KAISER FAMILY FOUNDATION

Medicare Policy

Raising the Age of Medicare Eligibility

A Fresh Look Following Implementation of Health Reform

JULY 2011

THE HENRY J. KAISER FAMILY FOUNDATION

Originally released in March 2011, this report and accompanying news release were updated in July 2011 to reflect additional provisions of the 2010 health reform law. These adjustments result in lower estimates of net federal savings and aggregate out of pocket spending attributable to raising the age of eligibility. Details are included in the errata at the end of this report.

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EXECUTIVE SUMMARY

As the debate over the federal deficit takes hold, some are proposing to raise the age of Medicare eligibility beyond age 65 as one among many options to reduce entitlement spending. Previous studies, conducted prior to the enactment of the 2010 health reform law, show that an increase in the age of Medicare eligibility would be expected to reduce Medicare spending, but also increase the number of uninsured 65 and 66 year olds, many of whom would be expected to have difficulty finding comparable coverage on their own, either because of prohibitively expensive premiums or coverage limitations imposed on those with pre-existing conditions. Our analysis differs from prior analyses of raising the age of Medicare eligibility primarily because it takes into account key provisions in the 2010 health reform law, which provides new avenues to public and private health insurance coverage for those under age 65, including expanded Medicaid eligibility and a new health insurance Exchange.

This study examines the expected key effects of raising the age of Medicare eligibility to age 67. We assume full implementation in 2014, rather than the more common assumption of a gradual increase, to illustrate the likely effects once fully phased in. We also assume full implementation of the 2010 health reform law. A full discussion of assumptions and their expected effects is included in the Technical Appendix. Key findings include:

- Federal spending would be reduced, on net, by $5.7 billion in 2014. This includes gross federal savings of $31.1 billion, offset by new costs for federal premium and cost-sharing subsidies under the Exchange ($9.4 billion), expanded coverage under Medicaid ($8.9 billion), and a reduction in Medicare premium receipts ($7.0 billion).

- Seven million people age 65 or 66 at some point in 2014 would be affected by the policy change for one or more months. This number is equivalent to five million people affected for a full 12 months. Of that five million, we estimate 42 percent would turn to employer-sponsored plans for health insurance, either as active workers or retirees, 38 percent would enroll in the Exchange, and 20 percent would become covered under Medicaid.

- Two-thirds of adults ages 65 and 66 affected by the proposal are projected to pay more out-of-pocket, on average, in premiums and cost sharing under their new source of coverage than they would have paid under Medicare. However, nearly one in three are projected to have lower out-of-pocket costs than they would have had if covered by Medicare, on average, mainly due to provisions in the health reform law that provide subsidies to the low-income population through Medicaid and the Exchange.

- Premiums in the Exchange would rise for adults under age 65 by three percent (an additional $141 per enrollee in 2014), on average, due to the shift of older adults from Medicare into the pool of lives covered by the Exchange.

- Medicare Part B premiums would increase by three percent in 2014, as the deferred enrollment of relatively healthy, lower-cost beneficiaries would raise the average cost across remaining beneficiaries.

In addition, costs to employers are projected to increase by $4.5 billion in 2014 and costs to states are expected to increase by $0.7 billion. In the aggregate, raising the age of eligibility to 67 in 2014 is projected to result in an estimated net increase of $3.7 billion in out-of-pocket costs for those ages 65 and 66 who would otherwise have been covered by Medicare. This analysis underscores the importance of carefully assessing the distributional effects of various Medicare savings proposals to understand the likely impact on beneficiaries and other stakeholders.

INTRODUCTION

As the debate over the federal deficit and national debt takes hold, some are proposing to raise the age of Medicare eligibility as one among many options to reduce entitlement spending.[1,2] Under current law, most individuals become entitled to Medicare when they reach age 65; individuals under age 65 can qualify for Medicare if they receive Social Security Disability Insurance (SSDI) benefits for at least 24 months, or if they have certain conditions, such as end-stage renal disease (ESRD). In contrast, the full retirement age for Social Security, previously age 65, is now 66 and is scheduled to increase to 67 by 2027, although many individuals choose to begin collecting Social Security benefits at the early retirement age of 62, or at age 65 when they first become eligible for Medicare.[3] The idea of raising the age of Medicare eligibility has been suggested many times in previous years, but never adopted.[4] Amid current policy discussions about the future of the Medicare program and reining in federal spending, the idea could gain new traction.

Previous studies have demonstrated that an increase in the Medicare eligibility age would be expected to: (1) reduce the growth in Medicare spending by reducing the number of people who would be covered by the program; (2) increase the number of uninsured adults, assuming a portion of those ages 65 and 66 would not obtain health insurance in the absence of Medicare; and (3) increase costs for employers who would be expected to incur higher costs for retirees if they were required to provide primary rather than secondary coverage.[5] According to a recent analysis by the Congressional Budget Office (CBO), gradually raising the Medicare eligibility age to 67 beginning in 2014 (fully phased in by 2027) would reduce federal outlays (on net) by approximately $125 billion between 2012 and 2021.[6]

In this study, we analyze the effects of raising the age of Medicare eligibility to 67 in 2014, with no phase in, in light of the changes made by the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA) (collectively referred to hereafter as the ACA, or the 2010 health reform law).[7] The ACA makes a number of changes that would affect individuals who would no longer be covered by Medicare, including health insurance reforms designed to make coverage more accessible and affordable for older adults, expansions of coverage to low-income adults with incomes below 133 percent of the Federal Poverty Level (FPL) and tax credits for those with incomes below 400 percent of the FPL, including caps on premiums as a share of income. In addition, the law includes two provisions that would limit cost sharing for low-income people with coverage in the Exchange by: (1) reducing cost sharing for enrollees with incomes up to 250 percent of the FPL by making them eligible to enroll in plans with a higher actuarial value; and (2) lowering the limits on out-of-pocket spending for enrollees with incomes up to 400 percent of the FPL.[8]

This study differs from others in that it is the first to examine the expected effects of raising the Medicare eligibility age, in a post-health reform environment, on federal and state spending, out-of-pocket spending for individuals ages 65 and 66, premiums paid by younger adults who purchase coverage through the Exchange, premiums paid by elderly and disabled beneficiaries under Medicare Part B, and the cost implications for employers. The recent CBO analysis takes into account the health reform law, but does not address the cost implications for individuals, employers, and states, and assumes the policy is phased in rather than fully implemented in 2014. We analyzed raising the Medicare eligibility age to 67 in a single year (2014), rather than on a phased-in basis, to illustrate the effects on individuals, federal and state governments, and employers when the policy is fully in place.

The main rationale for raising the age of Medicare eligibility above 65 is to reduce the growth in Medicare spending.[9] Proponents also observe that raising the Medicare eligibility age to 67 would conform to the full retirement age for Social Security, and reflect improvements in average life expectancy among Americans.[10] Raising the Medicare eligibility age also could encourage workers to delay retirement if they are physically able to work beyond age 65, which would increase both general revenues and payroll tax contributions, thereby strengthening the Medicare and Social Security trust funds and alleviating pressure on the federal budget.

Opponents point out that raising the age of Medicare eligibility, in the absence of alternative sources of coverage and subsides for those with modest incomes, would shift costs and risk onto retirees and increase the number of uninsured.[11] One study, for example, found that raising the age of Medicare eligibility would result in a significant increase in the number of uninsured 65- and 66-year-olds, disproportionately affecting black and Hispanic adults, and others with low incomes in this age group.[12] Others have documented that raising the age of eligibility could also increase costs for employers that offer retiree health benefits, with more retirees relying on employer plans for primary rather than secondary coverage.[13] Raising the Medicare eligibility age could also place a burden on those with physically demanding jobs who may be unable to work an additional two years, creating incentives to remain employed if that is the only option for retaining health insurance.[14] More fundamentally, opponents have argued that raising the age of eligibility would renege on a promise to workers who contributed payroll taxes to Medicare throughout their working lives with the expectation that they would be covered by Medicare when they reached age 65.

KEY QUESTIONS

The analysis addresses several key questions related to the effects of raising the age of Medicare eligibility from 65 to 67 in 2014:

1) What are the expected sources of health insurance for 65- and 66-year-olds who would no longer be covered by Medicare if the age of Medicare eligibility were increased?
2) How would an increase in the Medicare eligibility age affect net federal spending in 2014, taking into account both savings to Medicare and offsetting costs associated with subsidies for low-income individuals in the Exchange and the expansion of coverage under Medicaid?
3) How would an increase in the age of Medicare eligibility affect out-of-pocket spending for 65- and 66-year-olds who would no longer be covered by Medicare, taking into account premiums and cost-sharing?
4) What would be the effect on premiums for younger adults who get coverage in the Exchange?
5) How would this policy affect Part B premiums for those who would not be directly affected by the change in the Medicare eligibility age?
6) What would be the cost implications for states?
7) What would be the cost implications for employers associated with coverage of additional active workers and retirees who would no longer be eligible for Medicare?

OVERVIEW OF METHODS

In modeling the effects of raising the Medicare eligibility age to 67 in 2014, we made two key assumptions. First, we assumed that the Medicare eligibility age would be raised from 65 to 67 in 2014 rather than a more gradual phase-in—even though this does not align with the full age of retirement for Social Security in 2014, which is 66 years. We assumed full implementation in 2014 in order to illustrate the full effects on individuals, federal and state governments, and employers. Second, we assumed implementation of the ACA in 2014, as passed, including provisions that have important implications for 65- and 66-year-olds who would no longer be covered by Medicare, such as: (1) expansion of Medicaid coverage to people with incomes up to 133 percent of the FPL[15]; (2) the creation of new health insurance Exchanges with age rating bands that constrain the upper limit on premiums for older adults; (3) tax credits and cost-sharing assistance for individuals with incomes up to 400 percent of the FPL purchasing coverage through the Exchange; and (4) the individual health insurance mandate, with penalties for those who do not purchase coverage. We did not estimate the effects of raising the age of Medicare eligibility if the 2010 health reform law were to be repealed in full or in part, but we discuss the likely effects in the concluding section of this report.

