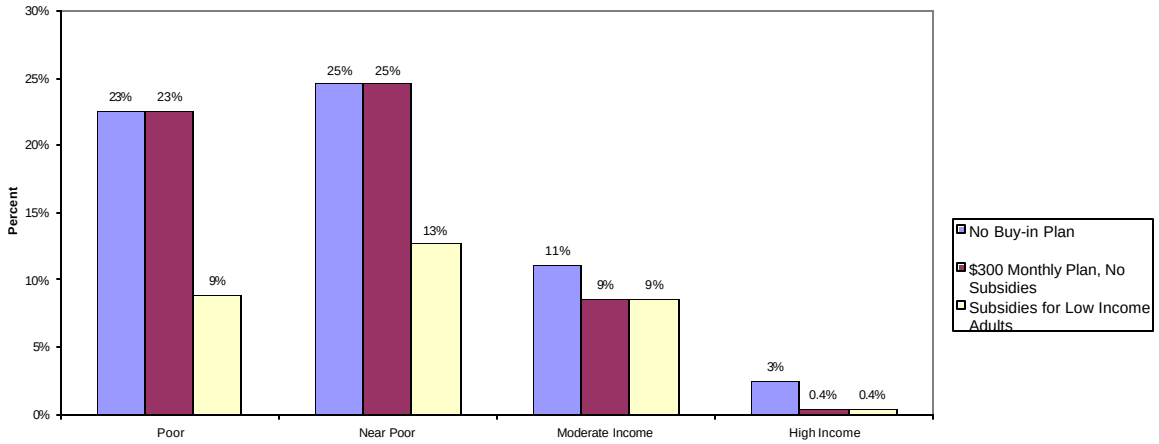
However, another 11 percent would have been underinsured, because they would not have been able to afford standard private coverage.

These estimates assume that private insurers would offer individual policies to all adults ages 65 and 66 who could afford and were willing to pay the premium costs. However, some adults with health problems are unable to find coverage at any price, and those who can obtain coverage are often offered policies that exclude preexisting conditions (Chollet and Kirk 1998; Pollitz, Sorian, and Thomas 2001). Nonetheless, the simulated uninsurance rate among the young elderly seems plausible, since it equals the actual level of uninsurance among those ages 62 to 64, and insurers are probably not that much less willing to cover those ages 65 to 66 than those ages 62 to 64.

Other studies have also considered how raising the age of Medicare eligibility to 67 would affect insurance coverage. For example, Wittenburg, Stapleton, and Scrivner (2000a) examined the impact of an increase in the age of Medicare eligibility (and the normal retirement age for Social Security) on disability-related Medicare coverage, using data from the 1993 Survey of Income and Program Participation (SIPP). They concluded that if the age of Medicare eligibility increased to 67, in step with the scheduled increase in the normal retirement age, 14.9 percent of adults ages 65 and 66 would retain their Medicare eligibility in 2022, when the increases would be almost fully phased in. This estimate is somewhat larger than the 13.8 percent figure reported by Davidoff and Johnson (2003) under the assumption that the increase had already taken place in 1998, because Wittenburg et al. assumed that SSDI participation rates for adults over age 60 would continue to rise over time.[19]

[19] They estimated that only 11.4 percent of adults ages 65 to 66 would have retained their Medicare coverage because of disabilities in 1993 if the age of eligibility had already increased to 67 (Wittenburg et al. 1999).

Exhibit 18
Simulated Uninsurance Rates at Ages 65 and 66 if the Age of Medicare Eligibility Were 67, Under Alternative Medicare Buy-In Plans, by Income, 1998



Note: The subsidized plan sets premiums at $43.80 per month for those for those with incomes below 150 percent of the poverty level and at $300 per month for everyone else. Individuals are classifed as poor if family income falls below the poverty level, as near poor if it falls between 100% and 200% of the poverty level, as moderate income if it falls between 200% and 400% of the poverty level, and as high income if it exceeds 400% of the poverty level.
Source: Davidoff and Johnson (2003).

