

Lowering the Medicare Age – A Comparative Analysis

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University of Pittsburgh, 2022

Abstract

This essay focuses on the financial, economic, and public health implications that would result from lowering the Medicare eligibility age to sixty (60). The goal of this analysis is to develop an appropriate recommendation for improving outcomes, lowering costs, and expanding access to care for people ages 60-64. The essay compares lowering the Medicare age, raising the Medicare age, and the status quo. Each policy proposal is assessed for its impact on federal budget spending, consumer and overall health costs, commercial insurance premiums, and access to care.

In today's insurance landscape, individuals ages 60-64 drive up costs for employers and private insurers. They account for the highest spending and are one of the main reasons costs continue to go up for consumers. Premiums, copays, and deductibles have increased over time. Costs are lower, and outcomes are better for Medicare enrollees in an older age group (65-69) based on better access to care and higher satisfaction. Hence, lowering the Medicare age, is a strategy that could lower costs in the private insurance market, broaden access to healthcare, and improve outcomes to individuals as they retire.

There are several implications to consider when determining whether to lower the Medicare age. First, expanding Medicare eligibility could increase the Federal budget. Alternatively, state budgets may be less burdened because fewer people would have Medicaid as their primary insurance. Hence, the Federal government would have more responsibility to cover this population.

However, consumers that have commercial insurance would see lower premiums and cost-sharing, since the highest risk group would transition to Medicare. Moreover, the savings employers realize through fewer covered lives could result in wage increases to employees. Wage increases would be taxed and increase revenue for the Federal government. More people will be insured, since expanding Medicare eligibility will reduce the uninsured. Currently, there are about 21 million people between 60–64 in the United States, 1.6 million of those that are uninsured. Overall, this essay will explore how lowering Medicare eligibility age will improve outcomes, expand access, and lower costs.

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Preface

No one in the United States should be uninsured nor should they have to delay health care. Every person deserves health coverage, whether through public or private means. Care should be affordable, and it should improve quality of life. I have worked in Medicare for seven (7) years for two of the largest integrated delivery and financing systems in the country: University of Pittsburgh Medical Center (UPMC) and Johns Hopkins.

Through my unique perspective, I have witnessed how payors and providers can work together and come to understand the complexities and considerations involved in developing health programs that are responsive to people's needs.

Medicare, and Medicare Advantage, provide a proven, stable, and effective approach to covering the highest need population: the elderly and the disabled. I hope the analysis in this essay can shed light on the various considerations and continue the dialogue towards a commonsense approach to expanding care to a highly vulnerable segment of the US population, people ages 60–64.

I would like to thank Dr. Coleman Drake, Dr. Steven Albert, and Dr. Lindsay Sabik, for their review and feedback, and for being gracious with their time.

1.0 Introduction

Health care costs in the United States have grown exponentially over the past decade.ⁱ Private insurance accounts for the largest growth in spending, more than Medicare and Medicaid. The largest portion of spending growth comes from beneficiaries ages 60–64. As people age, they typically face chronic conditions and other comorbidities that require them to use more health care services such as specialists, hospitals, prescription drugs, and durable medical equipment. Thus, it becomes more difficult for insurers to manage costs, putting more onus on enrollees to absorb care costs through copays, coinsurances, deductibles, and premiums. When people face steep costs, they are more likely to delay care until they obtain coverage that will better cover their costs, such as through Medicare or Medicaid. In 2020, people ages 60–64 postponed medical treatments or consultations at a higher rate than Medicare recipients over 65.ⁱⁱ

A major political proposal that has been debated for the past decade is whether to change the Medicare eligibility age. Republicans have proposed increasing the Medicare eligibility age to 67.ⁱⁱⁱ The primary objective for that proposal was to reduce government spending by delaying when individuals can enroll in Medicare. Conversely, most leading Democrats have proposed lowering the Medicare eligibility age. Some Democrats believe the Medicare age should be 60, while others believe it should be 55. Most Democrats want to lower the Medicare age for several reasons. First, lowering the Medicare age would reduce the number of uninsured in the United States. Second, private/commercial insurance premiums would be reduced since the highest cost faction of the private/commercial market are individuals ages 60 – 64. Third, having more people in Medicare will help improve outcomes for the 60–64 cohort, since they will have more access to care at reduced costs.

This analysis explores the benefits and challenges related to lowering the Medicare eligibility age, raising the Medicare eligibility age, and maintaining the status quo. Among the considerations of each proposal are Federal budget spending, consumer health care costs, commercial insurer premiums, and access to care for the uninsured and underinsured. A detailed literature review from liberal, independent, and conservative sources, and reputable scholarly sources such as Kaiser Family Foundation and the Commonwealth Fund, will lay out the important topical issues to arrive at an informed recommendation. Finally, I will recommend a sensible and realistic recommendation to achieve lower costs, better outcomes, and improved access to care in the pre-Medicare cohort ages 60–64. **Table 1** outlines each proposal and corresponding goals each proposal aims to achieve.

Table 1

	Lowering Medicare Age to 60	Raising Medicare Age to 67	Status Quo/Modest Enhancements
Proposal	<ul style="list-style-type: none"> • Allow all U.S. Citizens 60–64 to enroll in Medicare if they have worked at least 7 years • Medicare enrollment not mandatory but highly encouraged • Individuals can enroll in Medicare Advantage or Med Supp if they so choose 	<ul style="list-style-type: none"> • Set Medicare eligibility to 67 for all individuals except those with ESRD or a qualifying disability • Individuals 65 and 66 will be disenrolled at a certain date 	<ul style="list-style-type: none"> • Individuals can enroll in a state or federal marketplace; or • Individuals enrolled through their employer • Individuals eligible for Medicaid or other government coverage
Goal	<ul style="list-style-type: none"> • Universal coverage for individuals 60 and above • Reduce financial burden on commercial/employer groups • Increase access to care 	<ul style="list-style-type: none"> • Reduce Medicare’s share of the Federal budget • Encourage privatization of healthcare 	<ul style="list-style-type: none"> • Reduce the number of uninsured • Encourage competition • Expand Medicaid • Increase access to care

1.1 Lowering the Medicare Age

A. *Rationale*

Lowering the Medicare age has been discussed among politicians, public health professionals, and economists both recently and over the past decade. Underlying issues within the US Health System including rising costs, access to affordable healthcare, uninsurance, underinsurance, and poor health outcomes have triggered a national dialogue on how to improve the healthcare system. Democrats, and some independents, generally support lowering the Medicare eligibility age. Based on public opinion, lowering the Medicare age is highly popular among the electorate, both Democrat and Republican. In fact, an August 2021 report from Data for Progress^{iv} showed that 60% of all voters, including 75% Democratic, and 53% of independents, supported lowering the Medicare age to 60. Furthermore, in April 2021, a group of 17 Senators sent a letter to President Biden requesting to lower the Medicare age. In the letter they cited a Gallup poll that indicated 65% of Americans support lowering the Medicare age.^v Despite the often divisive and fractured nature of American society, Medicare is well-liked among the electorate. Additionally, Medicare endured for six decades, including many different iterations of Congress and presidential administrations. Hence, Medicare has staying power that is likely to continue for decades to come.