For this analysis, we assumed that all individuals ages 65 and 66 who were no longer eligible for Medicare in 2014 would obtain health coverage through private plans offered in the Exchange, through employer plans, or through Medicaid. We assumed that all individuals in the non-group market would receive coverage through the Exchange. We assumed those with incomes below 133 percent of the FPL would be covered under Medicaid, and those with incomes up to 400 percent of the FPL would receive premium tax credits (with caps on premiums as a share of income) and cost-sharing assistance for coverage purchased through the Exchange. Otherwise, we assumed no behavioral changes with respect to employment (individuals choosing to work longer) or employer practices (such as employers terminating coverage).

We developed a model that synthesizes data from a number of sources, including Medicare claims data from the 100 percent claims file (for enrollment and expenditures for beneficiaries ages 65 and 66), the 2010 Medicare Trustees Report (for 2006, 2008, and 2014 enrollment data), the National Health Expenditure projections of the CMS Office of the Actuary (for spending by type of service and source of funding), the Medicare Current Beneficiary Survey (MCBS) Cost and Use File 2006 (for variations in Medicare and out-of-pocket expenditures by different groups of beneficiaries, including by supplemental coverage), and the Health and Retirement Study (for determining income and subsidy eligibility for 65- and 66-year-olds).[16]

Individuals ages 65 and 66 were assigned to new health insurance coverage groups and subsidy categories in 2014, based on their likely response to the delay of Medicare eligibility. These groups include:

1) people originally entitled to Medicare prior to age 65 on the basis of disability, who would be unaffected by the change in age eligibility;
2) people known as the “working aged” (referred to as active workers in this analysis), for whom employer-sponsored insurance (ESI) would most likely remain primary;
3) people with full dual eligibility for Medicare and Medicaid under current law, for whom Medicaid would become the primary source of coverage;

4) retirees with generous employer-sponsored insurance, for whom the employer plan is assumed to become the primary source of coverage;

5) all others ages 65 and 66, for whom new coverage (i.e., Medicaid or private health insurance through the Exchange) was determined based on their income.

Our analysis of net federal savings takes into account expected reductions in Medicare spending that would be attributable to fewer beneficiaries covered under the program, and the expected offsetting costs associated with additional federal spending for tax credits to provide premium and cost-sharing subsidies through the Exchange and the Medicaid expansion, as well as foregone Medicare premiums. It does not take into account changes in revenues that could occur, for example, were 65- and 66-year-olds to work longer in response to this policy change, nor does it take into account revenue offsets attributable to higher employer spending. The analysis of out-of-pocket spending takes into account the expected costs that 65- and 66-year-olds would have incurred under Medicare, including premiums for Medicare and supplemental insurance, and cost sharing for Medicare covered benefits, and their expected out-of-pocket costs under other sources of health insurance in lieu of Medicare, including: (1) premiums and cost sharing associated with plans in the Exchange (taking into account premiums by age band, the cap on premium contributions for those with incomes at or below 400 percent of the FPL, and low-income subsidies); (2) premiums and cost sharing under an employer plan for active workers and retirees; and (3) nominal cost-sharing requirements for those newly covered under Medicaid. The analysis also examines the cost implications for employers and states.[17]

This study does not address the effects of raising the age of Medicare eligibility on the solvency of the Medicare Part A Hospital Insurance Trust Fund or on general revenues. An increase in payroll tax revenue, coupled with reductions in Medicare spending for services covered under Part A, would be expected to extend the life of the Trust Fund. An increase in general revenues (attributable to an increase in the number of older adults working, for example) would be expected to result in an increase in net federal savings.

A detailed description of the methods, data, and assumptions used in this analysis is included in the Technical Appendix. Appendix Exhibit 1 presents a summary of the effects of the proposal on savings and offsets. Appendix Exhibit 2 presents the change in out-of-pocket spending for coverage groups affected by the proposal. All estimates presented in the text and exhibits are rounded.

KEY FINDINGS

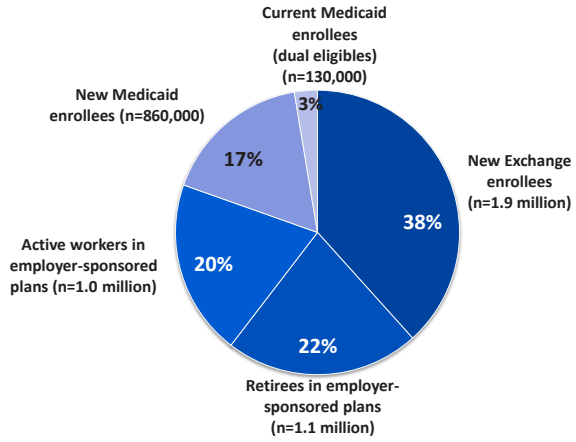
COVERAGE

This analysis begins by looking at the number of people who would be "ever affected" if the Medicare eligibility age increased from 65 to 67 in 2014. We then calculate the total number of "life years," an annualized measure that can be interpreted as the number of people affected in 2014.

- An estimated seven million people ages 65, 66, and 67 would be affected for one or more months by a policy that raises the age of eligibility to 67 in 2014, including individuals affected by this policy for less than a full year (i.e., they turned 65 after the first of the year, or turned 67 and aged onto Medicare after the first of the year). On a life-year basis, this translates into 5.0 million people who would be affected in 2014 if the Medicare eligibility age were raised to 67.[18] **(Exhibit 1)**

Exhibit 1

Projected Distribution of Medicare Beneficiaries Affected By Raising Medicare Eligibility Age to 67 in 2014, By New Source of Health Insurance Coverage



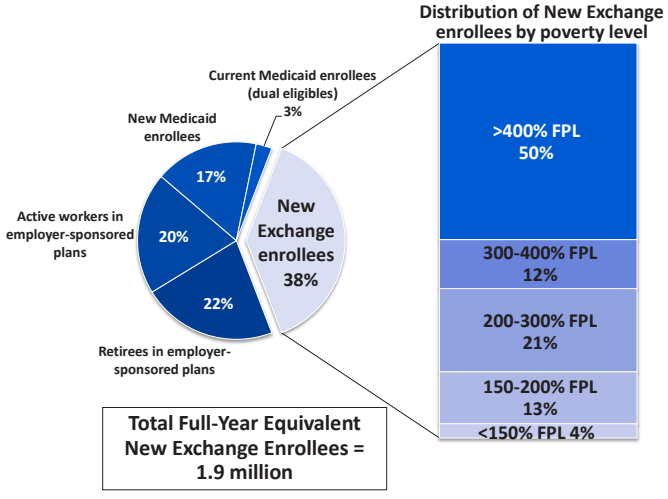
Total Number of Full-Year Equivalent Medicare Beneficiaries Affected = 5.0 million

SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: Estimates reflect annualized number of people ages 65 and 66 affected in 2014 by raising Medicare eligibility age to 67.

- Among the five million who would be without Medicare in 2014, the largest group, 38 percent (1.9 million), would be expected to gain coverage under private insurance purchased through a health insurance Exchange:
  - Half are estimated to be eligible for subsidies: 320,000 with incomes below 200 percent of the FPL and thus eligible for relatively generous subsidies, and 650,000 estimated to have incomes between 200 and 400 percent of the FPL, with premium subsidies that decline as income rises.
  - The remaining 960,000 adults are estimated to be in the Exchange but not eligible for premium subsidies because they have incomes above 400 percent of the FPL. **(Exhibit 2)**

Exhibit 2

Projected Poverty Distribution of Medicare Beneficiaries Estimated to Have Exchange Coverage in 2014 If the Medicare Eligibility Age is 67



Total Full-Year Equivalent New Exchange Enrollees = 1.9 million

SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: Estimates reflect annualized number of people ages 65 and 66 affected in 2014 by raising Medicare eligibility age to 67.

- Another 42 percent would be expected to receive coverage from an employer, either as active workers or retirees, rather than Medicare:
    - 22 percent (1.1 million) of this group would be covered by an employer-sponsored retiree health plan; for these individuals, the employer plan would become their primary source of health insurance coverage rather than being a supplement to Medicare.
    - 20 percent (1.0 million) would be covered as an active worker by an employer plan because they or their spouse are working beyond age 65; these adults would retain their primary employer-sponsored coverage but would not have secondary coverage provided by Medicare.
- The remaining 20 percent (1.0 million) of 65- and 66-year-olds would be covered by Medicaid, including 130,000 individuals who would have been covered by both Medicare and Medicaid (full dual eligibility) if the eligibility age was 65, and 860,000 people who would qualify for Medicaid under the ACA because they have incomes up to 133 percent of the FPL.

Medicare would continue to cover some 770,000 high-cost 65- and 66-year-olds who qualified for the program prior to reaching age 65 because of disability.[19] Their eligibility would not be changed as it would be for other individuals ages 65 and 66.

OUT-OF-POCKET SPENDING

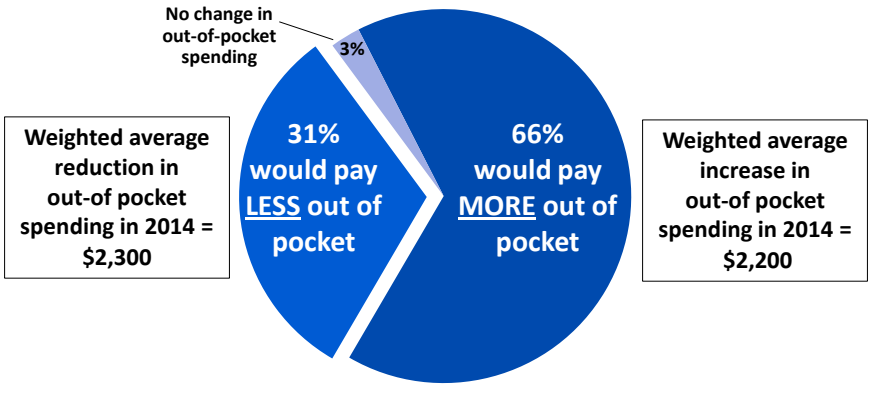
Raising the age of eligibility for Medicare is expected to affect beneficiaries' out-of-pocket spending, but the direction and magnitude of the change depends on a number of factors, most importantly whether beneficiaries would be covered by Medicaid or would receive subsidies for Exchange coverage. In the aggregate, raising the age of eligibility to 67 in 2014 is projected to result in an estimated net increase of $3.7 billion in out-of-pocket costs for people who would otherwise have been covered by Medicare.

