

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-04)  
Eligibility Age for Medicare Beneficiaries  
(December 2004)

EXECUTIVE SUMMARY

Council on Medical Service Report 1 responds to Substitute Resolution 711 (I-03), which calls on the AMA to “evaluate implications of any incremental changes to the Medicare eligibility age for the purpose of cost savings.” The resolution further states that “this evaluation should consider the impact that these changes may have on vulnerable populations with severe health disparities and lower than average life expectancy.”

This informational report provides an overview of current health insurance options available to older adults, and the primary options being discussed regarding changes to the Medicare eligibility age, specifically: lowering it to age 62; raising it to age 67; and creating buy-in options for individuals who are not yet age-eligible.

The majority of older adults who are not yet eligible for Medicare access health insurance through employers, or through the individual, non-group market. Approximately 37% of adults ages 62 – 64 receive coverage through current employers, and an additional 28% receive coverage from former employers. Although many early retirees rely on retiree health benefits offered by their former employers, there is evidence that companies will continue to increase cost sharing requirements for retirees or eliminate retiree coverage all together. Individuals who obtain coverage through the individual market may find it difficult to secure coverage that is both affordable and comprehensive, and some remain underinsured because of preexisting conditions or financial limitations.

Changes in the Medicare eligibility age would affect both insurance coverage levels and costs to the Medicare program. Lowering the age would expand coverage, but has been estimated to cost about \$5.4 billion per year, thus adding significant costs to a program already facing solvency problems. Increasing the eligibility age has been projected to result in an 11% reduction in Medicare beneficiaries, but only a 4.3% reduction in program costs, since beneficiaries with higher program utilization rates would probably retain eligibility for the program. Offering a buy-in option could reduce incidence of underinsurance for many older adults, but costly subsidies would be necessary in order to affect underinsurance rates among this group.

On the basis of its study, the Council does not believe that the potential reduction in Medicare spending or increase in health insurance coverage is significant enough to warrant a change in the Medicare eligibility age in the context of the current Medicare system. The Council believes that the Medicare program and financing of health care for retirees must ultimately undergo a fundamental change in order to ensure efficient and fiscally responsible access to medical services. Given the coverage and cost trade-offs associated with a change in the Medicare eligibility age, combined with the political discourse seeking such a change would entail, the Council continues to believe that AMA advocacy would be best directed toward the eventual need to transition from the current Medicare program to a system of privately financed pre-funded savings that can be used for post-retirement medical needs.

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - I-04  
(December 2004)

Subject: Eligibility Age for Medicare Beneficiaries

Presented by: William H. Beeson, MD, Chair

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1 At the 2003 Interim Meeting, the House of Delegates adopted Substitute Resolution 711, which  
2 calls on the AMA to “evaluate implications of any incremental changes to the Medicare eligibility  
3 age for the purpose of cost savings.” The resolution further states that “this evaluation should  
4 consider the impact that these changes may have on vulnerable populations with severe health  
5 disparities and lower than average life expectancy.” The Board of Trustees referred Substitute  
6 Resolution 711 (I-03) to the Council on Medical Service for study, with a report back to the House  
7 at the 2004 Interim Meeting.

8  
9 The original language of Resolution 711 asked that the AMA evaluate the implications of raising  
10 the Medicare eligibility age only. However, testimony suggested that the scope of the resolution be  
11 expanded to include a more comprehensive view of eligibility, including a consideration of  
12 lowering the eligibility age, and evaluating changes in the context of the potential effect on health  
13 disparities.

14  
15 This informational report provides an overview of the primary options being discussed regarding  
16 changes to the Medicare eligibility age, specifically: lowering it to age 62 to match the early  
17 retirement age of Social Security; raising it to match the normal retirement age for Social Security  
18 (67 by 2027); and creating buy-in options for individuals who are not yet age-eligible (e.g.,  
19 beginning at age 55). The report also provides a detailed analysis of the potential effects of these  
20 changes on government spending and health insurance coverage patterns.

