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# Potential Effects Of Raising Medicare's Eligibility Age

A thoughtful analysis of what savings might result from raising the age of Medicare eligibility, and what the downsides might be.

by Timothy A. Waidmann

**ABSTRACT:** Recent fiscal pressures on Medicare and an already enacted increase in Social Security's normal retirement age have generated discussion of raising Medicare's age of entitlement. This DataWatch examines potential impacts of raising Medicare's eligibility age to sixty-seven on public-sector health spending and individual insurance coverage. The proposed increase would affect a substantial fraction of beneficiaries without having a commensurate effect on expenditures, even in the long run. It is estimated that if the eligibility age were sixty-seven, upwards of 500,000 persons ages sixty-five and sixty-six would be left without any insurance, and even more would not be able to afford coverage with benefits similar to those of Medicare.

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**MEDICARE  
REFORM**

THE RECENT FISCAL CRISES in Medicare have led to a search for cost savings derived from a variety of sources. Most proposals have focused either on reducing growth rates in provider payments or on increasing cost sharing by beneficiaries.<sup>1</sup> A potential source of savings that has received less public discussion is a redefinition of entitlement to reduce the number of beneficiaries, although it is often mentioned as a possible option to deal with long-term demographic shifts. In 1995, for example, the Senate considered but quickly dropped a provision that would have raised the age of entitlement to sixty-seven beginning in the year 2000. The Senate passed a similar proposal in 1997, which would have begun in 2002, but the provision was dropped before the legislation went to the president.

The 1983 Social Security program reforms have already raised the normal retirement age from sixty-five to sixty-seven—a change that is being phased in starting in 2003 and will be complete in 2027.<sup>2</sup> The impending retirement of the baby-boom generation and increases in life expectancy both point to the need for the examination of further changes in social insurance programs targeted at the elderly.

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Before engaging in serious consideration of raising Medicare's eligibility age, one must look closely at its potential impacts. This DataWatch examines the potential impacts on Medicare enrollment levels and reimbursements.

## Potential Savings From An Eligibility Age Increase

**Methodology issues.** The simplest way to estimate potential savings to the Medicare program if the eligibility age were raised to sixty-seven is to calculate the fraction of total program costs for services used by persons ages sixty-five and sixty-six. Data from the Medicare Current Beneficiary Survey (MCBS) indicate that of the 36.8 million beneficiaries in 1992, 4.9 million (13 percent) were in that age group. In 1992, \$11.6 billion, or 8.7 percent, of total program costs was spent on this group. From a broader public financing perspective, however, this is not the most appropriate estimate of savings because not all beneficiaries in this age group would likely lose public-sector health benefits under a higher eligibility age. For example, persons receiving Social Security Disability Insurance (SSDI) benefits are entitled to Medicare benefits after a two-year waiting period, regardless of age. Thus, those sixty-five- and sixty-six-year-olds who were originally entitled to Medicare through SSDI most likely would keep Medicare coverage because they would retain their disability status until they became eligible as "retirees." In addition, many poor beneficiaries are also covered by Medicaid, which would largely substitute for lost Medicare coverage. In this case, lower Medicare costs would simply cause higher costs for another government program—Medicaid. A more accurate estimate of the public-sector savings from raising the eligibility age, therefore, should exclude Medicare savings from SSDI and Medicaid beneficiaries. In addition, some beneficiaries who would lose Medicare coverage but are not now covered by SSDI or Medicaid would face increased incentives to qualify for these programs, further reducing the estimated savings. For most of the calculations in this DataWatch we do not account for these further reductions. Thus, our estimates are plausible upper bounds of the potential savings from raising the eligibility age.

**Program costs.** Total Medicare reimbursements for Hospital Insurance (HI) (Part A) and Supplemental Medical Insurance (SMI) (Part B) coverage topped \$132 billion in 1992 (Exhibit 1). Of that, approximately \$14.4 billion (10.9 percent) was incurred by beneficiaries younger than age sixty-five and \$11.6 billion (8.7 percent) by beneficiaries age sixty-five or sixty-six. On a per capita basis, sixty-five- and sixty-six-year-olds cost the Medicare program less than two-thirds of the costs of the average beneficiary.

