



The Final Report of the Academy's Study Panel on Medicare Eligibility

# Examining Approaches to Expand Medicare Eligibility:

## Key Design Options and Implications

*March 2020*

NATIONAL  
ACADEMY  
OF SOCIAL  
INSURANCE

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*The perspectives expressed in this report are those of the Study Panel members and do not necessarily reflect the views of the organizations with which they are affiliated. Participation in a particular working group does not mean that any panel member advocates that approach.*

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**William J. Arnone**  
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## *Preface*

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# ABOUT THE REPORT

The National Academy of Social Insurance formed the Study Panel on Medicare Eligibility to examine the options for and implications of extending eligibility for Medicare beyond the current covered populations. Composed of 27 members, the Study Panel brought together expertise and experience from a broad range of perspectives. The Study Panel included members from numerous academic disciplines, such as economics, health policy, political science, sociology, medicine, and law, as well as people with direct experience working in areas related to public and private health insurance, as actuaries, health plan administrators, health care providers, labor representatives, and government regulators.

The Study Panel members and staff developed this report over 10 months of deliberations. Each panelist participated in one of the three working groups organized to address and develop analyses for each of three principal options for expansion—lowering the eligibility age, extending Medicare to all, and creating a Medicare buy-in. Based on plenary meetings and working-group calls, the staff drafted chapters that the entire Panel then reviewed. This final report represents a consensus among the Study Panel members and has been approved by the Board of Directors of the Academy.

This report presents a description of the current Medicare program and the principal ideas for using it to expand coverage, with an attempt to delineate each approach's policy tradeoffs, challenges, and implications. The report's analysis rests on the structure of the Medicare program as it exists today. Any future program changes may affect the report's analysis. In addition, as the report outlines the way in which some Medicare expansion proposals may interact with provisions of the Affordable Care Act, any changes in the insurance coverage requirements or marketplace structures may require reconsideration of the analysis contained in this report. While the Study Panel did not conduct modeling, this report delineates the design challenges of each proposal that need to be addressed to make informed policy decisions and cites findings from modeling work done by others. The report does not make recommendations; instead, it draws conclusions about likely impacts, where warranted, based on a review of the evidence and informed professional judgment. The report aims to help policymakers and the public understand potential impacts as expansion options continue to be considered and debated.



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# Executive Summary

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

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

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

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

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

## Medicare as a Platform for Reform

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

## Key Design Challenges and Policy Impacts

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

### Lowering the Age of Medicare Eligibility

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

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

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

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

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

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

## Approaches to Medicare for All

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

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

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

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

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

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

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

## **Establishing a Medicare Buy-In Program**

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

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

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

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

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

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

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

## Summary of Findings

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

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

## Closing Comments

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



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

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



# Medicare Enrollment

(VA File #)  GROUP HEALTH PLAN (SSN or ID)  (SSN)

3. PATIENT'S BIRTH DATE  
MM DD YY M

6. PATIENT RELATIONSHIP TO INSURER  
Spouse  Child

## Chapter 1: Context for Expanding Medicare Eligibility

## Overview

Improving access to affordable, high-quality health coverage and care and containing health care spending remain formidable policy challenges for the United States. Some policymakers and analysts view Medicare as a useful platform for expanding coverage because it has broad popularity, serves as a cost-effective source of health insurance coverage, and has potentially positive side effects across other parts of the health care system. Proposals to expand Medicare eligibility present, however, an extensive set of technical and program design considerations.

To address the problems of a lack of specificity in many proposals, the Study Panel examined options for and the implications of expanding eligibility for Medicare as it exists today or creating a Medicare-like coverage program. The Medicare-based proposals examined in this report do not capture the entire landscape of potentially useful health reform ideas. Rather, the Study Panel focused its work on several broad approaches to changing eligibility for Medicare. One approach is to lower the eligibility age incrementally. Another approach is to expand Medicare coverage to all, creating a universal system of coverage that acts as a third-party payer to independent providers. The third approach would involve creation of an optional Medicare buy-in under which some or all of the population would be eligible to purchase coverage through a program modeled on Medicare.

The report organizes the Study Panel analysis into five chapters and a series of appendices. The first chapter summarizes the current issues generating an impetus for proposals for health system reform and explores why Medicare is a potential platform for such. Following the description of the policy context in this chapter, the main chapters present the results of the Study Panel's investigation into three approaches to changing Medicare eligibility and the complexities involved in each approach. **Chapter 2** considers the rationale for lowering Medicare's eligibility age and the design decisions that accompany any such change. **Chapter 3** assesses options for using Medicare as a platform for universal coverage. **Chapter 4** considers the structure and potential impact of a Medicare buy-in option. **Chapter 5** summarizes key findings and policy tradeoffs in review of the three policy approaches and presents critical reform considerations. The substantive chapters assume that readers are familiar with the design of the current Medicare program; for convenience, Appendix A provides a detailed review of the key elements of today's Medicare program.

# Inadequacies of Current Policies and Goals of Reform Efforts

Cost-related pressures and concerns about the adequacy of access to affordable coverage and care are at the core of today's health reform debates.

## The High Cost of Health Care

U.S. per capita health care spending was \$9,892 in 2016, 145 percent higher than the Organisation for Economic Co-operation and Development (OECD) median of \$4,033. And U.S. spending on health care grew at a faster rate than the OECD median between 2000 and 2016 (Anderson, Hussey, and Petrosyan 2019). Health expenditures accounted for 17.2 percent of U.S. gross domestic product (GDP) in 2016, making the United States an outlier among the OECD countries, and it is a gap that has grown over time (Kaiser Family Foundation 2019b).

While a popular perception is that U.S. health care costs reflect higher quality care, the health system performs relatively poorly by international standards on important metrics, including the share of the population covered by insurance, measures of health care access and quality, and health outcomes. This comparison suggests that the United States is not getting good value in exchange for higher spending (Schneider et al. 2017). Studies comparing the United States to other countries attribute cost differentials to three factors: higher health care prices, fees, and salaries; higher administrative costs; and greater provision of expensive medical procedures. International studies have concluded that higher prices paid throughout the system for hospital stays, doctor visits, and drugs and devices are the primary factors (Anderson, Hussey, and Petrosyan 2019).

High and growing health care costs raises pressures on federal and state budgets to pay for Medicare, Medicaid, and other government insurance programs. In addition to paying taxes for Medicare and other public programs, individuals and families experience growth in health care costs in the form of higher premiums and out-of-pocket (OOP) spending on health care (deductibles, coinsurance, and copayments), which amount to more than \$28,000 a year for a family of four with employer-sponsored coverage (Girod, Hart, and Weitz 2018). A survey of 4,400 adults conducted in the spring of 2019 found that 58 percent said they had

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*A survey of 4,400 adults conducted in the spring of 2019 found that 58 percent said they had delayed or forgone medical or dental care in the previous year due to prohibitively high costs, and 38 percent reported that they did so “often” (Murad 2019).*

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delayed or forgone medical or dental care in the previous year due to prohibitively high costs, and 38 percent reported that they did so “often” (Murad 2019).

## Gaps in Health Insurance Coverage

The U.S. system of insurance coverage is failing many Americans—leaving 1 in 10 without coverage. In 2018, 8.5 percent of people, or 27.5 million, were uninsured at some point during the year. In the United States, the risk of being uninsured varies dramatically by race/ethnicity and income. According to the Census, in 2018, non-Hispanic white Americans had an uninsurance rate of 5.4 percent compared to 9.7 percent for black Americans and 17.8 percent for Hispanics of any race (Berchick, Hood, and Barnett 2018). In 2018, 13.8 percent of individuals in households making less than \$25,000 a year did not have health insurance compared with 3.2 percent in households making \$150,000 or more (Berchick, Hood, and Barnett 2018). Approximately 5 million undocumented immigrants were uninsured in 2017 (Blumberg et al. 2018).

Among those with coverage, many are underinsured, that is, they have insurance with OOP costs that are high relative to income, creating financial barriers to care and risks of economic insecurity. The share of the population that is underinsured more than doubled between 2003 and 2018, increasing from 12 percent to 28 percent of non-elderly adults (Collins, Bhupal, and Doty 2019).<sup>1</sup>

## Policy Goals and Objectives

**Table 1-1** provides a summary of the policy goals driving current reform proposals. Three policy goals are among the most commonly presented by advocates of reforms involving Medicare eligibility changes:

- expanding coverage
- increasing the affordability of coverage and care
- containing costs

Delivering on these policy goals simultaneously is not necessarily possible and may entail tradeoffs. In addition, each goal encompasses additional objectives that may not be achievable simultaneously. For example, some types of cost containment proposals could reduce both public and private spending, but others would shift costs from one source of financing to another. When considering whether to add people to a publicly financed program, choices among these policy priorities matter.

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<sup>1</sup> The term “underinsured” refers to adults who were insured all year but experienced one of the following: OOP costs, excluding premiums, equal to 10% or more of income; OOP costs, excluding premiums, equal to 5% or more of income for low-income (<200% of the federal poverty level) individuals; or deductibles equal to 5% or more of income.

Additionally, the problems to be addressed and, consequently, the goals of reform mean different things to different people. Increased affordability may connote the need to reduce the costs of care to patients, with increased generosity of benefits and/or lower cost sharing. Alternatively, affordability could be seen in the context of reducing the growing cost of insurance premiums borne by individuals, families, and businesses through greater cost control measures or shifts in how coverage is financed.

Similarly, while expanding coverage is a policy goal underlying many reform proposals, that goal is often balanced with other goals such as addressing the gaps in coverage among the insured population. To the extent that expanded coverage, affordability, and cost containment are sought simultaneously, achieving one could complicate, or compete with, the ability to achieve the others.

**Table 1-1. Potential Policy Goals and Objectives**

Policy Goal	Objectives
<b>Expand coverage</b>	1A Expand coverage across greater share of population
	1B Achieve universal coverage
	1C Increase comprehensiveness of covered benefits
<b>Improve access</b>	2A Increase access to and/or portability of coverage
	2B Increase access to care/ services
<b>Increase affordability</b>	3A Reduce cost burden borne by patients (out-of-pocket spending, including deductibles)
	3B Reduce cost burden borne by insured persons (premiums)
	3C Reduce cost burden borne by employers/group coverage sponsors (including states)
<b>Contain costs</b>	4A Constrain growth in health care costs, system-wide
	4B Constrain growth in federal expenditures on health care
	4C Constrain growth in state expenditures on health care
<b>Increase choice</b>	5A Increase choice of insurance arrangements
	5B Increase choice of health care delivery systems
	5C Increase choice of health care providers
<b>Improve equity</b> (by race, age, ethnicity, income, geographic location, gender, etc.)	6A Close disparities in access across population subgroups
	6B Close disparities in service use across population subgroups
	6C Close disparities in health outcomes across population subgroups
<b>Increase administrative simplicity</b>	7A Reduce administrative complexity for patients
	7B Reduce administrative complexity and associated costs for providers and/or insurers
	7C Reduce administrative complexity and associated costs for the federal government
<b>Increase social solidarity or fairness</b>	8A Ensure equitable contribution to financing the cost of coverage
	8B Ensure universal coverage of the eligible population
<b>Enhance quality, safety, and effectiveness</b>	9A Spur or foster innovation in health care delivery
	9B Establish or ensure appropriate incentives to maintain and improve quality
	9C Ensure effective accountability channels

For some stakeholder groups or segments of the population, other policy goals are more important, such as improved access to health services, increased choice among health care providers and/or plans, increased administrative simplicity of coverage and operational requirements, and reduced disparities and inequities. These goals may serve as criteria to be taken into account when comparing alternative approaches. For example, some members of the public might reject a path to cost control that limits consumer choice of insurer, even though the value of insurer choice for patients is not well established (Taylor et al. 2016).

In the chapters that follow, these policy goals and their related instrumental objectives serve as a framework for analyzing the implications of alternative policy design approaches and for comparing these approaches.

## Medicare as a Platform for Reform

Medicare is already one of the nation's largest sources of health coverage. A program through which close to 20 percent of U.S. health expenditures flow, Medicare provides coverage for about one of every six people residing in the country. Of the 60 million Medicare beneficiaries, 51 million are ages 65 and older, and nearly 9 million are younger than 65 but have a disability or qualifying health condition (Centers for Medicare & Medicaid Services 2019a).

Understanding Medicare's historic role in expanding coverage and improving the affordability of health care for vulnerable populations, as well as its popularity among beneficiaries and the general public, provides insight into the prominence given to proposals using Medicare to address current inadequacies in health care coverage and affordability.

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## The Medicare Program over Time

The Medicare program was signed into law in 1965 to provide health coverage and increased financial security for older Americans who were not well served in an insurance market characterized by employment-linked group coverage. Medicare was not only intended to benefit older Americans, its architects thought Medicare for the elderly was the first step toward eventually achieving health care coverage for all. The program has remained quite stable over time, however, with modest expansions in coverage and eligibility.

At the time of Medicare's enactment, insurance for hospital stays was typically the primary insurance benefit provided by employers, since physician services and prescription drugs represented a less costly and more predictable component of spending. Therefore, hospital coverage (Medicare Part A) constituted Medicare's principal benefit, automatically enrolling eligible beneficiaries, with coverage for physician services (Part B) offered as optional, supplementary insurance.<sup>2</sup> Part B coverage of physician and other outpatient services, however, is a critical part of the program with almost universal enrollment among traditional Medicare enrollees.

As private health insurance evolved to a more managed-care approach with an integrated benefit design, including both hospital and physician services, the Medicare Plus Choice program was enacted in 1997 under the addition of Medicare Part C that allowed Medicare HMOs to participate. Under the 2003 Medicare prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the Medicare Plus Choice program was relabeled as Medicare Advantage (MA), and MA plans now enroll more than one-third of Medicare beneficiaries. Also in the MMA of 2003, reflecting the increased importance and costs of prescription drugs in treating both acute and chronic health care conditions, Congress enacted the Part D prescription drug benefit. Drug coverage is available through MA plans or through stand-alone prescription drug plans. Other incremental changes to Medicare's plan design have been made, including adding benefits for wellness, prevention, and hospice care. To date, further attempts to update Medicare's benefit design and cap OOP expenditures for Parts A and B have not been successful.<sup>3</sup>

**Appendix A** of this report provides more detail about key elements of Medicare's design. An understanding of these details is important for assessing the program design changes suggested, or that might be envisaged, in tandem with the newest wave of proposed Medicare eligibility expansions.

## Medicare as a Reform Platform

Although expansion of Medicare is but one of myriad possible paths that might address the challenges in today's health care system, this approach is a feature of

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<sup>2</sup> The decision to make supplemental coverage (Part B) optional also reflected a compromise with the American Medical Association, which strongly opposed establishment of a universal, mandatory insurance program for physician services (Rohrlich 1966).

<sup>3</sup> In 1988, Congress passed a law to provide so-called catastrophic coverage, which would have imposed limits on OOP expenditures incurred by an individual Medicare beneficiary. In the wake of controversy about the approach to financing the enhanced coverage, that law was repealed prior to taking effect.

many proposed reforms.<sup>4</sup> Medicare’s prominence as a platform for health reform reflects the program’s enduring popularity among beneficiaries and the population as a whole; the program’s relative efficiency in furnishing affordable access to care; and interest in extending health and income security to a greater share of the population using a proven model of coverage.

## **Medicare’s Popularity**

Among the eligible population, the program has achieved near-universal enrollment. Today’s beneficiaries have relatively comprehensive coverage and access to care. Medicare beneficiaries enjoy broad access to providers. Only a small share of beneficiaries report problems finding a doctor who accepts Medicare to cover treatment, roughly comparable to the experience of privately insured older adults (Medicare Payment Advisory Commission 2019b). Satisfaction among beneficiaries and the country as a whole has been consistently high (Lopes et al. 2019).

A Kaiser Family Foundation poll found that, among the general public, 82 percent of individuals hold either a very or somewhat favorable view of Medicare (Kirzinger, Munana, and Brodie 2019). To some extent, Medicare’s prominence as a reform platform reflects the convenience of building on a known and popular entity, rather than on the specific characteristics of the program.

## **Medicare as a Vehicle for Extending Social Insurance**

Expanding Medicare would extend social insurance protection to encompass a greater share of the population. As “social insurance,” Medicare is a government-run program designed to protect people against financial insecurity (see **Text Box 1-1**) and has yielded important successes. While the Medicare beneficiary population encounters disparities in access to care by race and ethnicity, the disparities are less pronounced as compared to the privately insured population (Medicare Payment Advisory Commission 2019b). Individuals are eligible for coverage through Medicare without regard to their medical history or preexisting conditions, and Medicare provides coverage for individuals who qualify based on a disability or health condition.

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<sup>4</sup> Not all of today’s reform proposals involve changes to Medicare eligibility. Many reform proposals seek to enhance the Affordable Care Act provisions, for example. To the extent such changes do not involve changes in eligibility for Medicare (or a program similar to Medicare in design and function), discussion of those proposals is outside the scope of this report.

## Text Box 1-1. Why Do We Consider Medicare a “Social Insurance” Program?

Social insurance (SI) programs protect individuals against certain forms of risk. The United States has a number of such programs, including Social Security, Unemployment Insurance, Workers’ Compensation, and Medicare, which protect people from risks such as old age, disability, job loss, work injuries, and the need for health care.

Medicare ensures that older Americans and people with disabilities have access to health care. It protects against illness-related financial insecurity. It is “insurance” because it pools risk. It is “social” because it protects members of society who would not otherwise be able to purchase insurance. The following are seven characteristics that distinguish SI as it applies to Medicare:

- 1. Universality:** To manage risk, SI programs are inclusive of the eligible population. In the case of Medicare, Part A is automatic many workers and retirees. Participation in Part B is voluntary upon eligibility, but participation is incentivized to achieve near-universal enrollment.
- 2. Government sponsorship:** Governments create and oversee SI programs. The programs may be administered by a public agency (the Social Security model), by designated private (or quasi-private) institutions, or (as Medicare is) by a combination of public agencies and private contractors.
- 3. Contributory finance:** The resources to run SI programs are raised through contributions by employees and employers, dedicated taxes, or other earmarked revenues. Medicare Part A is funded mainly by flat-rate payroll tax contributions. Part B relies on general revenues and beneficiary premiums.
- 4. Eligibility derived from prior, covered work:** Part A eligibility is dependent on an individual having worked for a minimum period in jobs where the employer and employee have made payroll tax contributions, although spouses of age-eligible beneficiaries may also enroll.
- 5. Defined benefits prescribed in law:** Eligibility events and schedules of benefits are developed, announced, and applied to all participants. The provisions of the law and related regulations determine who gets benefits and how much they get. Congressional appropriations are not required to authorize spending money on these benefits.
- 6. Benefits not proportional to contributions:** Because an individual’s benefits are not determined by the amount of his or her contributions, Medicare redistributes resources from higher- to lower-income groups.
- 7. Separate accounting and explicit long-range financing plan:** SI contributions are earmarked to pay the SI benefits. Governments typically keep separate accounts that permit comparisons of program receipts and program benefits, and they project program revenues and expenditures into the future.

**Source:** *Gluck and Moon 2000.*

## Medicare's Cost Efficiency

Another factor explaining Medicare's appeal is its reputation among policy experts as a relatively efficient program in terms of per capita costs and cost growth. Between 2010 and 2018, Medicare per capita spending grew at a rate of just 1.7 percent, compared with 3.8 percent for private insurance; however, per capita Medicare spending growth is projected to increase over the next decade (Cubanski, Neuman, and Freed 2019).

In particular, Medicare's administered pricing system is viewed as an effective channel for cost control that many reform proposals aim to leverage. Traditional Medicare uses prospective payment systems, under which the program sets uniformly structured fee-for-service and bundled/episode-based payments, with adjustments for geography and additional provider characteristics.

Medicare's payment rates for hospitals, physicians, and other health care providers tend to be low in comparison with the rates paid by private insurers (Medicare Payment Advisory Commission 2019b).<sup>5</sup> Medicare also operates with relatively low administrative costs compared to private insurers (Tobias 2017).

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*Between 2010 and 2018, Medicare per capita spending grew at a rate of just 1.7 percent, compared with 3.8 percent for private insurance; however, per capita Medicare spending growth is projected to increase over the next decade (Cubanski, Neuman, and Freed 2019).*

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## Interest in Building on Medicare's Functional Roles

Another factor driving use of Medicare is the ability to build on one or more of the functional roles that it fulfills in the health care system. One example is its significant role in shaping and managing competition among private plans that serve beneficiaries in MA. Additionally, Medicare acts as a third-party payer or traditional insurer on behalf of beneficiaries who choose traditional Medicare. In that capacity, the program has generated innovations in payment policies, such as prospective payment systems for hospitals and other institutional providers and, more recently, bundled payments for episodes of health care that involve multiple providers. Medicare also acts as a regulator of the health care delivery system, including health care institutions and practitioners, through its program rules and payment incentives. It has been a driving force behind efforts to

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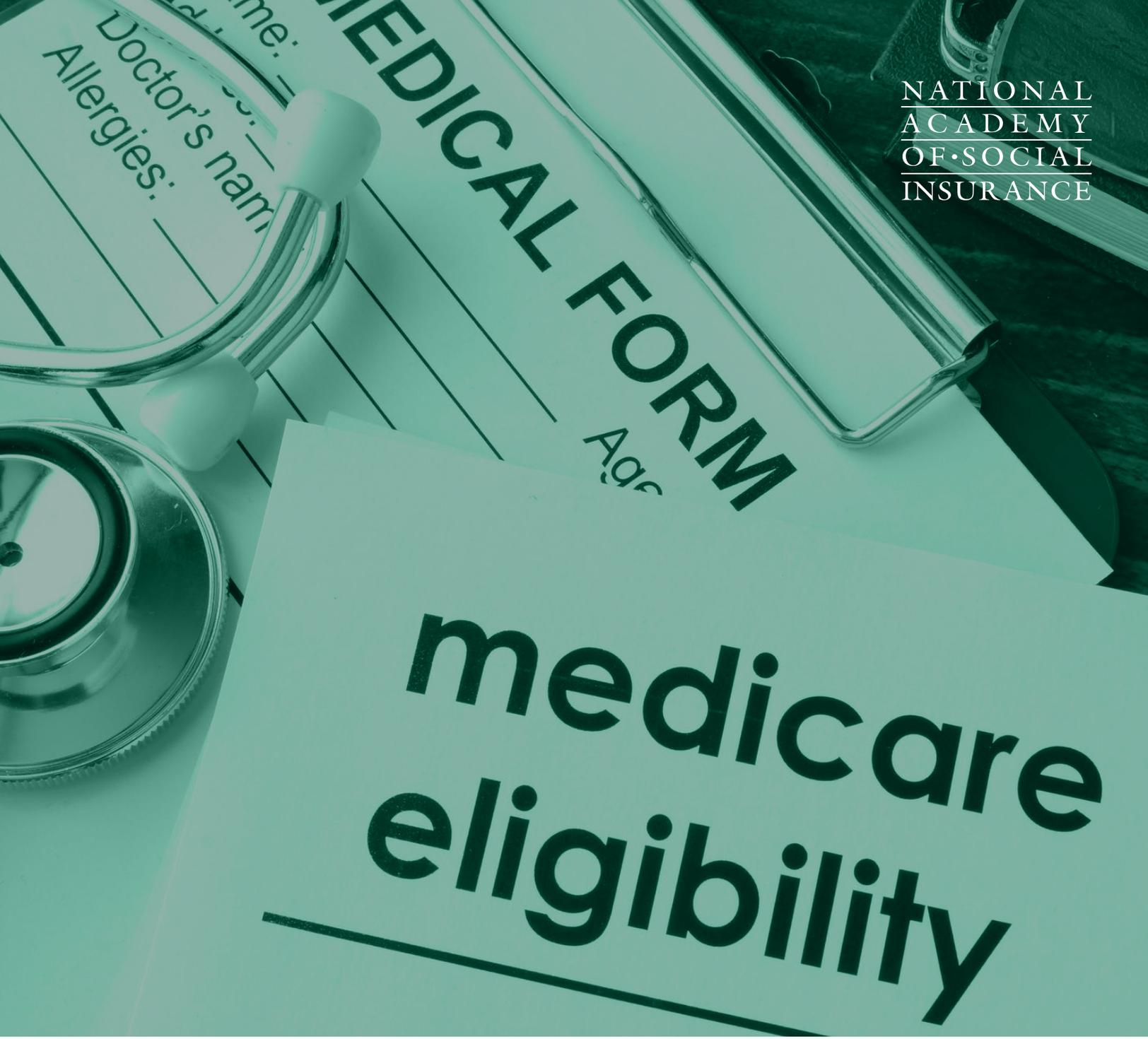
<sup>5</sup> According to the Medicare Payment Advisory Commission, which advises Congress on Medicare payment rates, constraining unit price increases may create pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms (Medicare Payment Advisory Commission 2019b).



improve health care quality and safety through standardized measurement and reporting on performance.

Although extending Medicare may seem like one of the most straightforward ways to approach reform, proposals to expand Medicare often deviate in design from a mere extension of existing program features to new populations. Some further design adjustments are necessary, including revisions to eligibility criteria and enrollment processes, but other changes go beyond what may be strictly required. In some cases, changes—such as new financing mechanisms—must be designed to meet needs for additional resources or address other complexities associated with Medicare expansions. In other cases, program changes would reflect a desire to correct perceived problems with Medicare’s current design, such as reducing beneficiaries’ OOP liability absent supplemental coverage or cost assistance programs.



A photograph of a medical form titled "MEDICAL FORM" with fields for "Name:", "Doctor's name:", and "Allergies:". A stethoscope is visible on the left. The form is clipped to a clipboard. A white card with the text "medicare eligibility" is placed over the bottom part of the form.

medicare  
eligibility

**Chapter 2:  
Lowering the Age of  
Medicare Eligibility**

## Chapter Summary

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

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

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

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

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

## Introduction

Medicare's basic eligibility age of 65 has remained unchanged since the program's enactment in 1965, although program eligibility has been expanded to younger people based on disability status and specific health conditions. In 1972, Congress expanded Medicare to include individuals with end-stage renal disease (ESRD). Individuals under age 65 with long-term disabilities who qualify for the Social Security Disability Insurance (SSDI) program are also eligible for Medicare after a two-year waiting period. In 2001, Congress eliminated the waiting period for individuals diagnosed with amyotrophic lateral sclerosis (ALS). The most recent expansion of Medicare eligibility occurred in 2009 for individuals diagnosed with a specific lung disease or type of cancer who live in an area subject to a public health emergency declaration by the Environmental Protection Agency for a specified period before diagnosis. **Appendix B** provides a discussion of the potential impacts of a health condition–based expansion of Medicare eligibility.

Extending Medicare to people under 65 could be a way to improve coverage for older adults, who may lose employer-sponsored insurance (ESI) upon retirement or job loss, and/or to transition to universal coverage. Under this policy option, all qualifying individuals above the new age threshold would become entitled to Medicare coverage that would essentially follow existing program design and regulations.

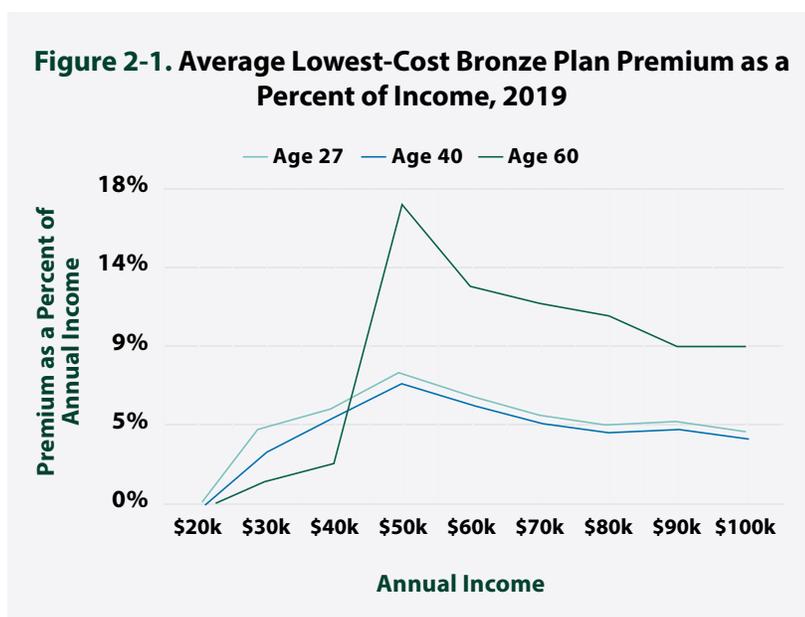
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*Under this policy option, all qualifying individuals above the new age threshold would become entitled to Medicare coverage that would essentially follow existing program design and regulations.*

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Approximately 35 percent of workers leave the workforce earlier than planned due to hardship, job loss, caring for an ailing relative, or health issues (Retirement Confidence Survey 2019). One study found that 69 percent of Americans retire before age 66, with about half retiring between the ages of 61 and 65 (Kadlec 2016). Some workers retiring before they are eligible for Medicare are left without access to employer-sponsored health benefits (Collinson, Rowey, and Cho 2018). Retiree health benefits provide a crucial source of affordable health coverage for workers retiring before Medicare eligibility, but in 2019, only 28 percent of all large firms (200 or more workers) that offered ESI coverage to current employees also offered retiree health benefits (Claxton et al. 2019). The availability of retiree coverage also differs by firm characteristics: Firms without union workers or with a lower share of high-income or older workers are less likely to offer retiree health benefits (Claxton et al. 2019).

Policymakers expected the ACA to cut down on “job lock,” in which workers stay in jobs to avoid losing their health coverage, by facilitating the purchase of individual coverage (Frakt 2017). ACA individual market premiums can be relatively expensive, however, for adults ages 50–64, especially for individuals who do not qualify for the premium tax credits.<sup>1</sup> Between 2016 and 2018, unsubsidized enrollment decreased by 40 percent (Centers for Medicare & Medicaid Services 2019f). As shown in **Figure 2-1**, the lowest-cost exchange plan available to a 60-year-old could constitute as much as 17 percent of monthly income (double the share for a 40-year-old) for individuals just above the subsidy income cutoff of \$48,560 a year (Fehr et al. 2019).<sup>2</sup> Thus, lowering the Medicare eligibility age could provide lower-cost coverage for older individuals facing high premiums in the ACA individual market.



**Note:** The income cutoff to qualify for subsidies was \$48,560 a year for individuals in 2019. ACA plans are available in four benefit tiers: bronze, silver, gold, and platinum (catastrophic plans are also available to certain enrollees). In each tier, plans are required to cover a certain percentage of a patient’s health care costs (i.e., actuarial value). Bronze plans are the least generous plans and require the highest out-of-pocket cost sharing but have lower premiums.

**Source:** Fehr et al. 2019.

<sup>1</sup> In this report, the “ACA individual market” refers to ACA-compliant plans both on and off the ACA exchanges operated by states and the federal government. ACA plans on and off the exchanges are part of the ACA single risk pool, but only plans on the exchanges are eligible for premium tax credits. In many states, plans not meeting the ACA requirements, typically referred to as “noncompliant plans,” are available outside of the ACA exchanges. Although noncompliant plans are available in the individual market, they are not included in the ACA single risk pool.

<sup>2</sup> Differences in per capita wealth accrual, however, as well as differences in demands on household budgets over the life course may or may not result in significant differences in affordability.