Among the five million adults who would be directly affected by an increase in Medicare eligibility in 2014, nearly one-third (1.6 million) are estimated to pay less under their new source of coverage than they would have paid out-of-pocket under Medicare.[20] Yet two-thirds (3.3 million) are estimated to pay more as a result of shifting from Medicare to another source of coverage. **(Exhibits 3-6)**

Exhibit 3

Projected Distribution of 65- and 66-Year-Olds By Change in Out-of-Pocket Spending If the Medicare Eligibility Age is 67

Based on New Source of Health Insurance and Subsidy Level in 2014



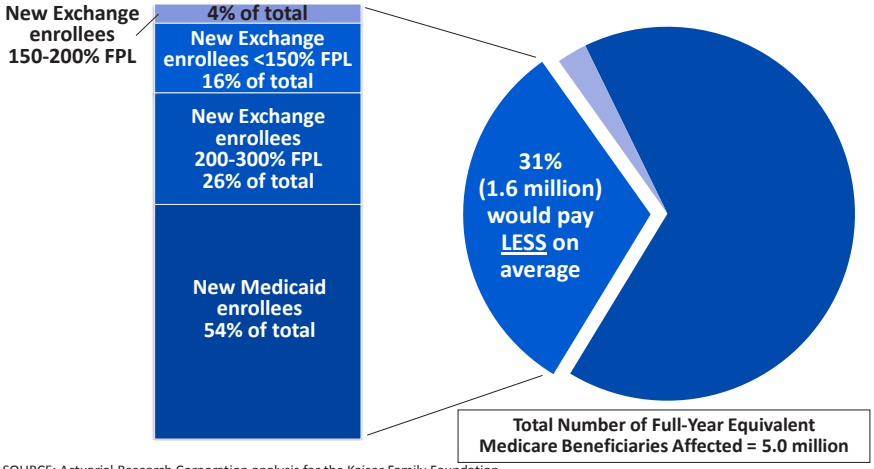
SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: Estimates reflect annualized number of people ages 65 and 66 affected in 2014 by raising Medicare eligibility age to 67. Estimates do not reflect individual changes in out-of-pocket spending, but rather the average change for each group of individuals, based on new source of health insurance.

The 1.6 million older adults estimated to have *lower* out-of-pocket spending than they would have had under Medicare include those with incomes below 133 percent of the FPL who would qualify for the Medicaid expansion and those with incomes less than 300 percent of the FPL who would qualify for relatively generous premium tax credits and cost-sharing assistance in the Exchange (Exhibit 4).

Exhibit 4

Projected Distribution of 65- and 66-Year-Olds Who Would Pay Less Out of Pocket If the Medicare Eligibility Age is 67

Based on New Source of Health Insurance and Subsidy Level in 2014



SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: Estimates reflect annualized number of people ages 65 and 66 affected in 2014 by raising Medicare eligibility age to 67. Estimates do not reflect individual changes in out-of-pocket spending, but rather the average change for each group of individuals, based on new source of health insurance. Column percentages do not sum to 100 percent due to rounding

- **New Medicaid Enrollees:** Adults ages 65 and 66 who would qualify for Medicaid because they have incomes below 133 percent of the FPL would have significantly lower out-of-pocket costs than they would have incurred under Medicare.
    - On average, these 860,000 low-income adults ages 65 and 66 would pay $3,200 less out of pocket in 2014 than under traditional Medicare, on average. Under Medicare, their estimated out-of-pocket costs in 2014 would have averaged $3,400, including $2,400 in Medicare and other premiums and $900 in out-of-pocket spending; under Medicaid their cost-sharing obligations would be nominal. (The 130,000 individuals who would have been dually eligible for Medicare and Medicaid without the change in the Medicare eligibility age—not included here—are assumed to have roughly the same out-of-pocket costs as they would have incurred otherwise.)

- **Exchange Enrollees Below 300 Percent of the FPL:** On average, those covered under the Exchange in lieu of Medicare are estimated to have lower out-of-pocket spending (premiums and cost-sharing) than they would have under Medicare provided that their incomes are below 300 percent of the FPL—but higher average out-of-pocket spending if their incomes are above that amount.
    - The 70,000 adults ages 65 and 66 with incomes *below 150 percent of the FPL* are estimated to have out-of-pocket spending that would be $3,200 less, on average, than it would have been under Medicare in 2014. This group is ineligible for Medicaid coverage under current law, and is estimated to have total spending of $2,500 in premiums and $1,400 in cost sharing for Medicare benefits in 2014 absent the policy change.

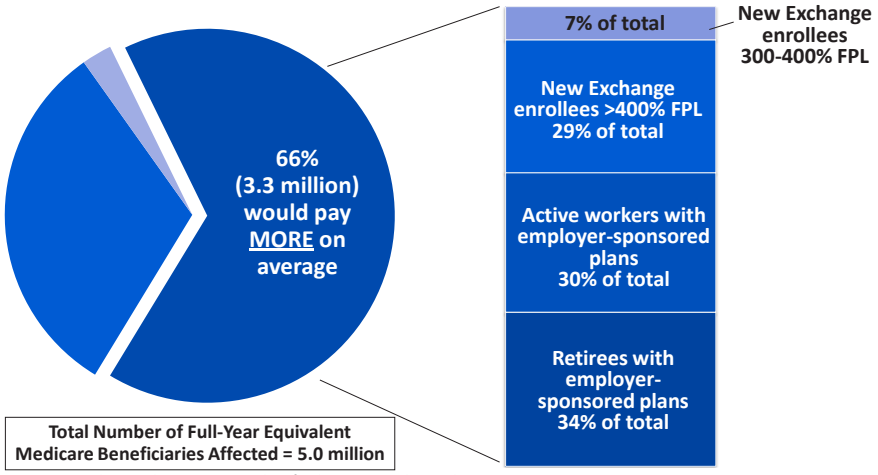
- The 250,000 adults ages 65 and 66 with incomes *between 150 percent and 200 percent of the FPL* are estimated to have out-of-pocket spending that would be $2,200 less in 2014, on average, than it would have been under Medicare. This group is also ineligible for full Medicaid coverage, and is estimated to have total spending of $2,500 in premiums and $1,600 in cost sharing for Medicare benefits in 2014 absent the change in eligibility.
- For the estimated 410,000 people with incomes *between 200 percent and 300 percent of the FPL*, out-of-pocket spending would be $200 lower in the Exchange than it would be under Medicare, on average. This group is estimated to have total spending of $2,600 in premiums and $1,800 in cost sharing for Medicare benefits in 2014 absent the change in eligibility; in the Exchange they would pay, on average, $2,200 in premiums and $2,000 in cost sharing.

The 3.3 million older adults who are estimated to have *higher* out-of-pocket spending in 2014 than they would have had under Medicare include those who have incomes above 300 percent of the FPL who would be eligible for reduced premium subsidies through the Exchange or ineligible for subsidies, and those with employer-sponsored insurance, either as retirees or as active workers (Exhibit 5).

Exhibit 5

Projected Distribution of 65- and 66-Year-Olds Who Would Pay More Out of Pocket If the Medicare Eligibility Age is 67

Based on New Source of Health Insurance and Subsidy Level in 2014



SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: Estimates reflect annualized number of people ages 65 and 66 affected in 2014 by raising Medicare eligibility age to 67. Estimates do not reflect individual changes in out-of-pocket spending, but rather the average change for each group of individuals, based on new source of health insurance.

- **Exchange Enrollees Above 300 Percent of the FPL:**
  - For the estimated 240,000 individuals with incomes *between 300 percent and 400 percent of the FPL* estimated average out-of-pocket spending would be $1,200 higher than it would be under Medicare. If covered by Medicare, they would pay, on average, $4,800 in 2014 ($1,500 in Medicare premiums, $1,900 in cost sharing, and $1,400 in other premiums, mainly Medigap). In the Exchange, they would pay, on average, $3,700 in premiums and $2,300 in cost-sharing. Under the Exchange, individuals in this group would be eligible for premium subsidies, although the value of the subsidy declines as income approaches 400 percent of the FPL
  - The estimated 960,000 65- and 66-year-olds with incomes *above 400 percent of the FPL* would bear the largest increase in average out-of-pocket expenses relative to what they would pay under Medicare —about $4,300 more in 2014 – because they are not eligible for subsidies. If

covered by Medicare, they would pay $6,800 in 2014, including $2,300 in Medicare premiums (including income-related premiums), $2,700 in cost sharing, and $1,800 in other premiums, mainly Medigap. In the Exchange, with age rating bands that would help to constrain their premium but without subsidies, they would pay $8,600 in premiums and $2,500 in cost sharing.

At higher incomes, total out-of-pocket spending (premiums and cost sharing) is estimated to be higher under the Exchange, on average, than under Medicare because higher-income Exchange enrollees are responsible for the full premium, whereas Medicare beneficiaries get coverage that is subsidized; beneficiaries pay about 25 percent of Medicare Part B and Part D premiums, and the federal government pays the remaining 75 percent. There is no premium for Part A. Further, out-of-pocket spending is estimated to be higher because plans in the Exchange are not expected to generate the price concessions for covered benefits that are available to Medicare, so enrollees' cost sharing is calculated on a higher base, which translates into higher out-of-pocket costs for those 65- and 66-year-olds who shift from Medicare to the Exchange.