Lawmakers and policy advocates have identified the 60–64 age group as the appropriate cohort in which to extend Medicare eligibility. In today’s large employer group market, people age 60 – 64 represent 7% of enrollees, but account for 15% of health plan spending.^{vi} Not surprisingly, health costs rise as people age. However, individuals in the 60 – 64 cohort, have higher per capita health spending than people ages 65 – 69 that are enrolled in Medicare. One of

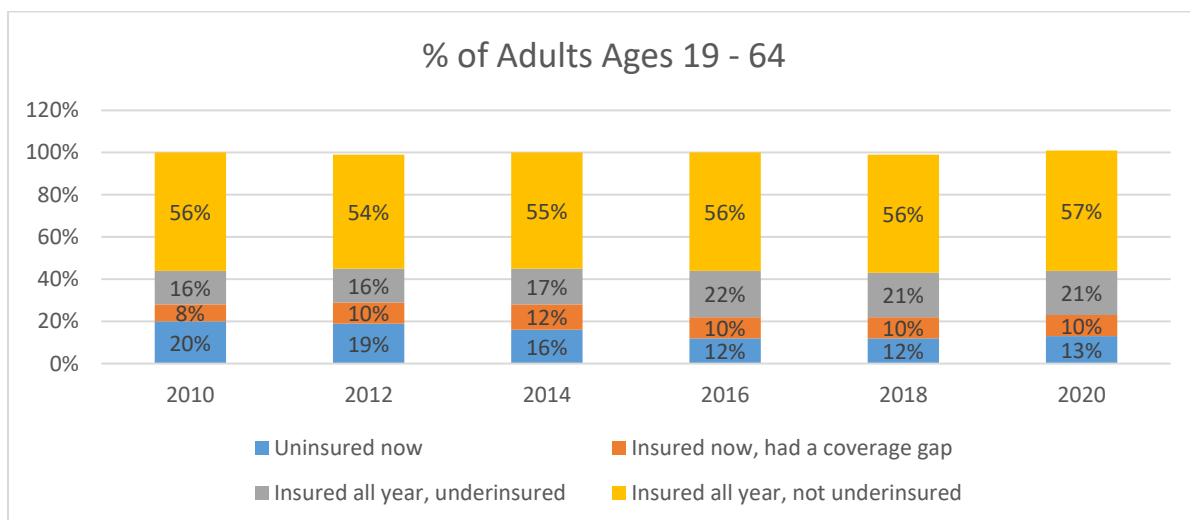
the main factors contributing to lower per capita spend for the older Medicare cohort is that payments to providers are lower in Medicare than to private plans. Hence, it is less expensive to cover people in Medicare than in the commercial market. In fact, one study showed that per beneficiary spend fell by more than 32% after they enrolled in Medicare.^{vii} The study was designed to compare individuals in Medicare to individuals in commercial insurance before age 65. Over a 6-year period (2007 – 2013), claims and encounter data were analyzed and developed into a regression model to identify spending trends. Although providers are paid less in Medicare than in Commercial, the study noted that access to care was not negatively impacted, nor did it reduce utilization.

Another motivation for lowering the Medicare age is to reduce the number of uninsured. According to recent estimates from Kaiser Family Foundation (KFF), about 8% (1.6 million) of individuals 60–64 are uninsured. Extending Medicare to these individuals can have a positive impact in several ways. First, these individuals will have access to preventive care and other services. This can help improve overall quality of life and avoid preventable hospitalizations or better manage chronic conditions. Second, hospitals would have fewer instances of uncompensated care since Medicare would be the payor for approximately 1.7 million enrolled individuals. Typically, when the uninsured use care, they cannot pay for it themselves, rendering the care uncompensated. Finally, individuals that are uninsured, and somehow manage to pay for their own care, could face serious economic hardship. According to the National Consumer Law Center, medical bills were the most common cause for bankruptcy.^{viii} In fact, the percentage of Americans ages 55 – 64, rose 66% from 1991 to 2016.^{ix}

Not only are the uninsured suffering from access to care and affordability, so too are the underinsured. Underinsured can be described in several ways. First, individuals have insurance

coverage, but not may be able to use coverage due to a high deductible. Second, individuals may have to pay large copays or coinsurances that can account for all or part of someone’s budget or savings. Moreover, if an individual has chronic conditions, or is a high utilizer, they will continue to accumulate costs throughout the year, which can often lead to debt bankruptcy. From a public health perspective, underinsurance becomes problematic because people tend to delay care until they can afford care, or they obtain insurance through Medicare or sometimes Medicaid. The Commonwealth Fund conducted a biennial health insurance survey in 2020 in which they analyzed the underinsured population. The survey based its underinsurance criteria as out-of-pocket costs accounting for a high percentage of their household income. **Figure 1** shows findings from the Commonwealth Fund survey. In 2020, 44% of individuals ages 19 – 64 were either uninsured or reported some type of underinsurance or coverage gap.

Figure 1



Affordability and gaps in coverage are problematic. Additionally, underinsured tend to delay care due to healthcare costs. According to a December 2021 KFF report, 51% of adults have delayed or gone without some type of medical care due to cost. Delaying care can create long-term health issues, shorten life spans, and reduce the overall quality of life.

B. Legislative Proposals

During the 2020 presidential campaign, many Democrats proposed various ways to expand Medicare eligibility. Even President Joe Biden proposed lowering the Medicare eligibility age to 60, before removing that provision from the American Families Plan.^x In an April 2021 letter, seventeen (17) U.S. Senators urged President Biden to lower the Medicare eligibility age in the American Families Plan. The letter stated several reasons to expand Medicare eligibility including improving access to care for the uninsured and underinsured. Moreover, the senators indicated that adults struggle to navigate through their insurance options and how out-of-pocket costs will impact their budgets. Perhaps more significantly, the senators noted that there is a massive spike in the diagnosis of cancer among Americans who reach the age of 65 that could have been diagnosed much earlier if the Medicare eligibility age had been lower.^{xi}

In addition to the Senators letter urging the Biden Administration to lower Medicare eligibility age to 60, more than 125 U.S. Representatives, led by Pramila Jayapal, introduced the Improving Medicare Coverage Act to lower Medicare eligibility age to 60.^{xii} The bill intends to provide relief to uninsured and underinsured individuals who would be able to receive critical health care coverage they otherwise may be unable to receive. Both the Senate letter and Representative Jayapal's bill highlight the Medicare program's popularity, and stress that lowering the eligibility age is a commonsense measure.