## EXHIBIT 1 Medicare Reimbursement, 1992

Beneficiary age/eligibility	Total reimbursement (millions)				Number of beneficiaries (thousands)	Per capita reimbursement
	Part A	Part B	Group health	Total		
Age 64 and younger	\$ 8,430	\$ 5,586	\$ 339	\$ 14,355	3,761	\$3,817
Age 65-66	6,847	3,932	772	11,550	4,906	2,354
Age 67 and older	63,161	35,872	7,083	106,116	28,100	3,776
All beneficiaries	78,437	45,389	8,194	132,021	36,767	3,591
Age 65-66 who were						
Originally disabled/ESRD	1,222	496	53	1,771	348	5,083
Aged Medicaid-eligible	1,071	497	32	1,601	392	4,086
Aged non-Medicaid	4,554	2,938	686	8,178	4,166	1,963

**SOURCE:** Author's tabulations based on 1992 Medicare Current Beneficiary Survey (MCBS).

**NOTE:** ESRD is end-stage renal disease.

Of beneficiaries ages sixty-five and sixty-six who were originally entitled because of disability or end-stage renal disease (ESRD), who are eligible for Medicaid coverage, or whose coverage would likely be cut if the eligibility age were increased, those who would be most affected used dramatically fewer resources per capita than other beneficiaries used in 1992. Those who were exempt from the age requirement used more resources per capita than other beneficiaries of any age (Exhibit 1).<sup>3</sup>

Potential reductions in spending differ somewhat by type of benefit. Fee-for-service reimbursements in Parts A and B could be reduced by 5.8 and 6.5 percent, respectively, while Medicare managed care payments could fall by 8.4 percent. Thus, if there is no increase in the rates of Medicaid and SSDI participation among sixty-five and sixty-six-year-olds, this analysis indicates that raising the eligibility age to sixty-seven would reduce the total number of beneficiaries by 11.3 percent and total annual program costs by 6.2 percent.

### Projected Population And Service Use By Age Group: 1998-2050

The estimates presented above are valid only if the age distribution and relative utilization patterns of the Medicare population remain constant over time. Reliable projections of medical spending do not exist. But if we assume that the per capita utilization rates of the affected sixty-five and sixty-six-year-olds remain constant relative to other beneficiaries, we can use population projections to estimate the long-run implications of raising the eligibility age. The U.S. Census Bureau has published projections of the age distribution through the year 2050.<sup>4</sup> Using these projections, we can estimate the proportion of aged beneficiaries who will be sixty-five or sixty-six (and not in Medicaid or SSDI) into the future and use

MCBS data to estimate the proportion of spending accounted for by that population.

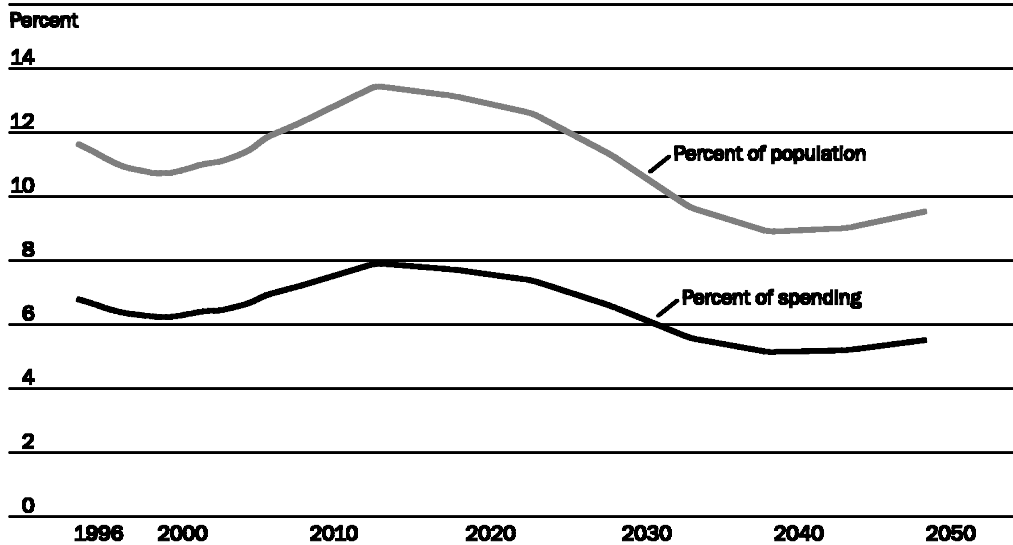
As the peak of the baby boom enters retirement (about 2015), affected beneficiaries are projected to make up 13.4 percent of all beneficiaries age sixty-five and older and their spending to account for approximately 7.8 percent of all Medicare spending on the elderly (Exhibit 2). When the “baby-bust” generation follows the boomers into retirement after 2030, the fraction of beneficiaries under age sixty-seven drops below 10 percent and their costs below 6 percent of all Medicare reimbursements.<sup>5</sup> This suggests that for this policy to address coming changes in the age structure of the U.S. population, it would need to be in effect well before the Social Security change has been phased in.