### 21 22 BACKGROUND

23  
24 The Medicare program has provided health insurance to virtually all individuals over age 65 since  
25 the program was established in 1965. Although some younger individuals with disabilities also  
26 receive Medicare benefits, approximately 85% of enrollees are over the age of 65. The Medicare  
27 eligibility age was originally set at 65 to match the “normal” retirement age for receiving Social  
28 Security benefits. However, in 1983, Congress passed legislation to phase in an increase in the  
29 Social Security retirement age from 65 to 67, with the phase-in set to begin in 2003 and be  
30 completed by 2027. The rationale for this change was that due to overall improving health  
31 conditions and increasing life expectancies, seniors could continue in the workforce longer while  
32 still enjoying the same number of years in retirement.

33  
34 As reported in Council on Medical Service Report 5 (I-03), the long-term financing and benefits  
35 structure of the Medicare program is unsustainable. The ratio of workers contributing payroll taxes  
36 to the number of beneficiaries will decline steadily as “baby boomers” become eligible for  
37 Medicare, life expectancy continues to improve, and future birth rates stay at levels similar to that  
38 of the last two decades. In addition, the projections for Medicare, under current law, manifest

1 mounting pressure on the federal budget beginning in a decade, trust fund exhaustion in little more  
2 than two decades, and unsustainable long-term growth in costs.

3  
4 The Medicare eligibility age has been the focus of attention for various reasons in recent years. In  
5 light of Medicare's financial pressures, proposals have surfaced to increase the eligibility age as a  
6 way of reducing costs and updating the program to reflect demographic trends. However, others  
7 have looked to Medicare as a means of securing health care coverage for older individuals under  
8 age 65, which, while inevitably increasing program costs, would also fill a gap in the insurance  
9 market that is likely to increase as the baby boomers age.

#### 10 11 THE URBAN INSTITUTE REPORT

12  
13 In December 2003, The Urban Institute published a report by Richard W. Johnson entitled,  
14 "Changing the Age of Medicare Eligibility: Implications for Older Adults, Employers and the  
15 Government." The report provides a comprehensive overview of the current literature addressing  
16 the potential effects of changing the Medicare eligibility age or of offering buy-in options, both  
17 with and without subsidies. The Council on Medical Service found this report to provide an  
18 excellent analysis of the potential impact of adjustments in the eligibility age by examining  
19 potential changes in insurance coverage patterns, workforce participation, and government  
20 spending. Many of the proposed options highlighted in this report are addressed in more detail in  
21 the Urban Institute report.

#### 22 23 HEALTH INSURANCE COVERAGE OPTIONS FOR OLDER AMERICANS

24  
25 Any change in the Medicare eligibility age will have implications for health care coverage for older  
26 adults. Coverage issues currently experienced by pre-Medicare eligible adults are likely to be  
27 replicated among individuals who would lose coverage if the eligibility age were increased. Older  
28 adults are at a unique transition point where they are likely to be withdrawing from the workforce,  
29 adjusting to more limited income levels, and experiencing increasing health concerns (Government  
30 Accounting Office, June 1998). Each of these factors presents unique challenges in addressing  
31 their health insurance needs.

32  
33 Although uninsurance rates are slightly lower for the pre-Medicare population than for other  
34 groups of adults, the consequences of delaying or forgoing medical care become more serious as  
35 one gets older (Johnson, 2003). The 55 – 64 age group is one of the fastest growing segments of  
36 the population, due to the aging of the Baby Boom generation, all of whom will reach age 55 by  
37 2020. There is some concern that as this population ages, the limitations on insurance options for  
38 older adults will become even more acute, and that uninsurance rates among this group will  
39 increase unless alternative coverage options are identified.