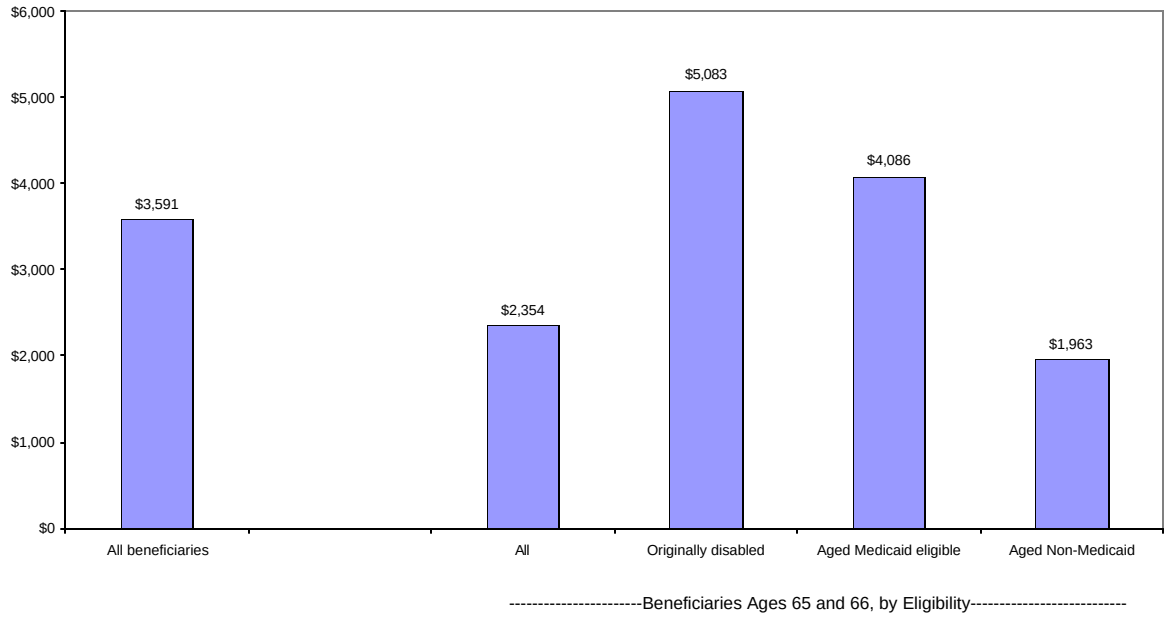
Waidmann (1998), using data from the 1992 Medicare Current Beneficiary Survey, estimated that only 7.1 percent of adults ages 65 to 66 would qualify for Medicare because of disabilities if the age of eligibility were increased, but he included only those who received disability-related Medicare benefits before the age of eligibility, ignoring the possibility that some adults ages 62 to 64 might develop disabilities and qualify for Medicare before age 67.[20] He estimated that another 8 percent would receive Medicaid coverage, and that 12 percent of the young elderly population would be uninsured. The uninsured estimate assumed that all non-SSDI, non-Medicaid beneficiaries with no supplemental insurance coverage and with annual incomes under $25,000 would lack coverage.

An increase in the age of Medicare eligibility would leave some of the most vulnerable young elderly adults without insurance. For example, according to estimates by Davidoff and Johnson (2003), 23 percent of the poor and 25 percent of the near poor (with incomes between 100 percent and 200 percent of the federal poverty level) would lack coverage, compared with just 3 percent of those with high incomes (exceeding 400 percent of the poverty level). In addition, about 26 percent of African Americans and 34 percent of Hispanics would be uninsured. Many uninsured young elderly adults with low incomes would have only limited access to health care. Research on the near elderly, for example, indicates that the uninsured generally receive little health care until they develop serious health problems, at which point they rely on charity care for services (Johnson and Crystal 2000). Thus, an increase in the eligibility age would likely put additional pressure on the already strained health care safety net.

Creating a Medicare buy-in plan would mitigate the adverse effects of an increase in the automatic age of eligibility, but low-income adults would benefit only if the premiums they

[20] The estimate of disability-related Medicare coverage appears to exclude those who would be dually eligible for Medicaid.