The prevalence of major chronic diseases—including diabetes and heart disease—increases rapidly as individuals transition into their 50s. Consequently, spending on acute health care services rises (Moon, Guo, and McSorley 2015). Lowering the age of Medicare eligibility to 50 could provide more affordable coverage for a large, expensive group of people in the ACA individual market.

Although it might be expected that removing older individuals, who have higher average costs, from the ACA individual market would reduce premiums for younger individuals remaining in ACA plans, this result would not necessarily be the case. The impact that lowering the age would have on affordability of coverage for newly eligible individuals and the population remaining in the ACA individual market depends on how design options are specified, as discussed below.

## Design Options

One way of extending Medicare eligibility to younger individuals is by retaining Medicare’s existing enrollment processes and penalties, covered benefits and cost-sharing requirements, and premium structures. In addition, the current policy of allowing persons with employer coverage to enroll in Medicare and have it operate as secondary or supplemental coverage could be retained and would likely become an even more important source of coverage for younger beneficiaries. Current payment rates for plans and providers, the role of private plans in Medicare, and the infrastructure used to administer the program also could be retained. Although defaulting to the current Medicare program structure is the most straightforward and administratively simple approach, extending the program to a younger population creates specific design challenges that policymakers need to address (**Table 2-1**).

**Table 2-1. Policy Design Issues for Lowering the Age of Eligibility**

<b>Eligibility</b>	Eligibility at 50 Eligibility at 55 Eligibility at 62
<b>Enrollment rules</b>	Medicare as secondary coverage Automatic enrollment process Delayed-enrollment penalties Quarters of coverage requirements Dependent coverage
<b>Benefit design</b>	Comprehensiveness of benefits Cost-sharing structure and amounts Role of Medicare Advantage
<b>Supplemental coverage</b>	Access to Medigap plans Employer-sponsored insurance
<b>Premiums</b>	Premium structure Premium and cost-sharing assistance

## Eligibility

Although the age of Medicare eligibility could be set at any threshold, this chapter considers extending eligibility to older adults at age 62, 55, or 50. The impact of lowering the age of eligibility on the broader insurance and health system hinges on how far the age of eligibility is lowered. Individuals in these older age categories are less likely than younger adults to be uninsured, limiting how much increase in overall insurance coverage would occur. **Table 2-2** provides the breakdown of coverage sources for specific age groups.

**Table 2-2. Source of Insurance Coverage for Adults, by Age Group, 2017**

*(In millions of people and as a percent of total)*

Age Group	Total	ESI	Medicare	Medicaid	Military (TRICARE or VA)	Private Nongroup	Uninsured
19–49	128.0 (100%)	78.0 (61%)	2.1 (1.6%)	18.9 (14.8%)	1.9 (1.5%)	8.9 (6.9%)	18.2 (14.2%)
50–64	62.5 (100)	38.7 (62%)	4.3 (6.9%)	7.0 (11.2%)	1.3 (2.1%)	5.7 (9.1%)	5.5 (8.8%)
50–54	21.0 (100)	13.6 (64.8%)	0.9 (4.3%)	2.3 (11.0%)	0.4 (1.7%)	1.7 (8.0%)	2.1 (10.2%)
55–59	21.4 (100)	13.5 (63.1%)	1.4 (4.3%)	2.4 (11.2%)	0.4 (2.0%)	1.9 (8.7%)	1.8 (8.6%)
60–64	20.0 (100)	11.6 (57.9%)	2.0 (10.1%)	2.3 (11.2%)	0.5 (2.6%)	2.1 (10.7%)	1.5 (7.4%)

**Source:** American Community Survey data 2019; Unpublished Urban Institute analysis of 2017.

**Notes:** ESI (employer-sponsored insurance), VA (Veterans Affairs). Adults living in group quarters are excluded. Hierarchy for assigning individuals to coverage groups is as follows: ESI, Medicare, Medicaid, military, individual market, uninsured. Percentages reflect what portion of the population in the relevant age group has the specified coverage.

A Medicare eligibility age of 62 would correspond with the Social Security program’s early retirement age and would assist retirees in obtaining affordable coverage. Although the Social Security eligibility age for full benefits—the full retirement age—was changed to increase gradually over time from 65 to 67, workers may choose to collect reduced Social Security retirement benefits when they are first eligible at age 62, which remains the most common age to begin claiming benefits (Social Security Administration 2018). In 2016, approximately one-third of new enrollees in Social Security were 62, and over 60 percent of new enrollees were below their full retirement age (Finch 2018). Alternatively, some policymakers have proposed raising the age of Medicare eligibility to 67 to match the full retirement age, a possibility discussed in **Appendix C**.

The rationale for choosing 55 or 50 as the age eligibility threshold is less firmly anchored in national retirement policy. Although the normal age for receiving penalty-free withdrawals from a 401(k) or individual retirement account is 59½, individuals who leave their job at age 55 or later (age 50 or later for qualified public safety employees) can begin penalty-free withdrawals from a 401(k) associated with that job, under certain conditions (Brandon 2019). Further, traditional defined-benefit pension plans that provide early retirement benefits typically make them available at age 55.

Lowering the age of Medicare eligibility to 50 or 55 would be a way to extend coverage to a group that incurs higher health care costs in comparison with younger cohorts. This group, however, experiences relatively low uninsured rates (8.8 percent for the age 50–64 population versus 14.2 percent for younger adults in 2017). Secondary payer provisions under Medicare would likely be important for many workers who would retain their ESI but might wish to enhance their benefits with Medicare supplementing that coverage. Depending on firm size and whether the individuals are disabled or age eligible, employer coverage is typically treated as primary—meaning that employer insurance pays first and Medicare coverage is supplemental (see **Appendix A** for more details).

The current Medicare program covers about 60 million beneficiaries. Although lowering the age of eligibility would increase that number, the impact depends on what age is chosen and how many newly eligible persons would delay enrollment or retain primary coverage through an employer. As described in the section below on policy implications, lowering the eligibility age to 62 or 50 could increase Medicare beneficiary rolls by 10 million or 57 million, respectively, and some beneficiaries would rely on Medicare as secondary or supplemental coverage only.

## **Enrollment Rules**

### **Automatic Enrollment Process**

Medicare’s automatic enrollment process has contributed to near-universal coverage among eligible beneficiaries, with 91 percent of eligible individuals enrolling in both Part A and Part B and 9 percent enrolling in Part A or Part B only (Centers for Medicare & Medicaid Services 2018b). Individuals receiving Social Security retirement benefits are automatically enrolled in traditional Medicare (Part A and Part B) once they turn 65. Enrollment in Medicare is also automatic after the 24-month waiting period for people who receive SSDI benefits.

Individuals who have not applied for or received Social Security benefits before they turn 65 are not notified of their eligibility for Medicare or the enrollment

process (Medicare Payment Advisory Commission 2019a). Currently, individuals who do not claim Social Security benefits before age 65 need to take action to enroll in the Medicare program. Lowering the age to 55 or 50 would make the current automatic enrollment process even more ineffective for beneficiaries who do not qualify on the basis of receiving SSDI. Lowering the age of Medicare eligibility would require changes to the enrollment process—such as adding eligibility notifications and outreach—to maintain near-universal coverage among all the eligible populations.

## Delayed-Enrollment Penalties

Beneficiaries who do not enroll in Part B and/or Part D during their initial enrollment period are subject to premium penalty surcharges unless they meet specific qualifications. Active workers enrolled in specified group plans and active-duty service members with coverage under TRICARE are eligible to enroll in Medicare during a special enrollment period with no late-enrollment penalty once their non-Medicare coverage ends. Active workers who delay enrollment and do not certify their current employer coverage face a monthly premium that is 10 percent higher for every 12-month period that they delayed enrolling in Part B (Centers for Medicare & Medicaid Services n.d.). Retired service members and retirees with health coverage through a former employer, individuals with a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or private plan purchased on the ACA exchanges, individuals with ESRD, and uninsured individuals face late-enrollment penalties if they do not enroll in Medicare Part B when they are first eligible (Centers for Medicare & Medicaid Services n.d.).

The Medicare Payment Advisory Commission estimates that 20 percent of current Medicare beneficiaries subject to the late-enrollment penalty were unaware of the penalty in 2016 (Medicare Payment Advisory Commission 2019a). If proposals to lower the age of eligibility retain the delayed-enrollment penalties, the program would need additional notification processes to inform eligible individuals about the penalties. Otherwise, the lower

the eligibility age is set, the greater the number of eligible individuals who may be unaware of their eligibility and the late-enrollment penalties.

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*If proposals to lower the age of eligibility retain the delayed-enrollment penalties, the program would need additional notification processes to inform eligible individuals about the penalties. Otherwise, the lower the eligibility age is set, the greater the number of eligible individuals who may be unaware of their eligibility and the late-enrollment penalties.*

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## Quarters of Coverage Requirements

Individuals or their spouses must have paid Medicare payroll taxes on 40 or more quarters (10 years) of qualified work to be eligible for premium-free Part A benefits. Individuals with 30 to 39 quarters pay a partial premium, and individuals with fewer than 30 quarters must pay the full premium to enroll in Part A (Centers for Medicare & Medicaid Services 2019a). Almost all enrollees qualify for premium-free Part A benefits, and that would likely continue to be the case if the eligibility age were lowered to 62, 55, or even 50, since the average 50-year-old would have at least 10 years of covered work, even before a spouse's work history is taken into account (Favreault 2018).<sup>3</sup>

Most individuals who are still working and covered through their employer would enroll in Medicare only if they met the quarters of coverage requirement, although some without access to ESI might choose to pay a full or partial Medicare Part A premium to enroll. For these workers, the program would need to specify whether quarters of coverage would continue to accrue after enrollment, as it does now, and whether the Part A premium would be eliminated once individuals meet the full quarters of coverage requirement.

## Dependent Coverage

Proposals to lower the eligibility age need to specify whether Medicare would remain a program for individuals or be modified to meet the family coverage needs more typical of a younger population. Except for dependents of beneficiaries who qualify based on an ESRD diagnosis, Medicare does not provide coverage for beneficiaries' children, while private insurance plans often offer dependent/family coverage at added cost. If Medicare's eligibility age were lowered to 55 or 50, a larger number and share of total beneficiaries would need a source of coverage for their dependents, whether through a current or former employer, the individual market, or Medicaid (Van de Water 2018). Retaining an individual-coverage design would increase complexity for families who currently have a common source of coverage.

## Benefit Design

While Medicare's benefit package has an unusual structure, divided into Parts A–D, the Medicare benefit is comparable to other types of coverage in comprehensiveness of covered services. Like other forms of coverage available today, Medicare leaves enrollees at significant risk of incurring high out-of-pocket

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<sup>3</sup> In Medicare, individuals may also qualify for premium-free Part A based on the quarters of coverage of their spouse if they are 65 or older and their spouse is at least 62. Any proposal to lower eligibility would need to specify whether this rule would be extended to the newly eligible population.

(OOP) costs. Proposals focused on lowering the age of Medicare eligibility would not address these gaps in Medicare’s current benefit package and cost-sharing structure, unless policymakers decided simultaneous benefit changes were warranted.

## Benefit Comprehensiveness and Cost-Sharing Structure

Lowering the age of eligibility would likely extend the current Medicare cost-sharing structure and amounts to newly eligible beneficiaries. The actuarial value (the percentage of total average costs a health insurance plan pays for covered benefits) of the traditional Medicare plan exceeds that of an ACA bronze- or silver-level plan (see **Table 2-3** below). The most significant difference between Medicare and other insurance is that traditional Medicare does not have an OOP maximum for enrollees, exposing beneficiaries to high OOP costs unless they have supplemental coverage or a Medicare Advantage (MA) plan. ACA-compliant plans in the individual and small group markets must abide by OOP maximum requirements and offer a defined set of essential health benefits (EHB), including drug coverage.

**Table 2-3. Actuarial Value Comparisons**

Health insurance coverage source	Actuarial value (%)
Traditional Medicare	80%
ACA plan (bronze)	60
ACA plan (silver)	70
ACA plan (gold)	80
Employer-sponsored insurance (PPO)	85
Employer-sponsored insurance (HMO)	89
Employer-sponsored insurance (HDHP)	79

**Notes:** ACA (Affordable Care Act of 2010), PPO (preferred provider organization), HMO (health management organization), HDHP (high deductible health plan). Data are not from the same years. Actuarial value is the average percentage of total health spending for covered benefits that a health plan pays, as opposed to the amount paid out of pocket by the enrollee.

Actuarial values of different insurance plans and programs are not necessarily directly comparable, especially if the analyses are done on different populations with different underlying health care utilization, different provider costs, and different assumptions regarding the impact of cost sharing on utilization.

**Source:** Actuarial Research Corporation 2017; Centers for Medicare & Medicaid Services 2017; McArdle et al. 2012.

The actuarial value of large group plans are slightly higher than that of traditional Medicare, depending on the type of plan (Actuarial Research Corporation 2017). Large group plans, including self-insured plans, are not required to cover all EHBs but must abide by the ACA out-of-pocket limits. Similar to traditional Medicare, individual and group plans usually do not cover dental, vision, or long-term services and supports, although some employers and MA plans may offer limited vision and/or dental benefits. At present, Medicaid is the only form of health coverage that provides for long-term services and supports.

While the Medicare program is designed primarily to cover retired individuals, it also covers younger persons, including people with disabilities, adults and children with ESRD, and dependents of individuals qualifying on the basis of an ESRD diagnosis. Although traditional Medicare does not cover all of the ACA EHBs, Medicare already pays for the services typically used by younger patients, such as pediatric and maternity care. Although Medicare currently pays for many these services, pediatric services and reproductive health services would likely need to be included explicitly in the traditional Medicare and MA benefit packages if the eligibility age were lowered.

### **Role of Medicare Advantage**

About a third of the roughly 60 million Medicare beneficiaries choose to receive Part A and Part B benefits through a private MA plan. If newly eligible beneficiaries were able to choose among these same options, MA plan payment rates and the risk-adjustment processes would need to be refined. Recent evidence suggests that MA plans tend to attract healthier enrollees than traditional Medicare and that current risk-adjustment practices may not fully account for this favorable selection, possibly leading to overpayments to MA plans and greater costs (Jacobson, Neuman, and Damico 2019). Lowering the age of eligibility could exacerbate the need to address selection-related and other inequities between MA and traditional Medicare.

### **Supplemental Coverage**

Reflecting Medicare's benefit gaps and beneficiary liability for OOP costs discussed above, four out of five traditional Medicare enrollees have some form of supplemental coverage, either through private insurance (including Medigap and private employer plans) or through Medicaid and other public sources of coverage (Cubanski et al. 2018).

## Access to Medigap Plans

Private Medigap plans provide supplemental coverage to 29 percent of enrollees in traditional Medicare to cover their cost-sharing requirements fully or in part (Cubanski et al. 2018). Premiums for Medigap plans average over \$2,000 a year (Medicare Payment Advisory Commission 2017). Under current law, Medigap issuers may not deny a policy or engage in medical underwriting for applicants 65 years of age or older during their initial open enrollment period (Social Security Administration, n.d.). In most states, Medigap insurers are allowed to practice medical underwriting and deny coverage or charge higher premiums to beneficiaries with preexisting conditions outside of this period. Although states can go beyond the minimum standards for guaranteed issue of Medigap policies, only 4 states have continuous or annual guaranteed issue, while 31 states require insurers to offer at least one Medigap plan to under-65 Medicare beneficiaries (Boccuti et al. 2018).

If Medicare eligibility were expanded to younger ages, federal law would need to ensure that newly eligible beneficiaries are able to purchase Medigap policies.

## Employer-Sponsored Insurance

Newly eligible beneficiaries would more likely be working and covered by ESI than current Medicare beneficiaries (see **Table 2-2**). Under Medicare's current primary/secondary payer requirements, lowering the age would likely affect costs to the Medicare program and employers. For current Medicare beneficiaries with employer-sponsored insurance at a firm with fewer than 20 workers, Medicare is the primary payer. For workers at larger firms with 20 or more employees, Medicare serves as the secondary payer. Medicare is also the primary payer for retired workers over the age of 65.

## Premiums

Under an expanded Medicare program, new and current beneficiaries would be pooled together, and all enrollees would be subject to the same benefit structure, premium calculation structure, and cost-sharing rules.<sup>4</sup> Pooling the new, younger enrollees with current Medicare beneficiaries would involve little to no change in the methodology for calculating premiums.

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<sup>4</sup> Medicare currently calculates Part A premiums for those not eligible for premium-free Part A based on the expected average per capita cost of Part A coverage. Part A premiums only apply to the minority of enrollees that do not have 40 quarters of work history. Part B premiums are set to cover 25 percent of expected Part B program costs for the year. Part D premiums are set to cover, on average, 25.5 percent of the cost of a standard Part D plan. MA and Part D premiums are set through a benchmark and bid process. (For more information, see **Appendix A**.)

The addition of healthier, younger beneficiaries to the Medicare risk pool is likely to lower per capita costs, which would, in turn, lower beneficiary premiums. Lowering the age to 62 may not alter premium amounts notably, but extending it to 50 would likely have a greater effect on Medicare's risk pool because the population would have lower health costs, on average, and because the number of new entrants to the pool would constitute a larger proportion of the total beneficiary population.

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*The addition of healthier, younger beneficiaries to the Medicare risk pool is likely to lower per capita costs, which would, in turn, lower beneficiary premiums.*

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## Premium and Cost-Sharing Assistance

An expanded Medicare program that retained the current premium and cost-sharing structure would likely also be paired with extension of the current cost-sharing and premium assistance programs to new low-income enrollees. The current cost-sharing and premium assistance programs are the Medicare Savings Programs (the Qualified Medicare Beneficiaries (QMBs), the Specified Low-Income Medicare Beneficiaries (SLMBs), and the Qualifying Individuals (QIs) programs) for Part B and the full and partial low-income subsidies for Part D. Under these programs, individuals must also meet income and asset test requirements (see **Appendix A**).

The Medicare Savings Programs provide essential financial assistance to low-income beneficiaries and would be critical to extend to the newly eligible population. Due to the influx of new enrollees to Medicare, costs for low-income beneficiaries qualifying for these programs would increase. Although state Medicaid programs would be responsible for paying the QMB and SLMB premiums for eligible beneficiaries, financial pressure on state Medicaid programs would be at least partially offset as older Medicaid recipients become primarily covered under Medicare.

## Policy Implications

Extending Medicare eligibility to a younger population would affect affordability of coverage, access to care, and overall health care system costs. This section assesses the general direction of likely changes and identifies design decisions that will most affect the magnitude of impact.

## Coverage of and Access to Health Care

Lowering the eligibility age would shift individuals previously covered by Medicaid, individual market insurance, certain employer group coverage, and the uninsured into Medicare as the primary coverage source. Medicare would become a secondary source of coverage for the vast majority of new beneficiaries who remain actively employed and have military or employer-sponsored insurance. The share of each cohort without coverage would decline substantially.

**Table 2-4** provides approximations of the number of potential added enrollees in an expanded Medicare program, broken down by whether they would have primary or secondary coverage under Medicare (based on the current coverage sources presented in **Table 2-2**).

**Table 2-4. Primary and Secondary Medicare Coverage for Newly Eligible Adults, by Eligibility Age (in millions)**

Eligibility age group	Newly Medicare eligible	New Medicare, primary	New Medicare, secondary	Newly Insured	Remaining uninsured
62–64	10.1	3.3	6.8	0.67	0.13
55–64	37.4	11.4	26.0	2.8	0.53
50–64	57.3	17.3	40.0	4.6	0.9

**Notes:** *These estimates reflect the current coverage sources with no assumptions regarding behavioral effects. “Newly Medicare eligible” includes all individuals in the age group who are currently not covered by Medicare, adjusted for the undocumented immigrant share among the uninsured (approximately 16 percent).*

*“New Medicare, primary” includes individuals covered by Medicaid, people with individual market insurance, and individuals who are uninsured, adjusted for the undocumented immigrant share among the uninsured (approximately 16 percent) (Blumberg et al. 2018).*

*Because the data did not include estimates of undocumented immigrants who are currently covered by ESI or individual market coverage, the new Medicare primary and secondary estimates may be overstated.*

*“New Medicare, secondary” includes individuals currently covered by ESI and military coverage. The data do not distinguish between large and small firms, so secondary coverage may be overestimated.*

**Source:** *National Academy of Social Insurance calculations based on unpublished Urban Institute analysis of 2017 American Community Survey data.*



According to these approximations:

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

## Uninsured Population

Depending on the new threshold age, the number of uninsured older individuals could fall by 670,000 to 4.6 million individuals—representing a reduction in the uninsured adult (ages 19–64) population of between 3 percent and 19 percent.<sup>5</sup>

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<sup>5</sup> Based on the estimates in Table 2-2, 23.7 million uninsured adults between the ages of 19 and 64 are uninsured.

Indirect or spillover effects for the younger adult market could partially offset that reduction in the uninsured by affecting the uninsured rates for younger adults. Because the 50–64 age group accounts for almost 40 percent of enrollment and 60 percent of the premium revenue in the ACA individual market, removing this group from the ACA risk pool would

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*Depending on the new threshold age, the number of uninsured older individuals could fall by 670,000 to 4.6 million individuals—representing a reduction in the uninsured adult (ages 19–64) population of between 3 percent and 19 percent.*

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likely affect the affordability of coverage for remaining participants (Blue Cross Blue Shield Association 2019). Many analysts have presumed that removing older individuals would reduce average cost in the risk pool and therefore lower ACA individual market premiums. Findings from recent studies suggest, however, that the opposite is likely to be true. These studies found that younger enrollees in the individual market were sicker than the average participant, as younger healthy individuals are less likely than their sicker counterparts to enroll in individual coverage, while older enrollees have a broader risk profile that is closer to the individual market average. If so, moving older adults to Medicare would increase premiums in the ACA individual market, which might actually *increase* uninsurance among the young and middle aged (Blue Cross Blue Shield Association 2019; Kotecki and Westrom 2020; Eibner et al. 2019).

Because many undocumented immigrants have coverage through employer plans and through unsubsidized ACA individual market plans, the number of undocumented immigrants who are uninsured could increase if they are ineligible for Medicare coverage and other sources of coverage are unavailable (Blumberg et al. 2019).

## **Comprehensiveness of Coverage**

For most of the population newly eligible for Medicare, comprehensiveness of coverage would likely be improved or unchanged. Individuals might gain more-comprehensive coverage in terms of benefits and/or less cost sharing, fewer utilization restrictions, and/or broader provider networks.

### **Workers**

Most workers who are newly eligible for Medicare and have employer-sponsored coverage would continue to have primary coverage through their employers. For some, this coverage could improve because Medicare would act as secondary (supplemental) coverage and could fill in gaps for workers with less-comprehensive coverage. Employers would still need to abide by laws governing age discrimination in their provision of benefits.

Medicare would become the primary payer for newly eligible retirees currently getting coverage from a former employer. These employers might respond to a lower Medicare eligibility age in a range of ways, including replacing current comprehensive coverage with less costly supplemental coverage, offering these individuals employer-sponsored MA plans, or even eliminating coverage.

### ***Medicaid Recipients***

If Medicare eligibility were lowered to 50, up to about 7 million older Medicaid recipients would become dually eligible for combined coverage—a status that increases the range of coverage options available.<sup>6</sup> For example, dually eligible beneficiaries can opt to participate in an MA plan of their choice, whereas standard Medicaid beneficiaries do not necessarily have a choice of plans.

### ***ACA Individual Market Policyholders***

Assessing the impact on comprehensiveness of coverage for individuals currently purchasing coverage in the individual market is challenging. Individuals with higher incomes who are not otherwise eligible for cost-sharing and/or premium subsidies in the ACA exchanges would likely have equivalent or better coverage under Medicare, where they would have lower premiums and potentially lower cost sharing, on average, albeit with no OOP limit if they chose traditional Medicare. Individuals who qualify for ACA cost-sharing reductions but do not qualify for financial assistance under the Medicare Savings Programs could experience a negative impact on comprehensiveness of coverage.<sup>7</sup>

### **Provider Access and Quality**

Virtually all acute care hospitals and more than 9 in 10 nonpediatric physicians accept Medicare (Medicare Payment Advisory Commission 2019a). The ability of Medicare patients to find a new primary care physician or specialist is robust and comparable to access experienced by older patients who are privately insured. This relative parity in physician access suggests that moving from private coverage to Medicare would not have an appreciable impact on this particular determinant of access for most new beneficiaries. Additionally, when examining physician

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<sup>6</sup> Some Medicaid beneficiaries would become dually eligible with Medicare as primary coverage. Others would qualify for partial benefits in that Medicaid would cover Part B premiums or they would be fully dual eligible and have all premiums and cost sharing.

<sup>7</sup> For example, for individuals with an annual income between 150 percent and 200 percent of the federal poverty level (above the threshold for Medicare assistance programs) who chose a silver-level plan in the ACA exchanges, their cost-sharing subsidies would increase the actuarial value of that ACA plan to 87 percent, which is greater than that of the traditional Medicare program, which is 80 percent (Kaiser Family Foundation 2018).

network size, research indicates that provider networks tend to be broader in MA plans compared to ACA individual market plans, suggesting that people shifting to Medicare from the individual market could experience increased provider access in both MA and traditional Medicare, the latter of which has virtually no network restrictions (Jacobson et al. 2017). Moreover, older Medicaid beneficiaries, who are much more likely to experience problems finding a physician, would likely see significant improvements upon becoming dually eligible for Medicare and Medicaid.<sup>8</sup>

Medicare generally pays hospitals and physicians rates that are considerably lower than commercial insurance, which could affect whether providers continue to participate at current levels. Commercial payment rates average nearly twice Medicare rates for inpatient hospital services. These differences are even more significant for outpatient hospital services, with one study finding that the mean private outpatient prices reached 293 percent of Medicare in 2017 (White and Whaley 2019). Commercial PPO payment rates for physician and other health professional services were, on average, 133 percent of Medicare's, with significant variation by type of service (Medicare Payment Advisory Commission 2019b).

Payment differences would affect provider revenues in a variety of ways. Lowering the age of Medicare eligibility would mean that providers would, on average, see more Medicare enrollees, potentially lowering revenue. In the case of smaller expansions of the Medicare population, however, the impacts could be marginal. Because of the disproportionate size of the Medicare beneficiary population as a share of their total patient caseloads, hospitals would likely continue accepting Medicare beneficiaries, despite lower per capita revenue. To the extent that previously uninsured patients stay with the same safety-net providers upon Medicare eligibility, those providers could see an increase in revenues reflecting improved payment rates and possibly increased service volume.<sup>9</sup> For some providers, revenue losses associated with a change in their patient mix from higher-paying coverage to Medicare would be partially offset by an increase in the share of Medicaid patients moving to Medicare.

The research literature demonstrates that differences in quality of care seen across the country show little relationship to the relative level of spending on care (McKellar et al. 2017). Providers can respond to payment rate differences in a variety of ways, including seeking to improve efficiency in the delivery of care (Medicare Payment Advisory Commission 2019a).

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<sup>8</sup> About 67 percent of nonpediatric primary care providers accept Medicaid patients (Boccuti et al. 2015).

<sup>9</sup> The Institute of Medicine definition of a safety-net hospital is an institution that, by mission or mandate, provides care to a substantial share of vulnerable patients regardless of their ability to pay (Institute of Medicine 2000).

## Cost Containment and Affordability

Expansion of the Medicare beneficiary population would have a number of effects on health care costs and the distribution of financing—relieving pressure in some ways and increasing it in others.

### Medicare

The costs borne by the Medicare trust funds would increase with eligibility expansion. Lowering eligibility to age 62 would mean that many of the new beneficiaries would be retired and Medicare would serve as primary coverage. If the eligibility age dropped further, a larger share of new beneficiaries would continue to be covered by ESI, with a lower impact on Medicare spending. The number of persons with Medicare as their primary coverage would increase by about 30 percent if the eligibility age were lowered to 50, as shown in Table 2-4. These new beneficiaries would rely on trust fund financing for a longer period compared with today's beneficiaries. Such an expansion in projected costs would necessitate additional funding for the trust funds (discussed further in **Chapter 3**).

### Current Medicare Beneficiaries

Existing beneficiaries would likely see a reduction in their premiums under Part B, Part C (Medicare Advantage), and Part D as younger and presumably healthier beneficiaries are added to the current Medicare risk pool. This possibility depends on whether Medicare payment rates remain the same under an expansion or the influx of additional beneficiaries provides more power to providers to leverage higher payment rates from Congress, which would increase per capita costs and beneficiary premiums.

### Medicaid and States

Medicare expansion would relieve cost pressures on the Medicaid program by shifting financial responsibility for newly eligible Medicare beneficiaries from Medicaid to Medicare. Since this Medicaid cohort tends to be relatively less healthy and use more services in comparison to younger Medicaid recipients, shifting the older cohort to Medicare could have a disproportionate impact on lowering costs for Medicaid programs. States that have larger Medicaid programs and states with higher per capita Medicaid costs would see greater savings as more of their costs would shift to Medicare.

## Employers

Since Medicare would become the primary coverage for retired workers under the age of 65, employers of all sizes that offer and pay a portion of the premiums for health coverage for these retirees would see cost savings if the early retirees shifted to enrollment in Medicare for primary coverage.

If current secondary payer laws were extended for newly age-eligible Medicare beneficiaries who continue to work, employers with fewer than 20 workers would see savings if more of their current workers were primarily enrolled in Medicare. Larger employers with 20 or more employees would likely not see any cost savings since Medicare would be secondary coverage for eligible workers. Employers of all sizes may see savings, however, if their employees choose to forgo employer-sponsored insurance in favor of Medicare coverage.

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*If current secondary payer laws were extended for newly age-eligible Medicare beneficiaries who continue to work, employers with fewer than 20 workers would see savings if more of their current workers were primarily enrolled in Medicare.*

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Over the long term, Medicare expansion could also change the labor market by affecting wages and retirement behavior. Medicare expansion could facilitate early retirement by reducing the cost of living during retirement years, although the ACA seems to have had only a small impact (Ayyagari 2018). Lowering the Medicare eligibility age could also reduce job lock and expand entrepreneurship at earlier ages by reducing the risk associated with leaving a job through which an individual obtains affordable health coverage (Fairlie, Kapur, and Gates 2011).

## Total U.S. Health Care Expenditures

In the short term, expansion of the Medicare beneficiary population would be expected to slow the growth in total national health spending to the extent that patients are shifted from coverage that pays providers at higher rates to coverage that pays providers at lower rates. This reduction could be partially offset by service volume increases driven by either uninsured individuals gaining coverage or individuals shifting from coverage that places greater restrictions on service use (for example, prior authorization) to traditional Medicare coverage, which places relatively few such restrictions. Over the longer term, the impact on cost containment depends on both how providers adapt to lower revenues and how policymakers react to pressure from stakeholders to increase payment rates or control utilization.

## Impact on Other Policy Goals

### Consumer Choice

Under a simple program expansion, some new beneficiaries would see levels of plan and provider choice that are comparable to, or better than, their current choices. Individuals covered by an employer that offers only one or a limited set of plan options and persons with individual coverage in an area with few plan options would have more plan choices under Medicare. New beneficiaries may also have a greater choice of providers if they are currently enrolled in a more restrictive HMO or PPO.