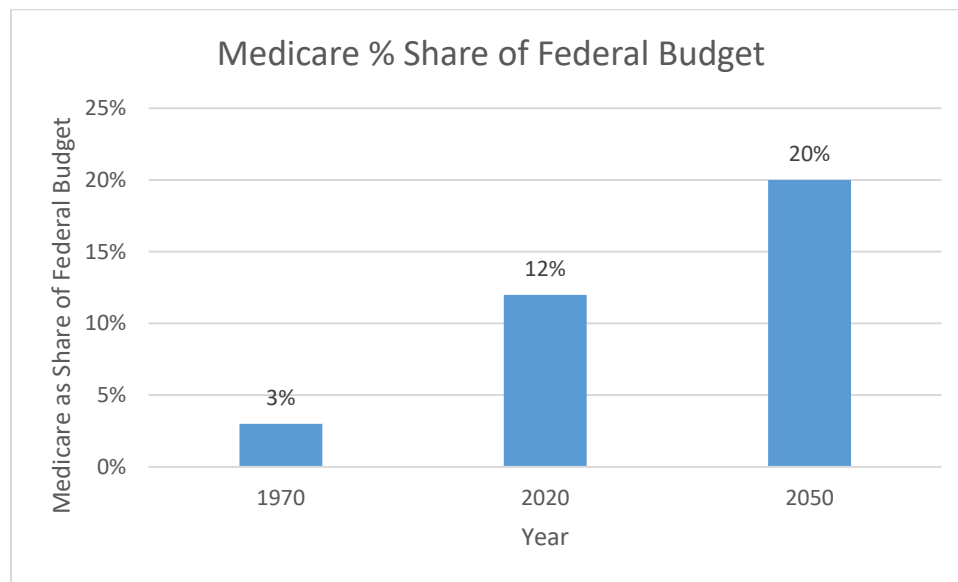
In a summary letter from Representative Jayapal,^{xiii} another factor that was used to argue for the bill is how the COVID pandemic impacted people. Specifically, many older people lost their jobs or retired during the pandemic and lost or changed their health insurance. Hence, the representatives are implying that health coverage for individuals 60–64 is not reliable since it is typically tied to their employment status. Lowering the Medicare age to 60 would bring about stability and predictability for millions across the country.

1.2 Raising the Medicare Age

A. Rationale

During the Trump Administration, and in preceding years, there were proposals to raise the Medicare age, typically to 67. Republicans in Congress have called for raising the Medicare age, usually to cut federal budget spending. According to the Congressional Budget Office, the federal budget deficit for fiscal year 2021 was \$3.0 trillion.^{xiv} Much of the federal budget is allocated to entitlements such as Social Security and Medicare. Hence, increases in Medicare spend impact the budget, thus increasing deficits. In fact, according to a 2022 budget forecast from Statista,^{xv} Medicare will increase as a share of the federal budget (see **Figure 2**).

Figure 2



In addition to deficit concerns, and Medicare’s growing share of the federal budget, Congressional Budget Office (CBO), along with Medicare actuaries, project the Medicare hospital trust fund will be depleted by 2026. Moreover, the CBO projects Medicare hospital trust fund deficits of over \$500 billion by 2031. Total cost per beneficiary is also projected to increase between 2021 and 2029, according to a 2020 Medicare Trustees report.^{xvi} Raising the Medicare age would reduce federal spending by reducing the number of people enrolled in the program.

Another factor that can exacerbate federal spending and budget deficits is the rapid increase in Medicare enrollment. Since 1966, Medicare enrollment has grown from 19 million to 64 million as of 2021. The Centers for Medicare and Medicaid Services (CMS) and the CBO, project Medicare enrollment to exceed 77 million by 2029.^{xvii} Unless the trust fund stabilizes or some other legislative mechanism is created to control spending, Medicare enrollment could threaten to explode the deficit in the future. Raising the Medicare age is one solution that can curb some of those high spending trends.

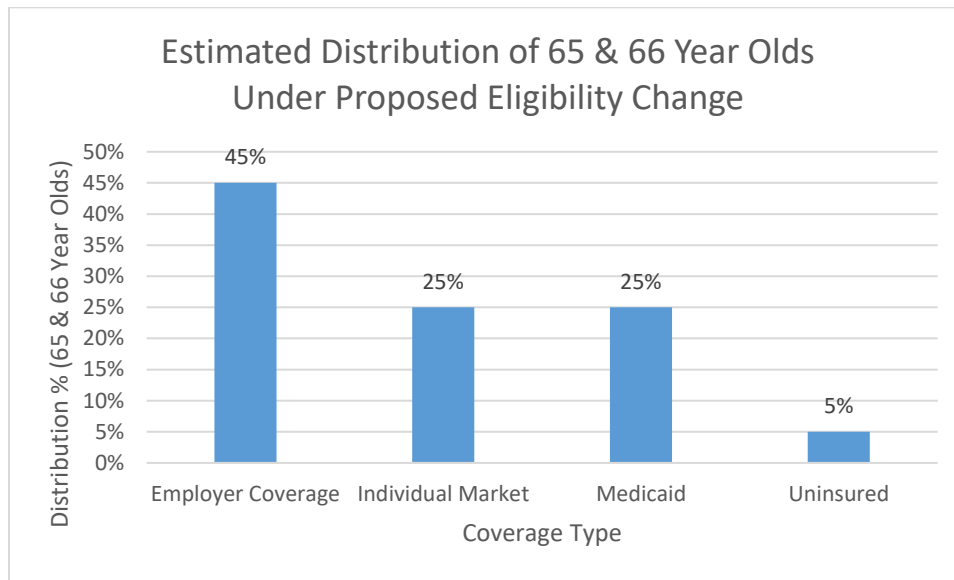
B. Legislative Proposals

During his tenure as speaker of the House, Congressman Paul Ryan developed a plan called “A Better Way,” in which he proposed to gradually raise the Medicare eligibility age from 65 to 67.^{xviii} Under this plan, individuals 65 and 66 would be eligible for tax credits in the commercial market. However, insurers would be able to charge this cohort higher premiums than they can under the Affordable Care Act (ACA). Ultimately, the “Better Way” proposal was not enacted, nor was it included in the proposed American Health Care Act of 2017.^{xix}

During the Obama Administration, Congressional Republicans proposed raising the Medicare eligibility age to 67 as part of budget negotiations. The so called “fiscal cliff” negotiations were ongoing through President Obama’s first term, and Republicans offered raising the Medicare age as a counterproposal.^{xx} According to estimates, raising the Medicare age to 67 would generate \$200 billion in savings.

In December 2016, the CBO published a report analyzing the impact of raising the Medicare age to 67. Implementing this option would have reduced federal budget deficits between 2020 and 2026 by \$18 billion.^{xxi} CBO estimated, by 2046, spending on Medicare would be about 2 percent less, amounting to 5.6 percent of gross domestic product rather than 5.7 percent. However, the CBO also estimated that 300,000 more people would be uninsured by 2026. **Figure 3** shows the estimated coverage distribution for individuals ages 65 and 66. Many people would also pay more for other insurance or health care than they otherwise would under Medicare.

Figure 3



1.3 Maintaining the Status Quo

A. Rationale

In March 2010, Congress passed the Affordable Care Act (ACA) which was a sweeping piece of healthcare legislation with several goals including providing protection for people with pre-existing conditions, expanding Medicaid, reforming the individual insurance market, and reducing the number of uninsured across the country. Several steps were taken to expand affordability such as premium tax credits, cost-sharing subsidies, and expanding Medicaid. The law was designed to mandate insurance that covers essential health benefits. The mandate was included so healthier beneficiaries can be included in the overall risk pool, to balance the older, potentially sicker population, since the law prohibited denying coverage to people with pre-existing conditions. However, much of the ACA's provisions have been removed due to court