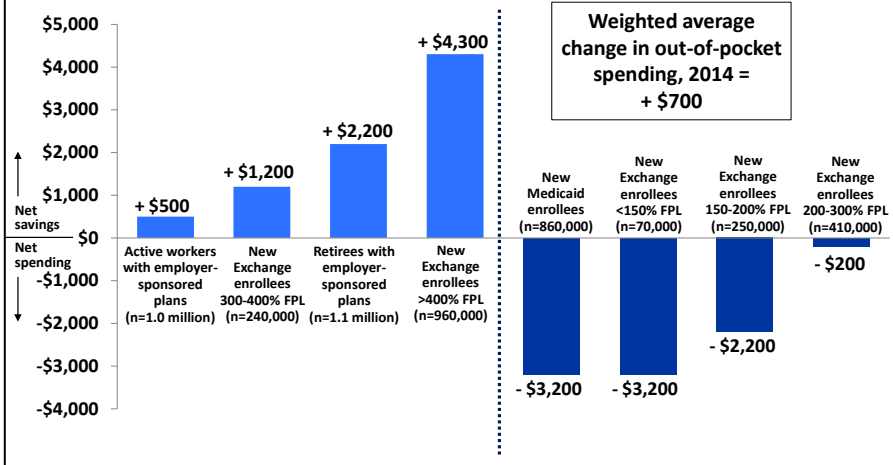
- **Retirees with Employer-Sponsored Coverage:** The 1.1 million adults ages 65 and 66 who would have had Medicare as their primary source of coverage, supplemented by an employer-sponsored retiree health plan, would be expected to get primary coverage under their employer plan. This would result in an estimated increase of $2,200, on average, in their out-of-pocket spending in 2014, relative to what they would have paid under Medicare. Higher premiums for this group of individuals whose employer plan becomes primary more than offsets the elimination of Medicare premiums paid by the group.[21]

- **Active Workers:** For the 1.0 million adults ages 65 and 66 who work (or have spouses who work) and receive coverage from an employer plan, the increase in the Medicare eligibility age would mean a loss of supplemental (secondary payer) coverage from Medicare. Working-aged adults generally have employer coverage as primary, but are entitled to Medicare Part A as a supplement to the employer plan. Out-of-pocket spending for this group would be $500 higher in 2014, on average, than it would be if they remained eligible for Medicare secondary payer coverage.

Exhibit 6

Net Change in Average Out-of-Pocket Spending in 2014 Among 65- and 66-Year-Olds If the Medicare Eligibility Age is 67

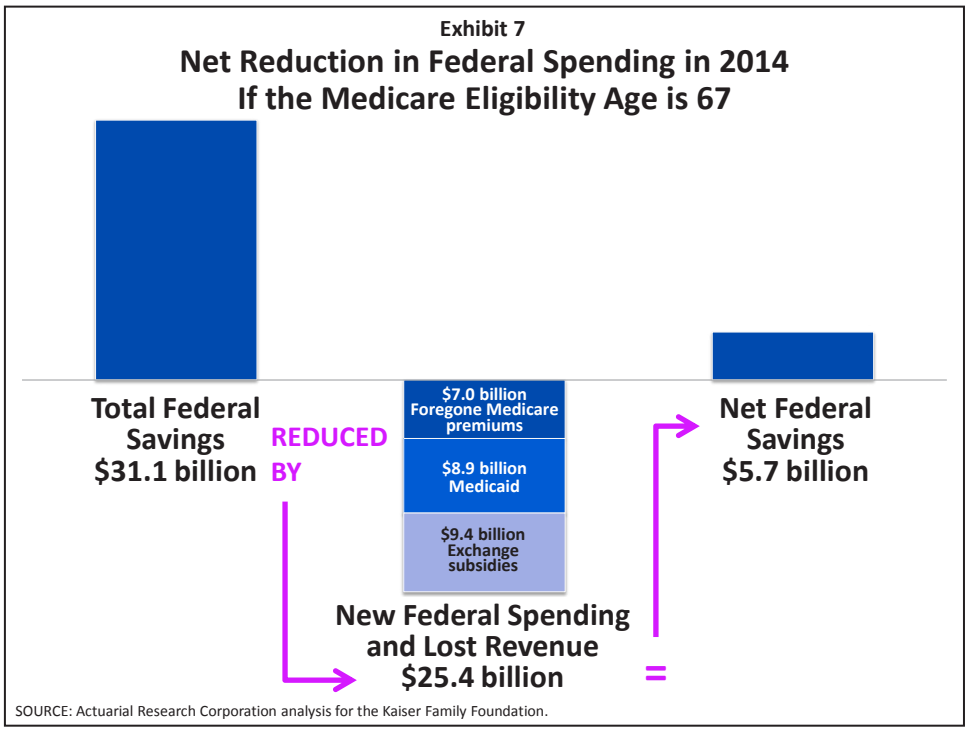
Based on New Source of Health Insurance and Subsidy Level in 2014



SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: Estimates reflect annualized number of people ages 65 and 66 affected in 2014 by raising Medicare eligibility age to 67.

IMPACT ON FEDERAL AND STATE EXPENDITURES

Consistent with several studies conducted prior to the enactment of the ACA,[22] our analysis shows a significant reduction in federal spending attributable to raising the age of Medicare eligibility from 65 to 67, effective in 2014. However, much of the savings would be offset by new costs, including the cost of covering new enrollees with incomes up to 133 percent of the FPL under Medicaid and premium subsidies in the Exchange for individuals with incomes up to 400 percent of the FPL. Savings to Medicare would also be offset by lower revenues associated with foregone Medicare premium payments from those ages 65 and 66 who would no longer be eligible. Altogether, these offsets would result in lower net federal savings than what they would have been prior to the implementation of the ACA **(Exhibit 7)**.[23]



- **Federal spending is estimated to decline (on net) by $5.7 billion in 2014.** Gross federal savings are estimated to be $31.1 billion because Medicare would no longer provide coverage to 65- and 66-year-olds (including $30.5 billion in savings to Medicare and $0.6 billion in federal savings on cost sharing for Medicaid buy-ins). However, federal spending would increase by $8.9 billion for Medicaid, as low-income 65- and 66-year-olds shift to Medicaid coverage, and by another $9.4 billion in premium tax credits and cost-sharing assistance through the Exchange, due to the shift of low-income 65- and 66-year-olds into the Exchange. Federal savings would be further offset by a total decline of $7.0 billion in Medicare premium receipts: 65- and 66-year-olds would no longer be required to pay Part B premiums, including the income-related Part B premium for individuals with incomes above $85,000 ($170,000 for couples).

- **State Medicaid spending is estimated to increase by $0.7 billion in 2014.** This total takes into account: (1) a $0.9 billion increase in state expenditures for individuals who otherwise would have been dual eligibles, with Medicare as their primary payer, for whom Medicaid becomes primary

payer; (2) an increase of $0.2 billion in Medicaid payments of Medicare Part B premiums for dual eligibles, since raising the age of eligibility is expected to result in an increase in Part B premiums (see *Impact on Premiums* below); (3) savings of $0.3 billion associated with individuals who qualify as new Medicaid enrollees, on whose behalf states would otherwise have made Medicare buy-in or cost-sharing payments but whose new Medicaid coverage would be fully-funded by the federal government in 2014; and (4) a $0.1 billion reduction in state payments of Medicare premiums on behalf of dual eligibles ages 65 and 66. Although Medicaid would become the primary source of coverage for an estimated 860,000 low-income 65- and 66-year olds, the federal government would pay 100 percent of the costs in 2014, so no additional costs are shown for states on behalf of these new enrollees that year. However, the ACA requires states to assume responsibility for 10 percent of the cost of newly-eligible individuals by 2020, so states would incur additional costs for this population in later years.[24]

IMPACT ON EMPLOYERS

- **Employers costs are estimated to increase by $4.5 billion in 2014 if the Medicare eligibility age is raised to 67.** This increase results from employer plans becoming primary rather than secondary payer that wraps around Medicare when Medicare is no longer the primary payer. We estimate that total premiums would increase as a result, increasing costs for employers and retirees, each of whom are estimated to pay half of the higher premium. The increase in retiree health costs would also be reflected in the long-term liability of employers for their retiree health obligations.

IMPACT ON PREMIUMS

Raising the age of eligibility is projected to result in an estimated aggregate increase of $2.2 billion in Part B premiums paid by (or on behalf of) remaining enrollees in 2014, and an aggregate increase of $0.7 billion in premiums paid by individuals purchasing coverage in the Exchange that year.

- **Medicare Part B premiums** would increase by three percent (nearly $4 per month, or $46 per year) in 2014. The exclusion of relatively healthy and lower-cost enrollees from Part B would raise the average cost across remaining Part B enrollees, and this would be reflected in the Part B premium, which is tied by statute to the projected costs per enrollee. The modest increase in the monthly Part B premium would affect all elderly and disabled beneficiaries who are covered by Medicare, other than dually eligible enrollees for whom Medicaid pays the Part B premium. (Depending on the Social Security cost-of-living adjustment for 2014, all enrollees would not actually have to pay the higher amount.) The proposal would not affect the income-related premium paid by Medicare beneficiaries with higher incomes.

- **Premiums for adults under age 65 in the Exchange** would increase by three percent ($141 per enrollee in 2014), on average, due to the shift of older adults from Medicare into the pool of lives covered by the Exchange. The increase in average premiums in the Exchange would also contribute to an increase in federal spending due to higher premium subsidies for families with incomes below 400 percent of the FPL.
    - For adults in the Exchange up to age 30, for example, premiums would rise by nearly eight percent, on average, as a result of including 65- and 66-year olds in the Exchange.
    - For adults in the Exchange between the ages of 30 and 34, premiums would increase by about five percent, on average.

IMPACT IN THE ABSENCE OF THE 2010 HEALTH REFORM LAW

As noted earlier, this study models the expected effects of raising the Medicare eligibility age to 67 in 2014—assuming full implementation of the ACA that year. If the law is repealed, or if the coverage provisions of the law are not fully implemented, our analysis would need to be revisited. Drawing from the results of our analysis and the results of other analyses conducted prior to the enactment of the ACA, we would expect that raising the age of Medicare eligibility to 67 in the absence of the health reform law would:

- **Yield similar Medicare savings due to fewer people being covered by Medicare but federal savings would be substantially higher** in the absence of federal outlays associated with the ACA for expanded coverage under Medicaid and subsidies for low-income individuals.

- **Increase the number of adults ages 65 and 66 who would be uninsured** in the absence of the health reform coverage expansions, the individual mandate to obtain coverage, and the age-rating bands that limit premiums for older adults, disproportionately affecting those without access to employer-sponsored coverage and others with modest incomes who would not likely be able to afford premiums in the non-group market.