### Disparities and Inequity

Given Medicare's positive track record in reducing racial and ethnic disparities (Vladeck, Van de Water, and Eichner 2006), the size of cross-population disparities in access, service use, and health outcomes could be reduced. Lowering the eligibility age would be of particular benefit to black Americans because they are more likely to be uninsured (Berchick, Hood, and Barnett 2018). Because the life expectancy for black Americans at age 65 is more than three years lower than for white Americans, black Americans receive fewer years of Medicare coverage under the current age eligibility standard (National Center for Health Statistics 2017).

Lower-income Americans face different eligibility rules for Medicaid coverage in different states and lower-income individuals in states that did not expand Medicaid under the ACA can be left uninsured, without access to subsidized plans in the ACA individual market. Lowering the age of eligibility would mean that low-income older Americans would have more equitable coverage across states.

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*Lower-income Americans face different eligibility rules for Medicaid coverage in different states and lower-income individuals in states that did not expand Medicaid under the ACA can be left uninsured, without access to subsidized plans in the ACA individual market. Lowering the age of eligibility would mean that low-income older Americans would have more equitable coverage across states.*

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### Social Solidarity and Perceived Fairness

Lowering the age of Medicare eligibility to 62 would likely have little impact on public perception of social solidarity or fairness, to the extent that including this

population is justified by the link between contributions and benefits. Further expansion might have a more detrimental impact on perceived fairness, especially if the quarters of coverage required for premium-free Part A benefits were lowered, given general understanding of Medicare as a benefit earned over a lifetime of work. Since most workers will have met the work-quarters threshold well before age 50, any rationale for reducing the threshold seems of limited relevance.

Another consideration lies in perceived intergenerational fairness since Medicare eligibility expansion would entail tax increases borne disproportionately by the younger generations to the benefit of older ones. The Medicare program benefits younger generations, however, by relieving the pressure to support and care for elderly family members, and the program provides jobs in the health care sector. Further, these benefits would be available to younger workers as they age, reducing the need to save more for health expenses.

## **Administrative and Transition Issues**

Although lowering the age is administratively simple relative to other expansion options, certain administrative and transition issues would need to be anticipated. The greater the expansion, the greater the importance of these issues. For instance, lowering eligibility to age 62 could occur on a defined date. Lowering eligibility to age 50, however, might be more smoothly accomplished through gradual extension, similar to the gradual transition to the increased eligibility age for full Social Security benefits. Any significant changes in the financing of the Hospital Insurance Trust Fund (Part A) might similarly benefit from a phase-in to mitigate undesirable market disruptions.

Structuring a workable enrollment process will be important under any expansion. Managing enrollment is easier if the eligibility age is reduced to 62, when many Americans begin to take Social Security benefits. For more extensive changes, and to assist Americans who delay Social Security receipt until after age 62, Social Security offices may need to be enlisted in enrolling newly eligible Medicare beneficiaries. The addition of an automatic notification process for eligible enrollees not already receiving Social Security benefits would be necessary to maintain near-universal enrollment among the eligible population. Public education efforts might be coordinated with the Social Security Administration's outreach to notify older persons as they approach the Medicare eligibility age, which would help existing as well as new beneficiaries.

## Conclusions

Lowering the age of Medicare eligibility is one policy option for addressing current problems with access to insurance, affordability of insurance, and the cost of health care, as well as achieving long-standing policy goals. The most important determinant of impact in achieving these goals is the size of the new beneficiary population. **Table 2-5** presents a summary of this report’s assessment of the likely impact of changes in eligibility on select policy goals. Key trade-offs include the added cost of the program to taxpayers and the magnitude of the impact in meeting policy goals.

**Table 2-5. Potential Impact of Lowering the Age of Medicare Eligibility**

Policy Goal	Potential Impact
<b>Expand coverage</b>	Decrease U.S. uninsurance rate by 3 percent (670,000 individuals), to 19 percent (4.6 million individuals) depending on new eligibility age (62, 55, or 50). The uninsured share may increase among young adults if premiums increase in the individual market.
<b>Improve access</b>	Increase the comprehensiveness of coverage available to many new beneficiaries. Reduce financial barriers to access to care for individuals previously enrolled in private plans, without or with limited cost-sharing assistance.
<b>Increase affordability</b>	Potentially reduce out-of-pocket burden for some new beneficiaries. May modestly reduce the affordability of coverage in the individual insurance markets. Generate savings to employers and state Medicaid programs.
<b>Contain costs</b>	More likely to improve overall U.S. health cost containment as more individuals are covered by Medicare and a greater share of providers receive Medicare rates. Shift responsibility for financing coverage to federal government, increasing costs to the Hospital Insurance Trust Fund and the federal budget.
<b>Increase choice</b>	Increase or provide comparable choice of coverage options for many new beneficiaries. Increase provider choice for individuals enrolled in traditional Medicare due to the absence of network restrictions.
<b>Improve equity</b>	Reduce racial and ethnic disparities in the new enrollee population.
<b>Increase social solidarity or fairness</b>	Cause little change in social solidarity if quarters of coverage work requirement is not changed. May prompt concerns about intergenerational redistribution of health care financing costs, depending on how taxes are levied. Perceptions of fairness or social cohesion could be improved, however, with greater access to affordable insurance.

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

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





## Chapter 3: Approaches to Medicare for All

## Chapter Summary

Medicare-for-all proposals aim to use the current Medicare program to achieve universal coverage and the related goals of making insurance and care more affordable and addressing inequities in access. In one approach to a Medicare-for-all system, virtually all Americans would be covered through a program that resembles traditional Medicare, where the government could pay providers for covered services and private insurance would be limited to a supplementary role. Under an alternate approach, a Medicare-for-all system could retain a role for Medicare Advantage (MA) plans, and enrollees would have a choice between a public plan like traditional Medicare and private plans that the government pays to provide coverage in a system of regulated competition.

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

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

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

A Medicare-for-all program would increase federal spending significantly. Changes in financing mechanisms might attempt to capture some current spending by states and employers as part of needed federal revenues. The

effects of Medicare-for-all on total national health expenditures are less clear; national spending could be less than or greater than it is under the current system. Factors affecting total expenditures include the degree of (a) increased service utilization by the formerly uninsured and underinsured, (b) increases in benefit coverage or reductions in cost-sharing requirements, and (c) savings achieved due to broader application of Medicare payment rates, administrative simplification, and reductions in drug costs. While analysts have reached different conclusions on the extent of costs or savings under Medicare-for-all, savings could be less and the administration more complex under a system that includes MA plans.

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

## Introduction

Campaigns for a national health insurance program began as long as a century ago. Such efforts include attempts to incorporate national health insurance in the Social Security Act of 1935 and continue through more recent health reform debates, including Medicare-for-all bills introduced in the 116th Congress. Medicare-for-all proposals, also known as universal Medicare, aim to use the current Medicare program to achieve universal coverage and the related goals of increasing the affordability of insurance and care and addressing inequities in access. The legislative and other proposals reflect significant design variations, which would have differing implications not only for simplifying administration and controlling system-wide health care costs and financing but also for the experience of health care providers, employers, and insured individuals.

A universal Medicare system may retain key characteristics of the current Medicare program, such as its provider payment rates and its administrative structures and processes. Many proposals, however, significantly deviate from the program as it stands today in certain respects, in effect creating a markedly expanded and arguably new program. For example, some Medicare-for-all proposals would enhance the current Medicare program by integrating the benefit package and expanding it to include dental, vision, hearing, and/or long-term services and supports (LTSS) and by nearly eliminating all premiums, copayments, and deductibles. In addition, the variety of roles envisioned for private insurance under a system of universal Medicare is an important point of debate, with different implications for attaining different policy goals.

## Design Options

Medicare-for-all proposals face a common range of design issues, including the role of private insurance, eligibility criteria, benefit design, provider payment and cost containment mechanisms, premium and cost-sharing structures and amounts, and financing mechanisms. A Medicare-for-all approach can follow, or diverge from, the current Medicare program's specifications. Each choice on the design issues presented in **Table 3-1** would have different implications for meeting policy objectives, as well as the potential for unintended or spillover effects.

**Table 3-1. Policy Design Issues to Address in a Medicare-for-All Program**

<b>Role of private insurance</b>	Medicare-for-all Medicare-for-all plus MA
<b>Eligibility criteria</b>	Undocumented immigrants Preservation of other federal programs Automatic enrollment
<b>Benefits and cost sharing</b>	Comprehensiveness of benefits Role of MA Cost sharing and utilization management Role of supplemental coverage
<b>Provider payment and participation</b>	Medicare payment methods and rates Alternative payment methods and rates Physician participation Prescription drug payment methods
<b>Governance and administration</b>	Federal and regional administration Administrative savings and challenges
<b>Financing</b>	Financing mechanisms

## Role of Private Insurance

### Private Insurance within Medicare

Private insurers play a significant role in the current Medicare program. Beneficiaries may elect to receive their Part A and Part B benefits through a private MA plan, may choose to purchase a private Medigap supplemental insurance plan, and—if they want prescription drug coverage—must choose either an MA plan with prescription drug coverage (MA–PD) or a stand-alone private prescription drug plan (PDP). Private insurers also contract to provide the vast majority of administrative services in traditional Medicare, performing functions such as adjudicating and paying claims, determining whether services rendered to beneficiaries are covered and medically necessary, and communicating with beneficiaries and providers. In this role, Medicare bears the entire risk of paying for benefit claims, not the insurer in the administrative role.

The share of beneficiaries enrolled in MA has grown over time, with 21.3 million (36 percent) of Medicare beneficiaries receiving benefits through an MA plan in 2018 (Centers for Medicare & Medicaid Services 2019a). The Medicare program directly pays MA plans a per person capitated monthly amount for covered services that is adjusted to reflect the demographics and diagnoses of enrollees (see **Appendix A**). Compared to private commercial insurance, MA plans are more regulated because they are required to follow Medicare’s coverage rules, participate in quality monitoring, and are subject to marketing regulations. Many have noted, however, deficiencies in MA quality information (Levinson 2018).

## **Private Insurance in Medicare for All**

In designing a universal Medicare-like program in the United States, policymakers and analysts have identified different roles for private health insurance. What is typically referred to as “single payer” or “Medicare-for-all” is a system in which all Americans would be covered through a program that resembles traditional Medicare, with expanded benefits. In such single-payer models, Medicare serves as the primary payer to providers of health care services, with insurance companies limited to the role of assisting in administering the program (without bearing the financial risk of paying for benefits). Private supplemental coverage might be permitted to address gaps in benefits by, for instance, reducing cost sharing and expanding benefits. To the extent proposals offer comprehensive coverage by eliminating all or almost all cost sharing and expanding benefits, private supplemental coverage would be less necessary. Advocates for such a model point to the likelihood of significant savings from the reduction of pharmaceutical expenditures, provider and insurer administrative costs, and payments for hospital, physician, and other services.

Other proposals retain a more substantial role for private insurance through the equivalent of an MA program, which advocates claim would keep an important level of choice and would use competition to drive increases in value for money spent. In this approach, private MA plans would continue to provide an alternative structure of coverage within the Medicare program.<sup>1</sup> MA plans would be able to contract with the Medicare-for-all program and receive payments for providing covered benefits. Under both Medicare-for-all systems, the federal government is paying for coverage, through either directly paying providers for care or paying MA plans that in turn pay providers and arrange for care. Further, an MA-type program could provide a way for employers and unions to

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<sup>1</sup> Depending on the benefit and cost-sharing design, there may be a role for commercial private insurance supplementary to the Medicare-for-all system.



offer coverage, similar to the way they do now under Medicare, with customized benefits and eligibility restricted to employees or members.

The decision of whether to allow MA plans to participate has significant implications for beneficiaries, provider revenues, administrative costs and complexity, regulatory challenges, and overall system costs. In virtually all international health care systems in high-income countries, private insurance, either traditional commercial insurance or a highly regulated competition between multiple plans, plays a role in providing coverage, as discussed in **Text Box 3-1**.

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*The decision of whether to allow MA plans to participate has significant implications for beneficiaries, provider revenues, administrative costs and complexity, regulatory challenges, and overall system costs.*

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### Text Box 3-1. International Comparisons

The health care systems of many high-income countries are classified as *single-payer systems*, which are publicly financed and administered health insurance programs that provide universal coverage for the population. In some single-payer systems, the public system acts as the insurer and payer for health care services, with private insurance playing a small role that is largely restricted to supplementing public insurance by covering cost sharing or filling gaps in benefits. Other single-payer systems permit individuals to opt out of the public system and instead purchase alternative (substitute) private insurance; still others, like Australia, encourage private coverage that duplicates and is coordinated with the public coverage in an effort to shift some health care costs to private financing.

Single-payer systems that rely on insurance models to finance care can be contrasted with systems in which the coverage and delivery of health care are financed and administered through an integrated system, referred to here as a *national health service* (NHS), in which providers are government employees. The NHS approach, exemplified in the United Kingdom, is not discussed further in this report.

Other countries achieve universal coverage through multiple, highly regulated (often nonprofit) nongovernmental plans that provide a defined set of benefits to the population with rules that require acceptance of all eligible individuals without regard to health, gender, or other personal attributes. Such systems are classified as *multi-payer models*, and the

countries rely on negotiation of provider payment rates and methods between the provider and payer associates—with the government playing an oversight and policy-setting role. Alternatively, the government may set payment rates directly. The government role typically includes negotiation for prescription drugs, maximizing national leverage to lower the cost of expensive medicines.

Whether national health service, single-payer, or multi-payer, an important characteristic of such systems is that they cover virtually the entire population—across all ages and regardless of employment status. Countries can achieve universal coverage while administering their systems at a regional or national level and with varying roles for federal versus state/provincial governments and private plans.

The United States has a fragmented health insurance system that, to date, has not achieved universal coverage. Eligibility for various public and private insurance programs is based on age, health status, income, and/or employment status. These health insurance programs differ not only in the population covered and in the generosity of coverage but also in the role of governments and the private insurance industry. The United States can best be characterized as a *multi-payer, mixed public and private model*. While this approach offers considerable consumer choice, it comes with high administrative costs, complicates coverage portability, and creates high risks of coverage gaps over the course of individuals' lives.

In both of these models, policymakers would need to decide whether individuals would be eligible to opt out of participating in the Medicare-for-all program, and if so, what private coverage options would be permitted. **Table 3-2** presents an overview of two Medicare-for-all models: a single-payer Medicare-for-all approach and Medicare-for-all plus MA approach. Under both of these options, private insurance outside of the Medicare-for-all system would be limited to a supplemental role, and private coverage that duplicates the Medicare or MA benefits would not be allowed. Additional permutations of these two models are possible, but these two approaches will be the focus of the analysis in this report.

**TABLE 3-2. Medicare-for-all Models**

	Single-payer Medicare-for-all	Medicare-for-all plus MA
<b>Availability of private Medicare plans</b>	None; only traditional Medicare, acting as a third-party payer to providers, is retained.	Yes, enrollees could choose between private plans in a MA-like system and traditional Medicare.
<b>Availability of supplemental coverage</b>	May allow private supplemental coverage, depending on comprehensiveness of coverage.	Yes, enrollees could choose between private plans in an MA-like system and traditional Medicare.
<b>Availability of alternative coverage outside of Medicare</b>	Duplicative coverage is prohibited.	Duplicative coverage is prohibited.

## Eligibility Criteria

Most Medicare-for-all proposals aim to extend Medicare coverage to all Americans, although the proposals have some variation in what populations are included under the umbrella of “all.” Most proposals would extend the Medicare program to cover the entire population—including the uninsured, workers currently covered by employer-based group plans, and people who are individually insured. In addition, these proposals would fold the Medicaid program and the population it covers into Medicare, changing the historical role of states in administering Medicaid. Proposals differ, however, in their treatment of issues such as undocumented immigrants and specialized federal programs for populations such as veterans and Native Americans.

## Undocumented Immigrants

Policymakers would need to determine whether eligibility would be restricted to only U.S. citizens and lawfully present noncitizens/residents, who represent approximately 97 percent of the U.S. population, or be expanded to encompass undocumented immigrants (Congressional Budget Office 2019). Under current law, undocumented immigrants are ineligible for Medicare, most states' Medicaid and Children's Health Insurance Programs (CHIPs), and for premium subsidies in the individual Affordable Care Act (ACA) exchanges. Currently, undocumented immigrants can obtain coverage through employer plans and through unsubsidized individual market plans. If they are ineligible for a Medicare-for-all program and duplicative private insurance options are eliminated, the number of uninsured immigrants would increase (Blumberg et al. 2019). An intermediate step would be to provide access to emergency services only—which exists under current law for uninsured undocumented residents (Congressional Budget Office 2019).

## Preservation of Other Federal Programs

Currently, the Veterans Health Administration, Military Health System (MHS), and the Indian Health Service (IHS) operate as separate care delivery and insurance systems. Medicare-for-all proposals typically preserve these separate arrangements, allowing the populations they serve to receive care, respectively, at Veterans Administration (VA) hospitals, MHS facilities, and IHS centers. Additionally, policymakers would need to determine whether insurance systems serving particular populations, such as TRICARE, would be permitted.

The state-based Medicaid program provides health insurance coverage for an estimated 75 million low-income people, including supplementing Medicare benefits for individuals dually eligible for Medicare and Medicaid by providing payments for Medicare premiums and cost-sharing requirements and providing additional LTSS, hearing, dental, and other services not covered by Medicare (Tolbert, Rudowitz, and Musumeci 2019). (See **Appendix A** for more information on Medicare Savings Programs.) A Medicare-for-all program could absorb Medicaid or instead retain a role for states in providing additional coverage for services that might be excluded from the Medicare-for-all benefit package, such as LTSS. Whether a role for states and Medicaid as a supplemental program remains depends on the comprehensiveness of benefits and cost-sharing provisions of the Medicare-for-all program. In addition, as discussed below in the financing section, proposals could retain a role for states in financing Medicare-for-all, such as requiring “maintenance of effort” payments.

## Automatic Enrollment

Although many individuals are automatically enrolled in Medicare Part A upon turning 65, the current Medicare program has many voluntary components such that individual enrollment decisions involve a considerable amount of choice and, often result in considerable enrollee confusion. Policymakers would need to decide how to enroll the entire population into the Medicare-for-all program and whether to make enrollment automatic or include some level of voluntary participation.

Although a universal Medicare program would need to establish an eligibility verification and enrollment process, establishing a system of universal eligibility would be simpler than other approaches because it would eliminate most potential restrictions on eligibility (Congressional Budget Office 2019). This process could include automatically enrolling individuals currently receiving coverage in federal programs or receiving coverage through an employer, enrolling individuals when they are issued Social Security numbers or, as in many countries with universal coverage, enrolling individuals upon birth registration. New processes would be needed to enroll the uninsured population, such as options for enrolling individuals when they receive health care services.

Under a Medicare-for-all program with MA, policymakers would also need to determine whether individuals would be automatically enrolled in the public plan by default and what the processes for enrolling in a specific private plan would be. For example, current enrollment and data-sharing rules make acquiring members relatively expensive for an MA plan. Policymakers would need to specify when or whether individuals would have the opportunity to switch between traditional and private Medicare options during enrollment periods or upon certain qualifying life changes, such as moving outside the geographic area served by an MA plan.

## Benefits and Cost Sharing

Although a Medicare-for-all program could mirror the benefit package and component structure of traditional Medicare (with separate Parts A, B, and/or D), current proposals generally offer an expanded, integrated benefit package that more closely resembles the most comprehensive

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*Although a Medicare-for-all program could mirror the benefit package and component structure of traditional Medicare (with separate Parts A, B, and/or D), current proposals generally offer an expanded, integrated benefit package that more closely resembles the most comprehensive models of private insurance, which include limited or no cost sharing.*

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models of private insurance, which include limited or no cost sharing. (See **Appendix A** for an overview of Medicare program design.) In a single-payer Medicare-for-all model, this uniform benefit package would serve as the primary insurance for the entire population.

### **Comprehensiveness of Benefits**

A universal Medicare program could cover a level of benefits comparable to the current Medicare program, including inpatient and outpatient hospital services, physician services, skilled nursing care, and hospice and home health care, as well as mental health services, preventive services, and outpatient prescription drugs. Most other wealthy countries provide comprehensive, acute care medical coverage and, if cost sharing applies to covered benefits, a cap on out-of-pocket (OOP) spending (which currently does not exist in the traditional Medicare program). Significant international variation exists in what additional benefits are covered and the extent to which those benefits, such as LTSS coverage, are covered under parallel programs (Mossialos et al. 2017). A Medicare-for-all program could extend benefits beyond the current coverage for acute care to include LTSS and dental, vision, and hearing services. Choices regarding the breadth of the benefits package have important implications for beneficiary access to needed services, federal spending, and total health care expenditures.

### **Role of Medicare Advantage**

A Medicare-for-all model could retain the choice that today's Medicare beneficiaries have in obtaining their benefits through traditional Medicare or MA plans, including employer- and union-sponsored MA plans. Depending on the specifications of the program, these private plans may be permitted to offer additional benefits, cash rebates, and/or lower cost sharing compared to the public plan benefit package. Plans would need to compete for beneficiaries based on other characteristics, such as quality or value offered, and so would need to demonstrate that their care management techniques yield better outcomes and share savings with beneficiaries in some way. Policymakers would need to determine how much flexibility MA plans would have in designing unique benefit packages and cost-sharing requirements. MA plans would likely continue to have provider networks and continue to manage and coordinate care or to incentivize modifications in care delivery. Regulatory constraints would continue to apply to the structure and breadth of networks. MA plan payment rates could continue to be determined through the benchmark bidding process or through reformed approaches, such as competitive bidding, with more efficient competition based on plan quality, efficiency, and price (Medicare Payment Advisory Commission

2019b). Policymakers would need to decide whether MA plans would negotiate provider payments directly with providers or have the ability to impose traditional Medicare rates.

To the extent that MA plans were retained as part of the design, plans would likely continue to have an incentive to attract healthier enrollees for whom spending would be below a given plan's bid (see **Appendix A** for an overview of MA payment). Although risk adjustment and other mechanisms can mitigate the selection behavior, evidence suggests that plans may still use tactics to retain favorable selection and “upcode” for diagnoses that make their enrollees appear less healthy than they actually are. These tactics, in combination with the quality bonus program and other mechanisms, contribute to Medicare overpaying some MA plans, which increases costs to the federal government (United States Government Accountability Office 2017; Goldberg et al. 2017; Jacobson, Neuman, and Damico 2019; Newhouse et al. 2014). A program with MA would likely need to include updated and refined methods to reduce overpayments to MA plans, such as appropriate benchmarks, improved risk adjustment, and increased transparency and auditing. Unless the Medicare-for-all program could effectively adjust payments to MA plans in a way that accurately reflects the patients they serve, the program could incur higher overall costs than a single-payer program.

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## **Cost-Sharing Requirements**

Cost sharing has a significant impact on utilization of health care services, and it may impede access to necessary care. A substantial body of research supports the hypothesis that individuals in plans with high cost sharing use fewer health care services than individuals in plans with lower cost sharing. The relevant literature indicates that higher cost sharing equally affects appropriate and inappropriate care and can lead to obstacles to care, resulting in adverse clinical impacts on patients (Brook et al. 2006; Gourzoulidis et al. 2017). For low-income populations, children, and patients with chronic conditions, cost sharing reduces health care utilization and increases adverse health outcomes (Chandra, Gruber, and McKnight 2010; Swartz 2010).

Although reductions in cost-sharing requirements produce savings for patients and ease access to care, less cost sharing under a Medicare-for-all program would

increase costs to the federal government and likely increase the utilization of services (Congressional Budget Office 2019). Because of the risk of erecting barriers to care and the higher administrative costs associated with cost sharing, some Medicare-for-all proposals are designed with no or nominal cost-sharing levels and instead would rely on other utilization management techniques.

A Medicare-for-all program with cost sharing could employ a variety of design features to minimize barriers to care. Retaining cost sharing for all beneficiaries but mitigating the burden on lower-income beneficiaries would lower program spending while protecting access for more-vulnerable individuals. Cost sharing for services could be set nationally, with protections for individuals who meet specific low-income requirements, as in the current Medicare Savings Programs (see **Appendix A**). Alternatively, cost sharing could be implemented on an income-based sliding scale, similar to the determinations of cost-sharing reductions in the ACA individual market and the Part D low-income subsidy program. Additionally, cost sharing could be reduced or eliminated for chronic conditions that require frequent and regular treatment. These refinements would likely add administrative complexity and cost in collecting and verifying individual and family income information.

## **Supplemental Coverage**

If Medicare-for-all excludes certain benefits or includes more than nominal cost sharing, state Medicaid programs or private insurance could provide supplemental coverage, as in the current Medicare program. In particular, a mechanism for supplementing coverage of low-income individuals may be necessary to avoid exacerbating health and access disparities (Congressional Budget Office 2019). Cost-sharing support and additional services such as LTSS could be administered through residual state Medicaid programs. Some supplemental benefits of this type could also be covered through private insurance policies, either purchased independently or provided through an employer. In a Medicare-for-all program that retains MA, enhanced MA plans could provide supplemental coverage. If MA plans are the only source for such supplemental coverage, however, fairness would require that at least one plan be available in all geographic areas.

In other countries, supplemental policies may also provide access to private providers or faster access to health care services. A universal Medicare program would need to specify what role private insurance policies should play in this new system. Allowing beneficiaries with supplemental or other private insurance plans to have more timely access to care or to be able to receive treatment from providers not available under Medicare-for-all, while arguably improving choice, would also likely create equity issues. This use of supplemental plans would also depend on the level of provider payments established under the plan. A universal Medicare program

would need to regulate when individuals can enroll, the comprehensiveness and pricing of private supplemental policies, and the ability of supplemental policies to use medical underwriting to avoid enrolling potentially more-costly enrollees.

## Provider Payment and Participation

A Medicare-for-all program would need to specify whether it would adopt the current Medicare provider payment methodology and rates or use alternative payment structures, such as shared-savings programs, all-payer rate setting, capitated payments, and/or global budgets. In addition, a system using MA plans would need a determination about the ability of private MA plans to rely on Medicare payment rates when contracting with providers.

## Medicare Payment Methods and Rates

The traditional Medicare program acts as a third-party payer, establishing fees for health care providers through formulas prescribed in law and regulation. It uses prospective payment systems, under which it sets nationally uniform fee schedules and bundled or episode-based payments, with limited regional variation for factors such as geographic differences in wages.

(More information about Medicare's payment methods is furnished in **Appendix A.**) A Medicare-for-all program could build on Medicare's current payment structure either by directly extending Medicare's current rates or by adding a modest percentage increase to Medicare's rates during the transition or indefinitely. Rates would still likely be lower relative to current commercial insurance rates.

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For hospitals and physicians, Medicare's payment rates are considerably lower than the rates commercial insurers pay. Commercial payment rates average nearly twice Medicare rates for inpatient hospital services, and these differences are even more significant for outpatient hospital levels, with one study finding that the mean private outpatient prices reached 293 percent of Medicare in 2017 (White and Whaley 2019). MA plans typically pay hospital rates similar to traditional Medicare, likely due in part to statutory and regulatory provisions that cap out-of-network MA payments at traditional Medicare rates. Such provisions change the negotiation dynamics between MA plans and hospitals (Berenson et al. 2015). Medicare base payments, on average, are higher than Medicaid base inpatient hospital

payments, with Medicaid paying 78 percent of Medicare's rates. After accounting for supplemental payments, however, Medicaid's average net payments to hospitals were actually 6 percent higher than Medicare, on average, with considerable variation across states (Medicaid and CHIP Payment and Access Commission 2017).

The gap between Medicare payments and commercial payments has grown dramatically over the past 10–15 years and varies significantly based on geography, type of service, and level of hospital consolidation. For example, in 2010, average inpatient payment rates ranged from 147 percent of Medicare rates in Miami to 210 percent in San Francisco, and outlier hospitals negotiated almost 500 percent of Medicare rates for inpatient care and 700 percent for outpatient care (Ginsburg 2010). Hospital consolidation and overall hospital market power is a factor driving the gap and variation in Medicare and commercial payment rates; stronger market power allows hospitals to negotiate higher rates from private payers (Cooper et al. 2019). Studies have found that lower Medicare price growth did not lead to higher prices negotiated with commercial insurers. Rather, lower Medicare prices led to lower cost growth, suggesting that constraining total revenues caused hospitals to implement steps to increase their cost efficiency rather than simply to shift the costs to commercial insurers (Clemens and Gottlieb 2017; Medicare Payment Advisory Commission 2019b; White, Bond, and Reschovsky 2013).

Like Medicare, private commercial insurance plans generally pay physicians on a fee-for-service basis but, as noted above, pay higher rates than Medicare, on average. The size of the differential varies significantly by service type, region, provider specialty, and level of provider consolidation (Pelech 2018). MA plans typically pay physicians rates similar to traditional Medicare for the same reason as they do hospitals (Maeda and Nelson 2018; Trish et al. 2017). In 2017, commercial preferred provider organization (PPO) payment rates for physician and other health professional services were, on average, 133 percent of Medicare's, with significant variation by type of service (Medicare Payment Advisory Commission 2019b). In 2016, Medicaid programs paid physicians 72 percent of Medicare's rates, with variation across states (Zuckerman, Skopec, and Epstein 2017).

Due to the variation in provider payment rates across regions and provider types, it is difficult to assess what the impacts would be of moving to Medicare rates for all patients.

## **Alternative Payment Methods and Rates**

Although a Medicare-for-all program could extend Medicare's payment structure, bundled payment per diagnosis payments encourage providers to deliver more services than may be optimal. To address these challenges, Medicare is



currently experimenting with various alternative payment models. For instance, through the Medicare Shared Savings Program, Medicare has integrated into its payment structure more opportunities for providers to share savings and risk. These experimental payment methods could be retained or extended under a Medicare-for-all program, although their efficacy is not yet established.

### **Global Budgets**

Under a global budget payment system, hospitals and other providers receive a fixed payment for a specified amount of time, such as quarterly or yearly. Providers are responsible for allocating funds to provide care and bear the financial risk if their costs of providing care exceed the global budget payment level. Due to the financial risk placed on providers, a Medicare-for-all system that includes global budget payments to providers would need to monitor volume levels and quality of services, safety, and performance standards to ensure access and high-quality care, as well as require a robust system to adjust for differing risks associated with individual patients. This payment method is not common in the United States, but the state of Maryland uses global budgets to pay hospitals and other providers that treat patients insured by Medicare.

Global budgets are compatible with payment mechanisms such as shared savings programs. Administratively, they work best under a single-payer system,

although they could also operate in a system with MA plans in combination with an all-payer rate-setting program (Berenson et al. 2016). Although some international systems continue to use global budgets, many that do so have begun to incorporate a component of activity-based financing as a productivity inducement, while others have abandoned global budgets for hospitals altogether, paying hospitals using diagnosis related groups, similar to traditional Medicare (Busse et al. 2011). Adopting global budgeting in a Medicare-for-all system would require many key design decisions, including the geographic level of the budget, the services and population covered under the budget, how the budget would be set initially, how it would grow over time, whether it would be set administratively or negotiated with providers, and how it would be enforced (Congressional Budget Office 2019; Long and Marquis 1994).

