

CHANGING MEDICARE ELIGIBILITY: PROGRAM DESIGN CHALLENGES

By **Paul N. Van de Water***

SUMMARY

Medicare's basic eligibility criteria have remained much the same for decades, while the program has evolved considerably in other respects. Ever since Medicare's start in 1965, older Americans have become eligible for benefits at age 65, which was Social Security's full retirement age at the time. Seniors are eligible for premium-free Hospital Insurance (HI, or Medicare Part A) if they meet Social Security's work-history requirement, and they pay a premium to cover a portion of the cost of Supplementary Medical Insurance (SMI, or Part B) and the Prescription Drug Benefit (Part D). Legislation in 1972 extended Medicare eligibility to disabled workers under age 65 (after a two-year waiting period) and to people with end-stage renal disease (ESRD). Since then, Medicare's eligibility requirements have not changed.

Recently, however, proposals to change Medicare eligibility have moved to the forefront of the public debate. Some proposals would make incremental increases or decreases in the age of eligibility, while retaining the existing financing structure and near-universal reach amongst the eligible population. Others would allow certain people under age 65 to "buy in" to Medicare, or a similar program, upon payment of a premium that covered much or all of the cost of the benefits. Still others would create a Medicare-like program (sometimes called "Medicare for All") that would cover the entire population and be fully tax-financed.

Although any of these proposals could be made to work, most of them have not been fully specified, and all raise significant technical and program design issues. These issues include:

- **Benefits and Cost Sharing.** Many design issues arise from differences between the benefit packages in traditional Medicare and private insurance. Notably, traditional Medicare lacks a catastrophic limit on out-of-pocket spending and does not provide benefits in a single package. Medicare's unique benefit package particularly creates complications if a buy-in is offered as an option in or alongside the Affordable Care Act (ACA) marketplaces.
- **Traditional Medicare and Private Plans.** Medicare beneficiaries may receive their benefits either through traditional Medicare or through private Medicare Advantage (MA) plans. A proposal to expand eligibility for Medicare could extend eligibility for traditional Medicare, Medicare Advantage, or both.

***Paul N. Van de Water** is a Senior Fellow at the Center on Budget and Policy Priorities and a Member of the National Academy of Social Insurance.

- **Relation to Employer-Sponsored Health Insurance.** Some buy-in proposals would offer those who are eligible for employment-based coverage the choice to participate, while others would not. Single-payer plans would largely do away with employer coverage.
- **Relation to ACA Marketplaces and Medicaid.** An expanded Medicare program may be designed as a partial or complete replacement for the ACA marketplaces, an offering inside the marketplaces, or as an optional alternative to the marketplaces.
- **Premiums and Subsidies.** The out-of-pocket cost of health coverage under any proposal to change Medicare eligibility, as well as its attractiveness to potential enrollees, will depend on how unsubsidized premiums are set and the extent of premium and cost-sharing assistance that is available to low-income beneficiaries.
- **Encouraging Participation and Continuity of Coverage.** Although participation in Medicare is not strictly mandatory, the program's design assures that participation among seniors is nearly universal and extremely stable. In Medicare buy-in proposals, some of the factors that lead to this stability in enrollment may be absent or weakened, potentially leading to adverse selection or other problems.

- **Provider Payment Rates and Participation.** Expanding eligibility for Medicare allows for the possibility of reducing health care costs by paying doctors, hospitals, and other health care providers using Medicare's lower rates, or something between Medicare and commercial rates. How providers would respond to significant decreases in their payment rates and incomes is another key issue.
- **Financing.** With the federal government facing large and growing deficits, any expansion of Medicare eligibility that would add to the deficit should be paid for. Some plans would be entirely financed by additional premiums, while others would be entirely tax-financed.
- **Transition and Implementation.** Depending on their scope, changes in eligibility for Medicare would take time and resources to put in place. Administrative funding should be adequate, and the implementation schedule should be ambitious yet realistic.

This paper does not presume that any particular restriction or expansion of Medicare eligibility should be adopted or rejected. Rather, it aims to identify the major design challenges involved in changing Medicare eligibility and outline alternative strategies and considerations involved in navigating each.

Proposals to Change Eligibility for Medicare

Proposals to change Medicare eligibility fall into three major categories, with each raising distinct design issues. Below are some leading current examples on which this paper draws to illustrate those issues.

The most straightforward class of proposals would increase or decrease the age at which non-disabled individuals become eligible for Medicare. The proposals discussed here would leave the financing structure and other elements of the program largely unaltered, although other proposals would combine an increase or decrease in the eligibility age with further changes.

- **Raising the Age of Eligibility.** House Republican budgets from 2010 on — as well as other budget plans — have proposed raising the age of Medicare eligibility from 65 to 67, or even higher, in order to reduce federal spending.¹ Proponents argue that the age of eligibility for Medicare should rise as lifespans grow, just as Social Security's full retirement age is gradually increasing.
- **Reducing the Age of Eligibility.** In contrast, other analysts have proposed reducing the age of eligibility to 62 (when workers can first claim Social Security retirement benefits), 55, or 50.² Under these proposals, almost everyone above the new eligibility age would be covered by an expanded Medicare, just as almost everyone over 65 is covered by Medicare today. (For those with coverage based on current employment, Medicare

coverage is secondary.) The goal would be to secure more efficient, stable health coverage for workers approaching retirement while removing a relatively expensive age group from the individual health insurance market.