Exhibit 19
Per Capita Medicare Reimbursement, 1992



Source: Waidmann (1998)

faced were heavily subsidized. According to estimates by Davidoff and Johnson (2003), 15 percent of the young elderly would participate in a buy-in plan priced at $300 per month.[21] However, most of the participants would have fairly high incomes, so that the buy-in would not reduce uninsurance rates for the poor or near poor (see exhibit 18). With an increase in the eligibility age, a Medicare buy-in plan could improve coverage rates for the young elderly if it charged lower premiums for those with limited incomes. For example, a buy-in plan that charged only $43.80 per month (the monthly Medicare Part B premium in 1998) for those with family incomes below 150 percent of the federal poverty level and $300 per month for everyone else would reduce uninsurance rates from 23 percent to 9 percent for the poor and from 25 percent to 13 percent for the near poor.

Potential Cost Savings for the Government

Raising the age of Medicare eligibility would generate substantial savings for the government, but the impact would be limited by the fact that low-income adults eligible for Medicaid, adults with disabilities, and older elderly adults would continue to receive public insurance, and these groups incur high health care expenses. Waidmann (1998) reported that those who would lose public insurance because of an increase in the age of Medicare eligibility use only slightly more than half as many health care services on average as the typical Medicare beneficiary. In 1992 per capita Medicare reimbursements for all beneficiaries was $3,591, compared with only $1,963 for non-Medicaid beneficiaries ages 65 and 66 who did not receive

[21] Unlike the buy-in plan for the near elderly proposed by the Clinton administration, none of the plans considered here for the young elderly would require supplemental payments by participants after the automatic age of Medicare eligibility.

disability-related Medicare coverage before age 65 (see exhibit 19). An increase in the age of Medicare eligibility would eliminate most young elderly adults from the Medicare program, but adults ages 65 and 66 made up only 13 percent of all Medicare beneficiaries in 1992, and those young elderly adults who would remain in the program because of disabilities had per capita expenditures of more than $5,000 in 1992.

According to Waidmann's estimates, which assume that the rate of SSDI participation at ages 65 and 66 and the age distribution of the Medicare population remain constant over time, raising the age of Medicare eligibility to 67 would reduce the total number of Medicare beneficiaries by 12.4 percent and total annual Medicare costs by 7.4 percent. The net cost savings for the federal and state governments would be even smaller, because almost 9 percent of those who would lose Medicare eligibility would receive public insurance through Medicaid (assuming that rates of Medicaid participation do not increase in response to the delay in Medicare eligibility).[22] Waidmann's analysis indicates that raising the age of eligibility would reduce the total number of adults receiving public insurance by 11.3 percent and the costs of public insurance by 6.2 percent.

Future changes in the age distribution of the population will affect the net savings from raising the age of Medicare eligibility. The share of elderly Americans between the ages of 65 and 66 will peak in the second decade of the century, when the oldest members of the large baby boom cohort begin reaching old age, and then decline until about 2040 (Bureau of the Census 1996). Wittenburg, Stapleton, and Scrivner (2000a) simulated the net savings for Medicare from raising the age of eligibility in step with the legislated increase in the normal retirement age for Social Security.[23] The simulations accounted for projected changes over time in population, per capita Medicare expenditures, and participation in SSDI. They show that an increase in the age of eligibility and normal retirement age would reduce Medicare enrollment by 11 percent (or 7.1 million adults) and annual Medicare expenditures by 4.3 percent (or $27.6 billion in 2000 dollars) by 2022, compared with projected enrollment and costs in 2022 if the Medicare and retirement ages were set at 65.

Most proposals to increase the age of Medicare eligibility would raise it in step with the legislated increases in the normal retirement age for Social Security. However, this would not significantly ease the financial pressures on the Medicare trust fund created by the aging of the large baby boom cohort. The retirement age will not reach 67 until 2027, by which time most of the baby boomers will have already reached 67. If the goal of an increase in the age of Medicare eligibility is to address the burdens presented by the aging of the baby boomers, it must be in place well before the Social Security change phases in.

The creation of a subsidized buy-in plan for young elderly adults in conjunction with an increase in the age of Medicare eligibility would further reduce the cost savings from delaying the eligibility age. Even without explicit subsidies, premiums paid by buy-in enrollees are unlikely to cover the cost of services received. Adverse selection drives up insurance costs because those most likely to utilize health services are also most likely to purchase insurance.

[22] State governments share Medicaid costs with the federal government.

[23] Details of the simulations are provided in Wittenburg et al. (1999) and Wittenburg, Stapleton, and Scrivner (2000b).