### ***All-Payer Rates***

In a Medicare-for-all model that retains a role for private insurance in paying for care—either through MA or supplemental insurance—how much discretion private insurers would have to negotiate provider payment levels and methods would need to be decided, as well as how those payments would interact with the universal Medicare program. Private insurers could continue to negotiate directly with providers to set rates or pay providers through all-payer rate setting, where the prices for services at a given hospital are based on the Medicare rate, regardless of payer. The all-payer rate for Medicare and private insurers could, for example, be set at current Medicare payment levels, at the average of all private payers and Medicare, or some other level. These all-payer rates could be used on their own to control provider payment levels or to create global budgets for providers.

### **Physician Participation**

Physicians may currently choose among options for participating in Medicare and accepting the program's payment methods and rates. (See Appendix A for details.) While most physicians participate in the program or accept Medicare payment methods and rates, not all do. A universal Medicare proposal would need to decide whether laws regarding physician participation would remain the same. A single-payer model where Medicare becomes the dominant source of coverage for the entire population creates strong incentives for physicians to participate.

In any Medicare-for-all system, policymakers would need to determine whether providers could offer services to private-pay patients only and, if so, whether to include restrictions on such care. In addition, a system with MA would require policymakers to decide what requirements and restrictions are placed on MA plan networks.

## Prescription Drug Payment Methods

The United States pays more than twice as much per capita for prescription drugs as the average country in the European Union or in the larger group of countries within the Organisation for Economic Co-operation and Development (Organisation for Economic Co-operation and Development 2018). Many federal programs typically pay lower prices for prescription drugs than do private payers. Medicaid includes a drug rebate program that requires manufacturers that want their drugs covered to provide a rebate for a portion of the drug payment, which in 2017 amounted to 50 percent of total Medicaid drug spending (Medicaid and CHIP Payment and Access Commission 2019). The VA uses a managed formulary that weighs the therapeutic value of a drug to determine the amount of the reimbursement, and it has the power to exclude specific drugs. Through its bargaining power and ability to establish formularies, the VA pays considerably lower prices than Medicare Part D plans, with estimates ranging from 40 percent to 80 percent less (Pollin et al. 2018). The 340B Drug Pricing Program within Medicare effectively compels manufacturers to offer drugs at significantly reduced prices to federally qualified health centers and certain hospitals serving low-income beneficiaries (American Hospital Association 2019).

The Medicare Modernization Act of 2003, which established the Medicare Part D benefit, includes a noninterference clause that stipulates that the Secretary of the Department of Health and Human Services (HHS) may have no direct role in negotiating or setting pharmaceutical prices in Part D. The Medicare program is the largest purchaser of prescription drugs in the United States. Unlike the VA, Medicare Part D may not require a particular formulary or price structure for Part D–covered drugs, and plans must cover all drugs in six protected classes. A single-payer Medicare-for-all program with a unified benefit design would likely alter this payment structure because the Medicare program would manage the drug benefits and assume the risk. In a Medicare-for-all program in which MA is retained, policymakers would need to decide whether MA plans would continue to manage the drug benefit separately and what role the government would have in setting prices for drugs with limited or no competition (Cubanski et al. 2019).

A Medicare-for-all program could grant negotiating power to the HHS Secretary in conjunction with implementing additional drug cost containment measures. To exert significant downward pressure on drug prices, the federal government would need mechanisms to bring manufacturers to the table and

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*A Medicare-for-all program could grant negotiating power to the HHS Secretary in conjunction with implementing additional drug cost containment measures. To exert significant downward pressure on drug prices, the federal government would need mechanisms to bring manufacturers to the table and secure lower drug prices*

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secure lower drug prices (Berwick and Johnson 2019). Allowing the public insurance program to exclude certain drugs from the formulary or add them to a nonpreferred list due to high price or low value—as other countries, commercial plans, and Part D plans for nonprotected drug classes commonly do—would likely lessen access to those drugs for enrollees. Mechanisms could be developed to ensure patient access to medically necessary off-formulary pharmaceuticals.

A universal Medicare program could reach further and include other cost controlling mechanisms such as value-based pricing, in which price benchmarks are determined through cost-effectiveness research and internal or external reference pricing. Internal reference pricing bases the price of a drug on the prices of similar drugs (for example, as a target for negotiated prices), whereas external reference pricing bases the prices for drugs on the price in one or several countries as a benchmark for negotiations (Congressional Budget Office 2019). A Medicare-for-all program would likely achieve significant savings in pharmaceutical spending, but the extent depends on what cost containment and negotiation mechanisms are included.

## **Governance and Administration**

The current Medicare program is administered by the Centers for Medicare & Medicaid Services (CMS), a component of the U.S. Department of Health and Human Services. Key Medicare decisions, including changes in the method of payment and payment levels, are defined in law and executed through detailed regulations. Congress performs oversight of the Medicare program through various committees, including the Ways and Means Committee and the Energy and Commerce Committee in the House and the Finance Committee and the Health, Education, Labor and Pensions Committee in the Senate. Policymakers would need to decide whether the Medicare-for-all program would build upon Medicare's current system of governance.

CMS includes 10 regional offices that oversee Medicare operations, financial management, and quality improvement operations (Centers for Medicare & Medicaid Services 2019d). A Medicare-for-all system would likely be administered by CMS and could retain the current regional office structure, or policymakers could decide to alter the role of regional offices. Additionally, the administrative role of states would need to be specified and could include continued oversight of physician and provider licensing, regulation of supplemental insurance, and/or implementation of payment and delivery system innovation (e.g., regional global budgets).

The current Medicare program relies on 12 Medicare administrative contractors (MACs), which are private insurers that compete for contracts to process Part A and Part B medical claims for the 38.5 million traditional Medicare beneficiaries in 12 geographic jurisdictions, and four durable medical equipment (DME) MACs to process DME claims (Centers for Medicare & Medicaid Services 2019g). If MACs

continued to operate within a Medicare-for-all program, their role would likely expand markedly in a single-payer program, but the expansion would likely be somewhat more modest under a system with MA plans.

## Financing Medicare for All

A universal Medicare program would increase federal spending significantly because spending that is now from private sources would shift on to the federal budget. Costs would vary depending on specific design features. That is because spending that is now from private sources would shift onto the federal budget. While federal spending on medical care would increase, private expenditures, including premium and out of pocket payments from individuals, could decline.

Whether overall health expenditures in the United States would necessarily increase is the subject of considerable debate, given the wide range of factors that would increase total spending (such as increased utilization) or would reduce spending because of factors such as lower payment rates, reduced administrative costs, and lower drug prices. **Table 3-3** provides an overview of national health expenditure (NHE) by all public and private payers, including individual OOP expenses, in 2018. Federal spending on Medicare and Medicaid amounted to \$1.1 trillion of the \$3.6 trillion NHE. At a minimum, any Medicare-for-all proposal would need to specify how it would finance the change in distribution of health spending and address related transition issues.

**Table 3-3. National Health Expenditures in 2018, by Source of Funds**

	Total NHE (in billions)	Percent of Total NHE
<b>National health expenditures</b>	<b>\$3,649.40</b>	<b>100%</b>
<b>Health consumption expenditures</b>	<b>\$3,475.00</b>	<b>95%</b>
Out of pocket	375.60	10
Health insurance	2,729.00	75
-Private health insurance	1,243.00	34
-Medicare	750.20	21
-Medicaid	597.40	16
Federal	370.90	
State and local	226.50	
-Other health insurance programs*	138.30	4
Other third-party payers, programs, and public health activity**	370.50	10
<b>Investment</b>	<b>\$174.40</b>	<b>5%</b>

**Notes:** NHE (national health expenditure).

\*Includes Children's Health Insurance Program (Titles XIX and XXI), Department of Defense, and Department of Veterans Affairs.

\*\*Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

**Source:** Centers for Medicare & Medicaid Services 2019e.

## Medicare-for-All Cost Estimates

The spending estimates for a single-payer Medicare-for-all program differ widely in their assumptions on savings from administration, provider payment levels, and pharmaceutical prices, as well as their assumptions about the increase in utilization of health care services and methodological approaches to estimating costs. These differences in assumptions and technical approaches lead to very different estimates of the immediate and long-term costs of a Medicare-for-all system for the federal government and for NHE overall. The estimates also include different assumptions on covered benefits and cost-sharing requirements. **Table 3-4** provides a breakdown of Medicare-for-all cost estimates for the most comprehensive single-payer program, analyzed and presented according to each study.

**Table 3-4. Cost Estimates of Single-Payer Medicare-for-All Proposals (in trillions of dollars)**

	Thorpe	Urban 2016	Blahous et al.	PERI 2018	Friedman	RAND	Urban 2019
<b>Budget window</b>	2017–2026	2017–2026	2022–2028	2017–2026	2019–2028	2019–2028	2020–2029
<b>Total federal spending in first year</b>	\$3.6*	\$4.1	\$4.2	\$2.9	\$2.8	\$3.5	\$4.1
<b>Additional federal spending in first year</b>	\$1.9	\$2.5	\$2.5	\$1.1	\$1.4*	\$2.4	\$2.8
<b>Additional federal spending over 10 years</b>	\$25	\$32	\$33	\$14	\$19*	\$31*	\$34
<b>10-year NHE</b>	\$39*	\$46*	\$58	\$39	\$35	\$55*	\$59
<b>Change in 10-year NHE</b>	–\$4.0	\$6.6	–\$2.0	–\$5.1	–\$12.5	\$5.1*	\$7.0

**Notes:** PERI (Political Economy Research Institute), and NHE (national health expenditure).

\*These numbers are not provided in the original study's analysis. Berwick and Johnson extrapolated the estimate using CMS health expenditure projections from data provided in the original analysis.

"Additional federal spending in the first year refers to the difference between total federal spending in the first year and current federal health care spending.

**Source:** Berwick and Johnson 2019; Blahous et al. 2018; Friedman 2018; Holahan et al. 2016; Liu and Eibner 2019; Thorpe 2016; Blumberg et al. 2019; Pollin et al. 2018.

In all of the cost estimates presented, federal spending would substantially increase as private health insurance spending becomes absorbed into a single-payer Medicare program. The estimates of the additional federal funding needs range from \$1.1 trillion to \$2.8 trillion in the first year and from \$14 trillion to \$34 trillion over 10 years.

As illustrated in **Table 3-4**, the estimates for total spending under a single-payer universal Medicare program also vary widely, ranging from \$12.5 trillion in savings to \$7 trillion in higher costs over a 10-year period. The variations reflect differences in proposal specifications and assumptions. For example, a 2019 Urban Institute report found that a single-payer plan that covered the ACA essential health benefits would reduce national health expenditures, but a single-payer plan that covered additional benefits, such as LTSS, and required no cost sharing would increase national health spending (Blumberg et al. 2019).

A 2020 systematic review of various Medicare-for-all and single-payer plan cost estimates, including state-based single-payer proposals, found that a majority of estimates determined that single-payer financing would result in net savings to overall health care costs (Cai et al. 2020). Nevertheless, the impact on federal and national health spending depends on the specific design features and modeling assumptions, including:

- generosity of covered benefits
- extent of utilization increases
- savings from the use of Medicare’s provider payment rates
- saving from lower prescription drug costs
- savings from reduced administrative costs for insurers and providers

The Medicare-for-all estimates did not assess the implications for federal spending for a Medicare-for-all program in which MA is retained. Under a Medicare-for-all program in which MA is retained, the federal government still acts as the payer to providers for individuals enrolled in the public plan and pays MA plans to provide coverage for their enrolled beneficiaries. The amount of federal funds needed under a system with MA would likely be greater than under a single-payer system because a program with MA reduces the potential administrative, provider payment, and drug cost savings. This impact depends, however, on the rules for setting capitation payments and the ability of MA plans to innovate and

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*In all of the cost estimates presented, federal spending would substantially increase as private health insurance spending becomes absorbed into a single-payer Medicare program. The estimates of the additional federal funding needs range from \$1.1 trillion to \$2.8 trillion in the first year and from \$14 trillion to \$34 trillion over 10 years.*

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manage utilization. For example, basing MA payments on competitive bidding (generally similar to Part D of Medicare) rather than the current system has been projected to lower federal costs (Lieberman et al. 2018).<sup>2</sup>

## Financing Mechanisms

A Medicare-for-all program would shift a significant level of private spending to the federal government, and policymakers would need to decide how the system would be financed. Under the multi-payer, mixed model employed today, U.S. residents' coverage and care are financed by a mix of public and private sources, including taxes, premiums, and OOP spending, with each public program having a unique financing structure. Under a Medicare-for-all system, policymakers would need to decide the extent to which the universal Medicare program would replace existing federal, state, local, employer, and household health care spending; what additional revenue sources would be added; and how funding would be administered.

## Federal and State Spending

A considerable amount of government spending on health care could be reallocated to fund a Medicare-for-all program. Currently, the Medicare program is primarily financed through individual and employer payroll taxes, general revenue transfers from the federal government, and beneficiary premiums. Payroll tax contributions made by individuals and employers could be retained as a funding mechanism for Medicare-for-all. If the payroll tax contributions were retained at current levels, additional revenues from other sources would be needed to meet increased federal spending.

General revenue funding would likely be an important source of financing for a Medicare-for-all program, but policymakers would need to decide not only the level of general revenue financing but also how that general revenue would be

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*The amount of federal funds needed under a system with MA would likely be greater than under a single-payer system because a program with MA reduces the potential administrative, provider payment, and drug cost savings. This impact depends, however, on the rules for setting capitation payments and the ability of MA plans to innovate and manage utilization.*

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<sup>2</sup> Under the current Medicare program, MA plans submit bids for the costs of providing Part A and Part B benefits to a standardized beneficiary in a specific geographic area. This is compared to county-level benchmarks, and the payment MA plans receive is based on how the bid compares to the benchmark (see **Appendix A**). In a competitive bidding model, MA plan bids would be compared to the market-level weighted average bid instead of a standardized benchmark to determine MA payments and enrollee premiums (Lieberman et al. 2018).

raised. Sources of additional revenue could include altering income tax rates, taxing capital gains and dividends as income, establishing a wealth tax, adding a sales tax on non-necessities, enacting a federal value-added tax, and other potential funding mechanisms.

Medicaid and CHIP are financed jointly by federal and state governments, raising the issue of whether states would retain responsibility—and potentially some federal funding—to cover services for vulnerable populations (e.g., medical transportation for low-income children or disabled individuals). Since states would save from shifting current Medicaid and CHIP enrollees to the federal program for basic acute care, policymakers would need to decide whether to require states to make maintenance of effort payments to the Medicare-for-all system in the amounts that they would have paid to cover their residents under Medicaid and CHIP. Depending on the financing design, states could be required to retain their current level of contribution.

### ***Individual and Employer Contributions***

Under the current Medicare system, premiums are collected from program enrollees, and Medicare-for-all could also require premiums. A required premium could be a flat rate for coverage that reflects a portion of total costs, or it could vary by individual and family characteristics, such as income level, age, or household size. In a Medicare-for-all program that includes MA, individuals choosing to enroll in an MA plan might pay a premium to finance additional benefits or have lower premiums if a plan's bid were below the new universal Medicare benchmark.

Alternatively, a Medicare-for-all program could rely solely on taxes for financing, simplifying the process of collecting contributions. Policymakers could expand the current payroll tax contribution system for individuals and employers, or policymakers could use a dedicated income-based tax paid by households. A financing system would be more progressive if higher-income households pay more and lower-income households pay less (or are even exempt). How any taxes for Medicare-for-all would compare to individuals' current spending on health care depends on the amount and design of the tax.

Some or all of employers' premium payments for employee benefits could be recouped to finance universal coverage under a Medicare-for-all program. In 2018, employers made \$561 billion in contributions to employer-sponsored private health insurance premiums. An increase in the payroll tax contribution dedicated to Medicare and paid by employers—\$113 billion in 2018 (Centers for Medicare & Medicaid Services 2019e)—could ensure that employers continue to contribute to

the financing of a universal Medicare program. Payments by employers on behalf of their employees could be used for a transition period or indefinitely, through a percentage tax on their payroll or through a percentage of their current spending on health insurance for their employees (an employer maintenance of effort payment). If funds are raised through a percentage of employers' current health insurance spending, only those employers currently offering coverage would pay into the Medicare-for-all system, raising equity issues across employers, which would be further complicated across time as new employers are established.

## Policy Implications

How various reform drivers and policy objectives would be affected by implementing a universal coverage program modeled on Medicare would hinge on the design decisions described above. But it is possible to foresee certain likely effects under various scenarios. This section assesses the general direction of prospective changes and discusses the design decisions that will most determine the magnitude of impact. The analysis focuses on two approaches to the design of Medicare-for-all:

- **A single-payer Medicare-for-all system**, with Medicare directly paying independent health care providers, in which private insurance's role would be limited to providing administrative services or optional coverage for services not covered by the Medicare package and/or the cost sharing associated with use of covered services.<sup>3</sup>
- **A Medicare-for-all plus MA system**, in which beneficiaries would choose whether to obtain services through traditional Medicare, in which the program pays providers, or through a private, risk-bearing MA plan operated by a private insurer that receives a capitated Medicare payment to manage benefits and pays providers in a heavily regulated system.

## Impact on Coverage and Access to Care

A move to a Medicare-for-all program stands to affect access to services for beneficiaries—both the newly covered as well as current Medicare beneficiaries.

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<sup>3</sup> The current Medicare-for-all proposals put forward a comprehensive benefits package and no or only nominal cost sharing, which would render private health insurance obsolete or valuable only for enhanced or peripheral services, such as upgraded, private hospital rooms or cosmetic surgery. For the purpose of our analysis, we consider that a Medicare-for-all program would either have a comprehensive benefit or that, like today, most beneficiaries would either qualify for additional public support (e.g., Medicaid, Medicare Savings Program) or would have private supplemental coverage (employer-sponsored or privately purchased, such as Medigap).

The main channels through which coverage and access would be affected include:

- a reduction in the share of uninsured individuals because of expanding coverage to more people, and
- a reduction in the share of underinsured individuals by achieving increased comprehensiveness in the benefits package and/or a reduction in cost sharing.

Taken together, these effects would increase the demand for services, which could delay access, including among current beneficiaries, if capacity is not adequate to meet demand.

Other notable channels through which access to care may be altered include:

- changes in restrictions on patient service use
- changes in the range of providers
- changes in the capacity of the health care delivery system to serve patients

## **The Uninsured Population**

A move to universal Medicare eligibility would nearly eliminate the share of the population that is uninsured, individuals who currently face significant financial barriers to accessing care—problems associated with forgoing needed health services and shortfalls in health and financial security.

Approximately 5 million undocumented immigrants made up about 16 percent of the uninsured population in 2017 (Blumberg et al. 2018). Implementation of a Medicare-for-all program that excluded undocumented immigrants would bring the uninsured share of the population down from more than 11 percent of nonelderly U.S. residents to approximately 1.8 percent (Kaiser Family Foundation 2019a). But because many undocumented immigrants have coverage through employer plans and through unsubsidized ACA individual market plans, the number of undocumented immigrants who are uninsured would increase if they are ineligible for a Medicare-for-all program and other sources of coverage are unavailable (Blumberg et al. 2019).

## **Comprehensiveness of Coverage**

According to a recent survey by the Commonwealth Fund, 45 percent of Americans, or 87 million people between the ages of 18 and 65, are inadequately insured, which is defined as having shortfalls in covered benefits or excessive cost sharing that presents financial barriers to obtaining needed services (Collins, Bhupal, and

Doty 2019). The extent to which individuals would have more-comprehensive coverage under Medicare-for-all depends on the covered benefits; whether cost sharing is required for covered services within the benefit categories; whether subsidies for any OOP spending are available for certain beneficiaries; and whether the program includes a cap on OOP spending.

Under a Medicare-for-all program in which the public plan provides access to services beyond those covered by Medicare currently, such as LTSS, with little to no cost sharing, comprehensiveness of coverage would improve for individuals currently covered by Medicare, by employer-sponsored insurance, or by ACA individual market plans. Additionally, beneficiaries would likely have access to a broader range of providers in the public Medicare-for-all plan compared to their current sources of coverage. Under a Medicare-for-all program with MA plans, enrollees in MA plans would still have provider network restrictions, but MA plan networks, on average, are less restrictive than current commercial private insurance.

For individuals currently receiving the most comprehensive forms of coverage available today— primarily Medicaid beneficiaries and beneficiaries dually eligible for Medicare and Medicaid—comprehensiveness of coverage could decline unless special provisions were made to ensure further assistance for these vulnerable patients. For example, these populations currently benefit from low OOP costs and have coverage for LTSS and medical transportation as well as support for social and behavioral determinants of health, among other services. Children under Medicaid and CHIP also have an extremely expansive set of benefits required under the Early and Periodic Screening, Detection and Treatment (EPSDT) program.

## **Access to Services**

In a Medicare-for-all program, it is reasonable to expect an increase in demand for health care services, especially among previously uninsured and underinsured individuals. How much demand increases depends on factors such as the comprehensiveness of universal Medicare benefits, the deployment of any new utilization controls, and any limitations in or adjustment to the supply of providers. Increased utilization would be less pronounced in a Medicare-for-all program with cost sharing, less-comprehensive benefits, and/or limits on supplemental coverage.

In the short run, eliminating or dramatically reducing the share of the population that is uninsured and underinsured could put pressure on the delivery system to meet the needs of these populations, possibly straining the delivery system in geographic areas that currently have inadequate health care workforces. Over the long term, effects are harder to predict because service supply and distribution of



services would be affected by changes in payment levels and methods. Presuming extension of fee-for-service and episode-based payment methods, service supply might drop when prices fall, but reduced administrative costs could offset some of the decline in payment rates, meaning that effective (net) prices would not fall as much as the nominal reduction in payment rates. Capacity could also be adjusted over time to meet levels of demand for services, such as adjusting processes for graduate medical education.

Some, but not all, international health systems experience different types of capacity problems not commonly seen in the U.S. health system at present, including longer waiting times for appointments or elective surgery (Schneider et al. 2017). Researchers attribute such problems to productivity shortfalls caused by provider payment methods such as fixed provider budgets, that fail to incentivize activity, and/or system-wide underfunding. Systems experiencing queuing and related access problems have attempted to respond by changing incentives, building capacity, and improving triage (Siciliani, Moran, and Borowitz 2014).

Under traditional Medicare today, beneficiaries are largely unencumbered by utilization management techniques commonly employed in private insurance. A Medicare-for-all program might adopt some techniques such as prior authorization or step therapy, as is currently allowed in Medicare Part D, to counter a potential

uptick in utilization.<sup>4</sup> Research has shown that utilization management approaches used in some MA plans, specifically HMOs, have been effective at controlling the use of services (Landon et al. 2013). A program of Medicare-for-all could also adopt stricter standards for coverage of new drugs, devices, and treatments—requiring, for example, proof of relative effectiveness or some indication of cost-effectiveness.

## Cost Containment

Expansion of the Medicare beneficiary population to include all or most U.S. residents would likely have numerous effects on health care costs and the distribution of financing across payers and individuals, relieving pressure in some ways and increasing it in others. As illustrated in **Table 3-4**, some analysts estimate that a Medicare-for-all system could have a deflationary effect on total health expenditures and the rate of growth in health expenditures over time, whereas others project an increase in expenditures. The cost of a Medicare-for-all program depends significantly on the savings in provider payment rates, savings from lower prescription drug costs, and savings from reduced administrative costs for insurers and providers. Such savings could be offset, perhaps entirely, by increases in utilization and the program’s share of spending due to increases in the generosity and comprehensiveness of benefits.

## Provider Payment and Quality of Care

Extending the current payment methods and rates—or the current Medicare payment rate plus a modest percentage increase—would contain costs in a universal Medicare program, presuming the new rates were lower than current rates, on average, across providers and geographic areas. These payment reductions would likely have a substantial impact, however, on provider revenues, especially in the case of hospitals, for which private rates in relation to Medicare payment levels are significantly higher. Some of the revenue loss would be recouped with increased utilization by the previously uninsured and underinsured, as well as by a significant reduction in the demand for uncompensated care. As previously discussed, to the

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<sup>4</sup> Step therapy requires patients to try a less expensive medication or treatment before the insurance plan will cover a more expensive treatment.

extent that Medicare-for-all succeeds in substantially reducing administrative costs for hospitals and physicians, the “net” revenue impact of lower Medicare payment rates would be offset in part.

The hallmark of successful cost containment efforts is reduced provider revenue, which could affect health care delivery and/or practice patterns and could create a negative impact on current or future health care processes, outcomes, and capacity. The link between payment rates and quality in health care, however, is not well established. The research literature demonstrates that differences in quality of care across the country show little relationship to the level of spending on care (McKellar et al. 2017). Providers have the ability to adopt changes to their cost structure in ways that do not have a negative impact on health care quality. The financial pressure may lead providers to change their input costs to increase their efficiency in delivering services (Congressional Budget Office 2019). To ensure quality of coverage, a Medicare-for-all program could continue the current value-based programs of Medicare that can influence quality, including the Hospital Value-Based Purchasing program, the Hospital Readmissions Reduction program, and other mechanisms for payments dependent on quality. To date, however, evidence of the effectiveness of these programs has been mixed.

### **Prescription Drug Savings**

A Medicare-for-all system would likely significantly lower prescription drug prices, revenue that may be partially offset by increases in volume associated with declines in the uninsured and underinsured. Lower sales revenue and profits could alter manufacturers’ incentives for innovation, although the relationships between lower revenue, investment in drug development, and innovation are not well established. In the current pharmaceutical system, drug manufacturers have an incentive to invest in drugs disproportionately prescribed for wealthier individuals with private insurance who pay higher prices for pharmaceuticals and have little incentive to invest in less-expensive drugs that improve health over the long term, such as antibiotics and early-stage cancer cures (Budish, Roin, and Williams 2015). While lower prices for pharmaceuticals may reduce investment in development of certain types of pharmaceuticals, some analysts argue that the inclusion of price-setting mechanisms that realign manufacturers’ incentives to produce more cost-effective drugs could yield an increase in the innovation of socially beneficial drugs (Sachs and Frakt 2016). Alternatively, the federal government could incentivize the development of new pharmaceuticals through direct investment of federal dollars.

## Administrative Savings

The U.S. health care system presents significant administrative complexity, contributing to the higher per capita spending in the United States compared to other high-income countries. According to one analysis, in 2014, 8 percent of U.S. health care spending went to administrative costs compared to an average of 4 percent for OECD countries (Organisation for Economic Co-operation and Development 2017). Some recent estimates of U.S. administrative costs are considerably higher (Himmelstein, Campbell, and Woolhandler 2020). Administrative expenses include activities such as hospital or physician practice billing and insurance-related (BIR) costs, such as costs for reporting to multiple payers and provider expenses for claims and payment processing. BIR costs also include overhead expenditures for health insurers for activities such as marketing. These high overall administrative costs can lead to significant waste in the U.S. health care system—expenditures not directed at providing health care services (Shrank, Rogstad, and Parekh 2019).

The traditional Medicare program spends approximately 1.4 percent of total expenditures on administrative overhead, although the Social Security Administration provides some administrative services for Medicare, including enrollment, eligibility determinations, and basic education that are not included in the expenditure estimates (Centers for Medicare & Medicaid Services 2019a). Proponents of moving to a Medicare-for-all system cite a reduction in administrative spending—both for the government and health care providers—as a main advantage of expanding single-payer Medicare to a broader population. A Medicare-for-all system could result in sizeable administrative savings from (a) the reduced administrative costs to providers (physicians, hospitals, clinics, nursing homes, etc.) associated with a move to a single-payer system; and (b) reduced administrative costs and mark-ups associated with the provision of health insurance.

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The exact level of system-wide administrative savings from moving to a single-payer model depends on a variety of factors and is not likely to achieve as

low an administrative overhead as the current traditional Medicare program. Researchers share a belief, however, that the cost would be considerably lower than the private health insurance industry's current administrative overhead, which runs about 12 percent per year (Himmelstein, Campbell, and Woolhandler 2020). Administrative savings for the federal government, private insurers, and providers would likely be less in a Medicare-for-all system that includes MA plans or if private supplemental insurance played a significant role.

## **Cost Containment in the Long Term**

Over the longer term, the estimated impacts on cost containment are highly speculative. Because health care costs tend to increase at least at the rate of per capita economic growth (and generally have increased faster), cost growth would likely continue. Political considerations might simultaneously work to increase costs—for example, by pressing for covering drugs and procedures that would otherwise not meet coverage criteria or by pressing for increased provider payment rates. Competing upward and downward pressures are common in universal coverage systems in other wealthy countries (Docteur and Oxley 2003).

## **Impact on Other Prospective Policy Goals**

Implementation of a system of universal coverage under a Medicare-for-all program could affect a range of other frequently asserted policy goals.

## **Consumer Choice**

A move to Medicare-for-all under a single-payer approach would result in eliminating one level of consumer choice—choice of insurer—while increasing choice of provider for Americans who today increasingly face a restricted network of participating providers. In a Medicare-for-all plus MA model, most new beneficiaries would see levels of insurer choice comparable to or better than the choice they have under their current coverage. Individuals currently covered by an employer with one or only a few options or people with individual coverage in an area with few plan options would have more plan choices in a system with MA. New beneficiaries would also have a greater choice of providers if they are currently in a more restrictive health maintenance organization (HMO) or preferred provider organization (PPO) and switch to traditional Medicare or a less restrictive MA plan, although more restrictive MA plans like HMOs are also likely to remain an available choice in this model. If Medicare-for-all retains a role for supplementary coverage, enrollee choice would be further increased. Policymakers would need to consider at what level insurer choice becomes a burden for beneficiaries.

## Disparities and Inequity

Given Medicare's track record in reducing racial and ethnic disparities, reductions in the size of cross-population disparities in access, service use, and health outcomes would likely occur under a Medicare-for-all program (Vladeck, Van de Water, and Eichner 2006). Medicare-for-all could eliminate the current gaps in coverage and increase access-related health equity, however, research has shown that disparities in access to quality care remain for insured minorities, even within the Medicare program today. Among older adults, research findings indicate that racial and ethnic minorities receive lower quality of care than whites, including disparities in the delivery of primary and preventive care (Ng et al. 2014). Within Medicare Advantage plans, a recent study found that beneficiaries in racial and ethnic minority groups reported experiences with health care delivery that were similar or worse than whites (CMS Office of Minority Health 2018). A Medicare-for-all program would need to address disparities in access to quality care, as well as other causes of disparities, such as housing availability and neighborhood conditions, food insecurity, and educational opportunities.

A Medicare-for-all system with little or no OOP costs would have a significant impact on reducing poverty and economic inequality. According to national census data, in 2018, OOP medical expenses accounted for 8 million out of 41.2 million, or 19.3 percent, of people living in poverty (Fox 2019). Reaching this, or even half this, level of effective poverty reduction would also have a measurable effect on reducing economic inequality.

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*A Medicare-for-all program would need to address disparities in access to quality care, as well as other causes of disparities, such as housing availability and neighborhood conditions, food insecurity, and educational opportunities.*

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A Medicare-for-all program allowing individuals to purchase coverage providing additional benefits or better access to providers could diminish improvements in equity. Designing Medicare-for-all program provisions or preserving aspects of state Medicaid programs to fill in benefit and cost-sharing gaps for lower-income individuals could ameliorate this impact.