A second group of proposals would create a new part of Medicare or a Medicare-based program for people under age 65 in order to expand health care coverage and make it more affordable. Such a buy-in could be limited to people above a certain age or could be open to all. Among the current proposals are the following:

- **Medicare Buy-In for Near-Retirees.** A limited form of this approach would allow those approaching retirement to “buy in” to Medicare upon payment of a premium. For example, Senator Debbie Stabenow has introduced a bill (S. 1742) that would make Medicare available to people between the ages of 55 and 64. A bill authored by Representatives Higgins, Courtney, and Larson (H.R. 3748) would enable individuals ages 50 to 64 to purchase Medicare through the ACA marketplaces.
- **Midlife Medicare.** The “Midlife Medicare” proposal by Princeton’s Paul Starr would establish a new part of Medicare, with its own separate financing, for people ages 50 to 64 who are not offered employer-sponsored insurance.³ Unlike most other buy-in proposals, it would be financed in part by general revenues as well as premiums.
- **Medicare Buy-In for All Ages.** This approach would establish a public plan modeled on Medicare as an option in the ACA individual and small business health insurance marketplace. The Medicare-X Choice Act (S. 1970), introduced by Senators Bennet and Kaine, illustrates this approach. The plan would initially be available only in areas with limited marketplace competition, but it would ultimately be available to all marketplace participants, including families with children.

The most far-reaching proposals would create a new public health care coverage plan that would cover everyone and subsume Medicare and most other government health insurance programs, as well as private insurance.

- **Single Payer.** The most prominent proposal of this sort, Senator Bernie Sanders’ Medicare for All Act (S. 1804), would



create a new tax-financed health care program for all U.S. residents. A temporary Medicare buy-in option would be available during a three-year transition period (for ages 55, 45, and 35 and above in the first, second, and third years, respectively). After that, a new “Universal Medicare Program” would take effect, and the current Medicare program, most Medicaid acute-care benefits, the Children’s Health Insurance Program (CHIP), the Federal Employees Health Benefits Program (FEHBP), Tricare, and the ACA marketplaces would cease. This new program would offer only a public plan and no private options. Insurers and employers would be prohibited from providing health coverage that duplicated the benefits under the new program.⁴

Benefits and Cost Sharing

Many design issues arise from differences between the benefit packages in traditional Medicare and private insurance.⁵ Traditional Medicare is somewhat less comprehensive than the typical plan offered by large employers, mainly because it lacks a catastrophic limit on out-of-pocket spending. The average benefit value of traditional Medicare for a person age 65 or older has been estimated to be about 97 percent of the value of the largest plan in the FEHBP and 93 percent of a typical plan for large private employers. These differences in generosity stem primarily from different cost-sharing requirements.⁶ Traditional Medicare is also different from other individual or group health insurance because it does not provide benefits in a single package but requires beneficiaries to deal with three separate parts, as well as possible supplemental cost-sharing coverage.

Traditional Medicare (through Parts A, B, and D) covers nine of the ten categories of health care items and services established as “essential health benefits” under the Affordable Care Act.⁷ The exception is pediatric services, which current Medicare beneficiaries — all of whom are adults — don’t require.⁸ (Medicare also doesn’t cover newborn care, which the ACA groups with maternity care.) Private MA plans (Part C) cover the same services, except for some that do not cover prescription drugs. Traditional Medicare does not cover most hearing, dental, or vision care, although most MA plans do to some extent. Typical large employer plans also provide limited dental coverage.

Traditional Medicare is less generous than typical large employer plans primarily because it has higher cost sharing for short hospital stays and no annual out-of-pocket limit for hospital and outpatient care.⁹ Traditional Medicare also has a lifetime limit on inpatient hospital days under some circumstances. In contrast, MA plans must have an out-of-pocket cap for Part A and B services. Some 23 percent of beneficiaries who are covered by traditional Medicare purchase private supplemental cost-sharing coverage (“Medigap” policies), and 34 percent receive supplemental retiree coverage from a current or former employer. About 22 percent of traditional Medicare beneficiaries also receive partial or full benefits from Medicaid, which has little or no cost sharing and covers a wider range of services. Nineteen percent of beneficiaries with traditional Medicare have no supplemental coverage.¹⁰ If a Medicare beneficiary is covered by a large employer health insurance plan because of the current employment of the beneficiary or spouse, the employer plan pays first, and Medicare pays second.

The significance of the differences between the benefit packages in Medicare and other insurance for a particular proposal depends in large part on whether Medicare would become the dominant source of health coverage for a particular group, as it is today for those over age 65, or whether it would be one of many payers, as it would be under the buy-in proposals. At present, when a person turns 65, he or she essentially moves from one health insurance regime to another, with different benefits and rules, and stays under the Medicare regime for the rest of his or her life. Virtually everyone enrolls in Part A upon turning 65, since coverage is costless for those who have paid payroll taxes and their spouse, and almost all who are not working



and covered by a large employer plan enroll in Part B at the same time.¹¹ Those who are eligible for premium-free Part A are not eligible for premium or cost-sharing subsidies in the ACA marketplaces, but low-income beneficiaries may receive assistance with premiums and cost sharing for Parts A and B through the Medicare Savings Programs.¹² In addition, the low-income subsidy (LIS) — also known as Extra Help — provides premium and cost-sharing assistance for Part D using different income and asset cut-offs.