#### 40 41 Employer-Based Coverage

42  
43 Sixty-three percent of Americans under age 65 obtain their health insurance through the workplace  
44 (Center for Studying Health System Change, August 2004). Between the ages of 51 and 64, the  
45 percentage of individuals receiving benefits through current employers falls significantly,  
46 underscoring the fact that retirement rates in the pre-Medicare eligible years increase as individuals  
47 approach age 65. In 1998, approximately 37% of adults ages 62 - 64 received health insurance

1 coverage through current employers, and an additional 28% received coverage through former  
2 employers (Johnson, 2003).

3  
4 Coverage through former employers is available under provisions of the Consolidated Omnibus  
5 Budget Reconciliation Act of 1985 (COBRA), or through retiree health insurance, offered  
6 voluntarily by some employers. Under COBRA, employers with 20 or more employees must  
7 provide continuation coverage to former workers for up to 18 months (29 months if the worker is  
8 disabled). Although COBRA allows former employees to access health insurance at group rates,  
9 and without individual risk assessment, it can be relatively expensive because individuals are  
10 responsible for the full cost of premiums, plus an administrative fee. In addition, once COBRA  
11 benefits are exhausted, retirees under 65 still must find alternative means of coverage, or risk being  
12 uninsured. This is particularly problematic for individuals forced to stop working due to chronic  
13 illness. Although they may ultimately be eligible for Medicare because of a disability, they often  
14 exhaust COBRA coverage before reaching the two-year waiting period between collecting Social  
15 Security Disability Insurance and becoming eligible for Medicare.

16  
17 One of the most significant trends that may affect health insurance coverage rates for older adults is  
18 the shrinking number of companies offering health benefits to retirees, citing increased costs  
19 associated with retiree health obligations (Kaiser/Hewitt, 2004). In 1988, two-thirds of companies  
20 offered retiree health coverage, compared with only 38% in 2003 (Schur, *Health Affairs*, 2004).  
21 Furthermore, according to a 2003 study conducted by the Kaiser Family Foundation and Hewitt  
22 Associates, 20% of large firms surveyed indicated that it is very or somewhat likely that they will  
23 eliminate health benefits for future retirees within the next three years (Kaiser/Hewitt, 2004).  
24 Among companies that do offer retiree health insurance, a significant portion of the costs are being  
25 shifted to the retirees. Of the firms surveyed in the Kaiser/Hewitt study, 71% reported having  
26 increased retiree contributions to premiums in the past year, and 53% increased cost sharing  
27 requirements. Increasing premium and cost sharing obligations could make retiree health coverage  
28 unaffordable for some individuals. The Medicare Prescription Drug, Improvement and  
29 Modernization Act of 2003 (P.L. 108-173) provides incentives for companies to continue providing  
30 retiree health benefits, but it is unclear how companies will respond to these incentives.

### 31 32 Public Sources of Insurance

33  
34 Public sources of health insurance are limited for most older adults not yet eligible for Medicare.  
35 Americans under age 65 can access Medicare or Medicaid only if they are blind or disabled. They  
36 also can qualify for Medicaid if they meet income and asset restrictions. Many pre-Medicare  
37 eligible adults have incomes too high to qualify for public programs, but face paying a large  
38 percentage of their income in order to obtain individual health insurance coverage, or even to take  
39 advantage of retiree health insurance or COBRA benefits.

### 40 41 Private-Sector, Non-Group Coverage

42  
43 Adults who lack employer-related coverage generally turn to the individual market for insurance  
44 coverage. Older adults rely much more heavily on the individual insurance market than do other  
45 age groups. A primary reason for this is that older people begin to experience more health  
46 problems and, therefore, are less willing to risk being uninsured (Johnson, 2003). However, older  
47 adults also face significant obstacles to securing affordable and comprehensive private insurance.

1 As with other age groups, coverage in the individual market may be difficult to obtain for those  
2 with preexisting health conditions. For older people, these limitations are exacerbated; risk related  
3 premiums can be extremely high because older people tend to have more illnesses and utilize more  
4 health services. Data from the 1998 Health and Retirement Survey indicate that approximately  
5 14% of Americans ages 55 – 64 have restrictions on their individual insurance policies because of  
6 preexisting conditions (Johnson, 2003).