## Administrative Simplicity for Beneficiaries

For many Medicare-for-all proponents, an important element of the program's attractiveness is its expected reduction in the administrative burden for beneficiaries. Offering a single source of coverage throughout an individual's

life, Medicare-for-all would establish full portability of coverage, and the single-payer model would essentially eliminate the administrative burden currently associated with switching coverage. Under a single-payer system, beneficiaries would find more choice of providers, but they would have no or limited options in coverage types. A Medicare-for-all system with MA would yield significantly smaller reductions in administrative burdens for beneficiaries.

## **Social Solidarity and Perceived Fairness**

Shifting to Medicare-for-all could significantly affect public perceptions of fairness or social solidarity in the U.S. health care system. A universal Medicare system could have an important positive impact on perceived fairness by providing coverage for all regardless of age, income, or health status. Medicare expansion would also remedy the differences in eligibility for coverage across states due to differences in edibility for Medicaid and subsidized coverage in the ACA individual market. Such a program does have significant impacts, however, on provider and insurer revenues and jobs, which is likely to foster political attacks that would affect public perceptions of the program.

Currently, Medicare coverage is perceived as a benefit earned through a lifetime of work, and a universal Medicare program would break the link between Medicare and employment. For some who see Medicare as disproportionately serving the needs of the beneficiary population subsidized by the payroll tax contributions of current workers, severing this link may improve their perception of fairness, whereas others who have paid into the Medicare program over their working lives may view it as a decrease in fairness. Similar concerns may arise from, for example, employees who accepted lower wage compensation in exchange for health benefits that are more generous than Medicare-for-all benefits or whose contributions to financing would increase.

## **Externalities and Economic Impacts**

A Medicare-for-all program stands to have not only very important implications for individuals (in their roles as current and future beneficiaries), taxpayers, and health care consumers but also significant impacts on the role of employers and private insurers.

Establishing a Medicare-for-all system would change the way individuals experience their health care in fundamental respects. Under Medicare-for-all, individuals would enjoy comprehensive, fully portable, and secure coverage with no financial barriers to access and no risk of job lock over the life span. Depending on how the program is financed, insured individuals' burden of



financing care would shift to taxes, away from premiums and OOP expenses. Lower or no premiums and OOP spending would potentially offset increased tax responsibilities and be more predictable than OOP expenses.

Under a Medicare-for-all system, employers would see an important shift in their role vis-à-vis their employees because they would no longer be the default source of employees' coverage, although employers and unions could sponsor MA plans for their current and retired workers. Depending on design decisions, employers could be charged with contributing to the costs of coverage during a transition period or indefinitely. Presuming that a Medicare-for-all system would eliminate or reduce the cost burden on employers, the extent to which employers would pass along the significant cost savings associated with the provision of insurance to their employees in the form of higher employee compensation or other benefits would vary over time and depend on competitiveness and other factors, such as industry and across job categories. Employer responses would also be affected by negotiations with unions, which in many cases have bargained for comprehensive health benefits with low cost sharing and wide provider networks in lieu of wages and other benefits. Without future contract negotiations tied up over health care benefits, unions could possibly exert more leverage to improve wages, working conditions, and retirement benefits.

Medicare-for-all would have a considerable impact on the business of private health insurers under either a single-payer Medicare-for-all system or one with MA plans. Under a comprehensive Medicare-for-all system, with benefits expanded to cover services beyond the current Medicare benefits package and with little to no cost sharing, private supplemental plans would be less necessary. In a Medicare-for-all plus MA system, MA plans would be required to compete with each other and with the public Medicare plan based on their ability to offer better value. Examples of such competition could include better customer service and actual or perceived advantages in quality of care, care coordination, disease management and wellness programs, and possibly cash rebates for selecting a low-cost plan.

A final spillover effect or externality to consider pertains to the broad economic impact of Medicare-for-all. Services that improve the health of individual patients are considered the principal products of our health system, achievements that are facilitated by adequate insurance coverage. The health sector also serves, however, as a source of high-paying jobs and innovative industries, yielding benefits in exports and returns to shareholders. Local hospitals and other providers serve as important employers in many local communities, and these providers would most likely see reductions in revenue as provider reimbursements fall, which could mean changes in the net number, quality, or wages of associated jobs, especially administrative workers in provider offices and hospitals. Cutbacks in provider revenues during a transition period could lead to disruption, unless the transition adequately cushions negative effects from such cutbacks.

## Transition Challenges

Although a Medicare-for-all program builds on the current Medicare system, transitioning presents significant challenges, potentially including moving providers to Medicare rates, enrolling the entire U.S. population, phasing out commercial private insurance or shifting the industry to play a different role, building new administrative systems, reducing or potentially eliminating jobs associated with private insurance, accommodating revenue reductions for drug and device manufacturers, and implementing new financing mechanisms.

A major source of potential financial savings in a Medicare-for-all system lies in using Medicare's provider payment rates—or Medicare plus a modest percentage increase—which presents significant transitional challenges. Unless accomplished over an extended period, paying providers, especially hospitals, at Medicare rates would be likely to reduce revenue substantially and produce staff layoffs, termination of least-profitable services, and other responses that would disrupt

health care services. An extended transition period would more likely allow provider systems time to adjust input costs to reflect lower revenues, although it would not avoid pressures to rationalize service offerings, such as eliminating unprofitable lines of service or locations that affect access to care.

Transitioning to Medicare-for-all would also affect the capacity of the health care delivery system. In the short run, eliminating or dramatically reducing the share of the population that is uninsured and underinsured would put pressure on the delivery system to meet the needs of these populations (Pollin et al. 2018). Depending on system design, physicians and other providers could have an increase in hours available for patient care, due to a reduction in their administrative obligations, which could offset some of the provider supply constraints. Adding reporting requirements such as new quality measures, however, might limit the increase in clinical time. Imposing new utilization management requirements could limit demand increases; however, it would add administrative complexity for providers and may limit the increase in time available for patient care. Over the longer term, it becomes harder to predict the effects on the supply and distribution of services caused by changes in payment levels and methods.

Although an extended transition period would be beneficial for health care providers and the capacity of the health care delivery system, it also increases the reliance on commercial private insurers to continue operating until implementation is complete. Under a move to a single-payer system, private insurers during a phase-in would have reduced incentive to provide quality service, and—absent sufficient incentive to do otherwise—some may discontinue operations in advance of full implementation of the new Medicare program. The potential for this type of disruption is lessened under a system where a significant role for private insurers is retained.

A gradual implementation could ease the administrative challenges for the federal government in establishing a universal Medicare program. Gradual implementation could be accomplished in a variety of ways, including limiting enrollment to a subset of the total eligible population or extending initial enrollment periods in the first few years of enactment.

Financing mechanisms would need to be phased in so that these contributions are not levied on employers and consumers while they are still paying for their current private insurance plans (Van de Water and Buss 2009). Therefore, a gradual transition to Medicare-for-all would likely need to be financed with new revenues outside of individual and employer payroll tax contributions.

Full implementation of a single-payer system would eliminate or at least dramatically shrink providers' administrative staffs and the commercial private insurance industry—estimated to comprise 800,000 individuals in 2017—leading to a significant number of displaced workers (Pollin et al. 2018). Private insurers, however, may still provide administrative services for the Medicare-for-all system. The impact would likely be less in a system with private MA plans, a system in which supplemental private insurance policies are available, or a system in which individuals are allowed to opt out and enroll in alternative sources of coverage. Policymakers would need to consider what financial support or retraining would be available for laid-off workers in the insurance industry.

## Conclusion

Adoption of Medicare-for-all would achieve nearly universal coverage and address many of the goals of efforts to improve the health insurance and care systems. How well a Medicare-for-all system would achieve its goals depends on decisions about—and preferences regarding—the role of private insurance, benefit comprehensiveness, cost controls, and financing. Table 3-5 presents a summary of this report's assessment of the likely impact on select policy goals if Medicare-for-all were implemented.

A single-payer Medicare-for-all approach could maximize administrative simplicity and reduce the burden on providers and patients while largely eliminating choice in insurance plans but giving many individuals a significantly increased choice of providers. A universal system has the potential to generate significant savings, but political considerations may limit or severely constrain how the system actually functions, especially with the potential for disruptions during the transition from the current multi-payer, mixed private and public system to single-payer Medicare-for-all.

A Medicare-for-all system that permits choosing between a public Medicare plan or a regulated private MA health plan could provide consumers with a choice of coverage type and potentially lessen disruption during the transition. Such a system can be expected, however, to have higher total costs and more administrative complexity. In practice, the complexity of the current mixed model, implementation challenges, potential pushback from individuals and stakeholders adversely affected by changing the status quo, and other political factors have the potential to alter the balance of attributes that distinguish the impacts of these two models.

**Table 3-5. Potential Impact of Alternative Medicare-for-All Programs**

Policy Goal	Medicare-for-all	Medicare-for-all plus MA
<b>Expand coverage</b>	Achievement of near-universal and fully portable coverage expected. With automatic enrollment, the residual uninsured might be limited to undocumented immigrants.	
<b>Improve access</b>	<ul style="list-style-type: none"> <li>■ Increased choice of participating providers, particularly for individuals formerly on Medicaid or in restrictive provider networks.</li> <li>■ Eliminated or reduced financial barriers to access, depending on design choices.</li> <li>■ Supply constraints may arise as delivery system adjusts to meet new levels of demand.</li> <li>■ Depending on design choices, the remaining uninsured (e.g., undocumented immigrants) may be at risk of exacerbated access problems if the safety-net delivery system does not adapt.</li> </ul>	<ul style="list-style-type: none"> <li>■ Increased comprehensiveness of coverage for many new beneficiaries (with possible exception of Medicaid beneficiaries).</li> <li>■ Potentially increased choice of participating providers, depending on how plan networks are set.</li> <li>■ Eliminated or reduced financial barriers to access depending on design choices.</li> <li>■ Supply constraints may arise as delivery system adjusts to meet new levels of demand.</li> <li>■ Depending on design choices, the remaining uninsured (e.g., undocumented immigrants) may be at risk of exacerbated access problems if the safety-net delivery system does not adapt.</li> </ul>
<b>Increase affordability</b>	<ul style="list-style-type: none"> <li>■ Significant shift in burden of financing to federal government. Impacts on states and employers depend on whether they contribute to the funding, along with whether and how much health care spending increases under the new system.</li> <li>■ For households, premium and OOP costs would likely be replaced by some type of tax contributions. Total contributions toward the cost of health care coverage could be significantly less for many households but higher for others.</li> </ul>	
<b>Contain costs</b>	<p>Significant potential for overall cost containment from:</p> <ul style="list-style-type: none"> <li>■ moving to Medicare payment rates for all providers</li> <li>■ reduction in administrative costs</li> <li>■ reduction in drug prices under administered pricing</li> </ul> <p>Utilization increases may offset savings unless utilization management tools are added; however, adding utilization management would tend to increase administrative complexity and cost.</p>	<p>Potential for overall cost containment may be less than a single-payer model, depending on:</p> <ul style="list-style-type: none"> <li>■ how the rates paid to MA plans are established</li> <li>■ whether MA plans' utilization controls compensate for the potentially higher provider rates (and drug prices)</li> <li>■ whether the savings from reductions in utilization compensate for higher administrative costs</li> </ul>
<b>Increase choice</b>	<p>Increased provider choice due to lack of network restrictions.</p> <p>Reduced choice of insurance coverage for all beneficiaries because coverage would most likely be in a comprehensive benefit package provided to all; however, private insurance may be allowed in a supplemental role.</p>	<p>Increased or comparable choice of coverage options for most new beneficiaries.</p> <p>Design choice would affect whether MA plans would remain viable competitors in a scenario where comparable (unmanaged) benefits at low or no cost sharing were offered under Medicare.</p> <p>For individuals choosing traditional Medicare, provider choice would increase due to no network restrictions.</p>
<b>Improve equity</b>	Reduced racial and ethnic disparities in the new enrollee population and reduced economic security due to decreased or eliminated OOP costs, depending on how the program is funded.	
<b>Increase administrative simplicity</b>	Reduced administrative burden for patients, providers, insurers, and the federal government, resulting in significant savings.	Reduced administrative burden for patients, providers, insurers, and the federal government, but less than in a single-payer Medicare-for-all program.
<b>Increase social solidarity or fairness</b>	Social solidarity or fairness may be positively or negatively affected, depending on specific design choices and people's preferences.	
<b>Enhance quality, safety, and effectiveness</b>	With continuing coverage over the course of a lifetime, Medicare would have greater opportunities and incentives to invest in preventive measures and measures to improve population health.	Possible effect on quality, safety, and effectiveness may be negative, neutral, or positive.







## **Chapter 4: Establishing a Medicare Buy-In Program**

## Chapter Summary

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

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

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

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

buy-in on specific policy goals, such as expanding coverage. Important policy impacts include the following:

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

While a Medicare buy-in program would build on the popularity of the current Medicare program without substantially restructuring or replacing all other forms of coverage, it would also add a layer of complexity to the current, already fragmented, health insurance system and complicate consumer decisions. A Medicare buy-in would significantly increase the administrative challenges for the Medicare program because buy-in enrollees would have a higher level of turnover due to events such as job changes. It would raise important challenges for coordination with other options such as the ACA market plans. A Medicare buy-in available to employers as well as individuals would add even more administrative complexity and require an enhanced administrative infrastructure to handle enrollment and disenrollment, collect payments, and manage eligibility for the individual and employer buy-in population.

## Introduction

In a Medicare buy-in program, individuals and/or groups would pay a premium to obtain coverage in a separate program modeled after Medicare. A Medicare buy-in has been proposed in different forms since the early 1990s, when it was seriously considered during the Clinton administration's push to expand health insurance coverage. Variants of Medicare buy-in programs were proposed again but not included in the reform efforts that ultimately led to the passage of the ACA in 2010. Medicare buy-in programs are part of the current conversation, including current legislative proposals that would extend buy-in eligibility to individuals ages 50–64.<sup>1</sup>

As discussed in this report and current legislative proposals, a Medicare buy-in would be a separate program modeled after Medicare. It would use a benefit design and premium structure built on the Medicare program, use provider payment rates based on Medicare's rates, and create a risk pool separate from the current Medicare beneficiary pool and the ACA individual market. Recent proposals would allow older adults to buy into the Medicare program to address concerns about unaffordable coverage, particularly for people who are not eligible for premium or cost-sharing subsidies in the ACA individual market. Before the ACA, the Medicare buy-in was a more administratively simple policy proposal than in the post-ACA realm, where a buy-in program would interact heavily with ACA provisions, target the same population, and raise issues of compatibility.

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*Before the ACA, the Medicare buy-in was a more administratively simple policy proposal than in the post-ACA realm, where a buy-in program would interact heavily with ACA provisions, target the same population, and raise issues of compatibility.*

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A Medicare buy-in program differs from directly lowering the eligibility age since coverage would be entirely optional; individuals would not default, or be automatically enrolled, into Medicare coverage when they turn age 50, and they could choose to enroll and disenroll. With a buy-in program, the premiums could be set to cover 100 percent of program costs in contrast with a lower age of eligibility, where the financing would be consistent with the current Medicare program, which is financed through payroll tax contributions, general revenues, and premiums. One of the main reasons that

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<sup>1</sup> S. 470 by Senator Stabenow and H.R. 1346 by Representative Higgins would allow individuals ages 50–64 to buy into Medicare Parts A, B, and D, or into Medicare Advantage (Part C). Both proposals would set premiums at the average annual per capita amount for benefits and administrative expenses for all enrolled individuals and would allow ACA premium tax credits and cost-sharing reductions to be used toward the buy-in.

policymakers have proposed a Medicare buy-in over lowering the age of Medicare is that a buy-in could be designed to be budget neutral or modestly increase spending if it includes subsidies. Allowing employers to buy Medicare coverage for their workers—as some do for their retirees through Medicare Advantage (MA)—could significantly increase the size of the buy-in program and raise additional design questions, including participation rules, plan choice, and administration.

Although the terms are sometimes used interchangeably, an individual “Medicare buy-in” as discussed in this chapter differs from what is commonly referred to as a “public option” (see **Text Box 4-1** below). Although other ways to design an optional, publicly administered health plan are available, such as including a public option in the ACA individual market, this chapter analyzes only buy-in options modeled on Medicare.

### **Text Box 4-1. A Medicare Buy-In or a Public Option?**

The distinction between a Medicare buy-in and a public option is not always clear. A Medicare buy-in, as discussed in this report, has been proposed since well before the passage of the Affordable Care Act (ACA) in 2010 as an approach to increase access to affordable coverage among older Americans. The idea of a public option was first proposed during the development of the ACA as a way to broaden choice for marketplace-eligible individuals and incentivize lower costs among plans competing in the ACA individual market. Both are now back under consideration, and it is important to distinguish between them.

A Medicare buy-in and a public option would each create an optional, publicly facilitated or administered health insurance plan. As analyzed in this chapter, a Medicare buy-in would use a benefit and premium design built on the Medicare program, use provider payment rates based on Medicare rates, but create a risk pool separate from the current Medicare beneficiary pool and the ACA individual market. Also, a buy-in could deviate from Medicare’s current design by increasing the comprehensiveness of the benefit package or using the ACA premium and cost-sharing

subsidy structure, for example. Such changes would increase the similarities between the buy-in and ACA plans. Nevertheless, in this analysis, a Medicare buy-in would not be required to meet ACA regulations.

In contrast, a public option would operate like any other ACA-compliant health plan and would likely be administratively simpler than a Medicare buy-in (Blumberg and Holahan 2016; American Academy of Actuaries 2019). A public plan option would compete directly in the ACA individual market, following ACA requirements and regulations. Enrollees would be included in the single ACA individual market risk pool. What would distinguish a “Medicare-like” public option from other ACA plans is that provider payment rates under the public option would be based on Medicare rates and enrollees would have access to Medicare’s provider network. For these reasons, the public option is sometimes referred to as a Medicare or Medicare-like option. A public option in the ACA individual market, including a “Medicare-like” plan that builds on Medicare’s payment rates, would lead to different design challenges and policy implications compared to a Medicare buy-in.

What follows is an examination of an individual Medicare buy-in approach, followed by a discussion of an employer buy-in approach and a description of the potential implications of key design features.

## Individual Medicare Buy-In

Policymakers would need to specify eligibility criteria and the enrollment process, covered benefits and cost-sharing requirements, the premium and risk-pooling structure, and the availability and parameters of premium and cost-sharing assistance programs for an individual Medicare buy-in program. **Table 4-1** outlines the key design issues that need to be addressed.

**Table 4-1. Policy Design Issues for Individual Medicare Buy-In**

<b>Eligibility</b>	Age restrictions Restrictions based on eligibility for coverage from other sources
<b>Enrollment</b>	Enrollment periods Use of the ACA exchanges
<b>Benefits and enrollee choice</b>	Covered benefits Choices among Medicare's benefit components Cost-sharing structure Access to Medigap policies
<b>Financing and premium design</b>	Medicare buy-in premiums Premium variations Medicare Advantage buy-in premiums
<b>Cost-sharing and premium assistance</b>	Applying the Medicare structure Applying the ACA structure

### Eligibility

How a Medicare buy-in program interacts with the existing health insurance landscape depends on the extent to which eligibility is restrictive or expansive. Eligibility is typically defined in terms of age and access to other coverage sources.

## Age Restrictions

Eligibility can be unlimited or restricted by age—for instance, to individuals 50 and older. Since the coverage needs of the older adult population are most similar to current Medicare beneficiaries, an age-restricted model would likely necessitate fewer deviations from the current Medicare program than would extending eligibility to all ages. Further, in an age-restricted Medicare program, eligibility would likely be limited to just individual coverage, as it is in today's Medicare program, rather than offer family coverage. A Medicare buy-in program with broad eligibility would allow for the largest potential enrollment but would have the greatest impact on other sources of health insurance coverage, including employer-sponsored insurance (ESI), Medicaid, and the individual market.

## Restrictions Based on Eligibility for Coverage from Other Sources

Eligibility would likely be restricted to individuals who are not already eligible for other federal programs, such as the current Medicare program, Medicaid, CHIP, or TRICARE. It could be limited further to exclude individuals with access to affordable ESI. Currently, individuals with ESI are eligible to participate in the individual market but are not eligible for ACA premium and cost-sharing assistance unless the ESI coverage does not meet affordability or minimum coverage requirements. Although extending eligibility to people already covered by ESI could sizably increase the number of individuals eligible for the buy-in, the extent to which individuals with ESI enroll in the buy-in program depends on whether they gain access to premium and cost-sharing subsidies and how the buy-in benefits and costs compare to their ESI coverage.

## Eligibility Estimates

Based on the 2017 American Community Survey data (see **Table 2-2** in **Chapter 2**), 5.5 million uninsured individuals and 5.7 million individuals with individual market coverage would be eligible for a buy-in limited to older adults ages of 50–64 without ESI or other federal coverage. Removing the age restriction would mean 23.7 million uninsured and 14.6 million individuals with individual market coverage who are ages 19–64 would be eligible. If individuals were also able to enroll their dependents in the buy-in program, the number of eligible buy-in participants would increase. The number of eligible individuals would increase significantly under a buy-in open to individuals with affordable ESI or to employers.

## **Enrollment**

A Medicare buy-in program would need to specify how individuals enroll in the program, a decision with important implications for the level of administrative complexity for beneficiaries and the program as a whole.

### **Enrollment Periods**

In Medicare, individuals are eligible to enroll in Medicare Part A upon turning 65, if they are not automatically enrolled, and may choose also at that time to enroll in Part B and/or Part D benefits. After the initial enrollment period, beneficiaries may enroll or shift plans only during the annual open enrollment period or after a change in the beneficiary's eligibility, such as moving or losing current coverage. Medicare's eligibility-driven initial enrollment period and subsequent annual open enrollment periods do not align with the annual open enrollment periods in the ACA individual market, which would inhibit the process of choosing between an ACA plan and a Medicare buy-in for eligible individuals. For this reason, policymakers might choose to align the buy-in enrollment window with the ACA individual market enrollment periods in each state, especially if a buy-in is open to everyone, irrespective of their current coverage options. Even with aligned enrollment periods, significant efforts would be needed to make eligible individuals aware of the buy-in and to facilitate enrollment.

### **Use of the ACA Exchanges**

Although an individual buy-in plan would, by our definition, not be part of the ACA risk pool, it could use the ACA exchanges to facilitate enrollment. This approach would be similar to how enrollment in Medicaid is facilitated through the ACA exchange platform, per ACA rules. Qualifying buy-in individuals could go to the ACA exchange in their state and choose between an ACA plan and a Medicare buy-in plan, enhancing plan choice but potentially facilitating adverse selection in the risk pool for either the buy-in or the ACA plans.

Using the ACA exchange platforms and aligning buy-in enrollment with the ACA open enrollment periods could raise awareness of the buy-in. Because the ACA exchanges are used primarily by individuals whose only potential coverage source is the individual market, further outreach would be necessary if buy-in eligibility were to include individuals with access to ESI, especially because enrollment periods for ESI, like current Medicare enrollment, do not necessarily match the ACA individual market enrollment periods.

## Benefits and Enrollee Choice

In a Medicare buy-in program that builds on the current Medicare benefit design, policymakers would need to define the choices among Medicare's benefit components, the covered benefits, and enrollee cost-sharing requirements.

### Covered Benefits

The benefits available to current Medicare beneficiaries are not significantly different from the coverage available in the ACA individual markets and ESI, if Medicare buy-in enrollees fully participate in Parts A, B, and D or select an MA plan.<sup>2</sup>

Although Medicare benefits are designed to cover the needs of older individuals, Medicare has the capacity to cover benefits for younger persons. Medicare already serves some younger populations, including people under the age of 65 with disabilities, children and adults with end-stage renal disease (ESRD), and dependents of adults with ESRD.

Although traditional Medicare does not adhere to the essential health benefits required of plans in the ACA that specifically cover benefits necessary for younger populations, it reimburses providers for medically necessary care used by its younger beneficiaries, including pediatric and maternity care. Policymakers could expand the covered benefits in a Medicare buy-in to cover those benefits explicitly, such as pediatric and reproductive health care, or could adhere to the essential health benefit requirement of plans in the ACA marketplaces.

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*The benefits available to current Medicare beneficiaries are not significantly different from the coverage available in the ACA individual markets and ESI, if Medicare buy-in enrollees fully participate in Parts A, B, and D or select an MA plan.*

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### Choices among Medicare's Components

A buy-in program could allow individuals to enroll voluntarily in each part of the Medicare program (A, B, and D) or require enrollment in Medicare in its entirety. Allowing individuals to buy into only certain parts of Medicare could leave them vulnerable to being underinsured. It also could allow healthier individuals to enroll in only some parts of Medicare, which would have negative consequences for other

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<sup>2</sup> Similar to traditional Medicare, ACA plans usually do not offer dental (aside from pediatric dental), vision, or long-term supports and services (LTSS) coverage, although some employers and MA plans offer vision and/or dental benefits. Plans in the ACA individual market must offer the set of essential health benefits, which includes prescription drug coverage. At present, Medicaid is the only form of medical coverage that typically pays for LTSS.

health care markets (selection issues are discussed further in **Text Box 4-2**). To avoid reducing the comprehensiveness of coverage and access to care, a Medicare buy-in could require that individuals enroll in Parts A, B, and D. The premium discussion below assumes that Medicare buy-in participants enroll in all Medicare components. Policymakers would need to determine whether enrollees would have access to MA plans in addition to the government-administered plan, which would raise additional design considerations regarding premiums and insurer participation.

### Text Box 4-2. Potential Selection Issues in a Medicare Buy-In

Selection issues could arise in an individual Medicare buy-in program, especially if the rules of the buy-in differ from the rules in current private markets, or if buy-in enrollees can choose between traditional Medicare and private Medicare Advantage (MA) plans.

In general, **adverse selection** occurs in voluntary insurance markets when individuals with high expected health spending are more likely to purchase insurance than individuals with low expected health spending. Higher premiums may result if mainly those with high expected spending enroll. Prior to the Affordable Care Act (ACA), to avoid enrolling potential high-cost enrollees, plans in the private market could practice medical underwriting, varying premiums by health status and denying coverage for preexisting conditions.

If rules prohibit insurers from medical underwriting and individuals can choose among plans, insurers have an incentive to use alternative tactics to avoid enrolling high-cost individuals. To do so they could use risk selection, sometimes characterized as “cream-skimming” or “cherry picking,” to enroll only low-cost individuals. Even if medical underwriting is prohibited, **risk selection** could be achieved through benefit coverage features, provider networks, or utilization controls that are not desirable to individuals in need of expensive health care. Depending on how selection strategies differ among insurers, some insurers could end up with a relatively low-cost enrollee population and others could have a higher concentration of more costly enrollees and higher premiums as a result.

A Medicare buy-in could be subject to adverse selection, especially if the benefits or premium structure are more attractive to high-risk individuals compared to other

insurance options already available. If a Medicare buy-in program allows enrollees to choose between traditional Medicare and MA plans, risk selection also becomes a concern.

Risk-sharing mechanisms currently used in Medicare and the ACA markets aim to mitigate selection issues, stabilize premiums for enrollees, and decrease financial uncertainty for insurers. These mechanisms could be considered for a buy-in program since uncertainty exists about who would buy into Medicare, making it difficult to set premiums. Risk adjustment (used in MA and Part D plans as well as in the ACA markets) alters premiums in plans based on the relative health of their enrollees. Such adjustments reduce insurer incentives to avoid high-cost enrollees. Reinsurance (used in Part D plans and temporarily in the ACA individual market<sup>3</sup>) provides additional funding for plans with high-cost enrollees. Risk corridors (used in Part D plans as well as in a temporary and limited way in the ACA individual market) provide additional funds to plans when claims are higher than expected, for instance, due to adverse selection; plans make risk corridor payments when claims are lower than expected.

The risk of selection issues occurring in a Medicare buy-in program depends on the program’s specific design features, including the eligibility criteria, benefit package, and premium structure, and whether MA plans are available. In addition to the direct effects of selection on a Medicare buy-in plan, unintended effects on ACA premiums could result if the buy-in population draws sicker or healthier enrollees away from the marketplaces. Therefore, it may also be appropriate to consider changes to ACA risk-sharing mechanisms if a Medicare buy-in is implemented.

<sup>3</sup> The ACA reinsurance program was in effect 2014–2016. Several states have since implemented a state-based reinsurance program in their ACA individual markets.

## Cost-Sharing Structure

Medicare beneficiaries face significant cost-sharing requirements and the risk of incurring high out-of-pocket (OOP) costs unless they have supplemental coverage or are enrolled in an MA plan. Even with an MA plan, beneficiaries can face high OOP costs up to a limit for services covered under Parts A and B and additional OOP expenses for prescription drugs. Proposals to establish a buy-in need to specify whether Medicare's current cost-sharing structure would remain the same or include restructuring. Restructuring the cost-sharing protections could align the buy-in program closer to ACA individual market plans but could create a cliff for people turning 65 who enroll in the current traditional Medicare program with no OOP limit.

The actuarial value (the percentage of total average costs a health insurance plan pays for covered benefits) of the traditional Medicare plan exceeds that of an ACA bronze- or silver-level plan (see **Table 2-3**) (McArdle et al. 2012; Centers for Medicare & Medicaid Services 2017). Silver-plan enrollees whose incomes are between 100 percent and 200 percent of the federal poverty line and who qualify for cost-sharing subsidies are eligible for plans with a higher actuarial value.<sup>4</sup> The most significant downside of Medicare cost-sharing requirements relative to ACA plans is the lack of an OOP limit, although enrollees in traditional Medicare with Medigap coverage (for an additional premium) or in an MA plan have OOP protection comparable to, or lower than, the ACA limits. The ACA OOP maximums include prescription drug spending, however, while MA and Medigap limits do not.

Comparing the comprehensiveness of benefits between a Medicare buy-in and other coverage options could be challenging for consumers, in part because Medicare has different cost-sharing requirements associated with each of its covered benefits and parts. Some policymakers have developed proposals to change Medicare's cost-sharing structure that could be implemented simultaneously with establishing a buy-in, such as unifying the Part A and Part B deductibles (Gutnik et al. 2014).

### *Access to Medigap Policies*

Private Medigap plans provide supplemental coverage to 29 percent of enrollees in traditional Medicare to help cover their cost-sharing requirements (Cubanski et al. 2018).<sup>5</sup> Medigap plans do not typically provide coverage for additional services,

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<sup>4</sup> Actuarial values of different insurance plans and programs are not necessarily directly comparable, especially if the analyses are done on populations with different underlying health care utilization, provider costs, and assumptions regarding the impact of cost sharing on utilization.

<sup>5</sup> Approximately 81 percent of individuals in traditional Medicare have a form of supplemental coverage (Cubanski et al. 2018).

though some plans provide coverage for additional hospital inpatient days. If the Medicare buy-in were to use current Medicare cost-sharing requirements, access to Medigap would make the buy-in plan effectively more comprehensive than an ACA-compliant individual plan because Medigap plans cover a significant portion of an enrollee's OOP expenses. An important consideration is whether buy-in enrollees would be guaranteed the ability to purchase Medigap plans; current federal law requires guaranteed availability of Medigap only upon initial Medicare eligibility at age 65.