Lowering (or raising) the Medicare eligibility age across-the-board would not require changes in covered services or cost sharing, although improving the benefit package merits consideration for other reasons. Beneficiaries newly (or no longer) eligible for premium-free Medicare Part A would cease (or begin) to be eligible for marketplace subsidies, if they met the other requirements. Lowering the eligibility age would greatly increase the number of beneficiaries who are still working (or whose spouse is working), have health coverage from a current employer, and would be subject to Medicare’s secondary payer rules, as discussed further below. Employed beneficiaries would still need a source of coverage for their children other than Medicare. For many employed beneficiaries, the income-related premiums would further discourage enrollment in Parts B and D.¹³

Medicare’s unique benefit package creates more complications if a Medicare buy-in is to be offered as an

option in or alongside the ACA marketplaces. The ACA went to some effort to standardize marketplace offerings by requiring that plans offer the essential health benefits, impose no annual or lifetime limits on benefits, and fit one of four “metal levels” of actuarial value. Traditional Medicare doesn’t meet all of these standards.

There are two broad ways of addressing this situation. One is to use the same benefit package for the Medicare buy-in as in traditional Medicare, effectively exempting it from the ACA’s requirements. This is the approach taken in S. 1742 and H.R. 3748, which would also extend guaranteed issue of Medigap plans to all buy-in enrollees. At present, with some exceptions, Medigap plans must guarantee issue only when a person age 65 or older first becomes eligible for Medicare. Under this approach, it also would be necessary to specify if buy-in participants would be required to purchase drug coverage, which is currently optional, and would be able to choose an MA plan. Enrollees who do not purchase drug coverage and supplementary insurance, or choose an MA plan, would have significant gaps in coverage. Depending on how these matters are resolved, this approach could result in many non-standard plans — traditional Medicare, with or without drug and Medigap coverage, and MA plans — competing with marketplace plans, which would exacerbate selection and risk adjustment issues for both Medicare and Medigap. The Stabenow and Higgins bills and the Starr proposal all require buy-in participants either to enroll in Parts A, B, and D of traditional Medicare or choose an MA plan with drug coverage. Medigap coverage, however, would remain optional for those in traditional Medicare.

The other approach is to create a new, distinct version of Medicare that would meet all the requirements of the ACA marketplaces, including coverage of children, as in the Bennet-Kaine proposal. At a minimum, Medicare-X options would be offered at the silver and gold metal tiers (with actuarial values of 70 and 80 percent, respectively). Although no precisely comparable figure is available for today’s Medicare, its actuarial value is, by one estimate, around 84 percent.¹⁴ The Medicare-like plan for younger individuals would thus have benefits that were better in some respects than traditional Medicare (notably the out-of-pocket cap) and worse in others (likely higher deductibles) and, with the availability of ACA premium and cost-sharing subsidies, could cost less for some people.

Since the Sanders single-payer proposal eliminates traditional Medicare and most other federal health insurance programs, issues of consistency with competing benefit packages don’t arise. Its benefit package would be extremely comprehensive and would include all of the ACA’s essential health benefits plus dental, hearing, and vision care. It would also have no deductibles, coinsurance, or copayments (except for brand-name prescription drugs). Providing such generous benefits, of course, would add considerably to the cost of the proposal.

Traditional Medicare and Private Plans

In today’s Medicare, beneficiaries may receive their benefits either through traditional Medicare, which offers a wide choice of health care providers, or through a selection of private MA plans, which provide a catastrophic limit on out-of-pocket spending and often other additional benefits but may have a limited network of providers, utilization management, and impose additional restrictions. A plan to expand eligibility for Medicare could extend eligibility for traditional Medicare, Medicare Advantage, or both. Since both public and private health plans have their own intrinsic advantages, most proposals to change Medicare eligibility maintain some form of competition and choice between public and private plans.¹⁵

The role of private plans in Medicare has grown over the years, and one-third of beneficiaries now receive their benefits through Medicare Advantage plans. Thus, Medicare has evolved from a pure single payer into a health insurance marketplace, to use Starr’s characterization. Today, people age 65 and over (as well as disabled workers and persons with ESRD) are part of the Medicare marketplace, and people age 64 and below may participate in the ACA marketplace. Each of the two marketplaces has its own distinct rules for plans, including benefit packages, premiums, cost sharing, and low-income subsidies. Expanding Medicare in a way that gave newly eligible individuals not only a choice of health plans but also a choice of health insurance marketplaces (and the plans within them) would offer those beneficiaries more options, but make it harder for them to compare plans and, as noted earlier, greatly complicate risk adjustment.

Medicare Advantage plans and the private plans offered in the ACA marketplaces differ importantly with respect to

how the plans are paid and how the plans pay providers. In addition, Medicare has broader participation and, hence, a more stable risk pool than the ACA marketplaces. These differences have made the Medicare Advantage market more attractive and profitable to insurers than the ACA marketplaces.

First, what Medicare pays MA plans, and the premiums paid by beneficiaries, are tied to the average spending per beneficiary in traditional Medicare in a local area. Over the years, Medicare has on average paid MA plans more than it would cost to cover the same beneficiaries in traditional Medicare, although the ACA has brought down the extent of these overpayments. In the ACA marketplaces, by contrast, the cost of coverage for subsidized participants is tied to the price of the second lowest-cost silver plan, which creates substantial competition among insurers to hold down premiums.

Second, Medicare prohibits providers who are outside an MA plan's network from charging beneficiaries more than Medicare rates. This cap, as well as competition from traditional Medicare, allows MA plans to demand similar or even lower rates from in-network providers. "Limits on payment rates for hospitals and doctors have not only kept down costs to seniors," explain analysts John Holahan and Linda Blumberg, "but also enabled commercial insurers to compete effectively with the traditional Medicare program."¹⁶ Plans in the ACA marketplaces lack this competitive advantage and generally must pay more to attract providers.