7  
8 Many older adults find themselves underinsured, having chosen policies with high deductibles and  
9 extremely limited benefits as a way of keeping premiums affordable. Still others are unable to find  
10 coverage at any price, because coverage is often denied to people with problems commonly  
11 associated with old age, such as arthritis, cardiovascular disease, or renal disease (Chollet and Kirk,  
12 1998).

#### 13 14 Health Insurance Coverage for Vulnerable Populations

15  
16 Among the 55 – 64 age group, disproportionate shares of the uninsured have low incomes and  
17 health problems. In 1998, 28% of older adults with incomes below the federal poverty level were  
18 uninsured. By comparison, only 4% of those with family incomes over 400% of the poverty level  
19 were uninsured (Johnson, 2003). Low income individuals are less likely to have access to  
20 employer-sponsored benefits, and although some receive coverage through Medicare or Medicaid,  
21 the majority must obtain private, non-group insurance, or remain uninsured.

22  
23 Of particular concern is the large number of older adults who are in poor health and lack health  
24 insurance. Fourteen percent of individuals reporting fair or poor health were uninsured in 1998,  
25 versus only 7% of those who said they were in excellent or very good health (Johnson, 2003).  
26 Similar to those with low incomes, individuals in poor health are less likely to have access to  
27 employer health benefits than those in good health; therefore they must rely on public programs or  
28 the individual market in order to obtain coverage. Public programs insure 29% of those in fair or  
29 poor health. Not surprisingly, the private, non-group market accounts for only 5% of the coverage  
30 of this group. Poor health exacerbates problems with securing individual coverage, including  
31 making premiums unaffordable and limiting coverage options due to health status.

32  
33 Among all uninsured older adults, 22% report having both low incomes and health problems  
34 (Johnson, 2003). Since poorer health translates into higher health insurance premiums, or  
35 unavailability of coverage at any price, low income people are especially vulnerable to being  
36 uninsured because they simply cannot afford private health insurance.

#### 37 38 LOWERING THE MEDICARE ELIGIBILITY AGE

39  
40 Most proposals to lower the Medicare eligibility age expand access to individuals beginning at age  
41 62, the age at which people are eligible to collect reduced Social Security benefits. Studies suggest  
42 that most workers now retire before age 65. In 1965, when Medicare was first established, only  
43 41% of people began collecting Social Security before they reached 65. By 1999, the percentage  
44 had increased to 75%, more than half of whom began collecting benefits at age 62 (U.S. House of  
45 Representatives, 2000). Since health insurance coverage is closely tied to employment, the  
46 potential for change in employment conditions or status for the pre-Medicare eligible population  
47 puts this group at particular risk for becoming uninsured, especially since they may experience

1 increasing health problems that make it difficult and expensive to obtain adequate coverage in the  
2 individual market.

3  
4 Advocates of lowering the Medicare eligibility age support the change as a way of ensuring health  
5 insurance coverage for the pre-Medicare eligible population. Opponents point to the solvency  
6 problems already facing the Medicare program under the current eligibility structure.

7  
8 Projected Impact on Insurance Coverage of Older Americans

9  
10 Extending Medicare benefits to all individuals at age 62 would virtually eliminate incidence of  
11 uninsurance in those ages 62 – 64, and would offer security and stability for many older adults who  
12 rely primarily on the private, non-group health insurance market. Although many people in this  
13 age group still benefit from employer coverage, or choose to allocate significant resources to  
14 securing private coverage, many people who need health care services the most are unable to  
15 secure them because of income or health status. In addition, many of those individuals who  
16 currently obtain coverage through the private market are likely to be underinsured, either because  
17 of certain coverage exclusions or because they choose less expensive plans which only provide  
18 minimum levels of coverage.