- **Increase the number of underinsured adults ages 65 and 66 in the non-group market,** in the absence of market reforms such as those that prohibit private insurers from imposing coverage exclusions for those with pre-existing conditions.

- **Increase Medicare Part B premiums for all other beneficiaries,** by removing from the Part B risk pool relatively healthy 65- and 66-year-olds, just as would be expected to occur if the health reform coverage provisions were fully implemented.

- **Raise employer and retiree premium contributions**, as employer plans become the primary source of coverage for people ages 65 and 66, rather than secondary to Medicare—similar to the expected effect if the health reform law is fully implemented in 2014.

Thus, with or without the health reform law, a policy to raise the age of eligibility would be expected to result in a reduction in Medicare spending, an increase in Medicare Part B premiums, and higher costs for employers that offer retiree health benefits and for retirees ages 65 and 66 in employer plans. In the absence of the health reform law, federal savings would be greater, but 65- and 66-year-olds who were no longer eligible for Medicare would be at greater risk of being uninsured and underinsured, and thus exposed to higher costs than if the provisions of the health reform law take effect.

CONCLUSION

Previous studies conducted prior to the enactment of the 2010 health reform law concluded that raising the age of Medicare eligibility would produce significant federal savings, but would also increase the number of uninsured older adults and shift risk and additional cost onto retirees who lack health insurance and onto employers that offer retiree health plans. Our analysis, which takes into account the coverage expansions and subsidies in the ACA, finds that net federal savings to the federal government would be considerably lower than previously estimated because the federal government would incur new costs associated with expanded coverage for 65- and 66-year olds under Medicaid and premium tax credits and cost-sharing assistance for lower-income individuals in the new health insurance Exchange.

We estimate that nearly one-third of the 65- and 66-year-old adult population who would be affected by an increase in the age of Medicare eligibility—those with low incomes who would qualify for Medicaid or generous premium tax credits and cost-sharing assistance through the Exchange—would face lower out-of-pocket costs than they would have paid under Medicare in 2014 as a result of this policy change – generally those with incomes below 300 percent of the FPL. However, two-thirds would face higher out-of-pocket costs, on average, due to higher premium contributions for employer-sponsored coverage and for coverage in the Exchange. The shift of adults ages 65 and 66 from Medicare to the Exchange is also projected to increase premiums that would be paid by adults younger than age 65 in the Exchange, as older adults enter the Exchange risk pool. In addition, Part B premiums paid by the elderly (ages 67 and over) and by disabled Medicare beneficiaries would be expected to increase, as the healthiest and lowest-cost segment of the Medicare population is removed from the Part B risk pool and shifted to the Exchange or to employer-sponsored plans. States and employers are also expected to see increased costs.

In light of the 2010 health reform law, this analysis updates—and to some degree upends—the conventional wisdom about the effects of raising the age of Medicare eligibility. As with previous studies, we find that raising the age of eligibility for Medicare would be expected to reduce Medicare spending, although the savings are expected to be lower than previously estimated because of the new costs of providing subsidized coverage to those with low incomes under Medicaid or the Exchange. Raising the age of eligibility is expected to reduce out-of-pocket costs for 65- and 66-year-olds with relatively low incomes, on average, while increasing premiums for others, including the majority of those ages 65 and 66 with incomes above 300 percent of the FPL, adults younger than age 65 in the Exchange, and seniors and people with disabilities who remain on Medicare. Given the magnitude of the changes that we estimate would occur by raising the Medicare eligibility age, this analysis underscores the importance of carefully assessing the distributional effects of various Medicare reforms and savings proposals to understand the likely impact on beneficiaries and other stakeholders.

TECHNICAL APPENDIX

DATA

We used data from five sources to prepare these estimates.

Medicare claims: Data from the 100-percent claims files were tabulated for this report. These data are useful because they include the beneficiary's date of birth, so that months of enrollment and expenditures incurred while the beneficiary was 65 or 66 years of age can be separated from other periods and expenditures.

The Medicare Current Beneficiary Survey (MCBS): We used the MCBS Cost and Use File for 2006[25] to estimate most of the expenditure patterns for different groups of people. The MCBS combines survey data with Medicare administrative data to create a picture of the enrollees' use of and spending for health care during the calendar year.

The Health and Retirement Study (HRS): This is a longitudinal survey of people ages 50 years and older.[26] The RAND Corporation cleans the data and transforms them to fit a uniform format; we used Version J of this dataset, covering data through Wave 9 (2008).[27]

The 2010 Medicare Trustees Report (TR): We used the "intermediate scenario" in this year's report[28] for Medicare enrollment and expenditures in 2006, 2008, and 2014 to anchor the estimates we produced.

National Health Expenditures (NHE) projections: The CMS Office of the Actuary (OACT) regularly projects spending by type of service and source of funds. This year, the Actuaries produced two sets of projections, one describing the world without implementation of the Affordable Care Act (ACA)[29] and the other describing a world after implementation of the Act[30]. We used the former set, as they contain more detail and the effects of the implementation of ACA were not terribly relevant to the elements we used.

CREATING DISPOSITION GROUPS

We used information from the Medicare administrative data to create five "disposition groups" for people age 65 or 66 years at some point in 2014—categorizations of people based on their likely response to the proposed delay of Medicare eligibility. These groups, which are hierarchical, are:
1. Persons originally entitled on the basis of disability: These people were enrolled in Medicare prior to their 65th birthday, and are unaffected by the delayed age of eligibility for the program.

2. People with Part A only: We used this enrollment measure to approximate the "working aged" population. The measure is approximate, in that it captures some retirees with other health insurance (such as the Federal Employee Health Benefit program), some who live outside the country, and others who simply choose not to enroll in Part B.

3. People who are dually eligible for Medicare and Medicaid: We used the marker that indicates State payment of the Part B premium to identify these people. The marker does not cover all dually-eligible

enrollees, as some states do not make buy-in payments, but it provides a reasonable indicator of people for whom Medicaid would become the primary, rather than secondary, form of insurance.

4. People on whose account a Part D Retiree Drug Subsidy (RDS) payment is made or who have creditable coverage under Part D: We used these markers to indicate an enrollee who is likely to have generous employer-sponsored insurance (ESI); we assume that this insurance would become primary if Medicare enrollment were deferred and that these people would remain with their existing insurance.

5a. People receiving a Part D Low-Income Subsidy (LIS) benefit: These people are assumed to be eligible for the new Medicaid expansion.

5b. All other enrollees aged 65 or 66 years: This remaining group of people is assumed to enroll either in the newly-expanded Medicaid program or in an Exchange. The category includes people without ESI or with limited ESI (proxied by the absence of drug coverage). Some members of the group may receive benefits through the Veterans Administration, through directly-purchased insurance (Medigap) or some other third party, or may have no other public or private supplemental coverage aside from Medicare.

Groups 5a and 5b were treated separately for the purposes of estimating Medicare savings, but were combined for the remainder of the analysis. This fifth disposition group was subdivided using income data from the HRS. This survey does not contain elements that permit an exact replication of the disposition categories, but we can place each survey participant approximately. For this fifth group, we created a measure of adjusted household income as a percent of the FPL, based on HRS Wave 9 (2008) data, to create five subcategories:

- Income under 133 percent of the FPL
- 133-150 percent
- 151-200 percent
- 201-300 percent
- 301-400 percent
- 401 percent and greater

To calculate this adjusted household income measure in order to derive the poverty groups, we started with the HRS measure of household income that excludes food stamps (variable name H9POVHHI). Because the ACA does not count Social Security income in determining eligibility for Medicaid, we subtracted SSI, DI, and OASI benefits for self (and spouse, if any) (variable names R9ISSDI, R9ISRET, S9ISSDI and S9ISRET), and then found the ratio of this measure to the applicable poverty threshold (variable name H9POVTHR). We used the adjusted income measure to determine who would qualify for Medicaid based on income less than 133 percent of the FPL and who would be eligible for subsidies in the Exchange.

Establishing the number of people affected

This number is based on Medicare administrative data. Using the 2008 enrollment files, we tabulated the number of enrollees who were 65 or 66 years old during the year, and the total number of months of that enrollment. That is, any enrollee who was 65, 66, or 67 years of age at the end of the calendar year was deemed to be affected, although 65-year olds and 67-year olds were only affected for part of the year. These estimates represent the number of people "ever affected." Separate estimates were constructed for the FFS and MA populations. The months for these enrollees were distributed among

the five disposition groups based on the information in their administrative record. Using these estimates, we also calculated the total number of "life years," an annualized measure—dividing total months of exposure by 12—that can be interpreted as the number of people affected in 2014.

To bring the 2008 counts to 2014, we used the Part A and Part B enrollment projections that underlie the 2010 Medicare Trustees reports. The same growth rate was applied to "ever-affected" people counts and to counts of months of exposure, assuming that—for the purposes of this simulation—the age composition of the Medicare population and the average number of months enrolled per person is effectively the same in 2014 as in 2008. The projected counts were made for MA and FFS enrollees separately.

Estimating Medicare benefits and premiums

Benefit figures are based on administrative claims data for 2008. Benefit outlays for FFS enrollees[31] were tabulated by the disposition groups described above, as a percentage of benefits for the total enrolled population. These percentages then were applied total Medicare benefit outlays from the 2014 Medicare trustees report. Separate estimates were constructed for Medicare Part A and Part B.

Medicare benefit outlays for MA enrollees are based on the ratio of the average Medicare per capita plan payment per enrollee for each disposition group to the average Medicare per capita plan payment for all MA enrollees. Data from the MCBS were used to calculate this ratio, which was then applied to the average Medicare MA benefit outlay for all MA enrollees for 2014 to estimate the average 2014 MA benefit outlays for each disposition group. Total MA benefit outlays for each group were estimated using the estimated number of MA enrollees in the group multiplied by their estimated average benefit outlays.

Medicare benefit outlays for Part D enrollees[32] are based on the ratio of average Medicare per capita Part D plan payments per enrollee for each disposition group to the average Medicare per capita Part D plan payment for all Part D enrollees. The ratio, estimated from the 2006 MCBS, was applied to the average Medicare Part D benefit outlay for all Part D enrollees for 2014 to estimate the average 2014 Part D benefit outlays for each disposition group.