Exhibit 20
Estimated Retirement Effects of Raising the Age of Medicare Eligibility to 67

Baseline Coverage	Percent of Sample	Pct. of Workers Retiring Between 1996 and 1998		Pct. Change in Retirement Rates
		Eligibility Age = 65	Eligibility Age = 67	
All	100.0	21.3	20.3	–4.7
RHI offer from own employer	40.6	20.3	19.4	–4.4
Employer-sponsored coverage from own employer, no RHI offer	19.9	18.7	16.4	–12.3
Employer-sponsored coverage through spouse's employer	9.1	24.5	22.4	–8.6

Note: Estimates were based on a sample of 3,566 HRS respondents aged 55 to 64 working at least 20 hours per week in 1996. The model assumed that changes in the age of Medicare eligibility age would not affect retirement decisions for workers with private nongroup coverage or public insurance, or coverage from former employers, or those without coverage.

Source: Johnson (2002).

For example, according to simulations by Davidoff and Johnson (2003), 61 percent of participants in a buy-in plan priced at $300 per month would have one or more serious health problems. By comparison, only 40 percent of those who would be eligible for the buy-in have serious health problems.

Potential Effects on Employment

As discussed in Section III, changes in the age of Medicare eligibility are likely to affect retirement decisions. Raising the eligibility age will increase the costs associated with retirement, especially for workers whose employers provide health insurance while they are employed but not after they retire. With an increase in the age of Medicare eligibility to 67, they would have to purchase expensive alternatives to employer-sponsored coverage for an additional two years if they choose to retire before age 65. Some workers may choose to avoid these additional costs by delaying retirement.

Johnson (2002) estimated the retirement effects of increasing the age of Medicare eligibility by calculating the health insurance cost of retirement, estimating how it influences decisions to withdraw from the labor force, and then using the results to simulate the impact of the policy change. As described more fully in Section III, the health insurance cost of retirement is the increase in premium expenses that workers would pay if they retired, compared with what they would pay if they remained at work. Using longitudinal data from the HRS, Johnson found that increasing the age of Medicare eligibility to 67 would reduce retirement rates by 12 percent (from 18.7 percent over a two-year period to 16.4 percent) for workers with employer-sponsored coverage whose employers do not offer RHI benefits (see exhibit 20). However, the impact would be more modest for workers with other types of coverage. Because insurance costs do not rise much at retirement for workers without employer-sponsored coverage or for those eligible

for RHI benefits, making them wait an additional two years for subsidized Medicare coverage would not substantially raise their retirement costs. Among all full-time workers approaching retirement age, increasing the age of Medicare eligibility to 67 would reduce retirement rates by about 5 percent (from 21.3 over a two-year period to 20.3 percent). This rise in labor supply would improve Medicare's financial position, by increasing the level of program revenue received from payroll taxes.

These estimates of the impact of raising the age of Medicare eligibility are at least as large as estimates of the impact of other reform proposals on retirement rates. Most studies of Social Security reform, for example, conclude that it would have only limited effects on retirement. Mitchell (1991) concluded that raising the normal retirement age from 65 to 67 would lead men to delay retirement by about only three months, as would increasing the penalty for early retirement. Gustman and Steinmeier (1991) estimated that increasing the Social Security delayed retirement credit from 3 percent to 8 percent per year and eliminating the Social Security earnings test would increase labor force participation rates by about 3.5 percent per year for adults ages 65 to 69 and would raise the average retirement age by only about three weeks. Mandating that all employers offer defined benefit pension plans to their workers would increase the cumulative probability of retirement between the ages of 50 and 70 by 4.9 percentage points (Samwick 1998). In relative terms, this tremendous expansion in pension coverage would increase retirement rates by only about 6 percent. Judged by these standards, then, increasing the age of Medicare eligibility can have relatively large effects on retirement.

Potential Effects on Employers

An increase in the age of Medicare eligibility could raise insurance costs for employers who provide RHI benefits. Under the current system, employers who offer RHI benefits generally pay a substantial share of health costs for retired workers up to age 65, when Medicare coverage begins. At that time, RHI coverage ends, or it becomes the secondary payer of health care costs, picking up some Medicare cost-sharing expenses and generally paying for some services that Medicare does not cover.[24] Raising the age of Medicare eligibility would increase the number of months of primary RHI coverage. Employers could respond to the increase in insurance costs by eliminating RHI benefits, offering them only to employees with the most years of service, or increasing the level of cost-sharing they require of enrollees. There is no empirical evidence to suggest the likelihood or size of an employer response.