Several unknowns about future program participation, which have not been included in these projections, may affect our conclusions. For example, the already enacted increase in the eligibility age for Social Security benefits also may increase the number of sixty-five- and sixty-six-year-olds who will receive disability benefits and, in turn, Medicare benefits. This would further reduce the projected future savings from an increase in the eligibility age.

## Impact On The Hospital Insurance (HI) Trust Fund

Since the HI trust fund balance is on its way to being depleted

**EXHIBIT 2**  
**Percentage Of Beneficiaries And Spending Accounted For By Beneficiaries**  
**Ages Sixty-Five And Sixty-Six, 1996–2050**



**SOURCES:** U.S. Census Bureau, “Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050,” *Current Population Reports*, P25-1130 (Washington: U.S. Government Printing Office, 1996); and 1992 Medicare Current Beneficiary Survey (MCBS) Cost and Use File.

*“Even if the eligibility age were raised immediately, no more than a year would be added to the life of the HI trust fund.”*

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before 2010, and only part of the estimated savings (Part A) affects the trust fund, the potential for an increase in the eligibility age to prolong the solvency of the trust fund will be small. This is particularly true if, as proposed, the increase is phased in over an extended period. The proposed twenty-four-year phase-in period means that by itself the age increase will have very little effect on the date of trust fund depletion, and it will miss a substantial portion of baby-boom retirement, which will begin in 2015. At this point, the phase-in will be only half complete. A twelve-year phase-in period would complete the process by the time that the baby boomers become eligible for Medicare. Even so, given current projections from the Social Security and Medicare trustees, such a policy change would have a negligible effect on the current solvency crisis.<sup>6</sup> In fact, even if the eligibility age were raised immediately, no more than a year would be added to the life of the HI trust fund. In addition to changing the rules in the middle of the game for people on the verge of retirement, quick action of this nature undoubtedly would stimulate political opposition from a wide range of interest groups.

### **Characteristics Of Beneficiaries Ages Sixty-Five And Sixty-Six**

One justification offered for delaying the raising of the eligibility age is that younger beneficiaries are likely to be in better health and more likely to be able to afford health insurance than are older beneficiaries. Coverage may be more affordable for these beneficiaries because either they are still working and have health insurance coverage through their employer, they have employer-subsidized retiree coverage, or they have higher incomes and more wealth with which to purchase individual insurance coverage.

**Health status.** Analysis of the 1992 MCBS confirms that, on average, these characterizations are correct. Compared with beneficiaries over age sixty-seven and disabled beneficiaries under age sixty-five, those who are ages sixty-five and sixty-six are less likely to characterize their own health as fair or poor and are more likely to be free of chronic conditions (Exhibit 3). Further, sixty-five- and sixty-six-year-old beneficiaries have about one fewer chronic condition on average than do both older and younger beneficiaries. When we look at only those likely to lose eligibility (last line of Exhibit 3), these differences are slightly larger.

**EXHIBIT 3**  
**Health And Economic Characteristics Of The Medicare Population, 1992**

<b>Beneficiary age/eligibility</b>	<b>Number of beneficiaries (thousands)</b>	<b>Percent in fair or poor health</b>	<b>Percent with a chronic condition</b>	<b>Average number of conditions</b>	<b>Income</b>	<b>Percent insured by current employer</b>	<b>Percent insured by former employer</b>
Age 64 and younger	3,761	59.6%	95.0%	3.28	\$13,144	10.3%	11.1%
Age 65-66	4,906	21.0	83.0	2.22	22,075	8.8	34.7
Age 67 and older	28,100	27.6	91.2	3.07	20,302	3.4	33.1
All beneficiaries	36,767	30.0	90.5	2.98	19,806	4.8	31.1
Age 65-66 who were							
Originally disabled/ESRD	348	51.9	98.0	4.26	15,047	6.0	24.2
Aged Medicaid eligible	392	43.8	91.4	2.82	7,177	0.0	0.0
Aged non-Medicaid	4,166	16.3	81.0	1.99	24,063	9.8	38.8