19  
20 Projected Impact on the Medicare Budget

21  
22 Extending Medicare benefits to those ages 62 – 64 has been estimated to cost about \$5.4 billion per  
23 year (Johnson, 2003), thus adding significant costs to a program already facing solvency problems.  
24 In addition, making health insurance available through Medicare at an earlier age could encourage  
25 more people to retire earlier, which would further reduce the tax base on which Medicare and other  
26 federal programs rely. Johnson, Davidoff, and Perese (2003) estimate that lowering the Medicare  
27 eligibility age to 62 would result in a 7% increase in retirement rates.

28  
29 Some have suggested that lowering the Medicare eligibility age would allow some older adults to  
30 receive medical services that would preclude later treatment of expensive acute illnesses, thus  
31 ultimately reducing per capita costs in the Medicare program. The Council did not find, however,  
32 any specific references to this level of potential cost savings. Accordingly, it seems questionable  
33 that any savings in this area would be sufficient to offset the additional costs of expanding the  
34 program.

35  
36 Because of the potentially large increase in expenditures associated with lowering the Medicare  
37 eligibility age, this option has generally been proposed within the context of creating a buy-in  
38 option for pre-Medicare eligible adults. This option will be addressed later in this report.

39  
40 RAISING THE MEDICARE ELIGIBILITY AGE

41  
42 Increasing the Medicare eligibility age to 67 would reduce program costs by eliminating coverage  
43 for some individuals between ages 65 and 67. In addition, it could encourage some seniors to delay  
44 retirement and stay in the workforce in order to continue to receive health benefits provided by  
45 their employers. This would help address some of the financing issues associated with Medicare  
46 (and other government programs), as those delaying retirement would be contributing to the tax  
47 base and gaining additional years to accumulate private savings, therefore reducing reliance on  
48 public programs.

1 Various attempts have been made by Congress to realign the Medicare eligibility age with the  
2 Social Security retirement age. In 1997, the Senate voted to increase the Medicare eligibility age to  
3 67 as part of the Balanced Budget Act of 1997, but the provision failed in the House of  
4 Representatives and was removed before the Act became law. Similarly, in 1999, the National  
5 Bipartisan Commission on the Future of Medicare recommended increasing the age to 67, again  
6 with the primary rationale that people are in better health and living longer than when the Medicare  
7 program was originally established.

8  
9 Supporters of an increase in the Medicare eligibility age argue that it is appropriate because it  
10 reflects demographic trends related to improved health status of older people and increased life  
11 expectancies. Opponents argue that it would put more older Americans at risk for being under- or  
12 uninsured, since coverage options for this group are limited.

#### 13 14 Projected Impact on Insurance Coverage of Older Americans

15  
16 Amy Davidoff and Richard Johnson of The Urban Institute developed a detailed microsimulation  
17 model to estimate the effects of raising the Medicare eligibility age to 67 (Davidoff and Johnson,  
18 *Health Affairs*, 2003). According to their model, raising the eligibility age would leave  
19 approximately 9% of the 65 – 66 year old age group uninsured (which is the current rate of  
20 uninsurance among individuals ages 62 – 64). The remaining 91% of the population would access  
21 insurance in various ways.

22  
23 According to Davidoff and Johnson's estimates, 52% of 65 – 66-year-olds who would lose  
24 Medicare coverage would secure alternative coverage through current employers or through  
25 COBRA or retiree health benefits. An increase in the Medicare eligibility age would likely  
26 encourage more workers to delay retirement in order to retain health insurance benefits through the  
27 workplace. However, a risk of increasing the Medicare eligibility age is that the change could  
28 further erode the availability of retiree health insurance, because it would extend the period during  
29 which retiree health insurance would be the sole source of health coverage for retirees, rather than  
30 being a supplement to Medicare. This could increase employer costs significantly, driving even  
31 more companies to increase retiree health insurance cost-sharing or eliminate benefits all together.