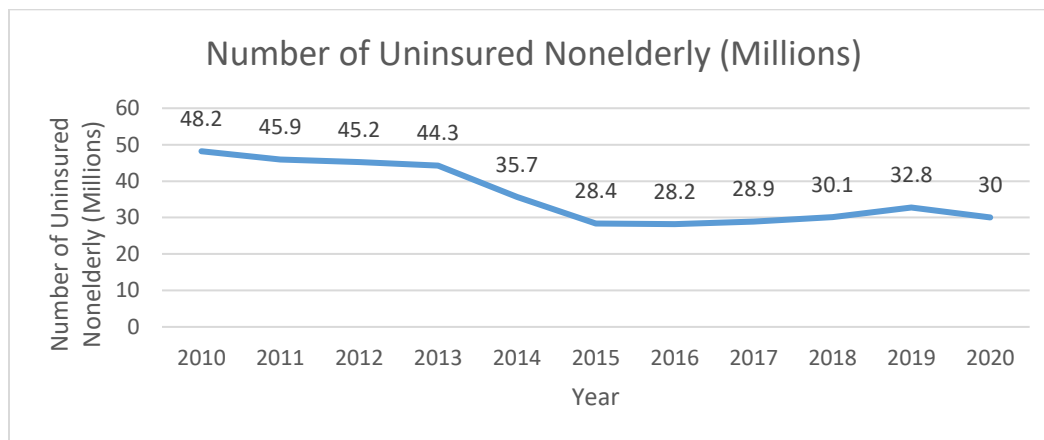
orders or weakened by previous executive or state actions. For example, in *National Federation of Independent Business v. Sebelius*,^{xxii} the Supreme Court held that mandatory Medicaid expansion was unconstitutional. Hence, states could choose to expand Medicaid but were not mandated to expand Medicaid. In the early years after the ruling, states led by Democratic governors expanded Medicaid, while most Republican states chose to forego Medicaid expansion. Currently, all but twelve (12) states have adopted Medicaid expansion.^{xxiii} If those states would have expanded Medicaid, over 2 million additional people would be covered by Medicaid, but they are currently in a coverage gap (**Table 2**).

Table 2

	Total	Currently Eligible for Medicaid	Currently in Coverage Gap	Currently May be Eligible for Marketplace Coverage
All States Not Expanding Medicaid	4,344,000	356,000	2,188,000	1,800,000

Since its inception, the ACA has been highly contentious. Despite this contentiousness, the ACA has been highly successful in reducing the number of uninsured individuals since 2010 (**Figure 4**).^{xxiv} The number would be higher if all states adopted Medicaid expansion. Of the roughly 30 million uninsured nonelderly, approximately 1.6 million are between 60 and 64.

Figure 4



When the ACA was launched, it included tax penalties for individuals that chose not to enroll in insurance. Since 2019, the tax penalty is no longer in effect.^{xxv} Hence, there is no mandate in place to encourage individuals to enroll in insurance. To compound matters, the ACA has faced over 2,000 lawsuits from individuals, states, and private entities.^{xxvi} Though the ACA is generally favorable, it remains divided. According to a KFF Tracking Poll, 53% favor the ACA, while 34% oppose the ACA, while 13% are unsure or refused to answer.^{xxvii} Compared to Medicare, however, the ACA is not as popular. About 77% of individuals polled in a 2015 KFF poll indicated that Medicare is an important program, and 60% said Medicare was working well. Unlike the ACA, Medicare is stable and insulated from legal and political attacks on its existence.

B. Legislative Proposals

The American Rescue Plan expanded the ACA by increasing financial assistance for people already purchasing health care coverage through the ACA's marketplaces. Under the American Rescue Plan, families with incomes over 400% of the federal poverty level (FPL) qualify for tax credits that limit their premium to no more than 8.5% of their income. Under the original ACA, individuals were eligible for tax credits if their incomes were between 100% and 400% of

the FPL. Individuals over 400% of the FPL were not entitled to any financial relief. Now, the American Rescue Plan limits the amount people over 400% FPL will spend as a percentage of their modified adjusted gross income.

In November 2021, the House of Representatives passed the Build Back Better Act (BBBA).^{xxviii} The BBBA includes three enhancements to make the ACA more affordable. First, the Act ensures that no one has to spend more than 8.5% of household income on premiums. Second, the Act increases premium subsidies through 2025 for people between 100% and 400% of the federal poverty level (FPL). Third, the Act allows individuals who received unemployment compensation to get marketplace coverage through the end of 2022. Thus far, the BBBA has stalled in Congress and does not appear likely to pass during the current Congressional term.

2.0 Analysis

2.1 Considerations for the Uninsured

Each of these reform options have different potential impacts on the number of uninsured people. Lowering the Medicare age to 60 will almost certainly eliminate the uninsured individuals between ages 60 and 64. According to an American Community Survey, only 0.8% of all individuals over 65 are uninsured.^{xxix} Medicare has proven success in covering nearly every eligible individual. If the uninsured rate were to maintain its current level while lowering the Medicare age to 60, only 12,800 people aged 60 and above in the country would be uninsured.

Conversely, increasing the Medicare age would increase the number of uninsured. There are several reasons why the number of uninsured would increase by raising the Medicare age. First, individuals ages 65 and 66 that reside in states that did not expand Medicaid, would have to find health coverage elsewhere. Thus, they may not be able to afford other coverage, or may forego coverage. Second, if Medicare is not an option for people ages 65 and 66, they will need to either rely on employer group or individual coverage. This could force people to work longer than they want to, and it puts them at risk of losing health coverage if they lose their job. Moreover, people that stay in the labor market longer, could lead employers to charge lower wages, since they can negotiate with more employees. Also, if enrollees purchase through the individual market, they may have to incur more in cost-sharing than they otherwise would through Medicare or Medicaid. Third, premiums would likely increase in the employer and individual market, as private plans would put more burden on enrollees to absorb more costs. This, in turn, could lead to people

becoming uninsured. More uninsured people would mean more uncompensated care, delayed care, and worse health outcomes.

Like lowering the Medicare age, maintaining the status quo, with some adjustments, could reduce the number of uninsured. Increasing premium subsidies could increase access to care and make it easier for people to find suitable coverage. Also, making marketplace coverage more affordable means people may be less reliant on employer coverage, particularly if their job status is uncertain.

There are several differences between lowering the Medicare age and maintaining the status quo. First, Medicare has a proven track record of providing access to care. Second, Medicare has negotiating power with providers to help keep costs lower. Moreover, the ACA is far less popular than Medicare, and more politically toxic. There are usually significant challenges to any legislation designed to improve the ACA. Given that the BBBA has stalled in Congress, the number of uninsured or underinsured would not be reduced to the extent it would through reducing the Medicare eligibility age. Furthermore, if Republicans gain control of Congress, and perhaps the Presidency in 2024, there is a chance the ACA could be repealed. If the ACA were to be repealed, the number of uninsured would increase exponentially. Medicare, on the other hand, has safer political standing, and has become a pillar of security for seniors.

2.2 Federal Budget Implications

Depending on whatever final legislation is enacted, lowering the Medicare age to 60 would either increase the federal budget, or remain near current levels. One study by the American Action Forum suggests that Lowering Medicare eligibility to age 60 would cost \$380 billion over 10

years—even after accounting for ACA savings from lower spending on subsidies and if employers continue to offer health insurance to those newly eligible for Medicare. The costs would then need to be covered by new taxes or cuts from other federal programs. If there is no new revenue to cover the expanded population, the Medicare trust fund will be insolvent. Consequently, during the 2020 presidential campaign, President Biden stated that any new federal costs associated with lowering the Medicare age would be financed out of general revenues, to protect the Medicare trust fund.

