Medicare at 60: A Preliminary Overview

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In April 2020, then-presidential-candidate Joe Biden proposed lowering the Medicare eligibility age from 65 to 60. Surprisingly, *Medicare at 60* and its likely consequences—from how many people it would cover to its fiscal costs—have not been explored in much depth.[2] The current proposal comes with several unanswered policy questions. Would coverage be mandatory or voluntary? Would new recipients be subject to the same rules as traditional Medicare enrollees or have their own rules? Would late-enrollment penalties apply to individuals who wait until 65 to enroll?

In this brief we explore how certain answers to these questions could prove costly and disruptive to the current program. Our preliminary estimates find that if traditional Medicare rules were applied to the *Medicare at 60* population:

- In 2018, as many as 16.9 million of 18.2 million 60- to 64-year-olds who weren't enrolled in Medicare would have enrolled in *Medicare at 60*.
- Medicare would serve as the primary payer for as many as 11.1 million of this group.
- Among this population, average Medicare-related expenditures were $8,400 in 2018. Assuming no change in average expenditures, Medicare could pay as much as $5,700 per new enrollee.
- With *Medicare at 60* implemented in 2022, the HI Trust Fund would likely be depleted in 2024 unless policymakers adopt alternative financing methods for the new Part A expenditures.

The brief begins with an overview of the current Medicare program, since expanding eligibility introduces a number of logistical challenges that could add to the overall cost and enrollment of the program, depending on what choices

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2 Sloan, Rosacker, and Frohberg (2020) is one exception.

are implemented. We then discuss the proposed policy and summarize relevant employment, insurance, and health expenditure data of prospective recipients of this expansion. We conclude with a discussion of future research topics, including the effects on health care providers, the commercial market for health insurance, and federal and state budgets. While the findings and discussions are necessarily speculative, they provide a preliminary overview of the data and will serve as the basis for a forthcoming analysis of *Medicare at 60*.

I. The Current Medicare Program

Medicare consists of three parts: Part A, or Hospital Insurance (HI), subsidizes inpatient medical care in hospitals or skilled nursing facilities; Part B, or Supplemental Medical Insurance (SMI), pays for outpatient medical care; and Part D provides prescription drug coverage. In 2019, 61.5 million people were enrolled in Medicare. But enrollment varies by part, with 61.2 million enrolled in Part A, 56.0 million in Part B, and 45.8 million in Part D.[3] The vast majority of Medicare enrollees—86.1 percent—are 65 or older. Participants who are under 65 qualify due to a disability or qualifying disease. Nearly 63 percent of Medicare participants participate in the traditional fee-for-service Medicare. The remaining share are enrolled in Medicare Advantage plans (Part C), which are administered by private insurers that receive capitated payments from Medicare for each enrollee. Most Medicare Advantage plans include Part D prescription drug coverage.[4] In recent years, the share of Medicare Advantage enrollees has risen.

Medicare spending is currently the second largest line item on the federal budget and is projected to grow faster than any other program over the next 30 years.[5] Medicare's fiscal challenges are best illustrated in the state of the HI Trust Fund, which is projected to be depleted by 2026. After that point, Medicare payroll taxes will be sufficient to cover only 87.5 percent of HI expenditures.[6]

Each part of Medicare has unique enrollment and premium rules that would be affected by changes in the eligibility age. We discuss each below.

Premiums

Part A does not charge premiums for workers and their spouses who paid Hospital Insurance payroll taxes for at least 40 quarters. Those with more limited work experience may enroll in Part A but must pay monthly premiums. In contrast, Parts B and D require enrollees to pay monthly premiums that cover approximately 25 percent of expenditures. Standard premiums are identical regardless of health or age. High-income individuals (about 4.2 million recipients, or 7.5 percent in 2019) pay additional income-related premiums that vary by income.

