



The Distributional Effects of Medicare at 60

Tom Church and Daniel L. Heil
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ABSTRACT

Tom Church and Daniel L. Heil¹

This paper explores the distributional effects of lowering Medicare's eligibility age to 60. Medicare at 60 is a seemingly simple change, but would significantly affect medical providers, the newly eligible, the federal budget, and the nation's health care system. We find that lowering the Medicare eligibility age to 60 would add \$42.6 billion to the federal deficit in 2023 and increase 10-year deficits by as much as \$452 billion. Payments for inpatient hospital services in

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2042 would fall by \$21 billion and revenue for physician and other providers services would fall by \$35.5 billion (in real 2022 dollars). Meanwhile, Medicare at 60 would benefit some new enrollees, but not all would be better off. Specifically, we find that over one-third of ACA marketplace enrollees would see their combined premium and out-of-pocket payments rise under the proposal.

¹ Tom Church and Daniel L. Heil are Policy Fellows at the Hoover Institution. The views expressed in this paper are those of the authors alone and do not necessarily reflect the views of the Hoover Institution. This work was supported by the Partnership for America's Health Care Future.

INTRODUCTION

President Biden's campaign proposal to lower Medicare's eligibility age to 60 remains a priority for many in Congress. Supporters argue the reform offers a straightforward approach to improve health insurance coverage for millions of Americans. The reform may appear simple, but it would have significant consequences for medical providers, the newly eligible, the federal budget, and the nation's healthcare system.

In an earlier analysis, Chen, Church, and Heil (2021) estimated that Medicare at 60 would increase Medicare enrollment by nearly 14 million individuals, including 1.4 million uninsured 60-to 64-year-olds. The expanded coverage, however, would come with a significant price tag: Medicare outlays would rise by \$82.9 billion in 2022 and 10-year federal deficits would rise by \$394 billion before accounting for interest costs.

Beyond its fiscal costs, significant questions remain regarding the proposal's effects on providers and the newly eligible population. Proponents of the proposal are quick to identify deserving populations who may benefit from Medicare at 60, but the policy would also produce unwanted side effects for many stakeholders. Hospitals and physicians could face steep revenue cuts as millions are shifted from private insurance payment rates to lower

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Medicare rates. New recipients with current insurance coverage could face large new premiums while gaining few additional benefits. Meanwhile, the likely winners of the new policy would include many high-income individuals that

policyholders may find less deserving of taxpayer-funded subsidies. An accounting of the distributional effects of Medicare at 60 is thus needed to ensure policymakers fully appreciate the consequences of this seemingly simple policy change.

This paper considers these distributional questions in depth. Using a revised version of the model developed in Chen, Church, and Heil, we estimate the effects of Medicare at 60 on healthcare providers and the newly eligible population. We also provide an update to the earlier enrollment and budget estimates.

We find that lowering the Medicare eligibility age to 60 would add \$42.6 billion to the federal deficit in 2023 and increase 10-year deficits by as much as \$452 billion (excluding interest costs). Meanwhile, moving millions of individuals from private coverage to Medicare would lead to payment reductions for hospitals and physicians. Payments for inpatient hospital services would fall by \$12.3 billion in 2023 while payments for physician and other provider services would decline by \$2.9 billion. Over the next twenty years, projected current-law reimbursement rates for Medicare enrollees are projected to fall relative to those who are privately insured or Medicaid recipients. Consequently, payments for inpatient hospital services in 2042 would fall by \$21 billion and revenue for physician and other providers services would fall by \$35.5 billion (in inflation-adjusted 2022 dollars).

The costs to providers and the government would be partially offset by gains to the newly eligible population. Nevertheless, Medicare at 60 would not benefit all new recipients. Specifically, we find that over one-third of ACA marketplace enrollees would see their combined premium and out-of-pocket payments rise under the proposal. The ACA participants most likely to be made worse off are those with incomes between 135 to 250 percent of the poverty line.

The paper is organized as follows. Section I summarizes the current Medicare program. Section II contains a review of the relevant literature on the effects of altering Medicare’s eligibility age. Section III provides an overview of the microsimulation model and discusses the changes made to the model since Chen, Church, and Heil. We then turn to the results in Section IV. Section V discusses limitations of our results. Section VI concludes.