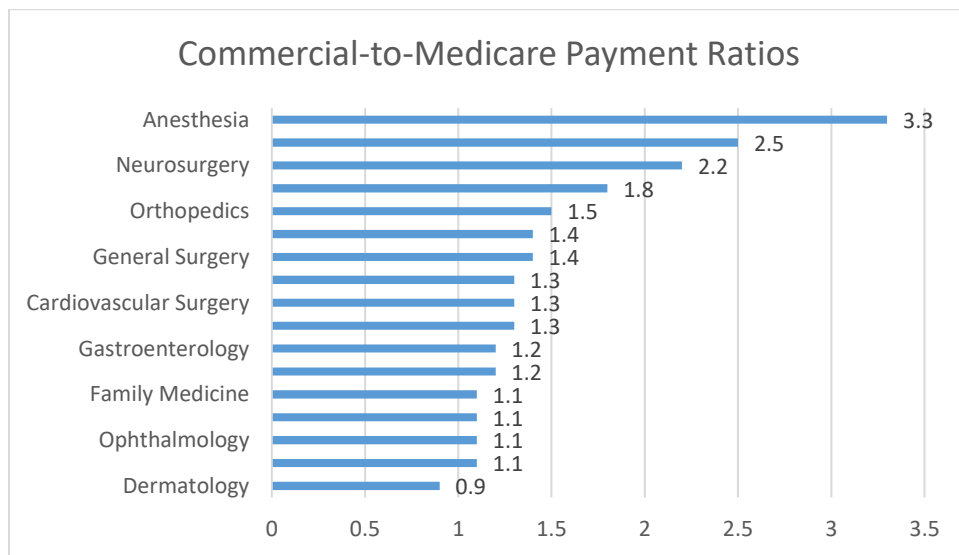
Wage offset could help reduce any potential reliance on new taxes or cuts to federal programs since there could be wage increases that would be taxed and generate new government revenue. Consider that the share of total annual compensation paid to American employees in the form of health insurance premiums rather than wages and salaries rose from 1.1% in 1960 to 4.2% in 1979 to 8.4% in 2018. If this post-1960 increase had been only half as large—and employers had spent the health cost savings on wages and salaries—the take-home wages of American workers would have been almost \$400 billion higher in 2018.^{xxx} Thus, the Federal government would recognize more tax revenue from higher wage earnings. Employers would not be as encumbered with the same responsibility to cover healthcare costs. This wage offset could result in net neutral federal budget spending.

On the other hand, raising the Medicare age would reduce Federal spending on Medicare. Also, Medicare would be reduced as a proportion of the Federal budget. There would be fewer Medicare enrollees for the Federal government to cover. According to the CBO, by 2046, spending on Medicare (net of offsetting receipts) would be about 2 percent less than it would be under current law, amounting to 5.6 percent of gross domestic product rather than 5.7 percent.

2.3 Hospital and Provider Revenue and Expenses

Hospitals and providers are key stakeholders in any of the potential structural changes in Medicare eligibility, or the ACA. If the Medicare age is lowered, hospitals and providers will be impacted in several ways. First, on average, hospitals and providers will be paid less per patient than they are under employer group or individual insurance. In fact, according to the Urban Institute, private insurers generally pay physicians substantially higher rates than Medicare does for the same service.^{xxxi} **Figure 5** shows the ratios comparing commercial rates to Medicare. In every major medical category, commercial rates are higher. Most hospitals and providers would deem lower payment rates to be a negative impact.

Figure 5



On the other hand, hospitals would see reductions in uncompensated care since there would be virtually no one without coverage. Providers would be able to identify patient issues since preventive care would likely increase because of increasing the Medicare age. Although rates

would be lower, volume in hospitals and provider offices would likely increase, since people would have better access to care.

Raising the Medicare age would allow hospitals and providers to maintain higher revenue streams. However, the individuals no longer eligible for Medicare may delay procedures or doctor visits, due to inability to afford costs. Furthermore, health outcomes tend to be poorer when people delay care, which complicates their treatment plans.

Maintaining the status quo could be the best solution for hospitals and providers. Since marketplaces preserve freedom of choice, there would still be a segment of the 65-66 cohort that would choose an individual or employer group plan. Hence, many hospitals and providers would maintain the higher revenue streams but would not face much uncompensated care nor would there be a significant decline in health outcomes, relative to expanding or contracting Medicare.

2.4 Consequences to Employer Group and Individual Markets

Perhaps the largest impact of these proposed healthcare reforms would be in the employer group and individual (aka Commercial) market. The Commercial market has been highly volatile and less predictable than Medicare. Since plans have limited ability to underwrite, given the rules against discrimination due to pre-existing conditions, high-cost members can cause steep price increases. These price increases could be passed on to members if losses exceed risk adjustment allocations.

Lowering the Medicare age to 60 would almost certainly be advantageous to consumers in the Commercial market. Since individuals ages 60–64 is the highest cost group in the Commercial market, premiums and cost-sharing would likely decrease. Once the highest cost members are

removed from the risk pool, the savings would be passed on to the members. This, in turn, would make Commercial insurance more affordable. Moreover, it is also possible that employers could use the savings to increase wages to their employees. Furthermore, individuals may choose to retire earlier, if they and/or their spouses can get coverage through Medicare. This would also help alleviate cost pressures on employers and private plans.

Raising the Medicare age would disrupt the Commercial market in several ways. First, individuals ages 65-66, would be compelled to stay with their employer coverage, which will drive up costs on employers or private plans. These costs would be passed on to employees or members in the form of increased premiums, deductibles, and cost-sharing. There will be more people deemed “underinsured” as a result. Consequently, wages would likely stagnate since employers would have a tougher time affording pay increases to their employees.

The Biden Administration generally prefers to maintain the status quo and want to strengthen the marketplace to be more competitive and drive lower consumer costs. If the BBBA protections become law, the marketplace could entice people to leave their employer coverage in favor of a marketplace plan. Hence, employer coverage enrollment could shrink over time while marketplace enrollment could increase over time.

2.5 Medicaid/State Budget Impact

States have an important stake in whatever changes occur in the Medicare system, or reforms to the ACA. Since states operate their Medicaid programs, and is a major part of their overall budgets, any changes will impact their fiscal planning. The Medicaid program is jointly funded by states and the federal government.^{xxxii} While federal funds represent the largest share

of Medicaid financing, state and local funds also play an important role in financing the program's spending. States have flexibility in determining the sources of funding for the non-federal share of Medicaid spending – though federal law does require that at least 40 percent of the non-federal share comes from state funds. The various reform options have vastly different potential consequences on the Medicaid program.

If Congress enacts legislation to lower the Medicare age to 60, states will likely have less fiscal responsibility to cover individuals 60–64 entirely. Moreover, the highest risk group in the 60-64 cohort would have Medicaid as a secondary payor. Hence, there would be less financial pressure on states. Individuals 60–64 that are enrolled in Medicaid, would become Medicare eligible. Depending on their income status, many of these individuals could be considered full dual eligible. Thus, they would have Medicare as a primary payor, and Medicaid as secondary payor with “wrap around” coverage. There may be some individuals 60–64 enrolled in Medicaid, but considered “partial” dual eligible, and would be required to pay some Medicare cost-sharing and premiums. It is possible that these individuals may have to pay slightly higher costs in Medicare than they would with their current coverage. One advantage beneficiaries would have by switching into Medicare, is access to care. Specifically, most providers accept Medicare, whereas fewer accept Medicaid, due to lower reimbursement rates. It is possible that states could use any potential savings from the 60 – 64-year-old becoming Medicare eligible to increase fee schedules for providers, thus improving access to care for remaining beneficiaries.