3 All Medicare program data presented in this brief are from CMS (2021).

4 Throughout this brief, we assume new enrollees choose traditional Medicare rather than Medicare Advantage.

5 CBO (March 2021).

6 CBO (February 2021).

Enrollment

Those qualifying at age 65 are generally expected to enroll within the seven-month period around their 65th birthday. For those receiving Social Security or Railroad Retirement benefits, enrollment in Parts A and B are automatic, while others must manually enroll. Individuals with qualifying employer-sponsored insurance (ESI) from a current employer or a spouse's current employer may defer coverage without subsequent penalties. After their employment or coverage ends, these individuals have an eight-month period (called the special enrollment period) to enroll without facing penalties. Participants may also defer Part D coverage without subsequent penalties if they have a prescription drug plan that is at least as generous as the standard Part D plan (so-called creditable coverage).

Late Enrollment Penalties

For those who qualify for premium-free Part A, there is no penalty for delaying enrollment. For those required to pay premiums, there is a 10 percent penalty that lasts for two times the number of years an eligible individual has delayed enrollment in Part A. For Parts B and D, failing to enroll during one's initial enrollment period or special enrollment period may result in permanently higher premiums. This is intended to prevent adverse selection among recipients where those with the highest expected health expenditures enroll immediately, while those with lower health care costs delay enrollment.[7] Generally, for every full year of delay, Part B premiums rise by 10 percent and 12 percent for Part D.

II. Speculative Effects of Medicare at 60

The effects of *Medicare at 60* depend crucially on how the under-65 population is incorporated into the program. Would the newly eligible face the same rules as existing Medicare recipients or would specific rules be tailored for this group? Below, we discuss the consequences of applying current Medicare rules to the newly eligible. To shed light on how the proposal could affect enrollment, premiums, and the federal budget, we include statistics from the current Medicare program and employment, insurance, and health expenditure data for the 60- to 64-year-old population.

7 Whether the issue of selection is important for the financing of Medicare is debatable. MedPac (2020) argues that Medicare's generous coverage means that even relatively young and healthy individuals cost Medicare more than they pay in premiums and thus delaying coverage reduces Medicare outlays.

Enrollment Requirements

In 2018, there were 18.2 million 60- to 64-year-olds without current Medicare coverage.[8] We call this group the *Medicare at 60* population. Table 1 breaks down their insurance status.

Table 1. Insurance status of 60- to 64-year-olds not enrolled in Medicare (millions)	
Government programs	
Medicaid	1.6
ACA Exchanges	1.5
CHAMPUS/TRICARE	0.3
Other	0.1
Other private sources	
Former employer coverage	4.0
Off-Exchange individual coverage	0.5
Other private plans	0.3
Uninsured	1.2
Total excluding current employer coverage	**9.5**
Current employer coverage	
Employer with fewer than 20 employees	2.0
Employer with 20 or more employees	6.7
Total	**18.2**

Notes: Data are from MEPS-HC (2020), corresponding to 2018 insurance status. Respondents could have reported more than one insurance status. We assign all individuals who reported ESI coverage as ESI recipients whether or not they reported an additional insurance type. Numbers may not sum to totals due to rounding.

Nearly 9.5 million have no ESI coverage from a current employer. They would be required to enroll or face subsequent late-enrollment penalties. This includes 1.2 million individuals that did not report any insurance in 2018 and 3.5 million that reported coverage from a government program (including the ACA's Marketplace Exchanges). In addition, there are 4 million who receive insurance coverage through a former employer or union. For this cohort, much of the benefit of this proposal could prove illusory; instead, the real beneficiaries would be the retirement health care plans who would no longer serve as the primary payer. Of course, not all would enroll even under the threat of late-enrollment penalties; some may not be eligible and others may choose to defer coverage. Nevertheless, current Medicare take-up rates among seniors suggest the vast majority of this group would choose to enroll. In 2018, 97.9 percent of the 66- to 70-year-old population without coverage from a current employer were enrolled in Medicare for the entire year.[9] If the under-65 population behaved similarly, we estimate that 9.3 million of the 9.5 million would choose to enroll.[10]

8 The data are the authors' calculations from the Household Component of Medical Expenditure Panel Survey (MEPS-HC, 2020), corresponding to 2018 data. The MEPS-HC data likely overstate the share of workers with coverage from a current employer with fewer than 20 employees because the employer-size question asks respondents for the total number of employees working at their location rather than across the entire firm.