## Financing and Premium Design

The affordability of a Medicare buy-in, both to the federal government and to enrollees, depends on the structure of premiums. A buy-in program as described in this report would be funded through self-supporting premiums, meaning that the premiums are set to cover all expected costs of claims and the administration of the program. As a result, financing for this option would likely come primarily from premiums. If provisions are made for the buy-in to offer income-related, publicly financed premium and cost-sharing assistance, the buy-in program would not necessarily be budget neutral. Buy-in enrollees would be pooled separately from current Medicare beneficiaries and enrollees in the ACA individual market; thus, current Medicare beneficiary premiums would be unaffected by the buy-in program. The stability of the buy-in risk pool would depend on the size and composition of the enrolled population, which hinges on the structure and the amount of the buy-in premium.

Several factors affect whether buy-in premiums would be more or less expensive than premiums in the ACA-compliant individual market, including provider payment rates and how they grow over time, administrative costs for the buy-in, how the buy-in risk pool profile compares with that of other coverage sources, how buy-in premiums vary among enrollees, and whether the premiums are self-supporting.

### Medicare Buy-In Premiums

If designed to be fully self-supporting, the Medicare buy-in premiums for Parts A, B, and D would be set to cover the per capita expected claim costs plus administrative expenses of the under-65 buy-in population. The amount of the expected costs depends on specific design features, including comprehensiveness

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*Several factors affect whether buy-in premiums would be more or less expensive than premiums in the ACA-compliant individual market, including provider payment rates and how they grow over time, administrative costs for the buy-in, how the buy-in risk pool profile compares with that of other coverage sources, how buy-in premiums vary among enrollees, and whether the premiums are self-supporting.*

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of benefits, provider payment levels, and the availability of any cost-sharing or premium assistance programs. Although the premiums, in principle, could follow the current subsidized Medicare premium structure, with enrollees paying only a portion of expected costs (see **Appendix A**), doing so would increase federal spending and affect whether ACA individual market plans would be able to offer competitive premiums. Furthermore, subsidizing premiums for all who choose to enroll blurs the line between lowering the age and an expansion of voluntary coverage options, and increases administrative complexity.

Expected claim costs could be calculated assuming enrollment rates and a risk profile reflecting the full eligible population, with no adjustment for selection. Alternatively, program costs could be estimated on expected enrollment, reflecting either favorable or adverse selection. While the potential for adverse selection under a buy-in is not known, if it were to occur, premiums calculated on the entire eligible population would be insufficient. Prior proposals have suggested that additional costs from adverse selection could be amortized over the lifetime of the enrollee through higher Medicare premiums. Plans in the ACA exchanges are subject to guaranteed issue and cannot vary premiums by health status, meaning that less healthy individuals already have a potential source of coverage comparable to what would be offered by the buy-in.

### ***Medicare Part D Premiums***

Under the current Medicare program, individuals without drug coverage through an MA–PD plan are eligible to enroll voluntarily in a prescription drug plan (PDP) under Part D. These plans are administered by private insurers and follow federal regulations. The plans are paid based on a competitive bidding process, in which the standard enrollee premium is based on the national average bid, and actual plan premiums reflect differences between the bid and the national average. Policymakers would need to decide whether this bidding process would apply to Part D coverage in a Medicare buy-in program. If so, as with current Medicare beneficiaries, buy-in enrollees could pay a separate premium for Parts A and B and for their specific Part D plan. The difference is that the buy-in premiums would be self-supporting.

### **Premium Variations**

Policymakers would need to decide whether one standard premium would apply to all enrollees or the premium would be allowed to vary based on enrollee characteristics, such as age or geography, similar to the variation allowed in the ACA individual markets. Enrollees choosing MA and/or Part D plans may pay more or less than the standard premium depending on their particular plan choices.

## **Age**

Premiums in a Medicare buy-in program could be uniform regardless of age, or they could vary by age, perhaps using the same age adjustment employed by plans in the ACA exchanges. In a Medicare buy-in, especially one in which eligibility is not age restricted, if premiums were uniform based on the average costs, younger buy-in enrollees would be paying more money and effectively subsidizing older buy-in enrollees. Because a buy-in is voluntary, uniform premiums could lead to higher enrollment among older persons and create selection issues between the buy-in and the ACA-compliant plans. In contrast, age-adjusted premiums could attract enrollees regardless of age. As discussed below, shifting older adults out of the ACA individual market could increase ACA premiums. Depending on how buy-in premiums vary by age, that effect on ACA premiums could be exacerbated or mitigated.

## **Geography**

Although a Medicare buy-in program may have self-supporting premiums, those premiums may be lower than other sources of coverage due to the extension of Medicare's lower provider payment rates. Health spending and provider payment levels vary across and within states, reflecting differences in local health prices and utilization. If a buy-in uses a standard premium across the country, enrollees in low-cost geographic areas would effectively subsidize premiums for enrollees in high-cost geographic areas.

Alternatively, Medicare buy-in premiums could vary by geography based on the costs and provider payment levels in each region. Policymakers would need to consider, however, how geographic areas and rating factors differ between the buy-in and the ACA individual market because differences could exacerbate or mitigate selection between the two markets.

## **Tobacco Use**

The ACA allows health insurers to charge tobacco users up to 1.5 times the premium charged to non-tobacco users in the individual market. Small group health insurers may also apply a tobacco-use premium adjustment if they offer wellness programs to enrollees. In 2014, 90 percent of plans on the individual ACA exchanges adjusted premiums for tobacco use, with a median adjustment of 10 percent (Kaplan, Graetz, and Waters 2014). Medicare does not have such provisions, and policymakers would need to determine whether the buy-in premiums could take tobacco usage into account.

## **Family Coverage**

If buy-in coverage were limited to older adults, policymakers would need to decide whether dependents would also be eligible. If so, an important design decision would be whether to create a premium structure for family coverage or enroll dependents as individuals. Like premiums under the ACA, premiums for each family member could be calculated separately and aggregated, with a limit on how many children are included in the premium calculation.

## **Medicare Advantage Buy-In Premiums**

MA premiums are based on a comparison of a given plan's estimated costs of providing Part A and Part B benefits (the bid) to a benchmark based on what traditional Medicare pays on average for benefits in a service area. If a plan bid is lower than the benchmark, the plan receives a portion of that difference in a rebate, most of which must be passed on to beneficiaries through additional benefits, lower cost-sharing requirements, or a lower monthly premium. If the plan bid is higher than the benchmark, enrollees must pay an additional premium (Congressional Research Service 2019b). MA insurers must charge all beneficiaries the same premium for a particular plan, irrespective of individual characteristics such as age and tobacco use.

If MA insurers were permitted a similar role for the buy-in population, they would presumably be required to submit bids for the buy-in population separate from their traditional Medicare bid, raising a number of policy decisions. Separate buy-in benchmarks would need to be calculated, a process further complicated by the need for a separate risk-adjustment system for private buy-in plans, and potentially other MA plan payment factors, such as quality bonuses.

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*If MA insurers were permitted a similar role for the buy-in population, they would presumably be required to submit bids for the buy-in population separate from their traditional Medicare bid, raising a number of policy decisions.*

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## **Cost-Sharing and Premium Assistance**

Although the premium structure for a Medicare buy-in is self-supporting, meaning that individuals' premiums pay for the total expected costs of benefit claims and program administration, the Medicare buy-in would likely need to include premium and/or cost-sharing assistance from the federal government to make the self-supporting premium affordable for many low-income enrollees. The absence of such assistance would likely result in a premium unaffordable for many in the eligible population and result in few individuals enrolling in the program. Two approaches provide models for assistance: (1) using the same premium and cost-

sharing assistance programs available to current Medicare beneficiaries or (2) using the same assistance programs available through the ACA individual market.

## Applying the Medicare Assistance Structure

Almost all current Medicare beneficiaries qualify for premium-free Part A and federally subsidized Part B premiums that vary based on income. The premium and cost-sharing assistance programs target individuals with very low incomes and are relatively modest. Approximately one in five Medicare beneficiaries is dually eligible for Medicare and Medicaid, either as full-benefit “dual eligibles” who qualify for Medicaid benefits in their states, or as partial dual eligibles who receive limited assistance through the Medicare Savings Programs (MSPs). **Table 4-2** provides an overview of the eligibility requirements and benefits of the MSPs.

**Table 4-2. Medicare Savings Programs for Dual-Eligible Beneficiaries, 2019**

Program	Monthly income limits	Asset resource limits	Costs paid by Medicaid
<b>Qualified Medicare Beneficiaries (QMB)</b>	<100% of FPL Single: \$1,061 Couple: \$1,430	Single: \$7,730 Couple: \$11,600	All Part A and Part B premiums, deductibles, and coinsurance
<b>Specified Low-Income Medicare Beneficiaries (SLMB)</b>	100% to <120% of FPL Single: \$1,061-\$1,269 Couple: \$1,430-\$1,711	Single: \$7,730 Couple: \$11,600	Part B premium
<b>Qualifying Individuals (QI)</b>	120% to <135% of FPL Single: \$1,269-\$1,426 Couple: \$1,711-\$1,923	Single: \$7,730 Couple: \$11,600	Part B Premium

**Note:** FPL (federal poverty level).

**Source:** Congressional Research Service 2019a.

Medicare Part D provides a low-income subsidy (LIS) to certain beneficiaries with limited incomes and resources to help them pay Part D premiums and cost-sharing amounts. Individuals who receive assistance through the MSPs and fully qualify for Medicaid and/or Supplemental Security Income are eligible for a full LIS. Individuals with an income below 150 percent of the federal poverty level (FPL) and limited assets may qualify for a partial LIS. Individuals who qualify for a partial LIS receive premium assistance ranging from 25 percent to 75 percent of the full LIS premium assistance, based on an income-based sliding scale (Congressional Research Service 2018).

Under the current MSPs and LIS, only individuals with incomes below 150 percent of the FPL are eligible for any premium or cost-sharing assistance, which is significantly lower than the income threshold for assistance in the ACA exchanges. The need for such assistance would be different for the buy-in population, complicating the issue of how much assistance to provide individuals with

low incomes. In a buy-in program that mandates self-supporting premium levels, the current Medicare assistance levels would be insufficient for making premiums and cost-sharing affordable for potential enrollees with low or moderate incomes. Policymakers could expand the MSPs for buy-in enrollees by increasing the income thresholds and/or the level of premium subsidy.

## Applying ACA Premium and Cost-Sharing Subsidies

The ACA individual market offers two types of financial assistance: advance premium tax credits and a cost-sharing reduction subsidy. These supports are available to enrollees who meet income eligibility requirements as long they are ineligible for other federal health insurance and lack access to an affordable employer-sponsored health insurance plan with an actuarial value of at least 60 percent.

### Advance Premium Tax Credits

Premium tax credits are available to individuals and families with incomes between 100 percent and 400 percent of the FPL who purchase a health insurance plan through the individual ACA exchanges.<sup>6</sup> The credit caps the percentage of income that an enrollee must pay for a benchmark plan. If the premium for that plan exceeds the enrollee’s premium cap, the federal government provides a tax credit for the difference; those tax credits can be used toward the benchmark plan or for any other plan on the exchange. The enrollee pays the difference between the premium for their chosen plan and their premium tax credit. The cap increases for individuals with higher incomes, thereby reducing the value of the premium subsidy. **Table 4-3** displays the advance premium tax credit eligibility for incomes 100–400 percent of the FPL.

**Table 4-3. Advance Premium Tax Credit Eligibility**

Income (% FPL)	Premium cap as percentage of income
Under 100%	No cap
100–133	2.08%
133–150	3.11–4.15
150–200	4.15–6.54
200–250	6.54–8.36
250–300	8.36–9.86
300–400	9.86
Over 400	No cap

**Notes:** FPL (federal poverty level). The tax credits for the 2019 benefit year were calculated using 2018 federal poverty guidelines, and tax credits for the 2018 benefit year were calculated using 2017 federal poverty guidelines. Alaska and Hawaii have different poverty level guidelines.

**Source:** Kaiser Family Foundation 2018a.

<sup>6</sup> Premium subsidies are not available for ACA catastrophic plans.

It would be possible to allow individuals to apply any ACA premium tax credits for which they would be eligible toward a buy-in premium instead. Under this option, the ACA benchmark of the second-lowest-cost silver plan available to the enrollee would be used to calculate the required income contribution and the advance premium tax credit amount. Enrollees could then apply the dollar amount of the tax credit to the Medicare buy-in premium or an ACA plan on the exchange.

This calculation could be complicated if the buy-in plan is considered when determining the ACA benchmark plan. Differences in actuarial values between the buy-in plan and an ACA silver-level plan, as well as differences in how premiums vary among enrollees (e.g., by age), would make comparing the buy-in plan to an ACA plan challenging when determining the benchmark. Moreover, if the buy-in affects which plan is designated the benchmark, premium tax credits would be affected, not only for enrollees in the buy-in but also for individuals remaining in ACA plans.

## Cost-Sharing Reductions

The ACA cost-sharing reductions are provided through plans with enhanced actuarial values and are available to individuals with incomes at or below 250 percent of FPL who receive premium tax credits and are enrolled in silver-level plans. Applying the ACA cost-sharing reductions toward a buy-in plan would be even more difficult than applying premium tax credits, not least because the cost-sharing reduction rules do not easily translate to the Medicare benefit design. An official actuarial value of the traditional Medicare program would need to be determined, which could vary depending on the value of Medicare's parts and could require a new cost-sharing structure for Medicare to be comparable. Additionally, the federal government currently is not funding cost-sharing reductions available in the ACA exchanges, a policy that is the subject of ongoing litigation.

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*Applying the ACA cost-sharing reductions toward a buy-in plan would be even more difficult than applying premium tax credits, not least because the cost-sharing reduction rules do not easily translate to the Medicare benefit design.*

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## Employer Medicare Buy-In

Although 90 percent of all workers were employed at a firm that offered health benefits to at least some of their employees in 2019, only 61 percent of workers reported being covered by employer health plans. Employer Medicare buy-in proposals aim to increase the number of firms offering, and employees taking up, health benefits by offering more affordable coverage, recognizing that cost is the



most cited reason that firms do not offer health benefits to their employees (Claxton et al. 2019). An employer buy-in program would include many of the same key design decisions as the individual buy-in; however, this option raises additional complexities. Employer buy-in programs could be designed using various eligibility criteria, coverage options, and participation requirements—each with different implications for the viability of an employer buy-in.

## **Firm Eligibility**

An employer buy-in could extend eligibility to all employers or limit eligibility depending on firm size. One option would be to limit buy-in eligibility to large firms, which could be defined in several ways. The ACA uses a threshold of 50 full-time-equivalent workers to distinguish large firms from small firms. Employers with at least 50 full-time-equivalent employees must offer coverage that meets affordability and minimum essential coverage requirements or pay a penalty if one or more full-time employee receives a premium tax credit through the ACA exchanges (Internal Revenue Service n.d.). This requirement is often referred to as an employer mandate or shared responsibility requirement. An employer Medicare buy-in could limit eligibility to firms required to meet the shared responsibility requirements to lower their costs and help them offer a less expensive insurance option.

Alternatively, the Medicare buy-in could limit firm eligibility to small employers, which are significantly less likely to offer coverage. In 2019, only 56 percent of

small firms offered coverage compared with 99 percent of large firms, and there is significant variation among smaller firms based on size (Claxton et al. 2019).<sup>7</sup> Offering the employer buy-in to smaller firms would be a more targeted approach to increasing coverage.

Both large and small firms face affordability challenges in providing coverage. An employer Medicare buy-in also could be open to all employers.

## Employer Buy-In Participation

Employers can currently offer employer group waiver plans (EGWPs), which are customized employer or union MA plans, to their retirees over the age of 65. In 2019, 4.4 million Medicare beneficiaries were in EGWPs, comprising 20 percent of MA enrollees (Claxton et al. 2019). Employers typically use these plans to provide coverage, including benefits that may be different from standard MA supplemental benefits, for retirees. The plans can be fully insured or self-insured. A Medicare buy-in program could extend the EGWP approach to allow employers to develop EGWP-type plans for their active employees in a separate program.

A Medicare buy-in program could allow employers to cover their employees under a Medicare-like program by voluntarily paying a premium based on the number of qualifying employees, although the premium for each employer could vary based on the employee characteristic mix, such as average age or geography. In this model, Medicare would assume the insurance risk and pay benefit claims, similar to a fully insured contract in the private sector.

As in an individual Medicare buy-in, it is likely that the employer buy-in premium would be designed to be self-supporting, although the Medicare buy-in could provide subsidies to some employers, such as small firms.

Currently, many employers directly provide health benefits to employees using company funds and assume the risk of directly paying claims. More workers are in self-funded plans than fully insured plans, as both larger employers and an increasing number of small and midsize firms are self-funding their health insurance coverage offers (Fronstin 2018). In this model, employers take

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*A Medicare buy-in program could allow employers to cover their employees under a Medicare-like program by voluntarily paying a premium based on the number of qualifying employees, although the premium for each employer could vary based on the employee characteristic mix, such as average age or geography.*

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<sup>7</sup> The Kaiser Family Foundation Employer Health Benefit Survey defines smaller employers as organizations with less than 200 employees and larger employers as organizations with 200 or more employees (Claxton et al. 2019).

on the liability of paying claims and keep any unspent portions of the insurance fund. Self-insured employers often purchase “stop-loss” policies from insurance carriers to protect themselves from large, unexpected costs on either the specific (individual employee) or aggregate (group) level. Most self-insured employers contract with third-party administrators to provide services that a fully insured plan provides, such as assistance in claims adjudication and payment, access to preferred provider networks, and management of enrollment and utilization (Wilmerding 2016). Insurance companies often contract with employers in administrative services only (ASO) arrangements, in which the insurance company provides typical third-party administrative services but assumes no risk for benefit claims payments (Banton 2019).

An employer buy-in could allow employers to continue to self-insure their workers and only buy into Medicare’s administrative services and extensive provider network, while benefiting from Medicare’s administered provider rates.<sup>8</sup> Under this model, Medicare’s private contractors would provide the services that a typical insurer in an ASO arrangement would handle. Employers would likely see a reduction in the cost of their claims because of Medicare’s lower payment rates to providers and lower administrative overhead, depending on the level of the Medicare ASO fee. This buy-in model would likely be more beneficial for large employers that already self-insure their workers, but it may incentivize smaller employers to buy in if it is less expensive than contracting with a private insurer in a fully insured or self-insured model. If small employers are given a choice between a fully insured buy-in and a self-insured buy-in, the fully insured buy-in risk pool could experience adverse selection and higher premiums as a result.

## **Employee Eligibility**

If employers can buy into Medicare coverage, policymakers would need to decide which workers they must cover and/or whom employers cannot exclude, especially in meeting nondiscrimination requirements. It is likely that an employer buy-in would only be offered in conjunction with an individual buy-in open to all ages, unless it were narrowly targeted to an employer’s pre-age 65 retirees, since employers may not legally offer different coverage for workers based on age.

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<sup>8</sup> Insurers in the stop-loss market are allowed to engage in medical underwriting and exclude coverage of claims for specific individuals, which may hinder employers with high-cost employees, especially small employers, from participating in the program (National Association of Insurance Commissioners 2015). Prohibiting medical underwriting in the stop-loss market could increase the participation of employers in the Medicare buy-in, but eliminating medical underwriting would likely increase average stop-loss insurance premiums.

## Full-Time, Part-Time, and/or Seasonal Workers

In 2019, only 28 percent of firms offering health insurance coverage offered it to part-time workers (Claxton et al. 2019). An employer Medicare buy-in would need to specify whether employers must cover only full-time workers, how *full-time* is defined, and whether all workers must be covered. If an employer buy-in aims to increase the number of workers covered, extending Medicare buy-in coverage to all employees, especially individuals least likely to have coverage, merits consideration.

## Spouse and Dependent Coverage

Of firms offering ESI in 2019, 94 percent of all firms offered coverage to spouses, and 94 percent of small firms and 100 percent of large firms offered coverage to dependents other than spouses (e.g., children), albeit with workers paying a higher share of the premiums for spousal or dependent coverage (Claxton et al. 2019). An employer buy-in program would need to specify whether spouses and dependents of eligible employees could be covered. A buy-in option may be less attractive to employers offering spousal and dependent coverage—and, more importantly, to their workers—if they would have to eliminate such coverage or supplement a Medicare buy-in to provide that benefit.

## Choice of Plans

As with an individual buy-in, policymakers would need to decide whether the buy-in benefit package would retain the same structure and cover the same benefits as the current Medicare program. If offered alongside the individual buy-in plan, the employer buy-in could offer the same benefits and cost-sharing structure to minimize complexity—or could require that employers buying into Medicare must purchase Parts A, B, and D.

Proposals should specify whether individuals who opt out of the Medicare buy-in offered by their employer would be eligible for ACA premium and cost-sharing subsidies. Under the ACA, individuals with access to employer coverage are allowed to purchase plans on the ACA exchanges but are not eligible for premium tax credits or other cost-sharing assistance unless the coverage they were offered fails to meet affordability and minimum coverage standards.<sup>9</sup> Whether a Medicare buy-in would qualify as a plan meeting affordability and minimum coverage requirements would need to be specified since this designation would affect access to ACA subsidies. Unless the buy-in satisfied these ACA standards,

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<sup>9</sup> Under the ACA, the definition of affordable for individual and family coverage is based solely on the costs of individual coverage, ignoring the significantly higher cost of family coverage (Brooks 2014). This “family glitch” has left families ineligible for advance premium tax credits and cost-sharing reductions in the marketplaces.

employers subject to the ACA's employer mandate would not choose to offer the buy-in to full-time employees because doing so would expose them to the employer penalty tax.

*Whether a Medicare buy-in would qualify as a plan meeting affordability and minimum coverage requirements would need to be specified since this designation would affect access to ACA subsidies.*

## Policy Implications

The impact of a Medicare buy-in program depends on participation among the eligible population, which in turn is a function of programmatic design decisions. These design features include:

- determining the eligible population
- whether employers have buy-in opportunities
- whether employees have access to subsidies
- the benefit and cost-sharing design
- how premiums are set
- whether premiums vary among potential enrollees
- availability of financial assistance to offset enrollee costs

Ultimately, the degree of participation would be determined by how attractive and affordable the buy-in is relative to alternative coverage options.

Although numerous ways to structure a buy-in can be envisioned, this section provides insights on the reasonably anticipated impacts of a buy-in by focusing on two plausible examples. It highlights key design decisions and identifies areas in which the effects are uncertain. These models include an individual buy-in, either age restricted to individuals 50 and older or open to individuals of all ages, and an employer buy-in. **Table 4-4** outlines the key assumptions of each scenario.

**Table 4-4. Select Medicare Buy-In Scenarios**

	Individual buy-in	Employer buy-in
<b>Eligibility</b>	Age-restricted (50-64) Expanded: All individuals	All employers
<b>Benefits and cost sharing</b>	Current Medicare benefit and cost-sharing structure (Parts A, B, and D combined) Choice of traditional Medicare or Medicare Advantage plan	Current Medicare benefit and cost-sharing structure (Parts A, B, and D combined) Choice of traditional Medicare or Medicare Advantage plan
<b>Payment rates</b>	Providers would be paid current Medicare rates (or Medicare rates plus a percentage)	Providers would be paid current Medicare rates (or Medicare rates plus a percentage)
<b>Risk pool and premiums</b>	Buy-in risk pool is separate from both Medicare and ACA individual market risk pools Premiums are self-supporting	Employees are part of the separate Medicare buy-in risk pool, unless employer is self-insured Premiums are self-supporting
<b>Premium and cost-sharing assistance</b>	No assistance programs, or Assistance based on Medicare or the ACA exchanges	No assistance for employers

**Notes:** ACA (Affordable Care Act of 2010).



## **Coverage and Access to Care**

An individual or employer Medicare buy-in would likely increase access to care for individuals who choose to enroll, particularly individuals who are uninsured or underinsured. In principle, a buy-in could also, through spillover effects, affect access for current Medicare beneficiaries and individuals in other insurance markets.

### **Impact on the Uninsured Population**

Like other proposals using Medicare as a platform for health reform, a goal of the various buy-in options is to extend coverage to a broader portion of the population. But in contrast to the other approaches discussed in this report, enrollment in the buy-in program would be optional and thus unlikely to become the predominant source of coverage for the newly eligible population.

#### ***Individual Buy-In***

An age-restricted buy-in for individuals ages 50–64 would provide access to a separate program based on Medicare for people closer in age to the current Medicare population. This option would have only a limited effect on uninsured rates because it targets a portion of the population that is already likely to have coverage. A recent RAND analysis estimated that 6 million people would participate in a buy-in restricted to individuals ages 50–64, only 1.1 million of whom would be newly insured (Eibner et al. 2019). Consistent with other analyses, the RAND analysis found that the shift of many older adults from an ACA individual

market plan to the buy-in would increase premiums for individuals remaining in the ACA market, leading about 600,000 individuals under age 50 to drop their ACA coverage (Eibner et al. 2019; Blue Cross Blue Shield Association 2019; Kotecki and Westrom 2020). Although an expanded individual buy-in may increase buy-in enrollment, the extent to which it would reduce the number of uninsured, rather than merely shift coverage among available sources, is unclear. Even if a Medicare buy-in had a lower premium than other coverage options, it could still be unaffordable, depending on the availability of premium subsidies.

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*Consistent with other analyses, the RAND analysis found that the shift of many older adults from an ACA individual market plan to the buy-in would increase premiums for individuals remaining in the ACA market, leading about 600,000 individuals under age 50 to drop their ACA coverage.*

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### **Employer Buy-In**

The extent to which employers would participate and enroll their employees in a Medicare buy-in program depends on how the employer buy-in is structured. Because so many large firms already offer coverage to their full-time employees, this option would be unlikely to affect the share of the population that is uninsured. A larger impact could be expected if employers are required to cover part-time or seasonal workers. Small employers that are less likely to offer coverage currently may be incentivized to do so if the cost of Medicare is lower than a private small-group plan, but it is difficult to predict the magnitude of the impact. Many small employers that do not already offer coverage may still choose to forgo enrolling in the Medicare buy-in program due to costs, even if it is less expensive than other coverage options, unless they face competitive pressure to do so in the labor market. Encouraging smaller employers to purchase Medicare coverage for their enrollees could reduce the number of employers in the ACA small-group markets, which could erode private small-employer coverage options.

### **Premium Amounts**

An individual buy-in program likely would have self-supporting premiums to cover all expected costs. Due to Medicare's relatively lower provider payment levels and administrative costs compared to commercial private insurance, a Medicare buy-in program may offer a more affordable coverage option than

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*Due to Medicare's relatively lower provider payment levels and administrative costs compared to commercial private insurance, a Medicare buy-in program may offer a more affordable coverage option than ACA individual market plans.*

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ACA individual market plans, but relative affordability and comprehensiveness of coverage depend on whether premiums vary by age or geography and whether enrollees have access to premium and cost-sharing assistance.

An age-restricted Medicare buy-in with self-supporting premiums that vary by geography but not age, with Medicare's current benefits and cost-sharing structure, and with the availability of ACA premium tax credits would shift many older adults from the ACA individual market to the buy-in program market (Eibner et al. 2019; Kotecki and Westrom 2020). The average ACA premiums for older adults exceed their average health claims, meaning they are subsidizing ACA premiums for younger adults, and removing the older adults from the ACA risk pool increases premiums for those remaining. Premiums for ACA bronze plans, for instance, would increase by an estimated 9 percent; however, the premium amounts vary by age. The RAND study estimates that the buy-in premium would be significantly lower than the cost of a bronze-tier plan for the average 60-year-old, but somewhat more expensive than a bronze plan for a 50-year-old. If premiums were to vary by age, they could possibly be lower than ACA bronze-level premiums for all enrollees ages 50–64 (Eibner et al. 2019).

Estimating the impact on premiums for an individual buy-in that is not age restricted is more difficult because the resulting buy-in premiums depend even more on whether they vary by age and whether the buy-in attracts healthy or less healthy enrollees. If individuals of all ages are eligible and premiums are uniform by age based on average costs, younger buy-in enrollees would effectively subsidize older buy-in enrollees. This design could lead to higher enrollment among older people, with commensurately higher premiums.

In a fully insured or self-insured employer buy-in model, it is likely that employer premiums would be lower than private commercial insurance because of using Medicare's payment rates. Determining whether this factor would result in lower individual employee premium contributions is difficult because the analysis depends on employer decisions and would likely vary among employers.

## **Comprehensiveness of Coverage**

The effects of an individual buy-in that builds on Medicare's benefit structure depends on whether enrollees are required to enroll in Parts A, B, and D, or in an MA plan (with prescription drug coverage) or enrollees can choose among Medicare's component parts. Assuming the former, the buy-in enrollees would have comprehensive coverage comparable to an ACA gold plan, a more generous plan than most ACA individual market enrollees choose (Centers for Medicare & Medicaid Services 2017; Kaiser Family Foundation 2019c). Buy-in enrollees who

choose traditional Medicare by enrolling in Parts A, B, and D could reduce their cost sharing further and address its lack of an OOP limit if they have access to, and choose to pay an additional premium to enroll in, a Medigap plan. Low-income enrollees who currently receive ACA cost-sharing assistance could have less generous coverage under a Medicare buy-in that uses the Medicare Savings Programs rather than the ACA cost-sharing assistance levels.

Similar issues arise under the scenario in which employers can participate in a buy-in. Assuming an employer would have to buy into a Medicare plan including all of its component parts, whether under a fully insured model or a self-insured model, comprehensive coverage for workers would be available.<sup>10</sup> Because the actuarial value of large employer plans typically exceeds that of Medicare, some workers may have less-comprehensive coverage under a buy-in (Actuarial Research Corporation 2017). If low-income individuals who are currently ineligible for ACA subsidies because they have access to ESI coverage deemed affordable could receive premium and cost-sharing assistance under the Medicare buy-in, affordability and comprehensiveness of coverage could increase.

## **Access to Providers**

Current Medicare patients generally are able to find a new primary care physician or specialist and have broad access to participating providers with no restrictions (Medicare Payment Advisory Commission 2019a). Access to providers would be improved for enrollees who were previously uninsured or who had narrow network plans from an employer. Medicare pays providers less than private insurance, however, so a shift in patient mix to more Medicare patients could lower providers' revenues. For some providers, revenue losses associated with a change in patient mix from higher-paying coverage to Medicare would be partially offset by an increase in the share of patients with insurance, though the effect would vary by provider type and the providers' patient mix. Hospitals are unlikely to refuse Medicare buy-in patients, but physicians have discretion to not accept new Medicare patients, be nonparticipating physicians, or entirely opt out of Medicare. Policymakers need to consider that the participation rates among specialists who typically serve younger patients, such as pediatricians, may be lower than participation rates among providers serving the typical Medicare population.

If the buy-in produces a modest net reduction in the share of the population that is uninsured, the effect of a buy-in on safety-net providers could be similar to the effect of the ACA. In Medicaid expansion states, providers saw an increase in the

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<sup>10</sup> Although the ACA requires that certain benefits be covered and that the self-insured plans meet affordability requirements, self-insured plans are not subject to essential health benefit requirements or state-mandated benefit laws (National Association of Insurance Commissioners 2015).

proportion of care provided to Medicaid patients and a decrease in self-pay or charity care cases. In serving patients making the transition from uninsured to insured, providers found ways to make care more efficient in order to maintain the patient volume, such as investing in patient–physician relationships and improving marketing, as well as investing in hospital infrastructure (Coughlin et al. 2015). The impact on provider revenue and participation depends on how many people participate in the buy-in program. A program with limited eligibility would not have as drastic an impact on provider revenue; therefore enrollees could have very broad access to providers. But with large enrollment, such as through an individual buy-in open to all ages or an employer buy-in, provider impacts would be amplified, and enrollees may have narrower provider access than in the current Medicare program, although it may still be larger than other forms of coverage.