I. The Current Medicare Program

The distributional effects of Medicare at 60 depend on how the newly eligible population would be integrated into the current program. An understanding of the existing system is necessary to appreciate the various dynamics that affect enrollment decisions and the welfare effects of the expansion. Below we provide an overview of the program and its eligibility requirements, premiums, and cost-sharing rules. We then discuss how the program’s reimbursement rates compare to payments made by private insurers.

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Medicare provides health insurance for the elderly and the disabled. In 2020, 62.8 million people were enrolled in at least one part of Medicare.² Approximately 87 percent of enrollees qualified by being 65 or older;

the remaining share qualified through a disability. In FY2020, Medicare expenditures totaled \$919 billion. Net of premiums and other offsetting receipts, the program added \$776 billion to the federal budget.³

Medicare provides services under three parts: Part A, or Hospital Insurance (HI), pays for inpatient hospital services; Part B pays for outpatient services; and Part D subsidizes prescription drug coverage. Parts A and Part B provide fee-for-service payments to providers on behalf of recipients. But a growing share of Medicare recipients are enrolling in Medicare Advantage, or Part C. Unlike traditional fee-for-service Medicare, recipients enrolled in Part C enroll with private providers who then receive capitated payments from Medicare to provide enrollees with medical services that would otherwise be covered under Parts A and B.

Part A expenditures are financed through the Hospital Insurance Trust Fund, which is funded by HI payroll taxes. CBO projects Part A outlays will exceed payroll tax revenue over the next five years, resulting in the depletion of the trust fund in 2027.⁴ Parts B and D are primarily funded through general fund revenue with the remaining share paid for by enrollee premiums and payments by states. Enrollee premiums covered 25.5 percent of Part B mandatory outlays in 2020. Similarly, recipient premiums and payments by states accounted for 20.2 percent of 2020 Part D outlays. In 2022, standard monthly Part B premiums were \$170.10.⁵ The average basic monthly premium for Part D was \$33 in 2022.⁶ High-income enrollees in Parts B and D must also pay income-related premiums.

Generally, Medicare enrollment for Parts A and B occurs automatically at age 65 if a person is already receiving Social Security payments. If newly eligible beneficiaries are not automatically enrolled, they are expected to do so within a seven-month period of becoming eligible. Failing to enroll during this period may trigger late-enrollment penalties that permanently increase Part B and D premiums for late enrollees. Eligible enrollees with qualifying medical coverage are allowed to defer enrollment in Part B and Part D without penalties. Deferred enrollment decisions for

² Enrollment data for current Medicare recipients are from the Medicare Enrollment section of CMS (2022).

³ Outlay, revenue, and trust fund data for the current Medicare program are from CBO (July 2021).

⁴ Nearly all Part A enrollees are eligible for premium-free Part A, but a small number lack sufficient quarters of covered work and must pay Part A premiums.

⁵ Part A and Part B premium and cost-sharing requirements for 2022 are from CMS (November 2021).

⁶ See CMS (July 2021).

those with qualifying medical coverage often depend on the size of one's employer. Small employers (fewer than 20 employees) may require their employees to enroll in Medicare. Large employers are prohibited from requiring their employees to enroll in Medicare; if employees enroll, the employer's insurance remains the primary payer while the government acts as a secondary payer.

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Each part of Medicare requires cost sharing by most participants. In 2022, individuals were required to pay a \$1,556 deductible for Part A. Long-term stays in hospitals or skilled nursing facilities trigger

daily coinsurance requirements. Part B generally requires 20 percent coinsurance along with a deductible (\$233 in 2022). Part D cost sharing varies depending on a recipient's annual drug expenditures and whether a drug is brand name or generic.

Low-income individuals may qualify for subsidies for their premiums or required cost-sharing amounts. State Medicaid programs pay for premium and cost-sharing payments for Parts A and B for individuals who qualify for the state's full Medicaid program. Those who do not qualify for a state's full Medicaid program may still qualify for premium or cost-sharing support through the Medicare Savings Programs. These programs are operated by state Medicaid programs with the federal government reimbursement rates set at the Federal Medical Assistance Percentage (FMAP) rate. Low-income individuals enrolled in Part D are also eligible for the federally-run Low-Income Subsidy (LIS) program; it pays for part or all of Part D premiums and cost-sharing requirements, depending on an enrollee's income.