9 We use age 66 rather 65 since many 65-year-olds were only Medicare-eligible for part of the survey year.

10 Those enrolled in the ACA exchanges would likely have lower enrollment than estimated here. Nevertheless, under current Medicare rules, this group would face

In addition, if current recipients are any indication, most with current-employer coverage would also enroll in *Medicare at 60*. In 2018, 91.7 percent of 66- to 70-year-olds with coverage from a current employer with fewer than 20 employees participated in Medicare for the entire year. These employers may require employees to enroll in Medicare when eligible. Even among individuals with coverage from a current employer with 20 or more employees—where Medicare only acts as a secondary payer—85.4 percent of 66- to 70-year-olds reported Medicare enrollment for the entire year. If the under-65 population with current-employer coverage have similar take-up rates, the number of new Medicare enrollees would be substantial. Under this assumption, 7.6 million of the 8.7 million 60- to 64-year-olds with coverage from a current employer would choose to enroll in Medicare. This would be in addition to the 9.3 million reported above. Thus, as many as 16.9 million 60- to 64-year-olds may opt to enroll in *Medicare at 60.* If we exclude those with coverage from a current large employer, the enrollment could be as much as 11.1 million.

Not all in this group would choose to enroll in all parts of Medicare. While participation in Part A is nearly universal among those eligible for premium-free Part A, the required premiums in Parts B and D reduce take-up rates. This is particularly true for those with coverage from a current employer who do not face late-enrollment penalties. In 2018, 36 percent of Medicare recipients aged 66 to 70 with coverage from a current employer reported enrollment in Part B. Likewise, 24 percent reported Medicare Part D coverage.[11] Among those without current employer coverage, 94 percent reported Part B coverage and 78 percent reported Part D coverage. Table 2 reports enrollment by part if the *Medicare at 60* population has the same enrollment take-up rates.

Table 2. Prospective enrollment in *Medicare at 60* by Medicare part (millions)

	Part A	Part B	Part D
2018 Medicare enrollment:	59.6	54.7	44.2
Potential enrollment from *Medicare at 60*	16.9	11.4	9.0
Covered by current employer with 20 or more employees	5.8	2.1	1.4
All other groups	11.1	9.4	7.6

Notes: Medicare enrollment data from CMS (2021). Potential enrollment is authors' calculation derived from MEPS-HC (2020), corresponding to 2018 insurance data. Current enrollment by part includes those covered under Medicare Advantage. Numbers may not sum to totals due to rounding.

The participation estimates in table 2 likely overstate the number of new participants under *Medicare at 60*. MedPac (2020) reports that despite the threat of late-enrollment penalties, an increasing number of individuals are delaying Medicare enrollment. One suggested reason for this trend is that more eligible individuals are delaying Social Security retirement benefits and are thus not automatically enrolled in Medicare at age 65. Requiring even younger groups to enroll could significantly exacerbate this problem because the majority of the newly eligible population are not currently receiving Social Security retirement benefits. Nevertheless, even if the take-up rate is three-quarters of what we project here, Medicare enrollment would rise by over 12 million.

late-enrollment penalties if they chose to delay Medicare coverage.

11 We use MEPS-HC (2020) data for determining enrollment by part. Enrollment differences by employer size were not statistically significant for Parts B or D. We assume all recipients reporting Medicare will be enrolled in Part A as only 0.6 percent of Medicare enrollees did not participate in Part A in 2018 (typically those not eligible for premium-free Part A).

