



Executive Summary

From the Final Report of the Academy's Study Panel on Medicare Eligibility
**Examining Approaches to Expand Medicare Eligibility:
Key Design Options and Implications**

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Executive Summary

The current system of insurance coverage in the United States has led to persistent gaps in access to affordable coverage and care—leaving 1 in 10 without coverage and nearly a third of adults under the age of 65 with inadequate coverage that puts them at risk of health and financial insecurity. Additionally, U.S. per capita health care spending was \$9,892 in 2016, 145 percent higher than the Organisation for Economic Co-operation and Development (OECD) median of \$4,033. U.S. spending on health care grew at a faster rate than the OECD median between 2000 and 2016 (Anderson, Hussey, and Petrosyan 2019). The rising cost of health care puts pressure on individuals and families, employers, and federal and state governments.

Improving access to affordable, high-quality health coverage and care and constraining health care spending remain formidable policy challenges for the United States. In response, candidates, state and federal officeholders, academics, and a variety of stakeholders are presenting a wide range of proposals, including proposals to change Medicare eligibility. The Study Panel examined three approaches to changing Medicare eligibility and assessed how variants of these approaches could be designed to address key policy objectives, including expanding coverage, improving the affordability of access and care, and containing health care costs. The three approaches considered were:

- lowering the eligibility age by just a few years to age 62 or to as low as age 50
- extending Medicare coverage to all
- creating a Medicare buy-in under which some or all of the population or employers would be eligible to purchase Medicare or Medicare-like coverage

Proposals to adapt Medicare to extend coverage to new beneficiary populations present a significant set of technical and program design considerations. This report attempts to identify the options for changing Medicare eligibility, or creating a Medicare-like program, and to provide an assessment of the issues that would need to be addressed. Such considerations include:

- eligibility criteria
- benefit structure, including covered services and cost sharing
- premium structure and whether subsidies are available for newly eligible populations
- provider payment rates and any regulations concerning provider participation
- the roles of Medicare Advantage and private supplemental coverage
- financing mechanisms
- the rules regulating interactions with other public and private insurance
- rules governing the transition to a new or modified program

Medicare as a Platform for Reform

Although myriad possible paths might address the underlying challenges in today's health system, this report focuses on assessing only approaches that use Medicare as the basis for expanding health insurance coverage. Some policymakers and analysts view Medicare as a useful platform for reform because it serves as a cost-effective source of health insurance coverage, because it is a program with broad popularity, and because expanding Medicare might have beneficial effects in other coverage markets and across the health care system.

Key Design Challenges and Policy Impacts

All of the discussed approaches involve underlying key design decisions that determine the impact that proposals would have on the affordability of coverage, access to care, and overall health care system costs.

Lowering the Age of Medicare Eligibility

In the years before reaching Medicare's current eligibility age of 65, individuals face risks that may leave them without access to employer-sponsored health insurance, such as job loss or early retirement for health or family reasons. Although Affordable Care Act of 2010 (ACA) provisions ensure the availability of comprehensive coverage in the individual market, older adults who lack employer-sponsored insurance may face relatively costly premiums in the individual market, especially if they do not qualify for premium tax credits. Relative to other Medicare expansion proposals, lowering the age of Medicare eligibility, discussed in **Chapter 2**, could serve as an administratively simple way to secure more affordable, stable health coverage for early retirees and workers approaching retirement compared to some other approaches. It would be a uniform change to Medicare rather than an optional offer of Medicare coverage (a possibility discussed in **Chapter 4**).

Extending Medicare to individuals under 65 could build on the current Medicare infrastructure, retaining today's covered benefits, provider payment structure, premium and cost-sharing structure, subsidies for low-income persons, and secondary payer provisions for persons with employer-sponsored coverage. Although defaulting to the current Medicare program structure is the most straightforward and administratively simple approach, extending the program to a younger population creates specific design challenges that policymakers would need to address, such as changing the enrollment processes. These challenges increase the further the age is lowered. While lowering the eligibility age to 62 would have a relatively small incremental impact, reducing the age to 50 would

almost double the number of Americans eligible for Medicare coverage. According to approximations presented in the report:

- Lowering the age of eligibility to 62 could extend Medicare eligibility to about 10.1 million additional individuals, of whom 3.3 million could transition to primary coverage under Medicare, including approximately 670,000 previously uninsured individuals.
- Lowering the age of eligibility to 55 could expand Medicare eligibility to about 37.4 million additional individuals, of whom 11.4 million could transition to primary coverage under Medicare, including 2.8 million previously uninsured individuals.
- Lowering the age of eligibility to 50 could extend Medicare eligibility to about 57.3 million additional individuals, of whom 17.3 could transition to primary coverage under Medicare, including 4.6 million previously uninsured individuals

An age-based expansion of Medicare eligibility would decrease the share of the population that is uninsured and underinsured, although the magnitude could be small if only incremental changes are made. While the uninsured share is currently much lower among adults ages 50–64 than the rest of the adult population, they tend to be sicker than their younger counterparts, so the consequences of being uninsured (or underinsured) can be more severe. Lowering the age of Medicare eligibility could provide significant cost relief to a cohort of older Americans, particularly middle-income persons who devote a relatively high share of their income to coverage, especially to individuals who purchase policies on the individual market and are ineligible for subsidies.