Part D subsidy premium payments were estimated for enrollees in the groups that receive premium subsidy, i.e., Medicaid and LIS recipients. The LIS subsidy estimate used the same ratio that was used to estimated Part D benefit outlays, because the amount of LIS subsidy is linked to Part D utilization.

Part D RDS payments were based on the 2014 per capita Medicare RDS payments adjusted by the relative drug use of all 65- and 66-year-old Part D plan members. This adjusted per capita was applied to the number of 65- and 66-year-old enrollees with RDS to estimate total RDS payments for this group.

Estimates of Medicare premiums paid by the people affected by the proposal were estimated in three pieces. First, we multiplied the number of person-months of enrollment in each disposition group by the 2014 monthly premium.

The estimate of income-related premiums was somewhat more complicated. We started with assumptions of the share of Part B enrollees that would pay an income-related premium in 2014, based on an analysis by Actuarial Research Corporation for the Kaiser Family Foundation.[33] We used the MCBS to rank Part B enrollees by income, and calculated the proportion of income in the top 15 percent that

was accounted for by people ages 65 and 66 years. This proportion was applied to the $6.1 billion projection of income-related premiums implicit in the Trustee's report to determine the amount paid by the disposition groups. The MCBS was used to split this payment among the disposition groups.

Finally, we estimated that the deferred eligibility of 65- and 66-year olds would affect the monthly premium paid by remaining enrollees. This is because the younger group accounts for a disproportionately low share of total Part B benefits. We multiplied the current-law 2014 monthly premium by the ratio of (100 minus percent of benefits) and (100 minus percent of enrollment months) to calculate the increase in the monthly premium, which by law covers a fixed percentage of benefits.

Estimating Medicaid costs

Two disposition groups affect spending under the Medicaid program. The first is the group that would otherwise be dually eligible under current law. Medicaid is secondary to Medicare for this group, paying cost sharing up to the amount that Medicaid would have paid had it been primary. If Medicare eligibility is deferred, Medicaid would become primary for these people. We assumed that the increased cost to Medicaid would be equal to the amount of Medicare benefits otherwise spent for the group; although Medicaid payment rates are lower than those for Medicare, there would be no reduction in the total amount spent, as any differences are already embedded in lower current-law Medicaid cost sharing payments. The federal and state governments would save a small amount of money on buy-in payments for people who would be dually eligible under current law.

The second group to affect Medicaid spending is the group that would enroll in the new Medicaid expansion under the ACA. Although the ACA limits the Medicaid expansion to people under age 65, we assume this age limit would be raised to include 65- and 66-year-olds to reflect the higher age of Medicare eligibility. We excluded Social Security from income, consistent with eligibility criteria specified in the ACA, to determine eligibility for Medicaid. We used the MCBS to estimate the ratio of total covered spending to Medicare benefits in 2006, and applied this markup to 2014 Medicare benefits to derive an estimate of total spending in that year. We assumed that Medicaid payments for these services would be 25 percent lower than this amount, to account for differences between Medicaid payment rates and those for privately-insured or uninsured patients. As with the group who are fully dually eligible, the federal and state governments would not incur buy-in premiums for people in this group who would otherwise be Qualified Medicare Beneficiaries (QMBs) or Specified Low-Income Medicare Beneficiaries (SLMBs), nor cost-sharing amounts for would-be QMBs. Further, we have assumed that Medicaid expansion enrollees would face cost sharing equal to two percent of covered spending—a percentage estimated from the Medicare Current Beneficiary Survey.

The Federal share of Medicaid spending for the first group (dually-eligible enrollees) is assumed to be the average FMAP, currently 57 percent. The second group would be covered by a Federal FMAP of 100 percent in 2014, according to the ACA (gradually phasing down to 90 percent by 2020).

Estimating costs of Exchange coverage

We estimated the effects of moving a subset of the 65- and 66-year-olds to Exchange coverage using the implied covered expense level in the Exchange reflecting health status. We increased this coverage level by five percent to adjust for the higher overall basis of payment expected in the Exchange relative to Medicare. We converted the adjusted coverage level to an average benefit payment in the Exchange,

assuming Silver coverage which has a 70 percent actuarial value for a standard population. The expected actuarial value adjusted for leverage from the higher covered charge would be about 82 percent for these new enrollees. This is then loaded (15 percent administrative load on benefits, so an implied loss ratio of .87).

We then apply 3:1 age bands consistent with the ACA, which has the effect of reducing the premium for 65- and 66-year-olds by about 12 percent. Subsidy payments for these persons were then calculated, based on the statutory adjustment to actuarial value for subsidized persons (the mechanism for cost-sharing subsidies) and premium subsidy percentages for these income bands from CBO estimates. The total reduction in out-of-pocket spending produced by the cost-sharing subsidy rules is based on the relationship between the base actuarial value of a Silver plan (.7) and the increased actuarial value for coverage for persons qualifying for cost-sharing subsidies (ranging from .73 to .94). Additional Exchange effects (e.g. higher premiums for adults under age 65) are calculated to reflect the average increase in Exchange premiums for Exchange enrollees absent the proposal—about a three percent increase. The estimates reflect premium subsidies which cap enrollee premiums at an income-related level.

Estimating employer-sponsored insurance costs

We assumed that people with employer-sponsored insurance (ESI) retiree benefits would continue to receive those benefits even if the employer plan became primary for retirees, rather than secondary to Medicare. We estimated that the total increase in ESI benefits would be the amount of Medicare benefits "saved," adjusted to reflect an average actuarial value of ESI of 0.9 compared to 0.85 for Medicare. We inflated the adjusted benefit figure by 20 percent to reflect payment rate differences, and added a 15 percent load to derive an estimate of the change in total ESI premiums. We split this amount equally between plan sponsors and retirees to approximate the current shares of the premium paid.

Estimating out-of-pocket costs

This model assigns individuals to groups based on income and insurance status, and estimates out-of-pocket spending for each group. Because the model was not constructed at the person level, it does not reflect variations in out-of-pocket spending within subgroups. Mean out-of-pocket spending is assigned to each individual in the group, so estimates do not reflect potential variations within the group. For this analysis, we assume that individuals with higher or lower out-of-pocket spending within each group balance out, but recognize this approach may understate the potential effects of this policy, in either direction.

Individuals affected by this proposal are affected differently depending on their source of coverage and their income (before and after losing Medicare eligibility).

- Those with Part A only, whom we assume to reflect working-aged beneficiaries for whom Medicare is secondary, are assumed to bear the cost of shifted Medicare benefits. This is because Medicare covers cost sharing for these people, and we assume that employers will not pick up cost sharing amounts.

- Retirees covered by ESI, and those who move to Medicaid or the Exchange, face different premiums. They are relieved of the cost of monthly Medicare premiums and any income-related premiums. But ESI retirees are expected to incur higher monthly premiums, and Exchange enrollees would be

responsible for the unsubsidized portion of their Exchange premium. Our premium estimates for Exchange enrollees incorporate the provision of the health reform law that limits enrollees' premium contributions for those with incomes up to 400 percent of the FPL.

- Medicare enrollees otherwise unaffected by the delay in eligibility pay higher monthly premiums, as discussed above.[34]

- Exchange enrollees would face different cost sharing than under current law. Based on tabulations from the MCBS, we estimated that the current-law cost sharing experienced by new Exchange enrollees would have ranged from 12 percent for the lowest-income group up to 19 percent for the highest-income group. We placed all these new enrollees in a "Silver" Exchange plan that nominally imposes 30-percent cost sharing on beneficiaries. However, a substantial portion of their spending would likely exceed the catastrophic cap and thus be exempt from coinsurance. We assumed this share to be 40 percent of incurred benefits, so that the effective cost share—which reflects both subsidized payments and waiver of cost share on benefits over the catastrophic cap—ranged from 3.6 percent of total benefits for the lowest income group up to 18.0 percent for the highest income group.

- Exchange enrollees under age 65 would face a higher premium because of the infusion of older members into the Exchange risk pool.

- Exchange enrollees over age 65 would face differing cost-sharing changes depending on their incomes.

Important assumptions and limitations

Several assumptions affect our estimates:

- **Full implementation of the proposal in 2014.** To the extent that the Medicare eligibility age is raised gradually over several years, a similar ramp-up of the effects of the proposal would need to be created.

- **Full implementation of coverage provisions of the ACA in 2014.** If the health reform law were to be repealed in full or in part, the analysis would need to be revisited.

- **All individuals would obtain coverage if they were not eligible for Medicare, either from an employer, a plan offered in the health insurance exchange, or Medicaid.** Thus, our analysis does not assess the cost or coverage implications of some 65- and 66-year-olds choosing to pay the penalty for not purchasing insurance rather than pay the full premium through the Exchange, if that were to be the only coverage option available to them. To the extent that some of these individuals elect to remain uninsured, the effects upon the Exchange would be reduced relative to our estimates. However, those who might opt to go without insurance coverage would most likely be higher-income people with lower health expenditures, which would minimize the effect upon the Exchange and net federal spending.

- **All individuals eligible for Medicaid, or relatively generous subsidies under the Exchange, receive this coverage.** This assumption results in a relatively optimistic assessment of the share of

beneficiaries who would be comparatively better off in 2014 if they shifted from Medicare to a new source of coverage, or to no coverage whatsoever. If Medicaid participation were to be lower than expected, or if premium tax credits and cost-sharing assistance take-up were to be lower than expected, then federal savings would be somewhat higher due to lower federal spending on subsidized coverage. At the same time, out-of-pocket spending for those not getting the most generous coverage to which they would be entitled under the ACA would likely be higher.

- **No behavioral effects regarding beneficiary enrollment in ESI.** That is, we assume that people with RDS or creditable coverage would remain in ESI. Recall that RDS or creditable coverage in 2006 was assumed to indicate generous ESI coverage, so that even if plans drop their RDS status by 2014 the generosity of benefits would cause people to remain in the plan. People with ESI coverage tend to have higher incomes, making them less likely to receive an Exchange subsidy. We assume the overall rate of ESI coverage remains the same between 2008 and 2014—at least for the types of ESI indicated by RDS or Part D creditable coverage. To the extent that this type of coverage diminishes, more people would likely turn to the Exchange.