The proposals to reduce Medicare's eligibility age could easily avoid the complications of competing marketplaces by retaining a clear demarcation between eligibility for Medicare and the ACA marketplaces. For example, in one simple approach, newly eligible Medicare beneficiaries under age 65 would no longer have access to subsidized private coverage through the ACA marketplaces, but they would be offered a choice of public and private plans through Medicare, just as those age 65 and over are today.

Designing the Medicare buy-in proposals for near-retirees is more difficult. Since those eligible for the buy-in would presumably continue to have access to private plans through the ACA marketplaces, they would have a choice

of public and private plans available to them, even if the buy-in provided access only to traditional Medicare but not to Medicare Advantage. However, in areas where few or no plans are offered in the ACA marketplaces, allowing access to Medicare Advantage plans might be the only way of providing a wide range of options.

The Stabenow proposal would allow buy-in enrollees to choose either traditional Medicare or an MA plan.¹⁷ This approach to a buy-in would effectively add not one option but many options to the ACA marketplaces. Offering a choice of marketplace plans, traditional Medicare with drug plan options, and MA plans — all with different benefit packages and provider networks — would complicate the structure of both Medicare and the marketplaces, as well as the choices facing consumers. For example, it is unclear how the buy-in amount for MA plans would be determined.

The Bennet-Kaine Medicare-X bill — like the proposals to reduce Medicare's eligibility age — maintains a bright line between Medicare and the ACA exchanges. It would add a public plan, similar to and built on traditional Medicare, to the ACA marketplaces, but it would not offer enrollees in Medicare-X the option of choosing an MA plan. Participants in the marketplaces would thus have access to both a public plan — Medicare-X — and whatever private plans participate in the marketplaces. Notably, the public plan would pay providers at Medicare rates, possibly giving private marketplace plans leverage to negotiate lower payment rates as well. This proposal, of course, could



be combined with other steps to strengthen the ACA marketplaces and encourage more plans to participate, thereby increasing the choices available to consumers.

The Sanders single-payer proposal solves the problem of competing marketplaces in an entirely different way — by setting up a new coverage system that would have only a public plan and do away with both private health plans and patient cost sharing. Advocates of this approach say that it would substantially reduce both health-insurance administrative costs and provider transaction costs.¹⁸ But critics argue that the reduction in competition and choice could entail sacrifices in innovation, access, and quality of care.

Other single-payer proposals would retain an option for choosing among private plans. These include former Representative Pete Stark’s “AmeriCare” plan (H.R. 1841, 110th Congress) and the Kennedy-Dingell “Medicare for All Act” (S. 1218 and H.R. 2034, 110th Congress).¹⁹ In these proposals, private plans would compete against a public plan and each other within a single marketplace, thereby avoiding having two different types of private plans with different benefits operating under two different sets of rules.

Relation to Employer-Sponsored Health Insurance

Offering Medicare or a Medicare-like plan as an option within or alongside the ACA marketplaces, as the buy-in proposals would do, might have a modest impact on employer-sponsored insurance (ESI) or a greater one, depending on the buy-in’s specifications. But lowering or raising the age of eligibility would entail significant changes. The Sanders single-payer plan would largely do away with employer coverage.

The Midlife Medicare proposal would explicitly exclude those who are eligible for ESI. Based on experience with the ACA, which has not significantly eroded employer-sponsored coverage, Starr argues plausibly that his plan would be unlikely to lead employers to drop coverage entirely. Moreover, age discrimination laws bar employers from dropping coverage selectively for older workers.

The Stabenow proposal, in contrast, would offer people with ESI a choice to participate in the buy-in. Because individuals buying in would pay the full cost of the Medicare coverage, it is not clear that many would select that option. Premiums for a buy-in for those above 50 or 55 could be high, since that age group is relatively costly, and a Medicare buy-in option might be particularly subject to adverse selection. Those with access to affordable employer coverage, as defined in the ACA, are not eligible for marketplace subsidies and would generally stick with their employer coverage. Those with access to ESI that is considered unaffordable are likely to have opted out of employer coverage already. And, for the reasons cited above, employers are unlikely to drop coverage in response to a buy-in.

The Higgins buy-in bill would allow employers to pay premiums on behalf of employees and require that enrollment in the buy-in must be “the choice of the individual and not the employer.” This provision could apparently allow employers to offer the Medicare buy-in as an alternative source of coverage to their older workers, permitting them to make an employer contribution to reduce their employees’ premiums. Since the bill also specifies that buy-in enrollees would be eligible for marketplace premium and cost-sharing subsidies, it may open the possibility of combining employer contributions and subsidies — something that is not possible under current law. If that’s what the bill intends, it could provide an attractive option both to employers and to many older workers.

Raising or lowering the age of eligibility for Medicare could also have significant effects on employer-sponsored insurance in some cases, thanks to Medicare’s secondary-payer rules. Medicare beneficiaries, unlike those with individual or other group coverage, typically seek other coverage to fill some of the gaps in traditional Medicare, particularly the lack of a catastrophic limit. If a Medicare beneficiary has retiree health coverage through a former employer or coverage as an active worker or dependent for a small employer, Medicare pays claims first, and the employer plan provides supplementary coverage. In these cases, raising (or lowering) the Medicare age would increase (or decrease) costs to employers.