Health Expenditures of the Medicare at 60 Population

Table 3 presents mean health expenditures for the *Medicare at 60* population. We exclude those with coverage from current large employers (20 or more employees) because Medicare would act as the secondary payer in those cases. The data are from the Household Component of the Medical Expenditure Panel Survey (MEPS-HC, 2020), which correspond to 2018 expenditure data. We maintain the original MEPS-HC spending categories, but pool them by the part of Medicare the expenditure is most likely to be incurred.

Table 3: *Medicaid at 60* population spending (2018)

MEPS-HC expenditure category	Mean spending of *Medicare at 60* pop	Share paid by Medicare for 66 to 70	Estimated mean Medicare spending of *Medicare at 60* pop
Part A expenses			
Inpatient care	$2,300	78%	$1,800
Part B expenses			
Office visits	$2,600	61%	$1,600
Outpatient care	$900	67%	$600
Emergency room care	$300	74%	$200
Home health care (Agency-Sponsored)	$200	63%	$100
Other medical supplies and equipment	$200	43%	$100
Total Part B	$4,100		$2,600
Part D expenses			
Prescription drugs	$2,000	69%	$1,400
Total expenses			
Total	$8,400		$5,700

Note: Data are from MEPS-HC (2020), corresponding to 2018 health expenditure data. Medicare share of spending excludes spending by those with ESI coverage from a current employer with 20 or more employees, as Medicare acts a secondary payer for this group. MEPS reports a small share of dental care, vision care, and independent home health care expenditures are also paid by Medicare, but we have excluded them from the estimates as they are generally not covered. Numbers may not sum to totals due to rounding.

Inpatient health expenditures, which we count under Part A, were $2,300 for the *Medicare at 60* population. This is likely an understatement of total Part A expenses as MEPS-HC expenditure data do not generally

capture spending in institutional settings such as extended stays in skilled nursing facilities.[12] Such expenses, however, are expected to be far lower for the *Medicare at 60* population than older recipients. Expenditures that would be paid for by Part B include office visits, outpatient care, emergency room care, medical supplies and equipment, and home health service.[13] Average spending on Part B categories totaled $4,100. Prescription drug expenditures for the *Medicare at 60* population averaged $2,000.

Medicare does not cover 100 percent of health expenditures. Each part of Medicare has particular coinsurance requirements that reduce the program's outlays, and individuals may pay out of pocket for additional care. Column 2 in table 2 shows the reported share of each expenditure category covered by Medicare 66- to 70-year-olds. In column 3, we apply the estimated shares to the estimated mean expenditures in column 1. Thus, if 60- to 64-year-olds behave similarly to the Medicare age 66 to 70 population, total Medicare expenditures would average $5,700 per new enrollee. Part A expenditures would be $1,800 per enrollee; Part B expenditures, $2,600; and Part D expenditures, $1,400.

> "Many in this group could be worse off under the expansion as their new premiums could exceed any additional benefit Medicare offers beyond their existing retiree health care plan."

Importantly, these estimates reflect current health expenditures. These expenditures, however, would change after recipients enroll in Medicare. Expenditures might fall since Medicare reimbursement rates for providers and hospitals are lower than those paid by private insurers. Shatto (2018) finds Medicare payments for inpatient hospital services are 62 percent of private insurer rates while physician services are reimbursed at 75 percent. Offsetting the effect of lower reimbursement rates are potential increases in medical utilization. Card, Dobkin, and Maestas (2008) find that Medicare enrollment causes "a sharp increase in the use of health care services," including a notable increase in hospital admissions at age 65. Importantly, the effects appear to be permanent and not caused by recipients choosing to delay care until they reach 65.