REIMBURSEMENT RATES FOR HEALTH CARE PROVIDERS UNDER MEDICARE

Medicare sets reimbursement prices administratively through various laws and regulations. For the most part, hospital services covered by inpatient or outpatient prospective payment systems cost a predetermined amount, adjusted by several factors. They include geographic location, intensity of services, health of the patient, and some hospital-specific adjustments like residency training programs or a disproportionately high share of low-income patients. Medicare physicians' services are paid based on a physician fee schedule, which includes adjustments for "relative amount of resources," geographic location, and some provider- or procedure-specific adjustments (e.g., when a service is provided by a nonphysician such as a nurse practitioner).⁷

Previous efforts to rein in growing costs have focused on paying physicians and hospitals less for their services. Notably, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 changed the formula for physician reimbursements. It set annual increases for physician reimbursement rates to 0.5 percent from 2015 to 2018, and then capped them at zero while implementing an incentive-based increase program. It replaced the Sustainable Growth Rate (SGR) formula that had been in place (but often overridden) since the 1997 Balanced Budget Act.⁸

Differences in reimbursement rates between private insurance and Medicare have risen over the last 20 years. CBO (2022b) notes that "between 2000 and 2018, private payers' payments rose from 116 percent to 145 percent of hospitals' costs, whereas Medicare's payments fell from 99 percent to 87 percent of hospitals' costs."⁹ There are many reasons why costs have diverged in the last two decades. Efforts to reduce Medicare costs have led Congress to enact limits on annual increases in fee-for-service reimbursement rates. As Medicare offers payment rates on a take-it-or-leave-it basis, health care providers have largely accepted the rates offered to them.

⁷ CBO (2022b), page 2.

⁸ H.R. 2. Medicare Access and CHIP Reauthorization Act of 2015. Available at: <https://www.congress.gov/bill/114th-congress/house-bill/2>.

⁹ CBO (2022b), page 7.

The effects of a Medicare expansion on healthcare providers depend on the expected reimbursement rates for both inpatient hospital and physician services. There is considerable variation in the estimates of the relative differences in rates. In a review of the literature, CBO (2022b) estimates that Medicare paid an average of 55 percent of commercial rates for inpatient services in 2018. For physician services, Medicare paid 77 percent of commercial rates. In comparison, Shatto and Clemens (2020) estimated that in 2022, Medicare will reimburse inpatient services at 59 percent and physician services at 70 percent of the rate paid by private insurers.

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The difference in relative prices paid by Medicare and commercial insurers also varies widely by state. In Tennessee, CBO estimates that private insurer reimbursement rates for inpatient hospital services were 270 percent

higher than Medicare rates in 2018. In contrast, private insurer rates in Pennsylvania were only 87 percent higher than Medicare. Similarly, the spread across states for physician services is significant. Payment rates for physician services in Wisconsin were 87 percent higher among private insurers than Medicare, while insurers in Alabama reimbursed physicians at slightly lower rates than Medicare (2 percent lower).

As discussed above, many of those enrolled in Medicare opt for Medicare Advantage plans. CBO (2022b) notes that while Medicare Advantage data are not as widely available as fee-for-service prices, “published research suggests that MA plans and the FFS program generally pay very similar prices for hospitals’ and physicians’ services.”¹⁰

II. Literature Review of Medicare Expansions

Medicare’s eligibility age has been fixed at 65 since the program was enacted. Over the program’s lifetime, there have been several proposals to raise the eligibility age to reduce the long-term costs of the program.¹¹ In recent years, however, some have proposed reducing the Medicare eligibility age as a seemingly simple way to increase insurance coverage and lower individual health expenditures. For example, President Biden’s FY2022 budget called for “giving people age 60 and older the option to enroll in the Medicare program with the same premiums and benefits as current beneficiaries.”¹² While it was ultimately omitted from the subsequent 2021 reconciliation bill, it remains a priority for many in Congress. Despite its growing popularity, there have been relatively few attempts at estimating the effects of the plan.¹³

Chen, Church, and Heil (2021) found that, if fully implemented in 2022, Medicare at 60 would increase ten-year federal deficits by \$393.9 billion and add nearly 14 million 60- to-64-year-olds to the Medicare rolls. Similarly, Holt and Parente (2021) estimated that Medicare at 60 would increase federal deficits by \$380 billion over ten years, with the possibility of deficits rising by \$1.8 trillion if all employers dropped their existing health coverage for 60- to 64-year-olds. Under their lower bound estimate, an additional 12.8 million individuals would enroll in Medicare by 2031. These results, however, are not directly comparable to Chen, Church, and Heil. Holt and Parente only estimated eligibility changes for those on employer-sponsored insurance, the uninsured, and those with individual coverage; they explicitly excluded Medicaid recipients from their analysis.