On the other hand, raising the Medicare age to 67 would require states to absorb higher numbers of Medicaid beneficiaries, thus increasing state budgets. While the federal budget would decrease, the net health care costs in the US could increase, when factoring in the impact on state budgets, and delayed care. Consider individuals that would be disenrolled from Medicare, or not

eligible for Medicare until age 67. Existing literature indicates individuals already delay costs as they age into Medicare. Once in Medicare, they are more likely to seek needed care. Should this trend continue with an advanced Medicare eligibility age, there would be worse outcomes and more complex health issues once they enter the Medicare program. It is unclear what a proposal to raise the Medicare age to 67 would have done to offset the expected budget increases to state Medicaid programs.

Maintaining the status quo, and perhaps adopting the BBBA, would have little impact on Medicaid or state budgets. While each reform option would have direct impacts on Medicaid, state budgets would still assume responsibility for long term supports and services (LTSS) such as nursing home care.

2.6 Health Outcomes

Healthcare, and public health strives to achieve better clinical outcomes. Expanding access to individuals typically improves clinical outcomes. Lowering the Medicare age would project to improve clinical outcomes since existing data shows that beneficiaries seek care more in Medicare than before they become eligible for Medicare. Moreover, lower out-of-pocket costs in Medicare removes a barrier to care, which is often cost.

Raising the Medicare age to 67 would likely result in worse clinical outcomes. Once individuals no longer have access to Medicare, they will either revert to the employer/commercial market, Medicaid, or be uninsured. In any of those cases, the outcomes would be worse than in Medicare. First, the employer/commercial market typically entails higher cost-sharing. Second, Medicaid has more narrow provider networks, which limits access to care. Third, individuals that

are not able, or choose not to enroll in insurance, are more likely to delay care until they become eligible for Medicare. If a person already has chronic conditions, delaying care will further complicate their health problems.

Maintaining the status quo, and adopting the BBBA enhancements, would likely help improve clinical outcomes because the assumption would be that costs would be lower for beneficiaries, thus easing access to care. Beneficiaries would have a more affordable option that maintains access to care, while controlling out-of-pocket costs. Furthermore, people that lose their jobs, at least in 2022, would not have to delay care, since they would be covered through the marketplace.

3.0 Discussion

3.1 Lowering the Medicare Age – Enrollment and Eligibility

Structurally, lowering the Medicare age would be established as a buy-in. Individuals between 60 and 64 would be permitted to enroll in Part A (hospital insurance) and Part B (medical insurance). If an individual has worked long enough and paid the required amount in Medicare taxes would qualify for free Part A, as individuals over 65 do today.^{xxxiii} If someone does not qualify for free Part A, they would pay a monthly premium. In 2022, the part A premium is either \$274 or \$499 depending on how long they or their spouse paid Medicare taxes. As for part B, individuals that do not receive social security, would pay a monthly premium for part B, ranging from \$170 to \$578 depending on their income level.^{xxxiv} For those that receive social security, their part B premium would be deducted from their monthly payment.

All individuals ages 60 - 64 that sign up for Medicare parts A and B would be able to purchase Medicare Advantage or Medicare Supplement plans as an alternative to Medicare FFS (i.e. Original Medicare). If they do not select a Medicare Advantage or Medicare Supplement plan, they would be enrolled in Medicare FFS, unless they choose to remain on their employer coverage. Rules around primary and secondary coverage between employers and Medicare would follow the current criteria. Hence, if an individual that signs up for Medicare works for an employer with less than 20 employees, Medicare would be the primary payor. Conversely, if an individual works for an employer with more than 20 employees, the employer would be the primary payor, and Medicare would be the secondary payor.^{xxxv} Individuals that are full dual eligible would qualify

for low-income subsidies in the Medicare buy-in approach, as they do today.^{xxxvi} Individuals that are not full dual eligible can apply for low-income subsidies.

3.2 Lowering the Medicare Age – Financial Impact

The main question voters and policymakers will have is how will the Federal government pay for lowering the Medicare age. Since the Medicare trust fund is projected to be depleted in 2026, and Part A expenditures are exceeding Part A revenues, the existing Medicare funding structure cannot support an expanded Medicare population.^{xxxvii} According to the Center on Budget and Policy Priorities, the Medicare hospital insurance program will not run out of all financial resources and cease to operate after 2026. Assuming the Medicare age reduction would be funded primarily through general revenues, as President Biden suggested, the new revenues would come through taxes on higher earnings. Employers would likely use savings from healthcare expenditures to increase wages for their employees.

One phenomenon that occurs when people rely on their employer for health insurance is “job lock.” Job lock occurs when workers, who don’t want to lose their current employer insurance, stay in their current jobs rather than make transitions that would better meet their needs.^{xxxviii} Thus, if workers are not reliant upon their employers for health insurance, they would be free to find a job that offers higher wages. As a result, the worker’s taxable income would increase, generating higher revenue for the Federal government.

Any CBO estimate would need to account for the incoming population’s expected costs. Given that individuals 60–64 currently cost *more* than individuals 65–69, the CBO would need to account for higher expected utilization from the incoming population, which could exceed the

current Medicare projections for the 65–69-year-old population. This will make the expansion expensive, and why funding the program will require multiple funding streams.

Another consequence to expanding the Medicare population would be provider and hospital revenue losses due to lower rates. While providers and hospitals would not see a reduction in volume, they would be receiving lower rates for the 60–64 population than they would for those currently in commercial insurance. This, however, may be partially offset by increases in rates from Medicaid beneficiaries moving from Medicaid as a primary payor, to Medicare as a primary payor. Moreover, hospitals would have far fewer instances of uncompensated care since they would receive payment from Medicare.

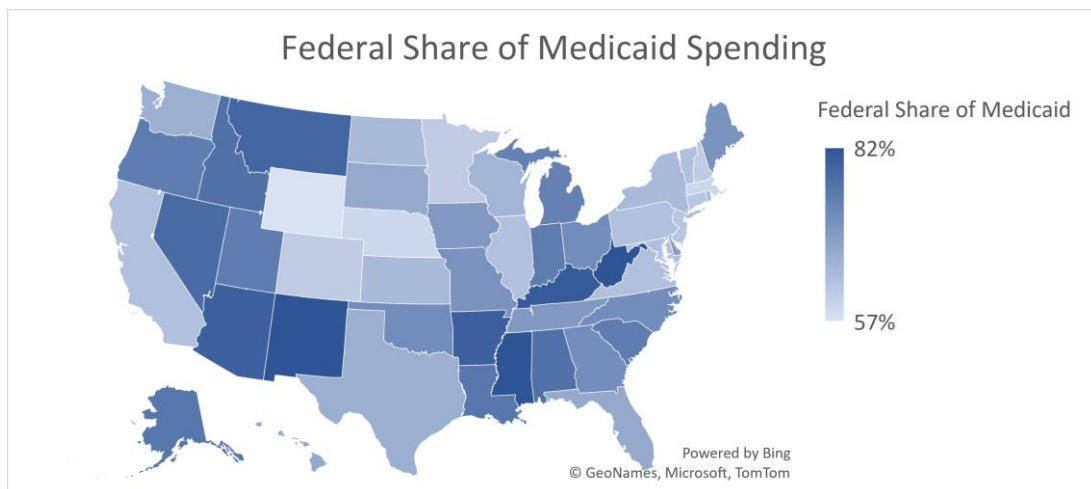
Much of the budgetary spend depends on how many people ages 60 – 64 choose to enroll in Medicare. People ages 60 – 64 may need to consider insurance for their dependents more so than someone that is over 65. Thus, they may be more likely to remain in their employer insurance until they no longer have dependents that rely on their insurance for coverage. Regardless of how many people choose to enroll in Medicare between 60 and 64, there will be a shift in costs from the private market to the federal government. One unintended consequence could be that providers raise rates on the remaining people in the market (i.e. people 19 – 59). Providers could seek to offset the revenue losses from the individuals becoming Medicare eligible by maximizing revenue for the remaining individuals. Thus far, researchers have generally found little evidence to support the notion that providers shift cost on to private payers to compensate for lower public payer payment rates.^{xxxix}