Premiums

If the newly eligible were incorporated into the existing system, they would pay the same premiums as current Medicare recipients.[14] Among the newly eligible, a substantial portion would be subject to income-related premiums. In 2018, single filers with adjusted gross incomes (AGI) above $85,000 and married filers with AGIs about $170,000 faced income-related premiums. Table 4 shows the share of *Medicare at 60* population with family incomes above these levels.

12 For more details on how MEPS-HC likely underestimates spending see Bernard, Selden, and Pylypchuck (2015).

13 About one third of home health services should be attributed to Part A. In 2019, Medicare spent $17.9 billion in home health services with $11.2 billion paid by Part B and $6.7 billion by Part A (See table MDCR SUMMARY AB6 in CMS, 2021). Nevertheless, given that home health care spending accounts for only 1.8 percent of total spending we do not divide between Parts A and B.

14 Since premiums for Parts B and D are intended to cover approximately 25 percent of expenditures, introducing this relatively healthier cohort to Medicare could slightly reduce standard premiums. The effects, however, would be relatively small since likely participation (excluding those coverage by current large employers) represents a small share—18.6 percent—of the Part B population. If the new enrollee part B expenditures were 20 percent lower than current recipients, premiums would fall by 3.1 percent.

Table 4. *Medicare at 60* population subject to income-related Part B premiums		
Current insurance status	**Total (millions)**	**Share subject to income-related premiums**
Uninsured/government health care	4.7	3.8%
Coverage from current employer	8.7	24.0%
Former ESI coverage	4.0	16.0%
Others	0.7	33.0%
Total	18.2	17.4%

Notes: Data are from MEPS-HC (2020), corresponding to 2018 income and insurance data. Numbers may not sum to totals due to rounding.

Overall, 17.4 percent of the *Medicare at 60* population would be subject to the income-related premiums. This is far higher than current Medicare recipients where only 7.5 percent are subject to the higher premiums. Among those subject to income-related premiums would include 16 percent of those who have coverage through a previous employer's plan. Many in this group could be worse off under the expansion as their new premiums could exceed any additional benefit Medicare offers beyond their existing retiree health care plan.

Finally, an additional policy question related to premiums is their subsequent growth rate. Part B premiums are subject to a hold-harmless provision that prevents annual premiums from rising by more than a recipient's Social Security cost of living adjustment. Since the newly eligible are largely not enrolled in the Social Security program, however, they would not be subject to the hold-harmless provision and could see their annual premiums rise considerably.

> "Medicare at 60 may also encourage workers to retire earlier...The decision to retire earlier would affect the federal budget, reducing income and payroll tax revenue and potentially increasing Social Security outlays if retirees decide to collect benefits sooner."

Effects on Medicaid and Other Federal Programs

State Medicaid programs provide premium support for low-income individuals (who are called dual eligibles). In 2019, 20.7 percent of Part B recipients—11.6 million people—received Medicaid assistance. Low-income individuals among the *Medicare at 60* population may find that Part B is too costly without these subsidies. Medicaid eligibility, however, is typically far more stringent for non-disabled adults without dependents than it is for those 65 and older. As such, some of the *Medicare at 60* population may not qualify for Medicaid assistance under current state rules. Congress would need to encourage states to alter their Medicaid program rules to ensure the newly eligible qualified for subsidies. The incentives in

the Affordable Care Act's (ACA) Medicaid expansion serves as a potential template. In the case of the ACA, the federal government agreed to cover 100 percent of expenses for those eligible for Medicaid under the ACA for the first three years before eventually falling to 90 percent permanently. These changes to Medicaid would further increase the federal cost of the expansion, while offering some potential cost savings to states.

Similarly, Part D offers low-income subsidies for those who are unable to afford Part D premiums. In 2018, 11.6 million qualified for Part D's low-income subsidies, or about 25.2 percent of Part D recipients. States also pay capitated "clawback" payments to the federal government for each Medicaid enrollee eligible for Medicare, suggesting that increasing the eligible Medicare population may put further strain on state budgets.