## Cost Containment

A Medicare buy-in would affect total national health expenditures and the distribution of financing across payers. Depending on how it were structured, it could possibly affect the federal budget and the Medicare trust funds. Proposals to allow segments of the population to buy into Medicare would need to address whether and how such an expansion would increase federal health expenditures and would need to offer mechanisms for addressing any increased costs.

As noted above, Medicare pays providers less, and in some cases significantly less, than private health insurance. Medicare also has lower administrative costs. Therefore, sizable savings and lower cost growth for health care could result if a significant number of individuals switched from private insurance to a Medicare buy-in program. The availability of a Medicare buy-in with lower premiums than private insurance could put pressure on private insurers to lower premiums to remain competitive. This impact would be greater under buy-in models with the broadest availability to individuals and employers, but it would also have the greatest impact on private insurers in the ACA exchanges and on provider revenue, which may produce insurer and provider resistance.

## Medicare and Other Federal Spending

If a buy-in option set premiums to be fully self-supporting, it would not have an impact on Medicare financing. Additional federal funding could be required if the federal government provides premium and cost-sharing assistance to individuals with low or moderate incomes. Such funding could be offset by lower federal subsidies for

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premiums and cost-sharing for ACA coverage. Costs to the federal government could also increase if there is adverse selection to the buy-in program that is not fully reflected in premiums.

## **Employers**

Employers with fewer than 50 full-time equivalent employees are not subject to the employer mandate under the ACA and thus may use the existence of an individual buy-in option available to all ages as an opportunity to lower their costs by ceasing to offer insurance. These employers could reason that their employees can obtain coverage through the buy-in, although little evidence suggests that this exodus occurred after the establishment of the ACA. By contrast, some small employers might begin offering coverage through an employer buy-in if it is meaningfully less expensive than current private market options.

## **Individual Market Enrollees**

As discussed above, people who have coverage through the ACA individual market could see changes in their health care costs as well. While an expectation exists that an age-restricted buy-in that removes older persons from the ACA risk pools would lower average costs and thus premiums, in the population remaining in the ACA-compliant individual market, some evidence indicates that premiums in the individual market would actually increase, affecting individuals ineligible for ACA premium tax credits.

## **Impact on Other Policy Goals**

### **Consumer Choice**

A buy-in would provide newly eligible individuals with another insurer choice or set of insurer choices in addition to plans sold on the ACA exchanges or made available through their employers. As noted above, new enrollees would likely experience more provider choice if the buy-in maintains traditional Medicare's broad provider networks because private plans (especially those in the individual market) often use narrow networks to obtain more competitive prices. MA plan networks are also generally broader than those for ACA plans (Jacobson et al. 2017).

### **Disparities and Inequities**

Due to the voluntary nature of the buy-in and its likely limited impact on coverage, a Medicare buy-in would likely not significantly reduce racial and ethnic disparities or reduce the size of cross-population disparities in access, service use, or health

outcomes. Establishing a Medicare buy-in that offers subsidies and allows low-income individuals to buy in could enhance socioeconomic equity by reducing the impact of state differences in eligibility for Medicaid coverage.

### **Administrative Simplicity: Beneficiary Perspective**

Under the current Medicare program, individuals face complex plan options and enrollment rules. The complexity begins when beneficiaries encounter the choice of enrolling in one of the 24, on average, MA plans with drug coverage available in their area, in lieu of traditional Medicare's Parts A and B (Jacobson et al. 2019). Individuals in Parts A and B can select a Part D prescription drug plan from among the 24 to 32 plans, depending on their state of residence (Cubanski, Damico, and Neuman 2019). Part D plans often change from year to year, necessitating annual reexamination of coverage options (O'Brien 2018). Finally, beneficiaries must decide whether to purchase supplemental coverage.

Individuals in a Medicare buy-in program could face these same decisions, depending on the extent to which insurers participate in the Medicare buy-in. They would also be eligible for coverage in the individual market or through ESI. Buy-in programs could be structured to replicate the level of choice—but also the resulting confusion.

### **Social Solidarity or Perceived Fairness**

Medicare Part A meets the criteria for a prototypical social insurance program because payroll tax contributions are mandatory and eligibility is automatic. Individuals make contributions over a working lifetime, and Medicare is seen as an earned benefit. Although allowing individuals to purchase Medicare coverage might raise questions of fairness, this concern could be minimized if premiums fully cover program costs or if eligibility were limited to older workers who likely meet the eligibility criteria other than age. Additionally, the buy-in program interacts heavily with the ACA individual market, in which eligibility is not based on work history.

## **Administrative and Transition Issues**

Establishing a Medicare buy-in raises unique administrative issues compared to other coverage expansion proposals. Unlike today's Medicare beneficiaries, who by design permanently stay enrolled in Medicare once they are eligible, enrollees in a buy-in program would be expected to have a higher level of churn due to events such as job change, divorce, and birth of children. To mitigate turnover,



a buy-in program could establish specified enrollment periods and qualifying events, consistent with ACA individual market or Medicare enrollment periods. An employer Medicare buy-in would add further administrative complexity and require additional administrative infrastructure to coordinate with employers.

In contrast to other Medicare expansion proposals, a Medicare buy-in faces the additional challenge of layering on top of a fragmented system and heavily interacting with complex ACA provisions. Although an individual buy-in plan would not be expected to be part of the ACA individual market risk pool, it could use the ACA exchanges to streamline enrollment, similar to the use of state ACA exchange platforms for Medicaid enrollment as required in the ACA. A buy-in could follow the same ACA administrative rules, such as enrollment periods, to facilitate enrollment in the buy-in plan.

Even if the buy-in uses the ACA exchanges for enrollment, consumers may still face complex choices, especially if cost-sharing assistance and subsidy eligibility differ between the buy-in and private ACA plans. An expansive public education marketing campaign would be needed to make individuals aware of the option

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*In contrast to other Medicare expansion proposals, a Medicare buy-in faces the additional challenge of layering on top of a fragmented system and heavily interacting with complex ACA provisions.*

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and how to enroll. With a buy-in offered outside of the exchanges, the role of marshalling public education programs and outreach becomes more crucial. Although a Medicare buy-in program would build on Medicare's current administrative platform, additional administrative systems would be crucial and would take time to put into place, especially with the addition of an employer buy-in. A gradual implementation could ease the administrative burdens while also giving various stakeholders more time to make any necessary adjustments. A transition period could phase in various buy-in elements either at the same time or sequentially, including provider payment rates, age of eligibility, and the benefit structure. Longer initial enrollment periods in the first few years of enactment may also be appropriate.

## Conclusion

Unlike other policy approaches discussed in this report, creating a Medicare buy-in program would provide an additional, optional coverage source for eligible individuals and the workers of employers that choose to participate. How much such an approach would meet policy goals, such as coverage expansion, cost containment, and affordability depends on key design choices, notably:

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

A buy-in would be subject to consumer choice. Individuals and employers would make their decisions about whether to opt for the buy-in based on its benefit package, provider access, costs (including premiums and any premium and cost-sharing assistance), and how those features compare to other coverage options and an individual's expected health care needs. With the addition of a significant amount of choice, however, comes an additional burden of administrative complexity, especially with the interaction of the buy-in and the ACA individual market. The optional nature of the buy-in program leads to greater consumer choice but also limits the potential impact of the buy-in on specific policy goals, such as expanding coverage. **Table 4-5** summarizes this report's assessment of the likely impact of a Medicare buy-in program on select policy goals.

**Table 4-5. Potential Impact of a Medicare Buy-In Program**

Policy goal	Buy-in program impacts
<b>Expand coverage</b>	<p>If eligibility were restricted by age (to older adults), a Medicare buy-in would likely have a limited impact on reducing the overall national uninsured rate.</p> <p>The broader the eligibility criteria, the greater the impact would be on reducing the number of uninsured.</p>
<b>Improve access to care</b>	<p>Individuals who were previously covered by insurance with narrow networks or were uninsured would likely have better access to care.</p> <p>A program with limited eligibility would likely have broad access to providers, but with large enrollment, provider revenue impacts are amplified and enrollees may have a narrower provider network than in the current Medicare program.</p> <p>Buy-in enrollees might have less access to specialists serving younger populations.</p>
<b>Increase affordability</b>	<p>The use of lower provider payment rates could lead to lower buy-in premiums with more comprehensive coverage, which could lower out-of-pocket costs.</p> <p>Under a buy-in program with Medicare financial assistance, individuals eligible for ACA premium and cost-sharing assistance may have less comprehensive coverage.</p>
<b>Contain costs</b>	<p>The use of Medicare payment rates for a larger share of the population could reduce national health expenditure to a greater extent than any associated increase in service use, presuming that most new enrollees were formerly covered by a private plan and that relatively few were uninsured.</p>
<b>Increase choice</b>	<p>All who are in the designated buy-in eligibility group would have increased choice of coverage options.</p> <p>For individuals choosing Parts A, B, and D, provider choice would increase because of no network restrictions; for individuals switching from a restrictive provider plan to MA, provider choice would also increase.</p>
<b>Improve equity</b>	<p>Depending on design features such as cost-sharing and premium assistance, a buy-in could be helpful in providing affordable coverage to lower-income persons, including individuals in states that chose not to expand Medicaid.</p>
<b>Increase administrative simplicity</b>	<p>A Medicare buy-in would increase both choice and administrative complexity for eligible individuals.</p> <p>It would not affect the administrative burden for providers.</p> <p>There would be a burden on the federal government to administer the program.</p> <p>Insurer administrative burden would increase by having to submit multiple bids in MA, a Medicare buy-in, and the ACA individual market.</p>
<b>Increase social solidarity or fairness</b>	<p>A buy-in program would have minimal impact, especially if premiums are self-supporting or eligibility is limited to older adults.</p>

**Notes:** ACA (Affordable Care Act of 2010), MA (Medicare Advantage).



To have a much larger impact but at significantly greater administrative cost, a buy-in could be opened to some or all employers. Such a feature could raise questions regarding the role of employers in a system where both provision and administration of benefits receive heavy tax subsidies.

Even under the broadest eligibility, a Medicare buy-in proposal would probably have a limited impact on the uninsured but could displace existing coverage in the individual and ESI markets, if open to employers. A buy-in might offer comparable or better coverage for enrollees at lower cost compared to their prior coverage.

The most important impact of a buy-in would be in making coverage more affordable by allowing more people to participate in a program with lower payment rates under Medicare's administered pricing systems. Developing a program design sufficiently attractive to secure enrollment may well require significant subsidies, raising questions about the cost-efficiency of this approach compared to other policy alternatives, such as increasing ACA premium subsidies. A buy-in also raises important questions about the interactions with other subsidized markets, including the ACA individual market and the ESI market. In addition, a buy-in program would carry significant cost in terms of added administrative complexity in Medicare and for consumers.





HEALTH INSURANCE

## **Chapter 5: Summary of Findings and Policy Tradeoffs**

## Overview

The Study Panel looked at three approaches to changing Medicare eligibility and assessed whether and how variants of these approaches would address key objectives of policy reform (see **Chapter 1**). The three approaches considered were:

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

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

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

## Key Design Decisions

Under all of the discussed approaches, key design choices determine the impact that each proposal would have on the affordability of coverage, access to care, and overall health care system costs.

### Comprehensiveness of Coverage

Under all of the approaches discussed in this report, comprehensiveness of coverage, affordability, and access to care for eligible individuals—particularly individuals who are currently uninsured or underinsured—would be improved. This impact depends on key design decisions regarding covered benefits, cost-sharing requirements, premiums and other financing mechanisms, and the inclusion of premium and cost-sharing assistance programs.

In both lowering the eligibility age and in Medicare-for-all, providing comprehensive coverage would increase the health and financial protection of covered individuals. Both options, however, would entail increased costs for the federal government due to increased utilization of services. To the extent that these options increase the share of costs paid by the government and/or cover formerly uncovered services, federal costs would increase, as would the expected benefits for eligible individuals.

The relationship between comprehensiveness of benefits and federal costs in a Medicare buy-in program is more complicated. The effects on comprehensiveness of coverage in an individual buy-in that builds on Medicare's benefit structure depends on whether enrollees are required to enroll in Parts A, B, and D or in an MA plan (with prescription drug coverage) or whether enrollees can choose among Medicare's component parts. In a self-supporting buy-in where enrollees are responsible for paying a premium that covers the expected costs of the program, the increase in costs to the federal government could be nominal. A buy-in may need to include federal premium subsidies, however, to compete with other available plan options. Further, providing additional benefits would increase premiums and therefore federal spending for premium subsidies.

### Choice of Plan and Administrative Complexity

Policymakers will need to consider how additional choice not only affects the administrative complexity for the program but also the value to consumers of added choice of insurance plans. The literature shows that health insurance shopping may be overwhelming for consumers due to the complexity and amount of choices, limited health insurance literacy, and inadequate decision support tools

(Taylor et al. 2016). This concern is especially important to address in a Medicare buy-in program that may significantly increase enrollees' choice of plans.

In a Medicare buy-in, the level and ease of enrollee choice directly affects the buy-in program's ability to attract enrollees. Medicare buy-in programs could be structured to replicate the level of choice—with the resulting confusion—current beneficiaries experience in considering the various parts of Medicare. These choices would be compounded by the other coverage options available to buy-in-eligible individuals, including through the ACA individual market or through an employer. Each set of coverage sources has its own enrollment rules, benefits, premiums, cost-sharing requirements, and assistance programs, making comparisons and choices difficult. Adding to this complexity and the need for a new enrollment infrastructure is that, although current Medicare beneficiaries make the decision to enroll once, under a buy-in, enrollment options may need to be reassessed much more frequently, due to changes in job, income, geographic location, and range of available insurance.<sup>1</sup> An employer Medicare buy-in would add even more administrative complexity to handle enrollment, collect payments, and manage eligibility for both the individual and employer buy-in population.

This balance between enrollees' plan choice and administrative complexity is also present in a Medicare-for-all program that retains a role for Medicare Advantage (MA) plans. Although a Medicare-for-all model with MA would retain the choice of insurer, administrative savings for providers and the system as a whole would likely be less robust if private MA plans are retained.

## **Level of Provider Payment Rates**

A common rationale across these proposals for using Medicare is the opportunity to use Medicare's provider payment mechanisms and prices to control health care costs. Using Medicare's payment rates in a Medicare buy-in program would lower the program's expected costs, thereby lowering the self-supporting buy-in premium. Lower premium costs could provide a more affordable option for some eligible individuals. Similarly, in lowering the eligibility age or in a Medicare-for-all program, the extension of Medicare's payment rates would be a major source of cost containment and would directly affect access to care and the costs of the program for the federal government and the overall health care system.

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<sup>1</sup> After initial enrollment, Medicare beneficiaries typically remain in the program for the rest of their lives. Nevertheless, they do face annual enrollment decisions in which they can move from traditional Medicare to a Medicare Advantage (MA) plan or vice versa. MA and Part D enrollees also have the option to change private plans.



In lowering the age of eligibility or in a Medicare buy-in program that has limited eligibility, participants would likely have broad access to providers based on the current Medicare program's provider network, but with larger enrollment, the provider revenue impacts are amplified and enrollees may have a narrower provider network than in the current Medicare program. Under a Medicare-for-all program, access to care for beneficiaries largely depends on whether supply constraints arise as the delivery system adjusts to meet new levels of demand, and under a Medicare-for-all system that includes MA plans, the impact depends on how plan networks are set. One consideration is whether Medicare's lower provider payment rates could be sustainable under an eligibility expansion or whether there would be additional pressure for policymakers to increase those rates. These considerations are also critically important for the willingness of providers to participate in any of these proposals, for access to care for eligible individuals, and the implications for the costs of any approach.

## Financing Mechanisms

Lowering the eligibility age and creating a Medicare-for-all program would increase costs to the federal government, although the magnitude is significantly greater under Medicare-for-all. Lowering the age of eligibility would directly add eligible individuals into the Medicare risk pool, so financing for this expansion could be funded through current Medicare's Hospital Insurance and Supplemental Medical Insurance trust funds. The increase in projected costs would necessitate additional

revenue for the trust funds, which could be raised by increasing the current payroll tax contribution rate or through other mechanisms. A universal Medicare program, especially one in which the program benefits and cost sharing do not resemble the current Medicare program design, would likely need to rely on other mechanisms beyond current payroll tax contributions to fund the program.

A buy-in option would not have an impact on current Medicare financing if it were structured to be self-supporting such that enrollee premiums covered the expected cost of care, in addition to any administrative fees or expenses required to run the program. It would, however, affect costs for those financing these premiums—either individuals or employers—and it retains the unpredictability of costs in the current system. If the federal government were to subsidize premiums and cost sharing for individuals with low or moderate incomes, then a buy-in program would require additional revenue that may or may not be available from the Medicare trust funds. Such additional funding could be offset in part by reductions in ACA premium subsidies for individuals who shift from a subsidized ACA plan to the buy-in.

## **Administrative Challenges**

The traditional Medicare program spends approximately 1.4 percent of total expenditures on administrative overhead (Centers for Medicare & Medicaid Services 2019a) and proponents of transitioning to a Medicare-for-all system often cite a reduction in administrative spending as a main advantage of expanding Medicare to a broader population. One feature that binds all of the proposals evaluated by the Study Panel is that these programs build on Medicare's administrative structure since Medicare has significantly lower administrative costs and greater simplicity than commercial insurance. Although extending Medicare's eligibility below age 65 may improve beneficiary simplicity in obtaining coverage, lowering the age or extending the program to all would create administrative challenges that may necessitate additional administrative systems. For all of the proposals, two of the most significant administrative challenges are creating a workable enrollment process and an effective public education campaign. And in the case of the buy-in, managing the option and assuring its compatibility with the ACA would generate substantial challenges.

## **Public Education Efforts**

Lessons from the experience of implementing the ACA suggest that a communication strategy and public education about policy changes in Medicare eligibility would be important. With lowering the age of eligibility or an age-restricted buy-in, such efforts might be coordinated with outreach by the Social

Security Administration to reach near-elderly persons as they approach eligibility. Under a Medicare buy-in, a more extensive public education marketing campaign would likely be needed to make individuals aware of the option and how to enroll. Even though the buy-in would not be part of the ACA individual market, a buy-in could use ACA exchanges to facilitate enrollment. If not using the exchanges, public education programs and effective outreach become more crucial. For the lower eligibility age approach, educational efforts would be important for individuals who are not subject to automatic enrollment procedures.

## **Workable Enrollment Process**

Structuring a workable enrollment process would be essential under any expansion. Changes to the enrollment process, such as strengthening the notification process for eligible enrollees not already receiving Social Security benefits, would be necessary to maintain near-universal enrollment among the eligible population. A universal Medicare program would need to establish an eligibility verification and enrollment process, especially during the initial transition to enrolling the entire population. Such a process could build on the current Medicare enrollment process but would require a significant scaling up of the current administrative structure. In contrast to lowering the age or transitioning to Medicare-for-all, a Medicare buy-in presents the additional challenge of layering on top of a fragmented system and interacting with complex ACA provisions.

## **Transition Issues**

All the proposals would require time between enactment of the relevant legislation and the effective date to establish the administrative and other systems to make the program fully functional. Such a transition could be accomplished by postponing the effective date for several years after passage of the legislation or through creating a gradual transition process. Although a gradual transition process could be included in either a Medicare buy-in or lowering the age, this feature is most important in the context of Medicare-for-all (see **Chapter 3**). For a program that has payment rates based on the current Medicare program, which are, on average, lower than commercial insurance rates, a gradual phase-in may ease the impact on provider revenues. A transition period could phase in other aspects of the program as well, such as the benefit structure and the age of eligibility or other eligibility factors. In addition, longer initial enrollment periods could be available during the first few years of enactment. A gradual transition would ease the implementation of a Medicare-for-all program, but it also increases the reliance on commercial private insurers to continue operating until the full implementation is complete.



Full implementation of Medicare-for-all would eliminate or at least dramatically shrink providers' administrative staffs and the commercial private insurance industry—estimated to comprise 800,000 individuals in 2017—leading to a significant number of displaced workers (Pollin et al. 2018). Policymakers would need to consider what financial support or retraining would be available for laid-off workers in the insurance industry.

Other transition issues will arise if each of these three proposals is viewed as working in concert over time, as opposed to being mutually exclusive of one another. For example, the age of Medicare eligibility might be lowered to 62 at the same time as younger individuals were made eligible for a buy-in. While both approaches are being implemented, policies might also be enacted to eventually transition to Medicare-for-all over a specified timetable. The implementation of a Medicare-for-all approach might then be based on evidence from the actual experience of the other two approaches.

## **Critical Policy Considerations**

In addition to the key design considerations and tradeoffs within each of the Medicare-based proposals discussed in this report, policymakers need to examine critical policy considerations for using Medicare as a platform for expanding coverage, such as the role of private insurance and stakeholder impacts.

## **The Role of Private Insurance**

Policymakers may decide to address the effects of different policy approaches on factors other than increasing affordability, expanding coverage, improving equity and reducing disparities in access, and containing costs. For example, policymakers may choose to assign priority to maximizing choice of coverage features, making changes in the delivery system, or improving service use and health outcomes. Because of the various prioritizations of goals, the Study Panel's report has paid substantial attention to the role of private health insurance in a system with expanded Medicare eligibility.

The U.S. health system today is built on a framework that involves significant roles for private health insurance, in ways that might be strengthened, weakened, or changed by expanding Medicare eligibility. To some, including a role for private health insurance is a way to maintain plan choice; however, the benefit of plan choice for consumers is not well established. Others value a private role for its own sake based on a conviction that private actors are inherently more nimble, flexible, innovative, and responsive to consumer demands. Preserving a role for private health insurance might also limit the possibility that universal coverage would mean a loss for people whose current coverage is exceptionally good; however, it may limit the ability of a universal program to contain health care costs. On the other hand, some view private health plans in social programs as inherently problematic, a mechanism for generating profits for private players, adding administrative complexity without providing commensurate public gains.

To the extent that Medicare provides health care coverage for more people or the population as a whole, the role of private health insurance in such a system requires careful consideration. For example, under a Medicare-for-all program with comprehensive benefits and low or no premiums, the basis for competition among Medicare and MA plans becomes less apparent. Private health insurance plans may evolve, however, to serve as Medicare administrative contractors as in today's Medicare program.

## **Importance of Stakeholder Impact**

It is also important to consider the impact of reform on key stakeholders, including hospitals and institutional health care providers, physicians and other health care professionals, private health insurance plans, employers and employees, and labor unions. The political feasibility of reform proposals hinges on the extent to which key stakeholders are negatively affected. The impacts on stakeholders could also affect the extent to which reform proposals can meet specific goals.

Representing a fifth of our economy, health care is a vibrant economic sector responsible for good jobs and innovative industries that produce valued products and exports. Reforms that expand coverage and include cost containment strategies would, by definition, entail losses in the profits and income of health care providers and private health plans. For example, under the approaches discussed in this report, the extension of Medicare's payment rates to providers could lower their revenue. In the cases of smaller expansions, this effect may be modest and offset partially by an increase in patients with insurance. Under larger expansions, this cost containment strategy may affect access to providers for individuals covered under insurance that pays Medicare rates. This impact can be moderated through phase-in approaches that give providers a chance to adjust to a new, lower-cost service structure. The effects of expansion can also be tempered through redistributive design features that could mean, for example, increased support for health care educational expenses or increased income for providers serving populations that are underserved today or for primary and preventive care providers that are considered undervalued in the current market.

Individuals who work for providers and plans administering current coverage systems will necessarily be affected by reforms that significantly cut administrative complexity and costs, by having their jobs eliminated or significantly changed. The impact on them can be moderated through robust transition plans that address the needs of these displaced workers. The impact of reforms on private insurers and providers, as well as the individuals who work for them, is a critical consideration in choices regarding provider payment methods and levels, whether and how to define prices for drugs and devices, and the role of private insurance systems.

Also very relevant to the debate about reforms involving Medicare expansion is the impact on employers and labor unions. The central role of U.S. employers in sponsoring and subsidizing insurance coverage for employees and their families dates back to wage and price controls instituted during the second world war, which were evaded through generous provision of untaxed employee benefits (Gruber 2011). Employee attachment to the benefits negotiated by labor unions in lieu of wage increases during the 1950s and 1960s reinforced employer-sponsored insurance (Lester 1967; Rice 1966). Public programs such as Medicare and Medicaid, as well as the health insurance purchasing exchanges or marketplaces, and Medicaid expansion made possible by the ACA, were enacted to help groups that fell through the gaps of an employment-oriented coverage system.

While the importance of maintaining a role for employers as sponsors of group coverage was diminished by the creation of a publicly subsidized and regulated individual insurance market in which medical underwriting is forbidden, the value of maintaining an employer role continues to be debated. Employers see provision

of health benefits as a means of competing in the labor market and recognize that dependence on such benefits helps them retain employees<sup>7</sup>. On the other hand, employers could see substantial savings through shifting either some or all employees to Medicare coverage.

Meanwhile, labor unions might see both gains and losses for workers from such a change in that many, but not all, workers would likely have better or comparable coverage. Workers have historically accepted lower wages, however, in return for health insurance benefits, though this depends on the negotiating power of each union. Additionally, policymakers will need to consider how to address the accumulation of past forgone wages by older union workers. The ability to renegotiate contracts to replace savings on benefit costs with higher wages for workers is not guaranteed, particularly if employers face new tax contributions to help finance coverage. Maintenance of effort requirements would disadvantage employers that currently provide generous coverage. Further, if individual workers were previously not required to contribute toward their coverage through a premium and now face higher taxes, some workers might feel that they are worse off compared to their current coverage even if the net total cost is lower.

## Questions for Future Study

While this report concentrates on potential Medicare eligibility expansions, it does not encompass all types of changes in Medicare eligibility or alternative reform efforts that might be imagined to expand access to affordable coverage. Although substantial bodies of research are available on many health care reform topics, fundamental policy questions regarding the use of Medicare as a platform for reform warrant further study.

For the analytical purposes of this report, the Study Panel did not assess the design and potential impacts of a public option within the Affordable Care Act (ACA) individual market risk pools (see **Text Box 4-1** in **Chapter 4**). A public option in the ACA individual market, including a “Medicare-like” plan that builds on Medicare’s payment rates, leads to different design challenges and policy implications compared to a Medicare buy-in. A public option would operate like any other ACA-compliant health plan, with the tiered actuarial values, cost-sharing requirements, and premium structures, and would avoid the complexity of risk-sharing issues across different age groups or competition between two insurance risk pools. Although a public option would likely be more administratively simpler than a Medicare buy-in, state and federal policymakers would still need to specify numerous design elements, including how to set provider payments, how to ensure sufficient provider participation, and where to implement the public option.

This report did not assess the impacts that these reform approaches would have on the labor market and the overall U.S. economy. Key questions for further research on this topic are the impact on the labor market and wages for workers, how the economy would adjust to greater expansion of federal responsibility for health insurance costs (including impacts on the nation's gross domestic product), and the distributional effects of additional taxes needed to fund more-extensive reform proposals.

Although the research in this report assessed general directions and approximated impacts, a significant limitation was that no original modeling was conducted. In two policy areas, modeling of premiums, coverage, and costs would be incredibly beneficial: the impacts of a Medicare buy-in open to all ages and an employer buy-in. Available studies provided modeling on the impacts of an age-restricted (50–64 years old) buy-in on premiums and enrollment and impacts on other sources of coverage and specific populations. Further modeling of these impacts for an all-ages and an employer buy-in would be essential for understanding the expected effects of all proposals and be used to convey how key policy decisions affect outcomes of interest, such as coverage, premiums, and federal spending.

## Closing Comments

Improving access to affordable, high-quality health coverage and care and constraining health care spending remain formidable policy challenges for the United States. When there is widespread public perception that coverage and access problems are significant enough to require action, a window for reform opens. Evidence that the nation has reached such a point includes polls indicating that health care is a top issue for voters heading into the 2020 presidential election, as it was in the 2018 midterm elections. Significant problems in the health care system do not necessarily point to particular paths for reform, but they do create demand for change.

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



The background is a solid teal color with a faint, semi-transparent overlay of financial data. At the top, there is a line graph with a jagged line and a smooth line, with x-axis labels 4 through 14. Below that is a bar chart with several vertical bars of varying heights. A pen is positioned horizontally across the middle of the page, pointing towards the right. The word "Appendices" is written in a white, serif font, underlined, and centered on the page. The overall aesthetic is professional and data-oriented.

# Appendices



# *Appendix A*

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## **Medicare Overview**

### **Eligibility**

Medicare currently provides coverage for 60 million beneficiaries: 51.2 million ages 65 and older and 8.8 million persons with disabilities (Centers for Medicare & Medicaid Services 2019a). Persons under the age of 65 who have received Social Security Disability Insurance (SSDI) benefits for at least 24 months are automatically enrolled in Medicare and are entitled to premium-free Part A benefits. The waiting period is waived for individuals who have qualified for SSDI due to amyotrophic lateral sclerosis. Individuals diagnosed with end-stage renal disease (ESRD) are eligible for Medicare without first having to receive SSDI benefits. In addition, individuals who were diagnosed with a specific lung disease or type of cancer and lived in an area subject to a public health emergency declaration by the Environmental Protection Agency for a specified period before diagnosis are entitled to Part A benefits and eligible to enroll in Part B.

### **Benefit Design**

The Medicare program organizes benefits into four separate components, each with its own cost-sharing and premium requirements. Part A covers inpatient hospital services, including room and board, hospital facility use, inpatient drugs/biologics and supplies, and diagnostic and therapeutic items. Part A also covers limited periods of patient stays in post-hospital skilled nursing facilities and covers hospice care and home health care following a stay in a hospital/skilled nursing facility.

Part B covers physician services, outpatient hospital services, and inpatient prescription drugs/biologics, durable medical equipment, clinical laboratory and diagnostic tests, and other medical services, including preventive care, physical and occupational therapy, speech–language pathology therapy, and ambulance care. Part B covers home health care when such care does not follow a stay in a hospital or skilled nursing facility. However, Part A covers all home health care for Medicare beneficiaries who lack Part B coverage.

Parts A and B together are referred to as traditional fee-for-service (FFS) Medicare, in which the federal government directly pays for covered health services. In 2018, 59.6 million people were enrolled in Medicare Part A, which represented 99 percent of individuals eligible to enroll (Centers for Medicare & Medicaid Services 2019a). Part B had enrollment of 54.6 million (91 percent of individuals eligible to enroll), the vast majority of whom were also enrolled in Part A. The current traditional Medicare benefit package does not cover long-term services and supports (LTSS) or dental, vision, or hearing services, and it has no limit on beneficiary out-of-pocket (OOP) expenses.