Lowering the age of Medicare eligibility could reduce premiums for the existing Medicare population, but the effect on younger adults in the ACA individual market is not clear. For newly eligible beneficiaries, lowering the age is likely to improve their access and choice of providers and plans, but it could reduce revenues for hospitals and physicians. Employers and states could see savings under this cost shift because the costs of coverage for an expanded beneficiary population would be shifted from private insurance and Medicaid to the Medicare program. Such a shift would reduce long-term solvency of the Medicare trust funds and increase pressures on the federal budget unless provisions to raise additional revenues accompanied the extension of the program. Lowering the age of Medicare eligibility without introducing other changes to the Medicare program is relatively straightforward administratively as compared to other eligibility changes considered in this report.

Approaches to Medicare for All

Medicare-for-all proposals, as discussed in **Chapter 3**, aim to use the current Medicare program to achieve universal coverage and to fulfill the related goals of increasing the affordability of insurance and care and reducing inequities in access. In one approach to a Medicare-for-all system, virtually all Americans would be covered through a program that resembles traditional Medicare in that the government could pay providers for covered services and private insurance would be limited to a supplementary role. Under an alternate approach, a Medicare-for-all system could retain a role for Medicare Advantage plans and enrollees would have a choice between a public plan and private plans in a system of regulated competition.

Either of these approaches to Medicare-for-all could extend many features of today's Medicare, but any proposal would deviate from current Medicare at least in terms of eligibility and enrollment and financing mechanisms. Other aspects could change as well, including covered benefits, cost-sharing requirements, and provider payment mechanisms. The specific program features carry important implications for health care providers and workers, employers, and insured individuals. Four design decisions are key to any such proposal: the role of private insurance plans, comprehensiveness of benefits, effectiveness of cost control mechanisms, and selected financing mechanisms.

Expansion of the Medicare beneficiary population to include all or most U.S. residents would do the following:

- The share of the population that is uninsured or underinsured would be significantly reduced, increasing access to care. This change increases the demand for services, however, which could result in delayed access to care if capacity is not adequate to meet the demand.
- Federal spending would increase, however, the impact on total health spending is not known. Financing would be redistributed across payers and individuals in their capacities as program beneficiaries, health plan enrollees, patients, employers, and taxpayers—relieving pressure in some ways and increasing it in others.
- Provider revenue would be lower, on average, but may be offset by reduced provider administrative costs and less uncompensated care.

A Medicare-for-all program would increase federal spending significantly. Changes in financing mechanisms might attempt to capture some current spending by states and employers as part of needed federal revenues. The effects of Medicare-for-all on total national health expenditures are less clear; national spending could be less than or greater than under the current system. Factors affecting total expenditures include the degree of (a) increased utilization by the formerly uninsured and underinsured; (b) increases in

benefit coverage or reductions in cost-sharing requirements; and (c) savings achieved to the extent that there would be a broader application of Medicare payment rates, administrative simplification, and reductions in drug costs. While analysts have reached different conclusions on the extent of costs or savings under Medicare-for-all, savings could be less and the administration more complex under a system that includes MA plans.

Transitioning from the current fragmented health insurance structure to a system in which Medicare covers almost the entire population would entail major changes to the current health care system, including significantly altering the role of the private health insurance industry, altering how health insurance is funded, and changing health care provider revenue. A gradual phase-in period accompanied by careful monitoring of impacts on service access and quality could facilitate the transition to the new system and minimize disruption by allowing providers and other stakeholders time to adapt to dramatically altered circumstances.

Establishing a Medicare Buy-In Program

A Medicare buy-in program, as discussed in **Chapter 4**, could be designed to allow individuals and/or groups not otherwise entitled to Medicare to enroll by paying a premium for coverage that builds on Medicare benefits, provider networks, and/or payment rates. Policymakers have typically proposed an individual Medicare buy-in to expand access to affordable coverage for older adults not yet eligible for Medicare who face relatively high premiums in the ACA individual market. A Medicare buy-in program could also be designed to cover a much broader segment of the population; for example, it could allow employers to buy into Medicare on their employees' behalf, in the interest of making comprehensive employer-sponsored insurance coverage more affordable for individuals and employers.