Since Medicare is now the secondary payer of health care costs for most workers ages 65 and older with employer-sponsored coverage, raising the age of Medicare eligibility should not increase the cost to employers of covering active employees. However, as discussed in the next section, the secondary payer rules for workers ages 65 and older are not strictly enforced. As a result, raising the age of Medicare eligibility could increase the costs to firms of employing older workers, perhaps reducing employment and wages for young elderly adults.

[24] In about two-thirds of RHI plans, coverage ends once participants become eligible for Medicare benefits (Kaiser Family Foundation and HRET 2002).

V. Making Medicare the Primary Payer for Older Workers

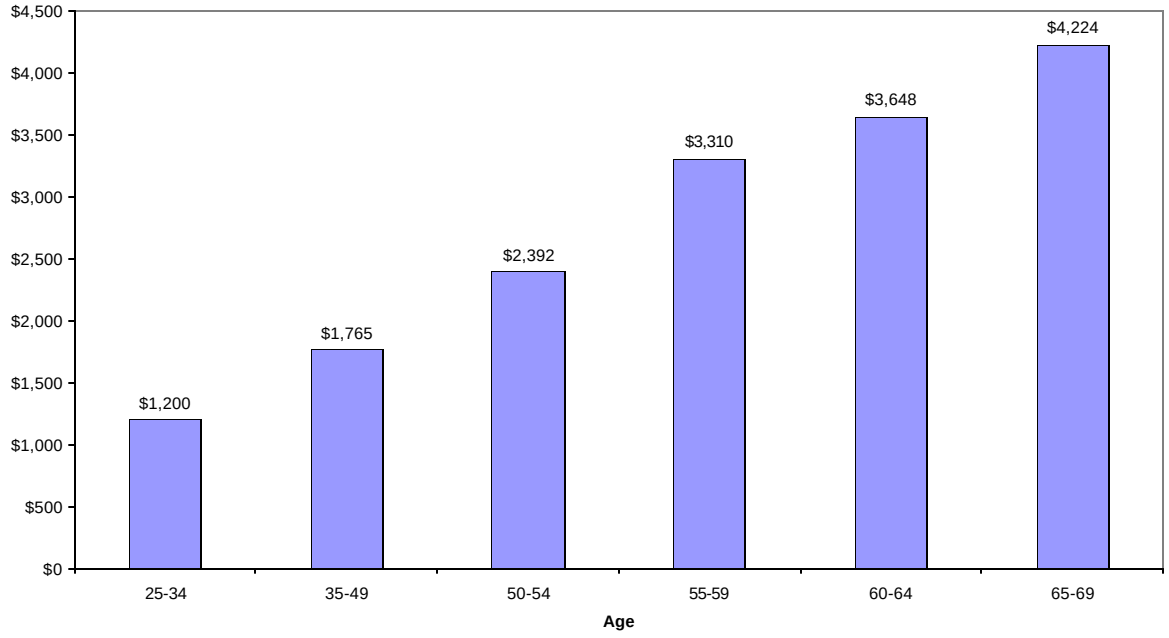
The large health care expenses that many older adults incur raise the costs of employing them and may reduce their employment options. Employers who provide health benefits face higher insurance costs from older workers, and age discrimination rules limit their ability to offset these costs by paying lower wages. As a result, employers may prefer younger workers, reducing the demand for older employees. One way to lower employment costs for older workers and perhaps improve their employment opportunities would be to raise the share of health care expenses paid by Medicare. This section examines the implications of establishing Medicare as the primary payer of health care costs for older workers.