32  
33 An estimated 22% of 65 – 66-year-olds would secure non-group coverage if the Medicare  
34 eligibility age were increased. Approximately 23% of current Medicare beneficiaries ages 65 – 66  
35 purchase separate Medigap policies, suggesting the availability of and willingness of individuals to  
36 obtain at least some level of private insurance coverage (Johnson, 2003). However, the cost of  
37 primary non-group coverage would be much greater than a Medigap policy, and by itself would not  
38 likely be as comprehensive as the combined Medicare/Medigap coverage, especially if cost or  
39 preexisting health conditions were issues. Davidoff and Johnson estimate that nearly one-half of  
40 those who would obtain non-group coverage would be underinsured because they would be unable  
41 to afford comprehensive non-group coverage. In addition, as noted earlier, some individuals would  
42 be unable to obtain adequate coverage at any price because of their health status.

43  
44 The remainder of the population would remain covered under public programs. Three percent  
45 would utilize Medicaid-related benefits, and approximately 14% of 65 – 66-year-olds would retain  
46 disability-related Medicare coverage. As noted below, this has important implications for potential  
47 cost savings for the program, since the per-capita costs of individuals retaining Medicare eligibility  
48 would exceed those of individuals who lose coverage (Waidman, *Health Affairs*, 1998).

1 Projected Impact on Insurance Coverage for Vulnerable Populations

2  
3 According to Davidoff and Johnson's simulations, an increase in the Medicare eligibility age  
4 would disproportionately affect ethnic minorities and those with low incomes. Approximately 26%  
5 of blacks and 34% of Hispanics would become uninsured, versus only 6% of non-Hispanic whites.  
6 Similarly, about a quarter of those with incomes below 200% of the poverty level would become  
7 uninsured, versus only 3% of those with high incomes. Lack of insurance did not necessarily  
8 appear to correlate with health status, since high rates of disability coverage would offset lower  
9 rates of private insurance. However, individuals left uninsured by an increase in the Medicare  
10 eligibility age would be less likely to receive health care unless they develop serious health  
11 problems, which could further strain the health care safety-net (Johnson, 2003).

12  
13 Supporters of increasing the Medicare eligibility age note that the increase per se would not  
14 disadvantage vulnerable populations any more than these populations are specifically  
15 disadvantaged by having the eligibility age set at 65. In its justification for recommending an  
16 increase in the eligibility age, the National Bipartisan Commission on the Future of Medicare  
17 explicitly addressed how the change would affect groups with differing life expectancies:

18  
19 It should be noted that at the inception of the Medicare program, a single eligibility age for  
20 all people inherently meant that subgroups that tend to live longer (e.g. white women)  
21 would receive more Medicare benefits than subgroups with lower life-expectancy (e.g.  
22 African-American men). Increasing the eligibility age does not alter that relationship  
23 (National Bipartisan Commission on the Future of Medicare, Feb. 1999).

24  
25 Projected Impact on the Medicare Budget

26  
27 Increasing the automatic eligibility age for Medicare would result in direct savings to the Medicare  
28 program, and would likely generate additional tax revenues for the program as some workers  
29 would be encouraged to delay retirement (retirement rates would be reduced by about 5%)  
30 (Johnson, 2003). However, overall 65 – 66 year old beneficiaries cost the Medicare program less  
31 than two-thirds of the costs of the average beneficiary (Waidman, *Health Affairs*, 1998). As noted  
32 above, a number of 65 – 66 year olds would retain Medicare coverage, either because they already  
33 qualified for disability insurance, or because they would become disabled prior to age 67. This  
34 would mean that the most expensive beneficiaries would retain coverage, thus potentially off-  
35 setting much of the effects of an eligibility age increase even further.