A buy-in program is not synonymous with a "public" option. A Medicare buy-in and a public option would each create an optional, publicly facilitated or administered health insurance plan. As analyzed in this chapter, a Medicare buy-in would use a benefit and premium design built on the Medicare program, use provider payment rates based on Medicare rates, and create a risk pool separate from the current Medicare beneficiary pool and the ACA individual market. A public plan option would compete directly in the ACA individual market, following ACA requirements and regulations, and enrollees would be included in the single ACA individual market risk pool. Creating a Medicare buy-in program would provide an additional and optional coverage source for individuals deemed eligible and workers with employers that choose to participate. How much a buy-in approach would meet policy goals such as coverage expansion, cost containment, and affordability depends on key design choices, notably:

- which populations are eligible and the extent to which those populations are inadequately served by their current coverage options
- premium levels and whether premiums are self-supporting
- how any cost-sharing and premium assistance programs are structured

A Medicare buy-in program differs from directly lowering the eligibility age because participation in the buy-in would be optional. Individuals and employers would make their decisions about whether to opt for the buy-in based on its benefit package, provider access, costs (including premiums and any premium and cost-sharing assistance), how those features compare to other coverage options, and an individual's expected health care needs. With the addition of a significant amount of plan choice, however, comes an additional burden of administrative complexity, especially with the interaction of the buy-in and the ACA individual market. The optional nature of the buy-in program also limits the potential impact of the buy-in on specific policy goals, such as expanding coverage. Important policy impacts include the following:

- For individuals in the ACA individual market with incomes above subsidy eligibility limits, a Medicare buy-in could provide more affordable coverage due to lower premiums from the use of Medicare's provider payment rates.
- The impact on overall coverage rates would depend on the breadth of eligibility and the affordability of coverage. A buy-in for individuals could have a limited impact on increasing the number of insured individuals because many buy-in enrollees would likely shift from other, more expensive coverage sources to the buy-in rather than becoming newly insured. Affordability and access to care for participating individuals, however, would likely be improved.
- In a buy-in limited to older adults (50–64), the shifting of older persons from the ACA individual market could increase premiums for the remaining younger adults in the ACA market.
- An employer buy-in would reduce the share of the uninsured population if firms not currently offering coverage participate in the buy-in, if employers expand coverage to currently ineligible workers, and/or if the employer buy-in causes workers who have forgone employer-sponsored coverage to participate.

While a Medicare buy-in program would build on the popularity of the current Medicare program without substantially restructuring or replacing all other forms of coverage, it would also add a layer of complexity to the current, already fragmented, health insurance system and would complicate consumer decisions. A Medicare buy-in would significantly increase the administrative challenges for the Medicare program because buy-in enrollees would have a higher level of turnover due to

events such as job changes. It would raise important challenges for coordination with other options such as the ACA market plans. A Medicare buy-in available to employers as well as individuals would add even more administrative complexity and require an enhanced administrative infrastructure to handle enrollment and disenrollment, collect payments, and manage eligibility for the individual and employer buy-in population.

Summary of Findings

These three approaches address the goals of increasing coverage, improving affordability and access to care, and controlling system-wide health care costs, but each one presents different orders of magnitude. A Medicare-for-all program, the most ambitious, aims for near-universal coverage and would likely have the greatest impact on access and affordability for the entire population. Although Medicare-for-all could have the greatest impact of the three options on system-wide cost containment, the impact depends on the level of provider payment rates, prescription drug pricing, and level of administrative savings. It would also require the greatest amount of additional federal revenue and resources while potentially lowering net costs for some individuals or other payers.

Lowering the age of Medicare eligibility and offering a Medicare buy-in program would target specific portions of the population, and the impacts on policy goals are by design more limited. The impact of lowering the age of Medicare eligibility would be similar in direction to Medicare-for-all, but it would have a much smaller scope, even if the eligibility age were lowered to 50. The Study Panel's analysis finds that the impact of a Medicare buy-in is most difficult to determine. It would be highly dependent on underlying design decisions and the complicated relationships that would be created with existing coverage options. The buy-in approach may have a limited impact on increasing overall coverage rates and controlling system-wide health care costs, but it would improve affordability and access to care for participating individuals. Although often suggested as a simple add-on to improve the ACA, in practice a Medicare buy-in would greatly increase the complexity of the current health care system.

Closing Comments

Improving access to affordable, high-quality health coverage and care and constraining health care spending remain formidable policy challenges for the United States. When there is widespread public perception that coverage and access problems are significant enough to require action, a window for reform opens.



Evidence that the nation has reached such a point includes polls indicating that health care is a top issue for voters heading into the 2020 presidential election, as it was in the 2018 midterm elections. Significant problems in the health care system do not necessarily point to particular paths for reform, but they do create demand for change.

Because it would make use of an existing and popular coverage platform, extending Medicare to a broader population may seem to be a straightforward way to address the challenges of affordability, coverage, and cost containment. Although positive impacts on coverage and access to care would result from extending Medicare to more Americans, such a change also involves substantial challenges in program design and implementation. Policymakers need to acknowledge that Medicare is a complicated program, one that some believe is also in need of reform; that the health care sector is a large, profitable share of the U.S. economy; and that any significant change in Medicare eligibility is likely to help individuals who qualify for coverage while potentially disadvantaging other stakeholders.

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