Medicare is the primary payer of health care costs for most older Americans. Employer-sponsored RHI benefits, private Medigap insurance, and Medicaid generally provide only supplemental coverage, picking up some of the cost-sharing that Medicare imposes on beneficiaries and sometimes paying for services that Medicare does not cover. However, for workers ages 65 and older with employer-sponsored insurance who are employed by firms with more than 20 employees, Medicare is the secondary payer. Employer-sponsored insurance reimburses health care costs first, while Medicare pays only for Medicare-covered services that employer insurance does not cover. Because health benefits provided by employers are almost always more comprehensive than Medicare, Medicare is liable for virtually none of the health care costs of these older workers. In addition, employers must provide coverage to workers ages 65 and older on the same terms as they offer coverage to younger workers. Firms cannot compensate workers who drop employer-sponsored coverage in favor of primary Medicare coverage, and workers who elect not to participate in the employer's health plan cannot receive RHI benefits from their employer, so they would forfeit all of the services that their employer's plan provides. Employers must also provide primary coverage to Medicare-eligible spouses of any employees under age 65, if they normally provide spousal coverage. Although there is some evidence that relatively few employers complied with the secondary payer rules when they were first went into effect in 1983 (Glied and Stabile 2001), the Centers for Medicare and Medicaid Services (CMS) has recently increased its enforcement efforts.[25] Secondary payer provisions saved Medicare $3.4 billion in 1998 (U.S. House of Representatives 2000).

These secondary payer rules were designed to reduce Medicare costs by limiting the ability of employers and older workers to replace employer-sponsored coverage with Medicare coverage. However, these rules also raise the costs of employing older workers for firms that provide health benefits, because the employer's insurance—not Medicare—reimburses most health care costs for older workers, which are substantially higher than costs for younger workers. As reported in Exhibit 21, in 1998 mean health care expenses for adults ages 65 to 69 were $4,224, compared with only $1,765 at ages 35 to 49. The difference is not quite as dramatic when the comparison is restricted to workers, because employed older adults are generally in better-than-average health and use relatively few health services, but it is still substantial. Mean 1998 health care expenses for workers were more than twice as large at ages 65 to 69 ($3,139) as at ages 35 to 49 ($1,414). These high costs can reduce the demand for older workers and limit

[25] See http://www.cms.hhs.gov/medicare/cob for details.

Exhibit 21
Mean Health Care Expenses by Age, 1998



Source: Author's tabulations of data from Agency for Healthcare Research and Quality (2001).

their employment options, as long as age discrimination rules or concerns about employee morale prevent firms from paying older workers lower wages than younger workers.[26]

There is some evidence that health insurance costs limit employment opportunities for older workers. Based on data from a nationwide survey of employers conducted in 1991, Scott, Berger, and Garen (1995) found that health insurance benefits are negatively and significantly related to the share of newly hired workers ages 55 to 64. Firms with more generous health plans are less likely to hire older workers than firms without plans or with less generous plans. However, workers ages 55 to 64 make up a larger share of the workforce in firms with generous health plans, because workers tend to stay longer in jobs that provide good health benefits. Thus, health insurance costs appear to limit new job opportunities for older workers, but they do not appear to force older workers out of existing jobs.

Establishing Medicare as the primary payer of health care costs for older workers would raise Medicare reimbursements for workers ages 65 and older and reduce employer-sponsored insurance costs. But it probably would not improve employment opportunities much for older workers, because the savings would amount to only a small share of total employment costs.

[26] In typical defined benefit plans, annual pension costs fall once workers reach the plan's early retirement age and especially the normal retirement age (Penner, Perun, and Steuerle 2002). These plans can be used to offset the high insurance costs of employing older workers. But defined benefit plans increase the cost of *hiring* older workers, because defined benefit pension costs generally rise sharply in the years immediately before the plan's early and normal retirement ages. These cost differentials do not exist in most defined contribution plans, which are becoming increasingly popular.

Under the assumption that employer-sponsored health insurance covers 70 percent of total heath care expenditures—the share in the 1998 Medical Expenditure Panel Survey (MEPS—employers paid $2,197 in health care costs on average for covered workers ages 65 to 69 in 1998 ($3,139 times 0.7).[27] Mean annual costs would fall to $696 if employer coverage were instead secondary to Medicare, under the assumption that employer coverage paid 22 percent of total health care costs—the share paid by private insurers for elderly Medicare recipients with private coverage in the 1998 MEPS. Thus, eliminating the secondary payer rules would save employers an average of about $1,500 per Medicare-eligible worker. Median earnings in 1998 for men ages 65 to 67 working full time equaled about $36,000 (Haider and Loughran 2001). Health care cost savings, then, would amount to only about 4 percent of salary.[28]

The impact on employment would depend on the sensitivity of the demand for labor to employment costs. Although estimates of demand elasticities vary, most studies find that the demand for all but the youngest workers is not very sensitive to wage levels (Hamermesh 1993), suggesting that the impact on employment would be small. Indeed, Glied and Stabile (2001) found no evidence that secondary payer laws reduced wages or employment for adults ages 65 and older. They found weak evidence that older workers shifted toward jobs that were exempt from the secondary payer rules, such as jobs at firms with fewer than 20 employees and part-time jobs that do not provide health insurance.