**SOURCE:** Author's tabulations based on 1992 Medicare Current Beneficiary Survey (MCBS).

**NOTE:** ESRD is end-stage renal disease.

**Financial status.** In addition to being healthier, the average beneficiary who is age sixty-five to sixty-six beneficiary also may be less financially burdened by losing Medicare coverage. The mean annual income in this age group is 11.5 percent (\$2,269) higher than for Medicare beneficiaries as a whole, and the percentage who have health insurance coverage through a current or former employer is also higher than average. However, although the average beneficiary in this age group may be better off than the average beneficiary, Current Population Survey (CPS) data indicate that approximately 21 percent of the age group who would be affected by the eligibility change have incomes below 150 percent of poverty and would have great difficulty purchasing insurance individually. Indeed, even after excluding SSDI and Medicaid beneficiaries, a person with the average income for this group (\$24,063) probably would face some difficulty obtaining affordable, adequate insurance.<sup>7</sup>

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**Alternative Sources Of Health Insurance Coverage**

Some sixty-five- and sixty-six-year-olds who continue to work will be covered through employers. As the eligibility age for full Social Security retirement benefits increases, the number of such persons is likely to increase also. If Medicare's eligibility age is raised, this effect will likely be augmented. These persons, however, now cost the Medicare program very little, since Medicare is the secondary payer for those with this type of insurance coverage.

**Number of uninsured.** For persons who do not have such coverage, a number are likely to have problems obtaining affordable insurance.<sup>8</sup> The MCBS enables us to get a rough estimate of the population likely to have difficulty. A plausible lower-bound estimate of the number of uninsured sixty-five- and sixty-six-year-olds is the



number of (non-SSDI, non-Medicaid) beneficiaries who have no supplemental insurance coverage and have annual incomes under \$25,000. Approximately 12 percent of beneficiaries likely to lose Medicare coverage fell into this group in 1992. Assessed against the 1997 population, this translates into roughly 527,000 beneficiaries. Beneficiaries earning less than \$25,000 who now have only an individual (Medigap) policy also would have a difficult time purchasing adequate insurance on their own. If we include these beneficiaries as well, the number of newly uninsured persons could go up to 1.75 million.<sup>9</sup> Although it may be argued that persons faced with a loss of Medicare entitlement would find other sources of insurance, Pamela Loprest and Cori Uccello found that fully 17 percent of persons ages fifty-eight to sixty-three had either no insurance or were covered only temporarily through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).<sup>10</sup>

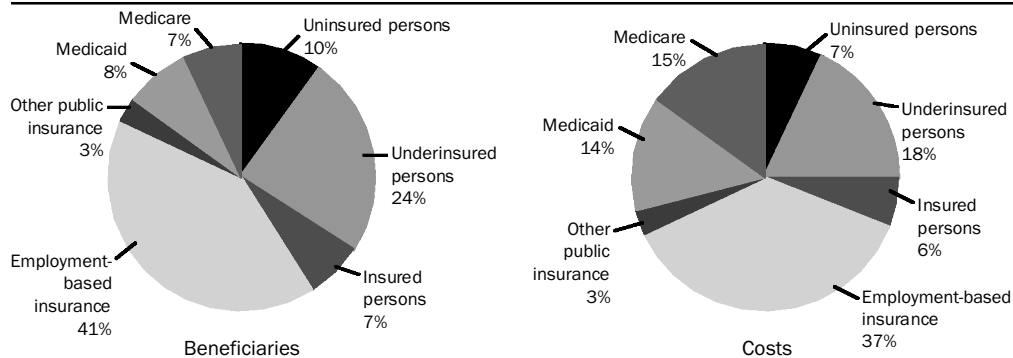
**Insurance sources.** One alternative would be to allow these persons to purchase Medicare coverage under a program similar to the current voluntary buy-in program. If there were no change in the prevalence of employer-based insurance for persons ages sixty-five and sixty-six, the actuarially fair premium for non-Medicaid, nonemployed beneficiaries would be \$2,940 annually (1997 dollars). It seems likely, however, that the healthiest beneficiaries would be able to obtain coverage through employment, which would leave a less healthy population to purchase insurance through Medicare. This would almost certainly raise the buy-in premium above this amount. Although this premium is low relative to the per capita spending of other beneficiaries, it is still expensive for beneficiaries with very low incomes. One alternative, which would reduce savings, might be to subsidize the purchase of Medicare insurance for low-income persons.