The increase in federal and state spending on the *Medicare at 60* population would be somewhat offset by spending reductions for those currently receiving subsidies from other government health care programs. This includes current participants of Medicaid, the ACA's premium subsidies, and the civilian and military retirement health care programs. The magnitude of these savings, however, would be relatively small. As shown in table 1, only 19.5 percent of the *Medicare at 60* population are currently enrolled in a government health care program.

Medicare at 60 may also encourage workers to retire earlier. Madrian and Beaulieu (1998) find that Medicare eligibility encourages those who are eligible to retire sooner. The decision to retire earlier would affect the federal budget, reducing income and payroll tax revenue and potentially increasing Social Security outlays if retirees decide to collect benefits sooner. The latter effect would represent a shift—not necessarily an increase—in Social Security spending since early enrollment in Social Security permanently reduces a retiree's benefits.

Effect on the HI Trust Funds

Without additional revenue sources or general fund financing, lowering the eligibility age would hasten the depletion of the HI Trust Fund. Estimating the effects on the HI Trust Fund from the expansion is beyond the scope of this brief. Nevertheless, it is worthwhile to note that relatively small increases in HI expenditures would have significant effects on the Trust Fund. Currently, CBO projects the Trust Fund to be depleted by 2026. By the end of FY2024, The Trust Fund's balance is projected at $75 billion.[15] Thus, if *Medicare at 60* were implemented in 2022, the HI Trust Fund could be depleted by 2024 if *Medicare at 60 HI* spending is $25 billion per year or slightly less after accounting for the associated declines in HI Trust Fund interest income.

"Thus, if Medicare at 60 were implemented in 2022, the HI Trust Fund could be depleted by 2024 if Medicare at 60 HI spending is $25 billion per year or slightly less after accounting for the associated declines in HI Trust Fund interest income."

III. Summary and Future Research

This brief has outlined several policy dimensions that would be affected by lowering Medicare's eligibility age. While the data presented are preliminary, they show that the

15 See CBO (February 2021) for current Trust Fund projections.

effects of expansion would be substantial. Depending on how the expansion is financed, it could also hasten the insolvency date of the HI Trust Fund.

More work is needed to determine the budget effects of *Medicare at 60*. This requires modeling complicated enrollment decisions that account for interactions with current coverage options such as ESI, retiree health care, and government assistance plans. The estimates must also account for expected changes in utilization and Medicare-level reimbursement rates for providers and hospitals. In addition, while we have focused on the potential effects on the traditional Medicare program, the budget effects related to Medicare Advantage plans and supplemental plans should also be modeled.

Further research is also needed to study alternative program rules for the under-65 population that would be needed to mitigate issues from a straightforward expansion. As noted throughout this brief, applying existing Medicare program rules to the newly eligible could create awkward consequences. From the enrollment process to hold-harmless provisions, Medicare's program rules were implicitly designed under the assumption that newly eligible Medicare recipients would be enrolled in Social Security. This would no longer be true if individuals were required to enroll at age 60. The expansion then could unwittingly lead to millions of individuals facing permanent late-enrollment penalties. These could be avoided by making *Medicare at 60* optional (i.e. delaying enrollment until 65 would not trigger late-enrollment penalties), but that would increase adverse selection among the newly eligible and negatively affect the risk pool.

Similarly, more attention is needed regarding how other federal health care programs and rules would be affected or need to be altered in light of *Medicare at 60*. For example, reflecting the role of Medicare in senior health care, health savings account plans have vastly different rules for those below and above age 65. Eligibility requirements for ACA premium tax credits for the *Medicare at 60* population may also need to be adjusted.

Finally, the effect Medicare has on ESI coverage and retiree health care plans would also become a far larger issue, as a significantly greater share of 60-year-olds are in the work force than 65-year-olds. Strengthening policies that discourage firms from shifting older workers onto Medicare may prove important for limiting costs and avoiding a disruption of existing health benefit arrangements.

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