3.3 Raising the Medicare Age

On its surface, raising the Medicare age would lower Federal expenditures, and be a smaller portion of the Federal budget since there would be fewer beneficiaries to cover. However, this may be short-sighted, and not account for all consequences that result from raising the Medicare age. Once individuals are no longer enrolled in Medicare, there would still be other ways the federal government would incur costs on this population. First, there would likely be an increase in Medicaid enrollment, for those individuals 65 – 66 that would qualify. As a result, there would be increased expenditures in Medicaid, which is jointly funded by the Federal government. Unless states would be expected to cover all new enrollees through exclusive state funding, the federal government would almost certainly increase spending in Medicaid.

The map in **figure 6** shows that the Federal government is already responsible for more than half of all Medicaid spending.^{x1}

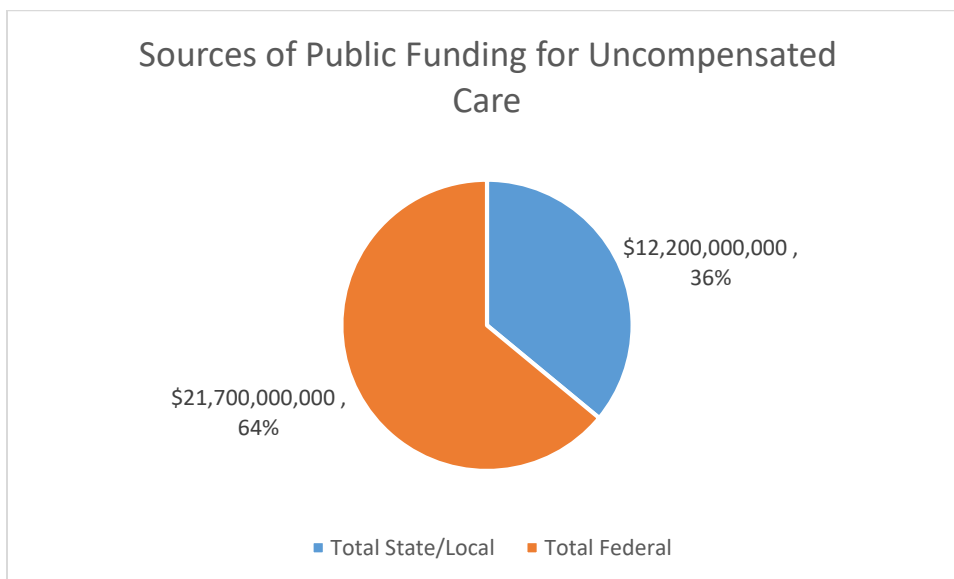
Figure 6



Adding individuals 65 and 66 years old would increase federal spending on Medicaid, especially when considering the complex needs of seniors, some of whom would enter (or re-enter) the Medicaid program.

Another consequence that would impact the Federal budget by raising the Medicare age would be the increase in uncompensated care. Since many individuals would end up uninsured, either by choice or by not having employer coverage, the result would be more uncompensated care. Uncompensated care would either be absorbed by hospitals, or be funded by some other means, much of which is federal funding. **Figure 7** below shows the current payment sources for uncompensated care.

Figure 7



If the Republicans win Congress and the Presidency in 2024, raising the Medicare age could return to the forefront as a policy initiative. If so, the CBO would need to account for not

only the decrease in Medicare spending, but also the increase in Medicaid spending and increase in federal expenditures for uncompensated care.^{xli}

4.0 Conclusions, Recommendations, and Public Health Implications

Any analysis that impacts the lives of millions of Americans and their access to health care should be grounded in public health. The Centers for Disease Control and Prevention (CDC) defines public health as “the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals.”^{xlii} In other words, when looking at the 60 – 64 cohort, one must not only promote health, but must do so while considering society, organizations, and other stakeholders. As such, lowering the Medicare age to 60, and welcoming the 60 – 64 cohort to the existing Medicare program is the most logical and appropriate solution to expand healthcare access, reduce uninsurance and underinsurance, improve clinical outcomes, and lower healthcare costs.

Lowering the Medicare age fulfills the three pillars of the public health “iron triangle.”^{xliii} The first part of the iron triangle is costs. Specifically, which ways can costs be reduced, either from a consumer perspective or overall per capita spend. From a cost perspective, consumers will be paying less for healthcare in Medicare than in the employer group or individual market. Employers and insurers will pay less for covering their employees, since the highest cost population will be removed from their population. There will be a reduction in the number of uninsured and underinsured, which means fewer people will delay needed care. When people delay care, costs rise.

The second and third parts of the iron triangle are quality and access. Quality can be evaluated in several ways, including satisfaction, reduction in unnecessary care, and improved clinical outcomes. Beneficiaries are pleased with Medicare, and it has consistent popularity among

the electorate. Expanding the Medicare population to cover more people will improve quality. Additionally, there would be improved clinical outcomes, as fewer people would delay care. Most providers accept Medicare, which guarantees access to care.

Not only does lowering the Medicare age achieve a public health mission, it is also more likely to achieve all aspects of the iron triangle than the other two reform options. Raising the Medicare age is not grounded in public health. Rather, raising the Medicare age is a short-sighted, incomplete policy that does not account for downstream economic impacts. Furthermore, raising the Medicare age would be detrimental to healthcare coverage and access to a large segment of the population. The 65-66 cohort would not be the only cohort that would be negatively impacted by raising the Medicare age. Individuals in employer sponsored coverage would like see premium and cost-sharing increasing, as employers would be gaining a high cost population, and passing costs to their employees. This would also create wage stagnation.

Maintaining the status quo and/or adopting BBBA enhancements, has a less certain impact on public health than lowering the Medicare age. Since the proposed BBBA enhancements maintain the existing marketplace structure, there could still be a sizable group of uninsured people in the 60 – 64 cohort.