### Shifting Burdens

More than 40 percent of Medicare beneficiaries ages sixty-five and sixty-six are estimated to have either retiree or employee coverage from a private employer. If employers continue this level of coverage after beneficiaries lose Medicare coverage because of a fully phased-in increase in the eligibility age, 37 percent of the cost savings from the age increase will be borne by employers (Exhibit 4). Another 32 percent of costs for this age group will be shifted to other governmental sources through Medicare (coverage of SSDI recipients), Medicaid, and other public insurance programs, which now cover about 18 percent of Medicare beneficiaries. The remaining 31 percent of costs will be shifted to the 41 percent of persons who now have either no supplemental insurance or private Medigap coverage

**EXHIBIT 4**

**Likely Distribution Of Beneficiaries Ages Sixty-Five And Sixty-Six And Spending After Increase In Eligibility Age**



**SOURCE:** Author's tabulations using 1992 Medicare Current Beneficiary Survey (MCBS) Cost and Use File.

only. Assuming that those earning more than \$25,000 per year can purchase adequate insurance individually, 25 percent of the cost savings will be shifted to under- or uninsured persons.

**Discussion**

The fundamental message of this statistical exercise is that a substantial fraction of beneficiaries would be affected by the most recent proposal to raise Medicare's eligibility age, without a commensurate effect on expenditures, even in the long run. In the meantime, because any such increase would be phased in over some period of time, and because a nontrivial portion of beneficiaries will be exempt, it is particularly unlikely that the current fiscal crisis facing the HI trust fund can be much affected by raising the eligibility age. From the perspective of beneficiaries, it is unclear how successful private labor and insurance markets would be at ameliorating the loss of health insurance coverage for those younger than age sixty-seven. For the less healthy and less wealthy in this group, difficulty in obtaining affordable coverage could create serious hardship.

Finally, if the goal of raising the eligibility age is to make Medicare consistent with Social Security, then some consideration also should be given to allowing voluntary buy-in (perhaps subsidized) at age sixty-two to correspond with Social Security's early retirement age. Obviously, this alternative may involve increased Medicare spending.

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## NOTES

1. B. Gage et al., "Medicare Savings: Options and Opportunities" (Unpublished report prepared for the Commonwealth Fund and the Henry J. Kaiser Family Foundation, June 1997).
2. Unlike Medicare, however, Social Security has an early retirement age of sixty-two at which persons can claim reduced benefits. This age will not change when the normal retirement age increases.
3. While the MCBS does not indicate the reason for original entitlement, we assume that a person whose entitlement date is prior to the legal date of entitlement for aged beneficiaries was entitled because of ESRD or because of participation in the SSDI program.
4. U.S. Census Bureau, "Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050," *Current Population Reports*, P25-1130 (Washington: U.S. Government Printing Office, 1996).
5. This is roughly consistent with projections made by the Congressional Budget Office in 1997. See Congressional Budget Office, *Long Term Budgetary Pressures and Policy Options* (Washington: CBO, March 1997), 41-42.
6. Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, *1997 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* (Washington: U.S. GPO, April 1997).
7. Based on average expenditure data from the National Medical Expenditure Survey (NMES), a plausible guess is that private nongroup coverage that covers 80 percent of expenses for an average sixty-five-year-old could cost upwards of \$6,000 per year, or 25 percent of annual income.
8. P. Loprest and C. Uccello, *Uninsured Older Adults: Implications for Changing Medicare Eligibility* (New York: Commonwealth Fund, April 1997).
9. To put this number in perspective, adding 1.75 million uninsured persons would increase the total uninsured population in the United States by 5 percent.
10. Loprest and Uccello, *Uninsured Older Adults*.