Medicare beneficiaries may elect to receive Part A and Part B benefits through a private Part C Medicare Advantage (MA) plan, which offers coverage with an integrated benefit package similar to private insurance coverage. Unlike traditional Medicare, MA plans include networks that limit enrollees to a set of providers in a specific geographic area in order to offer enrollees lower premiums, and they can include managed care mechanisms. MA plans may offer benefits to Medicare enrollees beyond traditional Medicare coverage, such as dental or vision coverage, and/or lower cost-sharing requirements (Congressional Research Service 2019b). Employers and unions may sponsor MA plans for current and retired employees or members. These plans can operate under somewhat different rules, such as being permitted to restrict eligibility to employees and members and to provide customized benefits. Additionally, MA offers Medicare special needs plans, which provide coordinated care plans for individuals with specific needs, including institutionalized individuals, individuals dually eligible for Medicare and Medicaid, and individuals with specific chronic conditions (Congressional Research Service 2019b). The share of beneficiaries enrolled in MA has grown over time, with 21.3 million (35.6 percent) of Medicare beneficiaries receiving benefits through an MA plan in 2018 (Centers for Medicare & Medicaid Services 2019a).

Beneficiaries in Part A and/or Part B or in an MA plan without drug coverage are eligible to enroll voluntarily in prescription drug plans (PDPs) under Part D. Medicare heavily regulates the PDP formularies, specifying what drugs must be covered within therapeutic classes. All PDPs must follow a standard coverage benefit structure or offer an actuarially equivalent plan. Plan sponsors may also offer enhanced benefit plans in addition to a standard PDP. Part D plan sponsors can negotiate with drug manufacturers to set prices sponsors can include step therapy requirements and placement of drugs in preferred formulary tiers and they can determine beneficiary cost-sharing amounts (Congressional Research Service 2019b). Part D enrollment was 45.8 million in 2018 (Centers for Medicare & Medicaid Services 2019a).

Coverage in the traditional Medicare program can be described as comprehensive—inclusive of services deemed medically necessary by a physician and, in the case of medicines or devices, deemed safe and effective by the U.S. Food and Drug Administration. Prior authorization is not required for services covered under Parts A and B, and the utilization management techniques employed by private plans are not used. MA and Part D plans have more scope to restrict coverage of services and medicines for their enrollees on the grounds of appropriateness or relative cost-effectiveness, within defined parameters such as mandatory coverage of medicines in certain protected classes.

## Premiums

A vast majority of enrollees are eligible for premium-free Part A benefits if they or their spouse are eligible for Social Security payments and have paid Medicare-eligible payroll taxes for 40 quarters (10 years). Individuals ages 65 and older without 40 quarters of coverage may choose to enroll and pay the full Part A monthly premium; however, 99 percent of Medicare beneficiaries do not pay a Part A premium (Centers for Medicare & Medicaid Services 2019b). The monthly premium is \$458 in 2020, up from \$437 in 2019. The premium is calculated from the expected average per capita cost of Part A for individuals ages 65 and older who are entitled to Part A coverage (Centers for Medicare & Medicaid Services 2018a). Enrollees who do not qualify for premium-free Part A may qualify for a reduced premium if they have between 30 and 39 quarters of covered employment (Centers for Medicare & Medicaid Services 2018a).

The standard monthly premium for Part B coverage increased from \$135.50 in 2019 to \$144.60 in 2019, which reflects an estimated 25 percent of program costs (Centers for Medicare & Medicaid Services 2019b). Since 2007, individuals with modified adjusted gross incomes that exceed a specific threshold are subject to a higher income-related premium that reflects a greater percentage of estimated program costs. Depending on income level, high-income beneficiaries' premiums are set to cover 35 percent to 85 percent of the expected per capita Part B costs for the year. The highest income-adjusted monthly premium is \$491.60 in 2020 (Centers for Medicare & Medicaid Services 2019b). Additionally, beneficiaries who enroll in Part B after their initial enrollment period pay a premium surcharge unless they are employed and receive employer-sponsored health insurance benefits. In 2018, 1.4 percent of Medicare Part B enrollees were subject to this penalty (Congressional Research Service 2019a). The penalty is waived for beneficiaries eligible for a special enrollment period, such as when an individual has previously had employer coverage. For individuals whose premium is automatically deducted from their Social Security payment, the Part B premium is also subject to a "hold-

harmless provision” that limits the dollar increase in Part B premiums each year to no more than the yearly increase in an individual’s Social Security benefit (Congressional Research Service 2019a).

MA plans receive a per person monthly payment adjusted to reflect the demographics and health history of enrollees. The amount paid to MA plans is not adjusted by the volume of services that an enrollee uses, but MA may pay providers on an FFS basis. The monthly payment made to an MA plan is based on a comparison of that plan’s estimated costs of providing all Part A and Part B benefits (the plan’s bid) with the maximum amount that traditional FFS Medicare will pay for the benefits in the plan’s service area (the benchmark). If the plan bid is lower than the benchmark, plans receive a portion of that difference in a rebate that must be passed on to beneficiaries, either through additional benefits, lower cost-sharing requirements, or a lower monthly premium. If the plan bid is greater than the benchmark, enrollees in that plan must pay an additional premium amount equal to the difference between the bid and the benchmark (Congressional Research Service 2019b). The MA benchmark is set between 95 percent and 115 percent of FFS Medicare costs, depending on whether the plan is located in a high-cost or low-cost FFS area (Kaiser Family Foundation 2019d). Payments to MA plans are adjusted through star ratings (1–5, with 5 being the highest) to reflect a plan’s performance on quality measures. Plans receiving a star rating of 4.0 or above receive a quality bonus payment.

Medicare Part D pays private prescription drug plans through a competitive bidding process in which the standard enrollee premium is based on the national average bid, and actual plan premiums reflect differences between the bid and the national average. Medicare pays PDPs a risk-adjusted monthly per capita amount reflecting that plan’s bid during a given year. Part D plan sponsors negotiate payments with drug manufacturers, set their own formularies, and determine cost-sharing amounts (Congressional Research Service 2019b). The standard enrollee monthly premium is estimated to be \$42.05 in 2020, up from \$33.19 in 2019 (Cubanski and Damico 2019). Similar to Part B, beneficiaries above a specific income threshold are subject to a higher income-related premium that reflects a greater percentage of estimated per capita program costs. This adjustment ranges from 35 percent to 85 percent of the national average cost of providing Part D benefits.

## Cost Sharing

Parts A and B of Medicare have cost-sharing requirements for beneficiaries. Part A includes a deductible and coinsurance for hospital inpatient stays and daily coinsurance payments for skilled nursing facility care, shown in **Table A-1**. Part B

enrollees are subject to a deductible of \$198 in 2020 and a standard coinsurance of 20 percent for most covered services, except for clinical laboratory tests, home health agency services, and preventive care services (Centers for Medicare & Medicaid Services 2019b). Unlike traditional Medicare, MA plans are required to have an OOP spending limit of \$6,700 for services covered by Parts A and B. **Table A-1** provides the cost-sharing requirements for hospital inpatient and skilled nursing facility stays.

**Table A-1. Medicare Part A Deductibles and Coinsurance, 2020**

Hospital inpatient			Skilled nursing facility		
<b>Days 0–60</b>	Deductible	\$1,408	<b>Days 0–20</b>	No charge	N/A
<b>Days 61–90</b>	Daily coinsurance	\$352/day	<b>Days 21–100</b>	Daily coinsurance	\$176/day
<b>Days 91–150 (lifetime reserve days)</b>	Daily coinsurance	\$704/day	<b>Days 101 and over</b>	Beneficiary responsible for all costs	Unlimited
<b>Days 151 and over</b>	Beneficiary responsible for all costs	Unlimited			

**Note:** N/A (not applicable).

**Source:** Centers for Medicare & Medicaid Services 2019c.

All private drug plans, including Part D PDPs and MA–PDs, must follow a standard coverage benefit structure or offer an actuarially equivalent plan, although plan sponsors may also offer enhanced benefit plans in addition to a standard PDP. Of the PDP enrollees in 2018, almost none were in a standard plan, 60 percent of PDP enrollees were in an actuarially equivalent plan, and 40 percent were in an enhanced plan (Medicare Payment Advisory Commission 2019b). In 2020, all PDPs are offering an alternative benefit design (Cubanski and Damico 2019). The standard Part D plan cost-sharing is shown in **Table A-2**. Previously, beneficiaries were exposed to a coverage gap called the “doughnut hole,” but in 2020 that has closed and beneficiaries are responsible for a 25% coinsurance during the former coverage gap phase (Cubanski and Damico 2019).

**Table A-2. Medicare Part D Standard Benefit, 2020**

Benefit phase	Total drug costs	Cost-sharing requirements		Total beneficiary out-of-pocket spending
Deductible period	\$0–435	Enrollees: 100%		\$435
Initial coverage period	\$435–4,020	Enrollees: 25% Plans: 75%		\$435–1,005*
Former coverage gap	\$4,020.00–9,719.38	<b>Brand Name</b> Manufacturer discount: 70% Enrollees: 25% Plans: 5%	<b>Generic</b> Enrollees: 25% Plans: 75%	\$1,005–6,350
Catastrophic coverage	\$9,719.38+	Enrollees: 5% Plans: 15% Medicare: 80%		\$6,350+

**Notes:** \*Maximum an individual would pay in a plan with no deductible.

**Source:** Centers for Medicare & Medicaid Services 2019d.

## Supplemental Coverage

Traditional Medicare has gaps in covered benefits, including long-term services and supports and dental, vision, and hearing services. Beneficiaries are at risk of incurring significant OOP costs for covered services as well. Approximately 81 percent of traditional Medicare enrollees have some form of supplemental coverage (Cubanski et al. 2018). Approximately one in five beneficiaries is fully “dually eligible,” qualifying for Medicaid coverage in their state, which covers cost sharing, the premium for Part B, and provides benefits not covered under Medicare. Many people with low incomes who do not qualify for Medicaid in their states may still qualify for cost-sharing assistance that reduces or eliminates their OOP costs, thereby reducing potential cost-related barriers to accessing services.

Many beneficiaries have private supplemental coverage either through a former employer or private Medigap policies that may fully or partially cover Part A and Part B cost-sharing requirements. Employer-sponsored insurance (ESI) coverage provides supplemental coverage to approximately 30 percent of Medicare beneficiaries (Cubanski et al. 2018). In 2019, only 28 percent of all large firms (200 or more workers) that offered ESI coverage to current employees also offered retiree health benefits (Claxton et al. 2019). The availability of retiree coverage differs by firms’ characteristics: Firms offering ESI benefits are more

likely to offer retiree health benefits if they have at least some union workers, a larger share of high-income workers, or a larger share of older workers (Claxton et al. 2019). Of these firms, 91 percent offered health benefits for early retirees (individuals retiring before the age of 65), and 61 percent offered health benefits to individuals ages 65 and older in 2019 (Claxton et al. 2019).

Approximately 29 percent of traditional Medicare beneficiaries in 2016 were enrolled in Medicare supplemental insurance plans to pay health costs not covered by Medicare, popularly known as Medigap (Cubanski et al. 2018). The benefits offered by these plans are standardized by the Centers for Medicare & Medicaid Services, but significant variation occurs in the operation of Medigap marketplaces across states. Beneficiaries are eligible to enroll in a Medigap plan during their open enrollment period (the first six months of their enrollment in Part B). During this open enrollment period, Medigap coverage must be offered on a guaranteed-issue basis, meaning Medigap insurers cannot deny a policy to any applicant based on age, gender, or health status. In addition, for Medigap coverage purchased during the open enrollment period, premiums cannot vary by health status. Most states allow Medigap insurers to practice medical underwriting outside of this open enrollment period and deny coverage or charge higher premiums to beneficiaries with preexisting conditions. Federal law does not require Medigap insurers to sell policies to beneficiaries who qualify for Medicare based on long-term disability or to any beneficiaries switching from a Medicare Advantage plan to traditional Medicare during the annual open enrollment period. States have the flexibility to go beyond these minimum standards for Medigap policies (Boccuti et al. 2018).

Medicare coordinates benefit coverage with other coverage sources. While in some circumstances, Medicare is the secondary payer, in most instances, Medicare is the primary payer, with any supplemental coverage providing secondary, wraparound coverage. The Medicare Secondary Payer provisions specify that Medicare is the primary payer for beneficiaries with supplemental coverage through a group health insurance plan under the following conditions: for individuals 65 years or older enrolled in a group health plan through an employer with fewer than 20 employees; for persons with a disability who are younger than 65 enrolled in a plan through an employer with fewer than 100 employees; and for people 65 years or older with retiree coverage through a former employer. Medicare is the secondary payer for beneficiaries with supplemental coverage from a group health insurance plan for individuals ages 65 and older if the employer has more than 20 employees and for people under the age of 65 with a disability if the employer has 100 employees or more. Medicare is the primary payer for beneficiaries dually covered by Medicare and Medicaid and for individuals with a private Medigap plan (Medicare Learning Network 2019).

## Cost Assistance Programs

Several cost assistance programs currently exist within Medicare. Medicare beneficiaries with low incomes and limited resources may qualify for one of three Medicare Savings Programs to assist with premiums and OOP expenses. The Qualified Medicare Beneficiaries (QMB) program is available to beneficiaries with incomes at or below the federal poverty level (FPL). QMB individuals are entitled to receive assistance for all Medicare Part A and Part B cost-sharing charges (including the Part B premium, all deductibles, and all coinsurance), paid by Medicaid. The Specified Low-Income Medicare Beneficiaries (SLMB) program is available to individuals with income greater than 100 percent but less than 120 percent of FPL. Beneficiaries who qualify for the SLMB program have their Medicare Part B premium paid by Medicaid. The Qualifying Individuals (QI) program is for individuals with income between 120 percent and 135 percent of FPL. As shown in **Table A-3**, Medicaid pays the Medicare Part B premium for these individuals; however, 100 percent of the payment comes from federal government allocations to states. Funds for the QI program come from the Medicare Supplementary Medical Insurance (SMI) Trust Fund (Congressional Research Service 2019a).

**Table A-3. Medicare Savings Programs for Dual-Eligible Beneficiaries, 2019**

Program	Monthly income limit	Asset resources limit	Costs paid by Medicaid
<b>Qualified Medicare Beneficiaries</b>	<100% of FPL Single: \$1,061 Couple: \$1,430	Single: \$7,730 Couple: \$11,600	All Part A and Part B premiums, deductibles, and coinsurance
<b>Specified Low-Income Medicare Beneficiaries</b>	100% to <120% of FPL Single: \$1,061–\$1,269 Couple: \$1,430–\$1,711	Single: \$7,730 Couple: \$11,600	Part B premium
<b>Qualifying Individuals</b>	120% to <135% of FPL Single: \$1,269–\$1,426 Couple: \$1,711–\$1,923	Single: \$7,730 Couple: \$11,600	Part B Premium

**Note:** FPL (federal poverty level).

**Source:** Congressional Research Service 2019a.

Medicare Part D also has cost-sharing and premium assistance programs. Medicare Part D provides low-income subsidies (LIS) to certain beneficiaries with limited incomes and resources to help them pay Part D premiums, cost-sharing amounts, and other OOP expenses. Individuals who receive assistance through an MSP, receive full Medicaid benefits, and/or receive Social Security income cash assistance are eligible for a full LIS. Eligible enrollees have their monthly premium paid up to a certain benchmark plan amount. Individuals with the full LIS also have no deductible, minimal cost sharing during the initial coverage period and during the coverage gap, and no cost sharing above the catastrophic threshold. Individuals with an income below 150 percent of FPL and limited assets may qualify for a partial low-income subsidy. Individuals may receive premium assistance equal to 25 percent to 75 percent of the cost of full LIS premium assistance, determined by an income-based sliding scale (Congressional Research Service 2018).

## **Provider Payments and Participation**

The traditional Medicare program acts as a third-party payer, establishing fees for a variety of providers including hospitals, physicians, skilled nursing facilities, and home health care workers, through formulas prescribed in law and regulation.

Under Part A, Medicare pays acute care hospitals through the inpatient prospective payment system (IPPS). The IPPS determines a uniform, national prospective amount paid for every discharge based on the diagnosis associated with the inpatient stay. Components of this amount include a discharge payment weighted by the Medicare severity–diagnosis related group to reflect the relative costliness of the average patient in each group. This amount is adjusted (a) by a wage index based on the location and the classification of the hospital, (b) for graduate medical education, and (c) whether the provider is a disproportionate share hospital that provides a certain volume of services to low-income patients. IPPS payments may also be altered to reflect quality-related program measures (Congressional Research Service 2019b). Medicare Part B pays hospitals a predetermined amount per outpatient service through the outpatient prospective payment system (OPPS). Each outpatient service is assigned to an ambulatory payment classification group weighted by relative cost and converted to dollars. Virtually all hospitals accept Medicare payments for their services, and in 2017, the Medicare FFS program paid 4,700 hospitals \$190 billion for covered services (Medicare Payment Advisory Commission 2019b).

Physician, nonphysician practitioner, and therapist services in Part B receive payment under the Medicare physician fee schedule, which includes over 7,000 services codes. Payments to physicians are adjusted based on relative values that reflect physician work and practice expenses, as well as geographic variations in costs. These values are converted to dollars using a national conversion factor updated annually.



Payments are also adjusted if the provider is enrolled in the Merit-based Incentive Payment System or participates in an alternative payment model (APMs) under the Quality Payment Program. Payment reform efforts have driven the shift from traditional FFS payments to APMs and risk bearing by providers, including bundled payments, accountable care organizations, and medical home models (Congressional Research Service 2019b).

Physicians and some nonphysician practitioners have options for participating in the program and accepting Medicare payment methods and rates. Physicians and some practitioners who “accept Medicare assignment” agree to accept the Medicare rate as the full payment for services and may bill a patient only for the coinsurance amount and the amount of any unmet deductible. Physicians who accept all Medicare assignments in a given year are considered “participating physicians,” and physicians who do not accept Medicare assignments on all claims for services are considered “nonparticipating physicians.” Nonparticipating physicians receive a 5 percent lower payment for the specific claims for which they accept Medicare assignment and are able to charge beneficiaries the difference between that amount and up to 109.25 percent of the Medicare fee schedule amount for that service (Medicare Payment Advisory Commission 2019b). Physicians and some nonphysician practitioners may also choose to completely “opt out” of Medicare and not accept Medicare assignment for any services and are free to enter into private contracts with patients; however, this is a very small percentage. Opt-out physicians and nonphysician practitioners are largely concentrated in the specialties of dentistry and behavioral health

(including psychiatry) (Medicare Payment Advisory Commission 2019b). Assignment is mandatory for some types of providers, including physician assistants, nurse practitioners, and clinical social workers (Congressional Research Service 2019b). In 2018, 96 percent of the physicians and nonphysician practitioners billing Medicare were participating providers (Medicare Payment Advisory Commission 2019b). Private commercial insurance plans tend to pay physicians using an FFS system similar to traditional Medicare, but on average, traditional Medicare pays providers less than commercial insurance, although this difference varies significantly by service type, region, provider specialty, and level of provider consolidation (Pelech 2018). MA plans typically pay physicians rates similar to those of traditional Medicare, likely due to regulations that cap out-of-network MA prices at Medicare FFS prices (Pelech 2018). In 2017, Medicare's payment rates for physician and other health professional services were, on average, 75 percent of commercial rates paid by preferred provider organizations, with significant variation in payment by type of service (Medicare Payment Advisory Commission 2019b).

Traditional Medicare also pays lower rates to hospitals than private commercial insurance does. The Congressional Budget Office (CBO) concluded that, on average, commercial rates for inpatient services were 89 percent greater than Medicare FFS rates and varied significantly across and within metropolitan areas (Maeda and Nelson 2017). Medicare FFS pays hospitals approximately 86.8 percent of their estimated average costs, while private payers pay hospitals 114.8 percent of their average costs (American Hospital Association 2018). The difference between Medicare FFS and commercial insurance payments to hospitals varies significantly based on geography, type of service, and level of hospital consolidation. Hospital consolidation and overall hospital market power are significant sources of this variation, where stronger market power allows hospitals to negotiate higher payment rates from private payers (Stensland, Gaumer, and Miller 2010).

## Financing Structure

The primary source of funding for Part A is a payroll tax contribution of 1.45 percent on both employers and employees, with self-employed workers paying the full 2.9 percent. The tax revenues are added to the Hospital Insurance (HI) Trust Fund along with interest on federal securities held by the trust fund, federal income taxes paid on Social Security benefits, and premiums paid by enrollees not entitled to premium-free Part A. In 2018, total revenue accrued by the HI Trust Fund was \$306.6 billion, total expenditures accounted for \$308.2 billion, and the HI assets (compiled surpluses from previous years) were reduced by \$1.6 billion. The assets were \$200.4 billion at the beginning of 2019, which represents about 62 percent of expenditures. The HI assets are expected to be depleted in 2026, at

which point Medicare revenues will cover 89 percent of expenditures (in 2026), declining to 77 percent by 2046, and rising to 83 percent by 2093 (Centers for Medicare & Medicaid Services 2019a).

Part B benefits are financed through the SMI Trust Fund and are not at risk of insolvency because financing is derived through beneficiary premiums with general revenues filling the gap. Beneficiary premiums are set to finance 25 percent of expected program costs. Total revenue for the SMI Trust Fund in 2018 was \$353.7 billion, and total expenditures were \$337.2 billion, adding \$16.5 billion to the SMI assets, which totaled \$96.3 billion at the end of 2018. Payments and spending under MA (Part C) are set based on spending in traditional Medicare and are taken from the HI and SMI Trust Funds (Centers for Medicare & Medicaid Services 2019a).

Medicare Part D is also financed through federal general revenues and beneficiary premiums. Beneficiary premiums are set to cover, on average, 25.5 percent of the cost of a standard Part D plan. Additional revenue comes from state “clawback” payments, which reflect a portion of the amounts that state Medicaid programs would otherwise have had to pay for dual-eligible enrollees’ drug coverage. Part D revenues are included in a separate account within the SMI Trust Fund. In 2018, total Part D expenditures were approximately \$95.2 billion, and revenues were \$95.4 billion (Centers for Medicare & Medicaid Services 2019a).

## **Governance and Administrative Structure**

The Department of Health and Human Services’ (HHS’s) Centers for Medicare & Medicaid Services (CMS) administers the Medicare program, with centralized decision-making, through a network of regional offices and private administrative contractors. Additionally, CMS contracts with private companies for administrative services, including claims adjudication, appeals from beneficiaries and providers, fraud detection, and a range of other services. Congress determines key features of the program, including changes in provider payment methodologies and levels. HHS promulgates detailed regulations to implement these congressional policies. In addition, Congress conducts oversight of the Medicare program through various committees including the Ways and Means Committee and the Energy and Commerce Committee in the House and the Finance Committee and the Health, Education, Labor and Pensions Committee in the Senate. Congress receives regular reports with recommendations regarding access to care and payment updates through the Medicare Payment Advisory Commission, as well as information and analysis from congressional bodies with a broader focus, including the Congressional Budget Office.

# *Appendix B*

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## **Health Condition–Based Expansion**

Of the roughly 60 million Medicare beneficiaries, nearly 9 million (about 15 percent) are people under 65 with a long-term disability or a qualifying health condition (Centers for Medicare & Medicaid Services 2019a). Persons under the age of 65 who have received Social Security Disability Insurance (SSDI) benefits for at least 24 months are automatically enrolled in Medicare and are entitled to premium-free Part A benefits. The waiting period is waived for individuals who have qualified for SSDI due to amyotrophic lateral sclerosis (ALS). Individuals diagnosed with end-stage renal disease (ESRD) are eligible for Medicare without having to first receive SSDI benefits. In addition, individuals who were diagnosed with a specific lung disease or type of cancer and lived in an area subject to a public health emergency declaration by the Environmental Protection Agency for a specified period before diagnosis are entitled to Part A benefits and eligible to enroll in Part B.

Proposals in the 116th Congress would extend Medicare eligibility based on additional health conditions. For instance, proposals would waive the 24-month enrollment waiting period for SSDI recipients who are diagnosed with Huntington’s disease or metastatic breast cancer. In addition, other bills propose eliminating the 24-month waiting period for all SSDI recipients (Dale and Verdier 2003).

Extending Medicare eligibility on the basis of additional health conditions or eliminating the waiting period for individuals receiving SSDI would make coverage and care more affordable for many of the newly eligible, especially individuals who lack health coverage and individuals in plans with significant cost-sharing requirements (Hamel et al. 2016). The impact would vary from individual to individual, depending on their prior coverage. These individuals would not necessarily have access to affordable Medigap supplemental insurance to defray traditional Medicare’s cost sharing because federal law does not protect Medicare beneficiaries under 65 against discriminatory treatment by issuers of Medigap policies.

Identifying which health conditions should qualify for expansion is a politically fraught challenge. People with ALS and ESRD were granted Medicare coverage

due to the catastrophically high costs of their treatment and their urgent need for health insurance coverage, as well as the relatively small shares of the population with these conditions. However, many health conditions can lead to catastrophic health care costs and/or medical bankruptcy, including various types of cancer, autoimmune diseases, and heart disease (Hamel et al. 2016). Although some health conditions might warrant an extension on such grounds, how to determine which conditions to cover is not a clear-cut exercise.

The costs to the Medicare program and the impact on current beneficiaries depend on the particular health condition(s) chosen for the eligibility expansion, the average treatment costs for the condition, and the number of individuals who newly qualify. Although ESRD patients make up about 1 percent of Medicare enrollment, treatment for the ESRD population accounts for 7 percent of Medicare spending (Kirchhoff 2018). In 2013, Medicare spent \$61,996 per ESRD beneficiary, compared to \$9,889 per non-ESRD beneficiary (Kirchhoff 2018). Adding another relatively high-cost group to the Medicare program would increase the relative cost of the risk pool and increase overall and average per capita Medicare spending, which could lead to increased Part A and Part B premiums and create a need for additional program financing. Eliminating the waiting period for all SSDI beneficiaries to qualify for Medicare would further increase costs in ways that might be more or less costly than extending eligibility to a limited number of health conditions. In 2007, 1.8 million SSDI beneficiaries were in the 24-month waiting period, and the Congressional Budget Office estimated that eliminating the waiting period entirely would increase costs to the federal government by \$6.8 billion in the first year (estimated on the presumption of starting in 2011), increasing total spending by about 1 percent, and \$110 billion from 2011 through 2019 (Guterman and Drake 2009).

Employers and state Medicaid programs could see savings due to a shift of persons with high-cost conditions to the Medicare program. Such savings would depend on the size of the newly eligible population and the application of secondary payer laws. For example, for people with ESRD who have current employer-sponsored coverage and enroll in Medicare, the group health plan is the primary payer for the first 30 months of enrollment, and then Medicare becomes the primary payer. For the ALS population, the group health plan is primary if it covers over 100 employees; otherwise, Medicare is the primary payer (Kirchhoff 2018; Medicare Learning Network 2019). Policymakers would need to decide whether the secondary payer rules for any new qualifying health conditions would be more akin to the ESRD or the ALS secondary payer rules. If employers are subject to the ESRD secondary payer rule, then employers would not see savings until after 30 months, but if it were structured similarly to the ALS secondary payer rule, small employers (less than 100 employees) would see

savings, while large employers (more than 100 employees) would not. Medicaid is the secondary payer for both individuals with ESRD and ALS who are dually eligible; state Medicaid programs would likely experience savings if primary coverage of individuals with expensive health conditions were shifted from Medicaid to Medicare (Medicare Learning Network 2019). In addition, shifting individuals with high-cost conditions from the individual market to Medicare could reduce premiums in the individual market.



## *Appendix C*

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# Raising the Age of Eligibility

Over the last decade, a variety of House Republican federal budget proposals advanced the idea of raising the age of eligibility for Medicare. Former Speaker of the House Paul Ryan’s “A Better Way: Our Vision for a Confident America” would have gradually raised the age of Medicare eligibility from 65 to 67. The House Budget Committee’s fiscal year 2019 budget resolution incorporated this same concept (Kaiser Family Foundation 2017).

Proposals to raise the age of Medicare eligibility aim to curb federal spending on Medicare, thereby reducing the federal deficit and improving the solvency of the Health Insurance Trust Fund rather than to reduce system-wide costs or contain cost growth (Jacobson 2014). Many of these proposals would gradually delay eligibility to age 67, eventually aligning it with Social Security’s current-law full retirement age for individuals born in 1960 or later. Other proposals would raise the eligibility age to 70 on the grounds that such a change would reflect gains in average life expectancy and would reduce the average number of years individuals are covered by the program, similar to the rationale often put forward for increasing Social Security’s full retirement age (Congressional Budget Office 2018).

According to estimates by the Congressional Budget Office (CBO), gradually raising the eligibility age from 65 by three months each year until it reaches age 67 would decrease federal spending on Medicare by 2.5 percent over the next two decades (Congressional Budget Office 2018). The net impact on federal spending would be smaller, however, primarily because higher federal spending for Medicaid and subsidies for insurance obtained through the Affordable Care Act of 2010 (ACA) exchanges would offset about three-fifths of the Medicare savings—assuming Congress expands eligibility for Medicaid and the ACA individual exchanges for the 65- to 67-year-old population. For example, net federal spending would decline by \$22 billion between 2023 and 2028, compared to a \$60 billion decrease in Medicare spending.

Increasing the Medicare eligibility age would affect other forms of health coverage and their respective stakeholders. CBO estimates that about 45 percent of people in the 65- to 67-year-old population would obtain insurance from their



own or a spouse's employer or former employer. This increase would directly affect (a) small employers (with fewer than 20 employees), which are exempt from the Medicare Secondary Payer rules for health coverage they offer; and (b) employers and other group health plans that offer pre-Medicare age retiree health coverage. Small-employer health plans would become the primary payer for active employees ages 65 and 66 and their covered spouses and children, increasing the overall cost of those plans. Sponsors of pre-Medicare retiree plans would be faced with choices about how to restructure this coverage, including whether to extend the offer of coverage to individuals ages 65 and 66 and how to pay for the sponsor's premium share. For plans expanding the offer of coverage and increasing the overall retiree health care liability, employers subject to public financial reporting requirements would report increases in the present value of their liability for post-retirement benefit obligations.

CBO estimates that 20 percent of 65- and 66-year-olds would move into or remain in the individual market (Congressional Budget Office 2018). The impact of raising the age of eligibility on national health expenditures overall is unclear because the savings to the federal government could be offset by increases in state spending on Medicaid and increases in private insurance spending, including employer spending and beneficiary out-of-pocket (OOP) spending (Congressional Budget Office 2018).

Raising the age would likely cause a significant increase in uninsurance among 65- and 66-year-olds, despite its modest impact on coverage population-wide. Although individuals may have other means to obtain insurance, an estimated 15 percent of the affected population would become uninsured (Arno 2017; Congressional Budget Office 2018). The Actuarial Research Corporation estimates that raising the age would increase uninsurance among 65- and 66-year-olds from about 2 percent to 18.7 percent and leave 1.9 million more individuals without health insurance (Arno 2017). Individuals at 67 who became uninsured would be more likely to forgo needed medical care, receive emergency care (for which providers are uncompensated), and have worse health when enrolling in Medicare (which would increase financial demand on the program (Arno 2017). A majority of 65- and 66-year-olds would likely end up paying more in premiums and OOP expenses with their alternative sources of coverage than they would have with Medicare, but some may end up paying less if they qualify for Medicaid or subsidies for ACA individual market coverage (Neuman et al. 2011). Additionally, delaying the entrance of relatively healthier, younger, and lower-cost beneficiaries may increase Medicare Part B premiums and raise costs for remaining beneficiaries (Neuman et al. 2011). This option could also exacerbate health inequities. For instance, black individuals have higher Medicare expenditures than white Americans from ages 65 to 67, and raising the age would likely have more negative health and economic effects for black persons (Yang, Huang, and Phillips 2014).



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