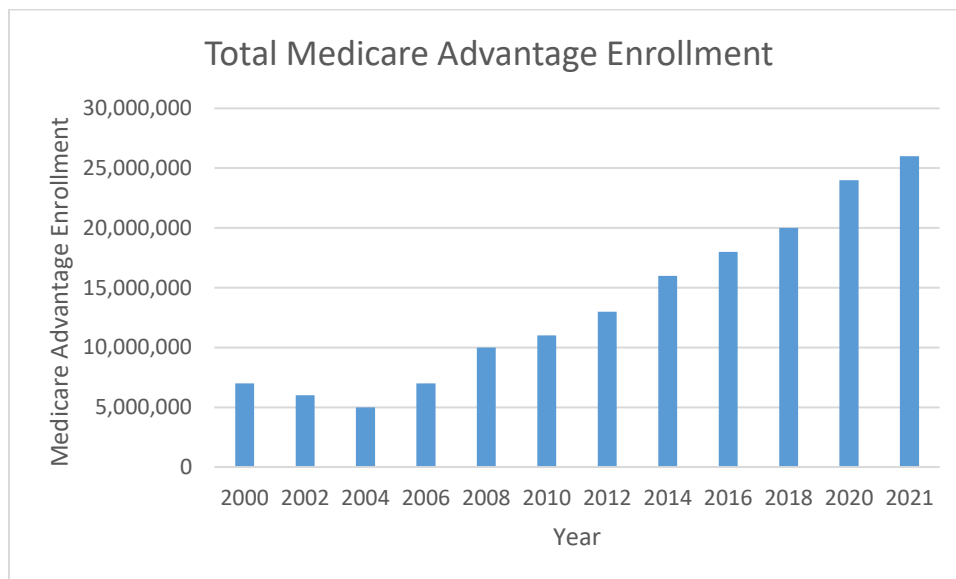
As an established, vibrant program for covering the elderly and disabled, Medicare is stable, proven, and trusted across the electorate. It provides the ideal platform for accepting new enrollees and achieving public health goals.

In addition to recommending a reduced Medicare age to 60, there would need to be a robust and coordinated approach to successfully implement the program change. First, Congress should re-introduce the Jayapal proposal, but with more detail on how it would be paid for. Second, a public awareness campaign, and grassroots movement should be developed to help garner support

for the policy change. This should include conservative and liberal members of the Democratic Party, with support from the Biden Administration. Third, to alleviate concerns around government growth or “socialism,” the administration should promote Medicare Advantage as a key piece to the expanded Medicare program. Since Medicare Advantage is a private plan option, this will give people choice in their healthcare, which is something typically valued in the population. In fact, once the new cohort becomes eligible for Medicare, the Federal government should actively encourage people to sign up for Medicare Advantage. Unlike Medicare, Medicare Advantage has an out-of-pocket maximum on cost-sharing, and typically covers benefits that Medicare does not such as supplemental dental, vision, and hearing. Hence, consumers could control costs, and have better access to dental, vision, and hearing coverage by enrolling in Medicare Advantage.

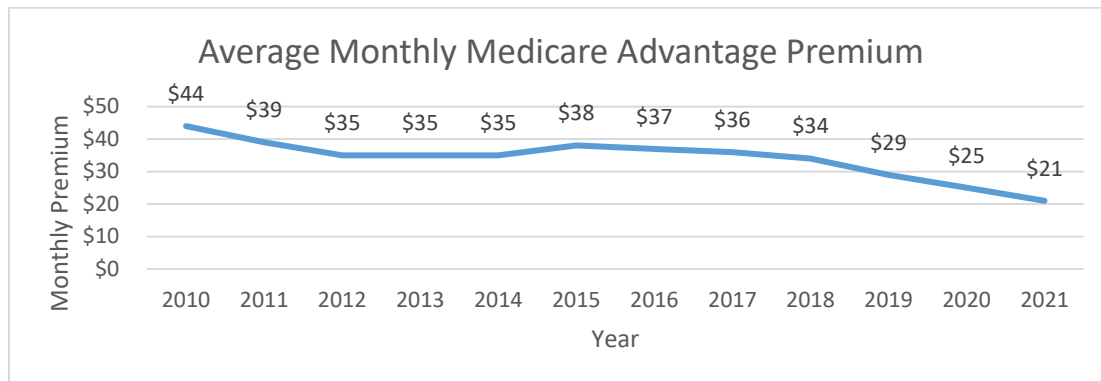
Medicare Advantage has grown steadily over the past two decades (**figure 8**).^{xliv}

Figure 8



As a result, Medicare has become more of a private marketplace, despite being primarily funded through taxpayer dollars in the Federal budget. Moreover, consumers are paying less for Medicare Advantage plans than in past years (see **figure 9**).^{xlv}

Figure 9



Medicare Advantage would be a core component to lowering the Medicare age. As of 2021, 65% of all Medicare Advantage enrollees pay \$0 in premium. According to a report from the Better Medicare Alliance, 98% of Medicare beneficiaries are satisfied with their coverage. Furthermore, Medicare Advantage has a 43% lower rate of avoidable hospitalization than traditional FFS. Finally, about 90 percent of Medicare Advantage plans offer wellness, dental, vision, or hearing coverage, which are not available in Traditional FFS Medicare, and approximately 68 percent offer all four benefits.^{xlvi}

While it is uncertain that any of the reform options will be enacted, the dialogue will continue in the upcoming mid-term and presidential election cycles. These options should be fully articulated and debated among the electorate so voters can make informed decisions before voting. Assuming each option is considered, the most logical option that should be adopted is to expand

the Medicare program by lowering the eligibility age to 60. **Table 3** summarizes the economic and public health considerations of each proposal.

Table 3

	Lowering Medicare Age to 60	Raising Medicare Age to 67	Status Quo/Modest Enhancements
Federal Budget Spending	<ul style="list-style-type: none"> Increased federal budget spending Eventually could be offset if revenue increases through higher wage taxes if employers use health cost savings to pass on to employees 	<ul style="list-style-type: none"> Decreased federal budget spending Eventually could increase if Medicaid spend increases and wages are depressed Overall health care costs could rise if people delay care 	<ul style="list-style-type: none"> Federal budget would continue a similar trajectory as it has been the past few years Increasing premium subsidies could slightly increase the federal budget
Consumer Health Costs	<ul style="list-style-type: none"> Reduced consumer health costs, especially if a large portion of members enroll in Medicare Advantage Predictable cost-sharing and premiums Protections for low-income recipients 	<ul style="list-style-type: none"> Increased consumer health costs Employers will raise premium and put more cost-sharing burden on employees 	<ul style="list-style-type: none"> Reduced consumer health costs if premium subsidies are expanded
Commercial Insurance Premiums	<ul style="list-style-type: none"> Reduced commercial insurance premiums Fewer high-cost enrollees in employer plans Employers likely to lower premiums for employees as a result 	<ul style="list-style-type: none"> Increased commercial premiums More high-cost enrollees in employer plans Employers likely to increase premiums 	<ul style="list-style-type: none"> Similar to today's commercial insurance market Possibly lower premiums if people choose to leave employer group for marketplace to take advantage of new

			cost-sharing protections
Access to Care	<ul style="list-style-type: none"> • Increased access to care • Most providers accept Medicare • Option to receive Original Medicare, or to enroll in Med Supp or Medicare Advantage 	<ul style="list-style-type: none"> • Higher cost-sharing typically leads to delays in care 	<ul style="list-style-type: none"> • Increased access to care • Cost-share assistance means fewer people will delay care

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