36  
37 A 2000 simulation by The Lewin Group projected that an increase in the eligibility age to 67 would  
38 result in an 11% reduction in Medicare beneficiaries, but only a 4.3% reduction in program costs,  
39 saving \$23.2 billion relative to the 1999 cost projections of the Medicare Trustees (Wittenburg,  
40 2000). These figures are based on a phase-in of the Medicare eligibility age according to the same  
41 schedule as the increase in the Social Security normal retirement age, and account for projected  
42 changes over time in population size and health characteristics, and Medicare expenditures.

43  
44 It should be noted that if an increase in the Medicare eligibility age were scheduled to correspond  
45 with the increase in the Social Security retirement age, this would not substantially affect the  
46 projections of the influence of the baby boomers on the Medicare Trust Fund. Under the Social  
47 Security phase-in schedule, the Medicare eligibility age would not fully rise to 67 until 2027, at  
48 which point most of the baby boomers will have already reached 67 and begun collecting benefits.

1 An increase in the Medicare eligibility age would need to be accelerated if a primary goal were to  
2 alleviate pressure on the Medicare Trust Fund (Johnson, 2003).

3  
4 INCORPORATING A BUY-IN OPTION

5  
6 Expanding Medicare access through a buy-in program would reduce the costs associated with  
7 lowering the automatic Medicare eligibility age, while offering a reliable health insurance option  
8 for older adults who may have difficulty obtaining or paying for coverage. A buy-in option also  
9 could be offered in conjunction with an increase in the Medicare eligibility age, therefore  
10 mitigating the potential loss of coverage by some older adults.

11  
12 Over the years, several proposals have been introduced to offer older Americans the opportunity to  
13 buy-in to Medicare before they reach the current eligibility age. In 1998, President Clinton  
14 proposed a buy-in option that would allow seniors ages 62 to 64 without employer-sponsored  
15 coverage to purchase the same package of benefits as regular Medicare beneficiaries. In addition,  
16 people as young as age 55 could purchase Medicare coverage if they had been laid off from jobs  
17 that provided health insurance and had exhausted their COBRA coverage. Although no action was  
18 ever taken on the Clinton proposal, the concept has resurfaced in bills presented to Congress in  
19 2001, 2002, and 2003. The two most recent bills, introduced in the 108<sup>th</sup> Congress, have not  
20 progressed out of the committees of jurisdiction.

21  
22 Projected Impact on Insurance Coverage of Older Americans

23  
24 The impact of a buy-in on health insurance coverage depends primarily on the cost of the buy-in  
25 relative to other available coverage options. Projections of participation in buy-in programs that  
26 are designed to be “cost neutral” (like the Clinton plan) indicate that the vast majority of  
27 participating individuals would already have private coverage, but would switch to the Medicare  
28 buy-in because it would be less expensive, or because they could secure more comprehensive  
29 coverage, since cost and benefit schedules would not vary based on health status. Since many  
30 older adults find it difficult to obtain coverage that is both affordable and adequate for their health  
31 care needs, many who are able to pay moderate premiums would benefit from buying in to  
32 Medicare (Johnson, Davidoff, and Moon, 2002).

33  
34 Unsubsidized buy-in plans would do little to extend health insurance options to the uninsured.  
35 Another study conducted by The Lewin Group predicted that less than 7% of individuals  
36 participating in a general buy-in plan would have been previously uninsured (Shiels and Chen,  
37 2001). As noted above, disproportionate numbers of uninsured older adults have low income  
38 levels; therefore even moderate premiums associated with a Medicare buy-in would represent a  
39 large percentage of family income (Shiels and Chen, 2001). In order to make a significant impact  
40 on the number of uninsured older adults, a buy-in program would need to be designed with  
41 substantial income-related subsidies.