- **No behavioral changes regarding the decision to retire.** We did not assume an employment effect resulting from raising the Medicare eligibility age; that is, we did not model the likelihood that individuals may choose to work longer if the Medicare eligibility age is raised, nor estimate the associated revenue effects (e.g., additional general revenues due to taxable wages paid by 65- and 66-year olds).[35] It is possible that raising the age of Medicare eligibility could encourage people who would otherwise choose to retire to remain in the workforce beyond age 65, either in order to continue to be eligible for ESI benefits or to earn enough to cover their new premiums or health costs through the Exchange. This would increase the number of individuals with employer-sponsored coverage and presumably reduce the numbers who get coverage through the Exchange. However, the coverage expansions and premiums subsidies in the health reform law, scheduled to take effect in 2014, could mitigate the incentive to delay retirement that would otherwise be expected with a delay in the age of Medicare eligibility. It is possible that incentives that favor early retirement in the ACA may offset some or all of the incentives to continue working that may result from extending the Medicare eligibility age. To the extent that individuals continue to work beyond age 65 without enrolling in the Exchange, their out-of-pocket spending is expected to be lower than if they were covered under the Exchange, but higher than if they were covered under Medicare. If Medicare coverage was no longer available to 65- and 66-year-olds and these individuals choose to work longer, we assume this would have a modest effect on employer costs because the employer plan would be primary for active workers and retirees ages 65 and 66, although it is possible that employer contributions to premiums would be higher for active workers than retirees. The effects on net federal spending, if any, would include a small increase in Medicare savings through the infusion of more Part A (Hospital Insurance) payroll taxes and a slight reduction in spending on the Exchange relative to our estimates.

- **No behavioral effects regarding employer offer of health insurance.** Currently, some plans cover retirees under age 65, and others cover people beyond that age. Our assumption is that those plans that cover workers to age 65 would extend the coverage until the age of Medicare eligibility. If raising the age of eligibility results in employers terminating coverage for current retirees or not covering the insurance gap for 65- and 66-year-olds, we expect that retirees would likely go to the Exchange for their coverage, or delay retirement and remain covered as active workers. We expect this would have a minimal effect on federal spending for Exchange coverage, because retirees tend to have higher incomes and would be unlikely to qualify for generous subsidies through the

Exchange. It could, however, result in an increase in out-of-pocket spending among retirees to the extent their former employer plan was more generous than coverage offered in the Exchange. To the extent that raising the Medicare eligibility age induced employers to terminate retiree health benefits, employers' additional costs would be expected to decline. We note that although there is a substantial transfer of costs to employers in the form of higher premiums, our estimate of this is dwarfed by the total cost of employer-sponsored insurance (close to $700 billion in 2014 for active and retired workers, according to CMS projections).

- **None of the 65- and 66-year-olds affected by the proposal will gain Medicare eligibility because of disability.** This is a somewhat strong assumption, as existing patterns of SSDI enrollment show new beneficiaries ages 64 and 65 years. However, this number is affected by many factors, and in the scheme of things is fairly small. To the extent that this assumption is incorrect, the savings to Medicare would be reduced because fewer people would be shifted off the program to other sources of coverage. It is likely that a large share would have been dually-eligible under current law, so the effect upon Medicaid would be reduced correspondingly.

- **No change in the demographic composition of the Medicare current-law population between 2008 and 2014.** In fact, there should be a small increase in the proportion of enrollment months attributed to people ages 65 and 66 to reflect the influx of older members of the Baby Boom generation. However, we expect the effect of our simplification to be negligible.

APPENDIX EXHIBIT 1: SUMMARY OF EFFECTS OF RAISING THE MEDICARE ELIGIBILITY AGE TO 67 IN 2014

Coverage Group	People ever affected (mil)	Life-years (mil)	% of 65-67 year olds affected	Net Federal change		Medicare $		Medicaid				Federal Exchange		Employers	
								Federal		State					
				Savings ($ bil)	Offsets ($ bil)	Savings ($ bil)	Offsets ($ bil)	Savings ($ bil)	Offsets ($ bil)	Savings ($ bil)	Offsets ($ bil)	Savings ($ bil)	Offsets ($ bil)	Savings ($ bil)	Offsets ($ bil)
TOTAL				**$31.1**	**$25.4**	**$30.5**	**$7.0**	**$0.6**	**$8.9**	**$0.4**	**$1.1**	**-**	**$9.4**	**$4.5**	**$9.0**
65-67 year olds directly affected	**7.3**	**5.0**	**100.0%**	**$28.9**	**$22.5**	**$28.3**	**$7.0**	**$0.6**	**$8.7**	**$0.4**	**$0.9**	**-**	**$6.8**	**$4.5**	**$9.0**
Active workers in employer-sponsored plans	1.5	1.0	20.0%	0.5	-	0.5	-	-	-	-	-	-	-	-	-
Currently fully dually eligible enrollees	0.2	0.1	2.6%	2.2	1.4	2.1	0.2	0.1	1.2	0.1	0.9	-	-	-	-
Retirees in employer-sponsored plans	1.6	1.1	22.1%	6.1	1.9	6.1	1.9	-	-	-	-	-	-	4.5	9.0
New Medicaid enrollees	1.2	0.9	17.0%	6.5	8.8	6.0	1.3	0.5	7.5	0.3	-	-	-	-	-
Total New Exchange enrollees:	2.8	1.9	38.3%	13.6	10.4	13.6	3.7	-	-	-	-	-	6.8	-	-
<150% FPL	0.1	0.1	1.4%	0.5	0.8	0.5	0.1	-	-	-	-	-	0.7	-	-
150-200% FPL	0.4	0.3	5.0%	1.8	2.6	1.8	0.4	-	-	-	-	-	2.2	-	-
200-300% FPL	0.6	0.4	8.1%	2.9	3.3	2.9	0.6	-	-	-	-	-	2.7	-	-
300-400% FPL	0.3	0.2	4.8%	1.7	1.6	1.7	0.4	-	-	-	-	-	1.2	-	-
400%+ FPL	1.4	1.0	19.1%	6.8	2.3	6.8	2.3	-	-	-	-	-	-	-	-
Other Exchange enrollees (unsubsidized)[1]	5.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Exchange enrollees (subsidized)[1]	19.0	-	-	-	2.7	-	-	-	-	-	-	-	2.7	-	-
Other Part B enrollees[2]	-	48.4	-	2.2	0.2	2.2	-	-	0.2	-	0.2	-	-	-	-

SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation, July 2011.
NOTE: mil is million; bil is billion. [1]Other Exchange enrollees refers to those ages 64 and younger who enroll in the Exchange. [2]Other Part B enrollees include those ages 67 and older and all enrollees originally entitled because of disability, regardless of current age.

APPENDIX EXHIBIT 2:
CHANGE IN OUT-OF-POCKET SPENDING FOR COVERAGE GROUPS AFFECTED BY RAISING THE MEDICARE ELIGIBILITY AGE TO 67 IN 2014

Based on New Source of Health Insurance and Subsidy Level

	Out-of-Pocket Spending (in $ billions)				
Coverage Group	**Savings**		**Offsets**		**NET**
TOTAL AFFECTED		***$16.7***		***$22.9***	***-$6.2***
TOTAL AGES 65-67 DIRECTLY AFFECTED [1]		***$16.7***		***$20.4***	***-$3.7***
Previously disabled enrollees remaining on Medicare	**Total**	**$0.0**	**Total**	**$0.0**	**$0.0**
Active workers in employer-sponsored plans	**Total**	**$0.0**	**Total**	**$0.5**	**-$0.5**
			Cost sharing	$0.5	
Current fully dually eligible enrollees (Medicare and Medicaid)	**Total**	**$0.0**	**Total**	**$0.0**	**$0.0**
Retirees in employer-sponsored plans	**Total**	**$2.9**	**Total**	**$5.3**	**-$2.4**
	Cost sharing	$1.1	Cost sharing	$0.9	
	Medicare premiums	$1.6	ESI premiums	$4.5	
	Income-related premiums	$0.2			
New Medicaid enrollees	**Total**	**$2.9**	**Total**	**$0.2**	**$2.8**
	Cost sharing	$0.8	Cost sharing	$0.2	
	Medicare premiums	$1.3			
	Private insurance premiums	$0.8			
Total new Exchange enrollees					
New Exchange enrollees <150% FPL	**Total**	**$0.3**	**Total**	**$0.05**	**$0.2**
	Cost sharing	$0.1	Exchange cost sharing	$0.02	
	Medicare premiums	$0.1	Exchange premiums	$0.03	
	Private insurance premiums	$0.1			
New Exchange enrollees 150%-200% FPL	**Total**	**$1.1**	**Total**	**$0.5**	**$0.6**
	Cost sharing	$0.4	Exchange cost sharing	$0.2	
	Medicare premiums	$0.4	Exchange premiums	$0.3	
	Private insurance premiums	$0.3			
New Exchange enrollees 200%-300% FPL	**Total**	**$1.8**	**Total**	**$1.7**	**<$0.1**
	Cost sharing	$0.7	Exchange cost sharing	$0.8	
	Medicare premiums	$0.6	Exchange premiums	$0.9	
	Private insurance premiums	$0.5			
New Exchange enrollees 300%-400% FPL	**Total**	**$1.1**	**Total**	**$1.4**	**-$0.3**
	Cost sharing	$0.5	Exchange cost sharing	$0.6	
	Medicare premiums	$0.4	Exchange premiums	$0.9	
	Private insurance premiums	$0.3			
New Exchange enrollees 400%+ FPL	**Total**	**$6.6**	**Total**	**$10.8**	**-$4.2**
	Cost sharing	$2.6	Exchange cost sharing	$2.4	
	Medicare premiums	$1.4	Exchange premiums	$8.3	
	Income-related premiums	$0.8			
	Private insurance premiums	$1.7			
Other Exchange enrollees[2] (unsubsidized) Other Exchange enrollees (subsidized)	**Total**	**$0.0**	**Total**	**$0.7**	**-$0.7**
			Exchange premiums (net)	$0.7	
Other Part B enrollees[3]	**Total**	**$0.0**	**Total**	**$1.8**	**-$1.8**
			Medicare premium	$1.8	

SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation, July 2011.
NOTE: [1]Excludes Other Exchange enrollees and Other Part B enrollees. [2]Other Exchange enrollees refers to those ages 64 and younger who enroll in the Exchange. [3]Other Part B enrollees include those ages 67 and older and all enrollees originally entitled because of disability, regardless of current age.