If a Medicare beneficiary is covered by a group plan based on his or her own employment or that of a spouse, and if the employer has 20 or more employees (100 or more in the case of a person eligible for Medicare because of a disability), the employer plan generally pays first, and Medicare is secondary. For these employed beneficiaries and their spouses, raising or lowering the Medicare age would have no direct effect on the health care costs of their employers, whose plan would be the primary payer under both current law and the proposal. The more the eligibility age were lowered, the more beneficiaries would be working and fall in this category.

Some analysts have expressed concern that Medicare's secondary payer rule constitutes an implicit tax on older workers.²⁰ Older employees at firms that offer health benefits must, in effect, give up valuable Medicare benefits, and lowering the Medicare eligibility age would put more workers in that situation. Making Medicare the primary payer would provide relief to older workers and their employers, but would entail significant costs to the federal budget.

Of course, raising the age of eligibility for Medicare could cause some workers who previously turned down an offer of employer-sponsored coverage to take it up again, if it is still available. Similarly, reducing the age of eligibility could cause some workers to drop ESI and rely on Medicare coverage instead, and employers could encourage this move by making their plans less attractive to older workers. In making this decision, workers would need to be aware of the possible effect on employer-provided retiree health coverage, since retiree coverage is often available only for those who were covered by the employer's plan as an active worker for a number of years just prior to retirement. This issue may diminish over time, however, since fewer employers are offering retiree health benefits.

Relation to the ACA Marketplaces and Medicaid

An expanded Medicare program may be designed as a partial or complete replacement for the ACA marketplaces (for example, by reducing the age of eligibility or adopting a single-payer plan), an offering inside the marketplaces (as in the Higgins bill), or an optional alternative to the marketplaces (Midlife Medicare).

Simply lowering (or raising) the Medicare eligibility age would shift people in their fifties or sixties into (out of) the Medicare risk pool and out of (into) individual or employer-sponsored coverage. This move would tend to lower (raise) premiums in both Medicare and the marketplaces, because the group being shifted would be younger and less costly than other Medicare beneficiaries, yet older and more costly than other marketplace participants.

The buy-in proposals for the near-elderly would put the buy-in enrollees in their own risk pool, separate from that of existing Medicare and, possibly, from that of the individual marketplace, as well. Today, premiums for older workers in the marketplaces are constrained by the requirement that premiums for the oldest workers not exceed those of the youngest workers by a ratio of more than three to one. If the premiums for the buy-in were determined by the health care costs of those participating, buy-in participants would no longer benefit from the three-to-one limit, which would tend to drive up their unsubsidized premium. However, paying providers at Medicare rather than commercial rates would work in the opposite direction, tending to hold down costs and premiums.

Whatever the approach, taking some or most older enrollees out of the individual market's risk pool would tend to reduce unsubsidized premiums for those remaining in that market. But doing so could possibly make the marketplace less attractive to insurers, especially in low-population rural areas, by removing a large fraction of enrollees. (More than a quarter of HealthCare.gov marketplace enrollees are age 55 or older.)

Another issue to be addressed is how proposals to change Medicare's eligibility age or create a buy-in would interact with the Medicaid program. At present, low-income Medicare beneficiaries with limited assets may also be eligible either for premium and cost-sharing assistance through the Medicare Savings Programs (MSPs) or for full Medicaid benefits. If Medicare's eligibility age were lowered, one possibility would be to extend Medicaid's rules for seniors to cover the new, younger beneficiaries. The subsidies provided by the MSPs, however, are less generous on several dimensions than those available in the ACA marketplaces, so some beneficiaries could be disadvantaged by being forced to move from the marketplace to Medicare.



The Medicare buy-in proposals address the relationship to Medicaid in different ways. Both the Stabenow and Higgins bills contemplate that buy-in enrollees will be eligible for ACA-type subsidies. Since the ACA subsidies are currently available only to people with incomes over 100 percent of the poverty line, these versions of a buy-in would be unlikely to attract any actual or potential Medicaid beneficiaries. The Midlife Medicare proposal, in contrast, explicitly contemplates being an option for poor uninsured individuals who live in states that have not expanded Medicaid, presumably through the extension of premium and cost-sharing assistance.

Premiums and Subsidies

The cost of health coverage under any proposal to change Medicare eligibility, as well as its attractiveness to new enrollees, will depend on how unsubsidized premiums are set and the extent of premium and cost-sharing assistance that is available to low-income beneficiaries.

The proposals to reduce the age of eligibility for Medicare apparently contemplate an extension of the current procedures. New eligibles would be added to the current Medicare risk pool. Most new beneficiaries would pay premiums that covered only 25 percent of the cost of Parts B and D, with the rest financed by general tax revenues, and people with low incomes and assets would be eligible for further premium and cost-sharing assistance through the Medicare Savings Programs and the low-income drug

subsidy. Whether newly eligible higher-income people, of whom there would be more if the eligibility age were reduced, would be required to pay higher income-related premiums applicable to other beneficiaries would need to be specified. The number of earnings credits required for premium-free Part A coverage (now 40 credits for people becoming eligible at age 65) would also have to be determined.

Premium and cost-sharing subsidies under the Medicare Savings Programs and low-income drug subsidy do not extend as high up the income scale as the ACA marketplace subsidies. Moreover, the LIS and, in many states, the MSPs impose asset tests. However, despite the three-to-one limit on age rating in the marketplaces, base premiums for Parts B and D are far lower than marketplace premiums for older enrollees because Medicare is largely tax-financed. On balance, traditional Medicare is probably more affordable than marketplace plans for most people on the cusp of becoming Medicare-eligible.