Establishing Medicare as the primary payer for workers ages 65 and older would raise Medicare reimbursements for workers ages 65 and older with employer-sponsored coverage. According to MEPS data, mean total health care costs for workers ages 65 and older with private insurance were $2,647 in 1998. If Medicare were the primary payer, Medicare would have paid about 59 percent of these costs, the share paid for nonworkers ages 65 and older in 1998, or about $1,560. Medicare actually paid $819 per capita in 1998 for workers ages 65 and older with private insurance. Adjusting for administrative costs, the underreporting of health care costs in MEPS, and increases in per capita Medicare payments between 1998 and 2000, the per capita cost of making Medicare the primary payer for elderly workers would be about $969.[29] Assuming 2.6 percent of adults ages 65 and older are employed and receive health benefits from their current employer (the share in the 1998 HRS data), this translates into annual costs of about $900 million, in 2000 dollars.

[27] MEPS data are available from the Agency for Healthcare Research and Quality (2001).

[28] Health care cost savings would equal an even smaller share of the total costs of compensation, which include the cost of taxes, retirement plans, and other benefits.

[29] Per capita benefit payments by Medicare grew by 1.8 percent from 1998 to 2000, and administrative costs are about 2.1 percent of benefit payments (Social Security Administration 2001). In addition, MEPS captures only about 80 percent of total Medicare payments. (See footnote 16 for more details.)

VI. Conclusions

Policymakers must balance competing objectives when setting an appropriate age for Medicare eligibility. Medicare is designed to improve the health and income security of older adults, and lowering the eligibility age would extend these benefits to additional members of society. However, it would also raise government spending on the program, reducing private consumption (through increased taxation), national savings (through deficit spending), or other public services. In addition, lowering the eligibility age might encourage some workers to retire at younger ages, exacerbating concerns about the ability of the economy to support the growing retired population. On the other hand, raising the age of Medicare eligibility may reduce program costs and encourage workers to remain in the labor force, but perhaps at the expense of the health and income security of some older Americans, particularly those with health problems. Better information about the relative costs and benefits is critical to evaluating the merits of changing the age of Medicare eligibility.

Lowering the automatic age of Medicare eligibility would improve coverage for the near elderly. Under the current system, in which Medicare covers those younger than 65 only if they have disabilities, about 9 percent of adults ages 62 to 64 are uninsured. Although a larger share of younger adults are uninsured, the uninsurance rate at older ages is alarming because many of the near elderly have health problems that require medical care. In addition to virtually eliminating uninsurance at ages 62 to 64, lowering the automatic age of Medicare eligibility would improve security for those who rely on the expensive and risky individual insurance market, all of whom would instead be able to obtain less costly and more secure Medicare coverage. It would also reduce employer costs for retiree health benefits and both retiree and employer costs for COBRA continuation coverage.

However, extending Medicare coverage to all adults ages 62 and older would be expensive, costing about $5 billion per year in 2000, and it would crowd out private sources of insurance, which now cover most near elderly adults. In addition, lowering the automatic age of Medicare eligibility to 62 would not improve health and income security for near elderly adults not old enough to qualify for Medicare.