ENDNOTES

[1] Kaiser Family Foundation. (January 2011) Comparison of Medicare Provisions in Deficit Reduction Proposals http://www.kff.org/medicare/8124.cfm.
[2] See, for example, the Rivlin-Ryan proposal "A Long-Term Plan for Medicare and Medicaid" released November 17, 2010; "The Roadmap to America's Future, Version 2.0'' proposed by Representative Ryan January 27, 2010, and "The Future is Now: A Balanced Plan to Stabilize Public Debt and Promote Economic Growth," by Bill Galston and Maya MacGuineas, released September 30, 2010; Committee for a Responsible Federal Budget. (September 2010) *Let's Get Specific: Health Care.* http://crfb.org/sites/default/files/Lets_Get_Specific_Health_Care.pdf Accessed November 3, 2010.
[3] The early retirement age for Social Security benefits is age 62.
[4] National Bipartisan Commission on the Future of Medicare. (March 16, 1999) *Building a Better Medicare for Today and Tomorrow.* http://thomas.loc.gov/medicare/bbmtt31599.html Accessed October 21, 2010.
[5] Committee for a Responsible Federal Budget. (September 2010) *Let's Get Specific: Health Care.;* Johnson, Richard W. (December 2003) *Changing the Age of Medicare Eligibility: Implications for Older Adults, Employers, and the Government.* The Urban Institute.*;* Johnson, Richard. (November 15, 2005) *Raising the Medicare Eligibility Age with a Buy-In Option: Can One Stone Kill Three Birds?* The Urban Institute.*;* Johnson, Richard W. and Amy J. Davidoff. (July/ August 2003) "Raising the Medicare Eligibility Age: Effects on the Young Elderly." *Health Affairs.;* Waidmann, Timothy A. (1998) "Potential Effects of Raising Medicare's Eligibility Age." *Health Affairs,* Vol. 17(2).; Wittenburg, David C., David C. Stapleton, and Scott B. Scrivner. (2000) "How Raising the Age of Eligibility for Social Security and Medicare Might Affect the Disability Insurance and Medicare Programs." *Social Security Bulletin,* Vol. 63(4).
[6] Congressional Budget Office. (March 2011) *Reducing the Deficit: Spending and Revenue Options.* http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf Accessed March 14, 2011.
[7] Public Law 111-148, Public Law 111-152.
[8] Kaiser Family Foundation. (April 2010) "Explaining Health Care Reform: Questions about Health Insurance Subsidies." *Focus on Health Reform.* http://www.kff.org/healthreform/upload/7962-02.pdf
[9] Congressional Budget Office. (July 16, 2009) "The Long-Term Budget Outlook." *Testimony of Douglas W. Elmendorf, Director before the Committee on the Budget, United States Senate*. http://www.cbo.gov/ftpdocs/104xx/doc10455/07-16-Long-TermOutlook_Testimony.pdf Accessed October 21, 2010.
[10] In 2006, the average American life expectancy was almost 7 years higher than it was in 1965. See Arias, Elizabeth. (June 28, 2006) "Table 11. Life expectancy by age, race, and sex: Death-registration states, 1900–1902 to 1919–1921, and United States, 1929–1931 to 2006." *National Vital Statistics Reports*, Vol 58:21.
[11] See, for example, Johnson, Richard W. (December 2003) *Changing the Age of Medicare Eligibility: Implications for Older Adults, Employers, and the Government.* The Urban Institute for the National Academy of Social Insurance.
[12] See, for example, Amy J. Davidoff and Richard W. Johnson, Raising The Medicare Eligibility Age: Effects On The Young Elderly. *Health Affairs*, 22, no. 4 (2003): 198-209.
[13] Kaiser Family Foundation. (September 1997) *Retiree Health Trends and Implications of Possible Medicare Reforms*, by Hewitt Associates LLC.
[14] Kaiser Family Foundation. *Retiree Health Trends and Implications of Possible Medicare Reforms*.
[15] The ACA includes a five percentage point disregard for modified adjusted gross income (MAGI) in calculating who is newly eligible for Medicaid, effectively increasing the FPL threshold to 138 percent. We did not incorporate that higher threshold in our model of the effects of raising the eligibility age. Doing so would shift approximately 38,000 65- and 66-year-olds to Medicaid coverage from the lowest-income group that would enroll in the Exchange.
[16] The Health and Retirement Study is sponsored by the National Institute on Aging (grant number NIA U01AG009740) and is conducted by the University of Michigan. The RAND HRS Data file is a longitudinal data set based on the HRS data, developed at RAND with funding from the National Institute on Aging and the Social Security Administration.
[17] Estimates of federal and state costs do not take into account higher costs associated with retiree health costs for public retirees for whom the employer plan would likely become the primary source of retiree health benefits.
[18] For example, a person who turned 67 on July 15, 2014 would be affected for the months of January through June, and would count as half of a life-year.
[19] Medicare would also continue to cover individuals with End-Stage Renal Disease (ESRD) and ALS (Lou Gehrig's Disease), although this is a relatively small number of people.
[20] This policy simulation was not carried out at a person level. Within each group, some individuals may pay more and other pay less under the proposed policy; we have ascribed the average gain or loss to each member of the group.
[21] We assume that retirees bear the cost of their coverage (shared roughly equally with employers), but to the extent younger adults enter the retiree risk pool, average premiums for retirees could decline, potentially reducing premiums for older retirees. We make no assumptions about employers' reaching caps on retiree health contributions and shifting additional costs onto retirees.
[22] Committee for a Responsible Federal Budget. (September 2010) *Let's Get Specific: Health Care.;* Johnson, Richard W. (December 2003) *Changing the Age of Medicare Eligibility: Implications for Older Adults, Employers, and the Government.* The Urban Institute.*;* Johnson, Richard. (November 15, 2005) *Raising the Medicare Eligibility Age with a Buy-In Option: Can One Stone Kill Three Birds?* The Urban Institute.*;* Johnson, Richard W. and Amy J. Davidoff. (July/ August 2003) "Raising the Medicare Eligibility Age: Effects on the Young Elderly." *Health Affairs.;* Waidmann, Timothy A. (1998) "Potential Effects of Raising Medicare's Eligibility Age." *Health Affairs,* Vol. 17(2).; Wittenburg, David C., David C. Stapleton, and Scott B. Scrivner. (2000) "How Raising the Age of Eligibility for Social Security and Medicare Might Affect the Disability Insurance and Medicare Programs." *Social Security Bulletin,* Vol. 63(4).

[23] The model does not estimate additional costs for federal and state governments associated with higher retiree health premiums for federal/state retirees.
[24] The federal share of the cost for newly-eligible Medicaid enrollees drops to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and subsequent years.
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[30] Sisko, A. M., Truffer, C. J., Keehan, S. P., Poisal, J. A., Clemens, M. K., & Madison, A. J. (2010). National Health Spending Projections: The Estimated Impact Of Reform Through 2019. Health Affairs , 29 (10), 1933-1941.
[31] HCPP enrollees were treated as MA. Estimated benefit outlays for Part A services for HCPP enrollees were transferred from FFS benefit outlays to MA outlays.
[32] Excluding Part D subsidies and RDS payments.
[33] See Kaiser Family Foundation, Income-Relating Medicare Part B and Part D Premiums: How Many Medicare Beneficiaries Will Be Affected? December 2010, http://www.kff.org/medicare/8126.cfm.
[34] There is no transfer of the income-related premium to this group, because there is no target amount of money to be achieved.
[35] In its recent budget options report, CBO did not estimate an increase in tax revenues attributable to delayed retirement associated with raising the age of Medicare eligibility (CBO, March 2011).

Errata to "Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform"

July 2011

Calculation of Premium Subsidies

Exchange premium subsidies in the March 2011 version of this report understate federal premium subsidy payments and overstate premium obligations for those 65- and 66-year-olds with incomes below 400 percent of the federal poverty level (FPL) who would shift from Medicare to the Exchange if the Medicare eligibility age was raised to 67. The revised report (July 2011) includes an adjustment to federal premium subsidy payments and enrollee premiums to reflect the interaction between premium variations by age and the cap on the premium payments, which varies by income.

The original and corrected premiums are shown below.

Premium costs by poverty band for persons shifting to Exchange (per member per year)	**Original estimates (March 2011)**	**Revised estimates (July 2011)**	**Premium difference**
New Exchange enrollees (<150% FPL)	$518	**$268**	**-$250**
New Exchange enrollees (<200% FPL)	$1,985	**$1,036**	**-$949**
New Exchange enrollees (<300% FPL)	$4,143	**$2,167**	**-$1,976**
New Exchange enrollees (<400% FPL)	$6,992	**$3,651**	**-$3,341**
New Exchange enrollees (400%+ FPL)	$8,632	**$8,632**	**No change**

Net Effects

The changes included in this report produce a lower estimate of the increase in net aggregate out-of-pocket spending for those 65- and 66-year-olds who would lose Medicare coverage (from $5.6 billion in the March 2011 report to $3.7 billion in the July 2011 report), and a lower estimate of net federal savings (from $7.6 billion to $5.7 billion) in 2014. In addition, new Exchange enrollees with incomes between 200 and 300 percent of the FPL are estimated to see a modest reduction in out-of-pocket costs ($200 on average) after shifting to the Exchange, rather than an increase of $1,800, as was previously estimated. The overall direction of the effect for other coverage groups is unchanged from our earlier analysis. According to our estimates in the revised report from July 2011, two-thirds of people ages 65 and 66 would pay more as a result of a policy to raise the Medicare eligibility age to 67, a modest decrease from the three-fourths estimate in the March 2011 version of the report.

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