42  
43 Projected Impact on Medicare Budget

44  
45 While Medicare buy-in plans would cost the Federal government less than expanding the Medicare  
46 program outright, it is unlikely that even the most conservative buy-in plan would, in fact, be “cost  
47 neutral.” The Congressional Budget Office estimated that President Clinton’s original buy-in plan  
48 for adults 62 to 64 would cost about \$300 million per year (Johnson, 2003). In addition, as noted

1 above, the primary beneficiaries of an unsubsidized buy-in program would be previously insured  
2 individuals seeking more affordable and more comprehensive health care coverage. This could  
3 lead to an adverse selection problem, since individuals with health problems will be more inclined  
4 to seek insurance coverage, and would benefit more by enrolling in the Medicare program where  
5 they are not subject to the individual risk rating methods used in the private market (Johnson,  
6 2003).

7  
8 Implementing a buy-in program that would help reduce the number of uninsured older Americans  
9 by providing premium subsidies would be a substantial cost to the government. Clearly the cost  
10 would vary depending on the level of subsidy, but, studies indicate that subsidies would have to be  
11 very generous in order to have a significant impact on insurance levels. As an example, capping  
12 insurance rates at 5% of income would yield a 38% decrease in uninsurance rates. Yet, this level  
13 of subsidy would cost \$2.7 billion annually (Shiels and Chen, 2001).

#### 14 15 RELEVANT AMA POLICY

16  
17 The AMA does not have policy that directly addresses the Medicare eligibility age. However,  
18 there is extensive policy highlighting the need for fundamental changes within the Medicare  
19 program to ensure its long-term viability, including Policies H-165.890, H-165.996, and H-165.987  
20 (AMA Policy Database). Specifically, Policy H-165.987 outlines the AMA's vision for long term  
21 Medicare reform, as follows:

22  
23 The AMA reaffirms its policy that the current Medicare program should be replaced with a  
24 self-funded, private-sector approach to financing health care for the elderly, with equitable  
25 means testing provisions. The AMA supports proposals to shift the funding of Medicare  
26 from the current tax financed pay-as-you-go system to a system of mandatory individually-  
27 owned private savings, with a required minimum contribution, accumulated tax-free and  
28 dedicated to funding post-retirement medical care. The government would provide a  
29 contribution to economically disadvantaged individuals making smaller than average  
30 contributions to their retirement accounts.

#### 31 32 CONCLUSION

33  
34 Proposals that examine changes to the Medicare eligibility age presume that the fundamental  
35 benefits and financing structure of the Medicare program remain unchanged. Any change to the  
36 Medicare eligibility age clearly would have some impact on costs to the federal government and on  
37 health insurance coverage rates among older Americans. The policy goals of a change in either  
38 direction would include easing the financial burden of the Medicare program and ensuring that  
39 older Americans have access to affordable and adequate health care coverage. To some extent  
40 these goals are mutually exclusive, although it may be possible to achieve both marginal cost  
41 savings and marginal increased coverage rates through a combination of increasing the Medicare  
42 eligibility age and offering a buy-in option.

43  
44 The Council on Medical Service is reluctant to perpetuate the flaws in the current system by  
45 utilizing it as a means to expand insurance coverage, and does not believe that substantial cost  
46 savings can be achieved by making modifications targeting a single segment of Medicare  
47 beneficiaries. The Council does not believe that the potential reduction in Medicare spending or

1 increase in health insurance coverage is significant enough to warrant a change in the Medicare  
2 eligibility age in the context of the current Medicare system.  
3  
4 As reflected in current Policy H-165.987 and several recent reports of the Council on Medical  
5 Service (Council on Medical Service Report 5, I-03, and Council on Medical Service Report 9,  
6 A-03), the Council believes that the current Medicare program and financing of health care for  
7 retirees must ultimately undergo a fundamental change in order to ensure efficient and fiscally  
8 responsible access to medical services. Given the coverage and cost trade-offs associated with a  
9 change in the Medicare eligibility age, combined with the political discourse seeking such a change  
10 would entail, the Council continues to believe that AMA advocacy would be best directed toward  
11 the eventual need to transition from the current Medicare program to a system of privately financed  
12 pre-funded savings that can be used for post-retirement medical needs.

References for this report are available from the AMA Division of Socioeconomic Policy  
Development.

Fiscal Note: None