The Stabenow, Higgins, and Bennet-Kaine proposals would set premiums for the buy-in population at a level sufficient to cover its costs without any general revenue contribution. If the buy-in arrangements attracted less healthy enrollees, as they might because of traditional Medicare's wide choice of health care providers, this adverse selection would drive up premiums. If the buy-in is priced on a nationwide basis while marketplace plans are priced regionally, this result would be accentuated, since the buy-in would be more attractive to people in high-cost areas.²¹ These factors could drive up costs and premiums and reduce the attractiveness of the buy-in.

The Midlife Medicare proposal responds to this concern by providing general revenue financing to offset the effects of adverse selection. Although the plan does not detail how the general revenue contribution would be calculated, it could be adjusted over time to achieve a desired level of participation. The plan would also provide ACA-type premium and cost-sharing assistance, but tied to Medicare's higher actuarial value and possibly extending to about 400 percent of the poverty level.

Finally, creating two distinct "Medicare" programs — one for those age 65 and over and one for those under 65, with

different benefits, premiums, cost sharing, subsidies, and Medigap protections — could raise questions of equity, especially on the part of enrollees in traditional Medicare who might feel relatively disadvantaged.

Encouraging Participation and Continuity of Coverage

Although participation in Medicare is not strictly mandatory, the program's design assures that participation among seniors is nearly universal and extremely stable. All workers and their employers must pay payroll taxes for Hospital Insurance, and virtually every person eligible for premium-free benefits enrolls. Although Supplementary Medical Insurance and drug benefits are voluntary, eligible people have a strong incentive to participate, since they face late-enrollment penalties and pay only a fraction of the cost of the benefits.

Medicare's design also leads to stability in Medicare Advantage and Medigap enrollment, which makes MA and Medigap attractive to health plans, although it represents a mixed blessing for consumers. In 2014, only 2 percent of prior year MA enrollees voluntarily shifted to traditional Medicare, and 11 percent voluntarily shifted from one MA plan to another. In contrast, four times as many marketplace enrollees shifted plans. In part because of the greater year-to-year volatility in premiums among marketplace plans, marketplace enrollees who switch plans save more than twice as much on premiums than MA enrollees who switch plans.²² Beneficiaries who opt for MA may find themselves unable to purchase supplemental coverage against catastrophic expenses if they later want to return to traditional Medicare, however, since the federal government and many states do not require an annual open enrollment period for Medigap plans.

In Medicare buy-in proposals, some of the factors that lead to this stability in enrollment may be absent or attenuated, making participation somewhat less attractive to private Medicare Advantage and Medigap plans. The ability of participants to switch annually without any penalty from a marketplace plan or uninsurance to Medicare, and from Medicare Advantage to traditional Medicare, is also likely to exacerbate adverse selection. If insurers that offer MA or Medigap coverage to the over-65s were required to offer essentially the same coverage to under-65s as well, it could



indirectly affect the options that these plans provide to current-law beneficiaries. Both the Stabenow and Higgins bills would provide for guaranteed issue of Medigap policies to all buy-in enrollees.

The Midlife Medicare proposal explicitly attempts to reduce adverse selection by promoting continuity of enrollment. It suggests requiring enrollees in Midlife Medicare to agree to maintain coverage in the program until age 65, subject to specified exceptions, such as becoming eligible for employer-sponsored insurance. Such a provision, of course, would not prevent people from deferring initial enrollment until they faced a costly health problem.

Provider Payment Rates and Participation

Expanding eligibility for Medicare allows for the possibility of reducing health care costs by paying doctors, hospitals, and other health care providers using Medicare's rates instead of the usually higher rates paid by private plans. For some, this step is a major attraction to expanding Medicare, although it is also highly controversial. How providers would respond to these changes in their payment rates and incomes is another key issue.

Medicare's payment rates for hospital inpatient services are about 47 percent below commercial rates, on average.²³ If eligibility for Medicare were expanded by reducing the eligibility age or through a buy-in option, hospitals could face a significant drop in revenues. How this would affect hospitals' participation in Medicare and the quality of care are important questions.

Monitoring access to physician services and quality of care will be important if Medicare is expanded and more physician services are covered at Medicare rates. MedPAC assesses the adequacy of Medicare's payments to physicians using a variety of measures. In its most recent report, MedPAC finds that Medicare beneficiaries generally have the same (or, in some cases, better) access to clinical services as privately insured individuals. However, both Medicare beneficiaries and privately insured individuals report more difficulty accessing primary care than specialty care.²⁴ This undervaluation of primary care could become an even greater issue if eligibility for Medicare were expanded.

The Sanders single-payer plan would make the most dramatic changes in health care payment arrangements, and its consequences would be the most difficult to anticipate. Provider payments would be established "in a manner that is consistent with the process for determining payments" under Medicare, and rates would likely be set somewhere between current Medicare and commercial levels, since the health care system would be hard-pressed to accommodate an immediate shift to Medicare rates. The plan would also establish a national health budget, although what would happen if spending threatened to exceed the budget is not specified.

Despite the reduction in payment rates, total acute care health spending would rise under the Sanders proposal, according to one estimate.²⁵ That's because the decrease in the uninsured, the elimination of cost sharing, and the coverage of additional services would increase utilization. Of course, the increased volume of services would not offset the reduction in payment rates for each individual provider. Providers would find it difficult to practice outside the new system, since the bill would prohibit the sale or provision of health insurance that duplicated the benefits of the public plan. By ending private health insurance, the Sanders plan would not only eliminate jobs at insurance companies, but also positions in doctors' offices and hospitals that are involved with billing and other insurance functions; for the first five years, the plan authorizes transitional assistance to such displaced workers.