A Medicare buy-in plan provides a less expensive option for extending Medicare benefits to younger adults. It would allow near elderly adults not old enough for automatic Medicare benefits to purchase coverage, and the program could be extended to adults as young as 55 (or to individuals of any age, for that matter). However, lowering the automatic eligibility age would do nothing to improve coverage for near elderly adults younger than 62. And it would be expensive. However, this initiative would not help the uninsured much unless it included substantial subsidies for those with low incomes. A buy-in plan that charges premiums approximately equal to the cost of services it provides would reduce the size of the uninsured population ages 62 to 64 by no more than 12 percent, and some estimates suggest that the impact could be as small as 1 percent. With subsidies for low-income adults, a buy-in plan could be much more effective. For example, uninsurance rates would fall by more than one-third if premiums were capped at 5 percent of income, and uninsurance rates for the poor would fall by more than half if those with family incomes below 150 percent of the federal poverty level had to pay only for Part B coverage. Relating premiums to income would target public benefits to those who need them most. Tying the subsidies to lifetime earnings, as Short, Shea, and Powell (2001)

recommend, would reduce the incentive to retire early to qualify for low-cost insurance coverage.

However, subsidies inevitably increase program costs. Costs could reach $525 million per year (in 2000) for a buy-in plan for those ages 62 to 64 that subsidized premiums for all participants by 25 percent and $2.7 billion for a plan that capped premiums at 5 percent of income. Costs would run even higher if the buy-in program were extended to those as young as 55. Even without subsidies, the buy-in plan would cost the government about $300 million per year, because some of the premium payments would not be received until long after services were provided.

Raising the age of Medicare eligibility to 67 would have only limited effects on most young elderly adults. More than half would receive employer-sponsored coverage from their own workplace or their spouse's workplace, and another 17 percent would receive Medicaid benefits or maintain Medicare coverage because of disabilities. However, more than one in five young elderly adults would be forced to rely on expensive private nongroup coverage, and one-half of those could only afford policies that provided limited coverage. In addition, an increase in the age of eligibility would leave 9 percent of the young elderly uninsured. Raising the age of eligibility would hit those with limited incomes especially hard. For example, almost one in four poor and near poor young elderly adults would lack coverage. Creating a Medicare buy-in plan for the young elderly would mitigate the adverse effects of an increase in the automatic age of eligibility, but low-income adults—who comprise a disproportionate share of the uninsured—would benefit only if the premiums they face were heavily subsidized.

An increase in the age of eligibility could generate substantial savings for Medicare. By 2022, annual savings could reach $28 billion (in 2000 dollars), compared to what the program would pay out under current rules. The reduction in the total cost of public insurance would be somewhat lower, because some of the young elderly would move from Medicare to Medicaid. In addition, the reduction in Medicare enrollees would exceed the reduction in costs, because many of the most expensive beneficiaries—including the oldest old and those with disabilities—would remain in the program. According to one study, raising the age of eligibility would reduce Medicare enrollment by 11 percent and Medicare expenditures by 4.3 percent.

Changing the age of Medicare eligibility would influence labor supply decisions for older workers. Recent estimates suggest that lowering the age of eligibility to 62 would increase retirement rates by about 7 percent, while raising the age of eligibility would reduce retirement rates by about 5 percent. Introducing buy-in plans would induce smaller effects on labor supply. In addition, changing Medicare rules to make Medicare the primary payer of health care costs for older workers probably would not substantially improve employment options for older adults, primarily because the secondary payer rules are not rigorously enforced now.

Setting the age for Medicare eligibility is necessarily arbitrary. Although a clear consensus exists in this country for providing universal health benefits to older adults (Kaiser Family Foundation 1998), it is not clear when an individual becomes old. Finding the appropriate age involves difficult trade-offs. Lowering the age of Medicare eligibility would improve health and income security for some adults younger than 65, but it would raise costs and encourage some workers to retire early, exacerbating concerns about the ability of the economy to support

the growing retired population. Raising the age of Medicare eligibility would reduce programs costs and encourage workers to remain in the labor force, but at the expense of the health and income security of older Americans, particularly those with health problems.

Nonetheless, recent improvements in health status and increases in employment at late midlife (Crimmins, Reynolds, and Saito 1999; Quinn 1999) may have reduced the need for subsidized health benefits at age 65. As the normal retirement age for Social Security benefits slowly rises to age 67 in 2022, it may make sense to increase the age of Medicare eligibility to 67, since the eligibility age always coincided with the normal retirement age (before the retirement age began increasing in January 2000). However, many adults could benefit from an option to buy into the Medicare program at younger ages. Similar to the early retirement option for Social Security, the buy-in program would permit individuals to receive limited subsidized benefits before the full entitlement age. The buy-in option would be particularly important to vulnerable populations, especially if plan premiums varied with the ability to pay.

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