Financing

Recent cost estimates for most proposals to change Medicare eligibility are not available, but a few older Congressional Budget Office (CBO) estimates provide an

indication of the likely federal budgetary costs or savings. Pay-as-you-go procedures would require that any increase in the deficit be offset through raising revenues or cutting other spending. Although pay-as-you-go rules could be waived, further large increases in deficits when the economy is operating near full employment are inadvisable.

Raising Medicare's age of eligibility to 67 would reduce the deficit by \$18 billion over 10 years, CBO estimated in 2016.²⁶ Medicare spending would drop by \$55 billion, but two-thirds of that would be offset by increased spending on Medicaid coverage and marketplace subsidies for those who would no longer be eligible for Medicare.

By the same logic, if the age of eligibility for Medicare were lowered to 55 or 50, there would be offsetting savings for Medicaid and subsidies, but there would still be substantial net costs. The Hospital Insurance payroll tax could be increased to cover the Part A costs, and premiums from new enrollees would help cover the costs of Parts B and D, but additional general revenue financing would also be required.

CBO estimated in 2013 that adding a Medicare-like public plan to the health insurance marketplaces would reduce the deficit by \$158 billion over 10 years, but that estimate was made before the marketplaces were operational and before various administrative and legislative changes to the ACA.²⁷ CBO estimated that spending for marketplace subsidies would fall because the benchmark premium (the second cheapest silver plan) would fall in many areas. CBO also assumed that revenues would rise because some employers would drop coverage or offer less generous coverage, thereby reducing spending on health benefits and increasing taxable earnings. With the benefit of several years' experience, that assumption now seems much less plausible, and the extent to which a Medicare-like plan would still be estimated to reduce the deficit is unclear.

The Sanders single-payer proposal would require very large amounts of new federal revenues, although it would reduce health spending by state governments and private payers. An earlier version of the Sanders proposal would increase federal spending by \$29 trillion over 10 years, the Urban Institute estimated.²⁸ Sanders has provided a list of options for financing his proposal that total \$16 trillion.²⁹

Transition and Implementation

A final issue concerns the process and timetable for implementing any new arrangement. Many of the current proposals for expanding Medicare eligibility do not specify an implementation schedule. The Bennet bill (introduced in 2017) provides that Medicare-X would be available in some areas in 2020 and would be available everywhere in the individual market by 2023. The Sanders bill would phase in a Medicare buy-in over the first three years after enactment and put the new single-payer plan in place in year four.

Other new health programs have been put in place under various time frames. For example, the original Medicare program was signed into law by President Lyndon Johnson on July 31, 1965, and benefits for hospital and physician services began on July 1, 1966 — less than a year later. Medicare's prescription drug benefit was put in place in a period of about two years after its enactment in December

2003. Massachusetts enacted its health reforms in April 2006, and enrollment in the new coverage arrangements proceeded in phases from October 2006 through May 2007. The Affordable Care Act and the Health Care and Education Reconciliation Act were signed in March 2010; some important provisions became effective in 2011, and the major coverage expansions went into effect in 2014.

These experiences offer some lessons in planning for possible future changes in Medicare eligibility. Administrative issues deserve careful consideration in developing legislation; advance planning pays substantial benefits. Administrative funding should be adequate, and the implementation schedule should be ambitious yet realistic.³⁰ Even so, allowing more time for implementation does not necessarily mean that everything will go smoothly, as the initial problems with the ACA website (Healthcare.gov) show.

CONCLUSION

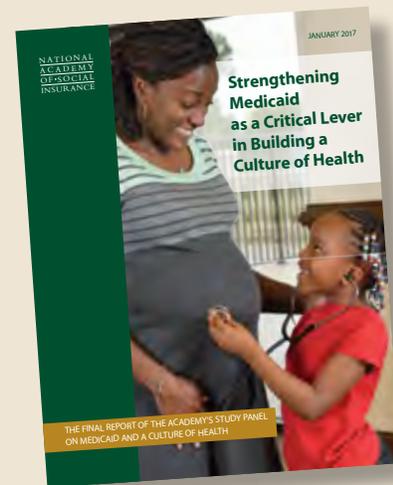
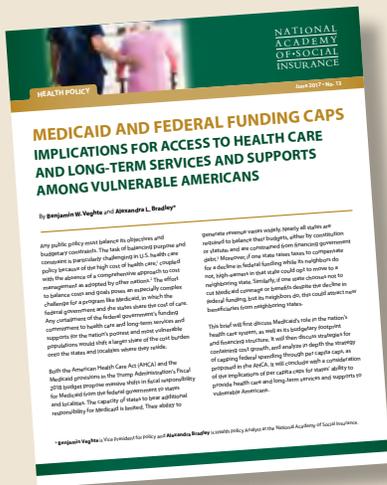
Changing eligibility for Medicare today is more complicated than starting from a largely blank slate, as was the case when Medicare began in the 1960s. Health care spending represents a vastly larger share of the economy, many more people earn their livelihood in the health care sector, more sources of health coverage are available, and any change is likely to disadvantage some people while it helps others, at least in the short run. This complexity contributes to the challenges that have been outlined here and that must be addressed in designing policy options to expand or contract eligibility for Medicare.

ENDNOTES

- 1 Krawzak, 2018. The House plans would also gradually convert Medicare to a premium support, or voucher, system, but here we consider only the increase in the eligibility age. For an analysis of this proposal, see Neuman, Cubanski, Waldo, Eppig, & Mays, 2011.
- 2 Bodenheimer, 2017; Altman, 2015.
- 3 Starr, 2018a; 2018b.
- 4 Jacob Hacker of Yale has proposed creating a new part of Medicare — Medicare Part E (for “Everyone”) — that would cover everyone who didn’t have high-quality coverage from their employer or Medicaid. Unlike single-payer, Medicare Part E would seek to improve employers’ role rather than replace it. See Hacker, 2018.
- 5 Blumberg & Holahan, 2016.
- 6 McArdle, Stark, Levinson, & Neuman, 2012.
- 7 Affordable Care Act, Section 1302 [42 U.S.C. 18022].
- 8 To be eligible for Medicare, a person under age 65 must receive Social Security Disability Insurance, which has a work-history requirement, and undergo a two-year waiting period. These criteria effectively preclude children from receiving Medicare benefits.
- 9 McArdle et al., 2012, p. 4.
- 10 The Henry J. Kaiser Family Foundation, 2017, p. 3.
- 11 Beneficiaries who do not sign up for Part B when first eligible must pay a late-enrollment penalty unless they have coverage from their own or their spouse’s current employer. Similarly, those who do not initially sign up for Part D prescription drug coverage face a late-enrollment penalty if they have not maintained other creditable drug coverage.
- 12 Watts, Cornachione, & Musumeci, 2016.
- 13 Medicare beneficiaries with incomes above \$85,000 for single people and \$170,000 for married couples (around 6 percent) are required to pay higher premiums for Parts B and D of Medicare (Cubanski & Neuman, 2017). The percentage of working-age people with incomes above those levels could be more than twice as high.
- 14 Bailey, 2014. This estimate reflects only Parts A and B and is based on the current Medicare population.
- 15 Dowd, 2009.
- 16 Holahan & Blumberg, 2018.
- 17 Whether the Higgins proposal intends to allow for enrollment in MA plans is unclear; the bill is silent, although the section-by-section summary refers to benefits obtained through “managed care plans.”
- 18 Merlis, 2009.
- 19 Collins, Nicholson, & Rustgi, 2009.
- 20 Penner, Perun, & Steuerle, 2003.
- 21 The Higgins bill states that the premium shall be adjusted “as necessary... by a geographic adjustment to address regional affordability concerns.” The Bennet-Kaine bill provides that “premiums shall vary geographically... with differences in the cost of providing such coverage.”
- 22 Jacobson, Neuman, & Damico, 2016.
- 23 Maeda & Nelson, 2017, p. 1.
- 24 MedPAC, 2017.
- 25 Holahan et al., 2016.
- 26 CBO, 2016, pp. 250-2 (Health — Option 9).
- 27 CBO, 2013, pp. 195-7 (Health — Option 2).
- 28 The figure excludes \$3 trillion in additional spending for long-term services and supports, which is not included in the most recent version of the proposal. Holahan et al., 2016, pp. 2-4.
- 29 For further details, see: *Options to Finance Medicare for All*, September 13, 2017, <https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?inline=file>.
- 30 National Academy of Public Administration & National Academy of Social Insurance, 2009.

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MEDICAID AND FEDERAL FUNDING CAPS: Implications for Access to Health Care and Long-Term Services and Supports among Vulnerable Americans

By: **Benjamin W. Veghte** and **Alexandra L. Bradley**,
June 2017

Health care costs in the United States are by far the highest in the world, and hence controlling them is a perennial challenge of public policy. Any effort to balance the costs and fundamental goals of a program as complex and sizable as Medicaid poses challenges for both states and the federal government. However, controlling overall Medicaid costs and capping federal Medicaid spending are fundamentally different approaches. Recent proposals to curtail the federal government's funding commitment to health care and long-term services and supports for the nation's poorest and most vulnerable populations would shift a substantial share of the program's cost burden onto states. Yet, the capacity of states to bear additional responsibility for Medicaid is limited. There are strategies for controlling costs in the health care system, such as addressing the social determinants of health, that would not fundamentally alter the structure of the program and would maintain Medicaid's great strength to grow in response to a range of often unpredictable factors.

This brief discusses Medicaid's role in the nation's health care system, as well as its budgetary footprint and financing structure. It discusses strategies for containing cost growth and analyzes in depth the policy of capping federal spending through per capita caps, and its implications for states' ability to provide health care and long-term services and supports to vulnerable Americans.

Strengthening Medicaid as a Critical Lever in Building a Culture of Health

By: **Sara Rosenbaum, Trish Riley, Alexandra L. Bradley, Benjamin W. Veghte, and Jill Rosenthal**,
January 2017

Strengthening Medicaid as a Critical Lever in Building a Culture of Health is a nonpartisan study panel report which offers a series of steps that would enable Medicaid to leverage its unique role as an insurer to increase its capacity for addressing the underlying social determinants of health. The study panel was convened to assess the current and possible future role of Medicaid in building a Culture of Health. The panel included state Medicaid program directors, public health and health policy experts, health researchers, medical and health professionals, and health plan representatives.

While the current political landscape signals new policy discussions about the future of the program and its funding, the analysis and options included in this report recognize that health care coverage is a critical underpinning for improving health. Whether and how Medicaid might be changed, its role as an insurer is foundational; this report assumes that Medicaid will continue to be central to the health care safety net as an insurer of low-income, vulnerable populations.

Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund, its directors, officers, or staff. To learn more about Commonwealth Fund publications when they become available, visit the Fund's website and sign up for email alerts.

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Phone: 202-452-8097 • Fax: 202-452-8111 • nasi@nasi.org

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