Beyond the fiscal effects, however, there has been little research on the distributional consequences of the proposal.

¹⁰ See Notes section in CBO (2022b). Consistent with CBO’s conclusion, the estimates we present below assume no difference in reimbursement rates for those covered by Medicare Advantage versus traditional Medicare.

¹¹ For an overview of the earlier estimates, see section IV of Chen, Church, and Heil (2021).

¹² OMB (2021), page 24.

¹³ The Congressional Budget Office (2022a) has noted they are producing their own estimate of Medicare at 60, although it is unknown when this may be released.

In a 2020 study, the National Academy of Social Insurance analyzed several approaches to lowering the Medicare eligibility age. While their report did not include a score, it did discuss many of the dimensions and potential effects of any proposal to lower the Medicare eligibility age. In particular, the report noted the potential distributional impacts of the proposal:

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.¹⁴

Although not explicitly an estimate of lowering the Medicare eligibility age, Schulman and Milstein (2019) estimate the effects on hospitals if Medicare fee-for-service payments were universal. They find:

Given the relative proportion of patients with each type of insurance, the estimated net effect on hospitals would be a 15.9% decline in revenue, equal to a loss of \$151 billion nationally incurred by 5,262 US community hospitals. Given a current average profit margin of 7% including nonoperating income, hospitals could quickly face the prospect of margins as negative as 9%, equal to an \$85.6 billion annual loss, unless they could rapidly reduce waste and become more efficient.¹⁵

The effects to hospitals, however, would be much smaller if Medicare eligibility were only extended to 60- to 64-year-olds. In addition, the net effect on health care providers would be more muted if they were to engage in cost shifting from Medicare or Medicaid to commercial insurers. Health scholars, however, are generally skeptical that hospitals engage in much cost shifting. CBO offers a descriptive analysis that estimates a one percent increase in Medicare or Medicaid discharges is “associated with only a 0.1 percent increase in commercial insurers’ prices relative to Medicare’s prices.”¹⁶ The lack of cost shifting means that, absent offsetting efficiency gains or increased utilization, health care providers would be worse off if patients shift from commercial insurers to Medicare recipients.¹⁷

III. Data and Methods

To provide estimates on the effects of Medicare at 60, we update the microsimulation model developed in Chen, Church, and Heil (2021). A detailed discussion of the model is available in that paper.¹⁸ Here, we provide a brief overview of the model and discuss important changes made since the 2021 estimates.

We use the microsimulation model to estimate enrollment, premiums, and medical expenditures for the newly eligible Medicare population, as well as the changes in payments to physicians and hospitals. These changes are motivated by adjustments to reimbursement rates for existing services, as rates paid by private insurers remain much higher than those paid by the government for Medicare or Medicaid patients. The model uses microdata projections of health care spending, insurance premiums, and insurance statuses. It projects total health care spending by category, type of payer, and Medicare part.¹⁹

¹⁴ NASI (2020), page 10.

¹⁵ Schulman and Milstein (2019), page 1661.

¹⁶ CBO (2022b), page 26.

¹⁷ Chenew et al. (2021) raise the possibility of “consolidation-induced cost shifting,” where hospitals with higher shares of Medicare patients have lower profits and are thus more likely to close or be acquired. This increase in consolidation could increase aggregate costs, but not on a per-hospital basis.

¹⁸ See section V and the appendix of Chen, Church, and Heil (2021).

¹⁹ The underlining data projections are created in an updated version of the dataset described in Church and Heil (2019).

The new estimates reflect updated economic assumptions and new survey data. Specifically, we incorporate new data from the Current Population Survey (CPS) and the Medical Expenditure Panel Survey's Household Component (MEPS-HC) into the model.²⁰ We also adjust the economic assumptions in the model, so they match the most recent versions of CBO's economic and budget projections.²¹

Our revised estimate for Medicare at 60 assumes the eligibility age would be set at 60 in January 2023, in time for enrollment changes in the fall of 2022. Except for the revised reimbursement rate assumptions (discussed below), the model used here follows the same assumptions as Chen, Church, and Heil. In particular, we assume those who are newly eligible for Medicare would face the same rules as the existing population, including late-enrollment penalties for those who do not have existing coverage.

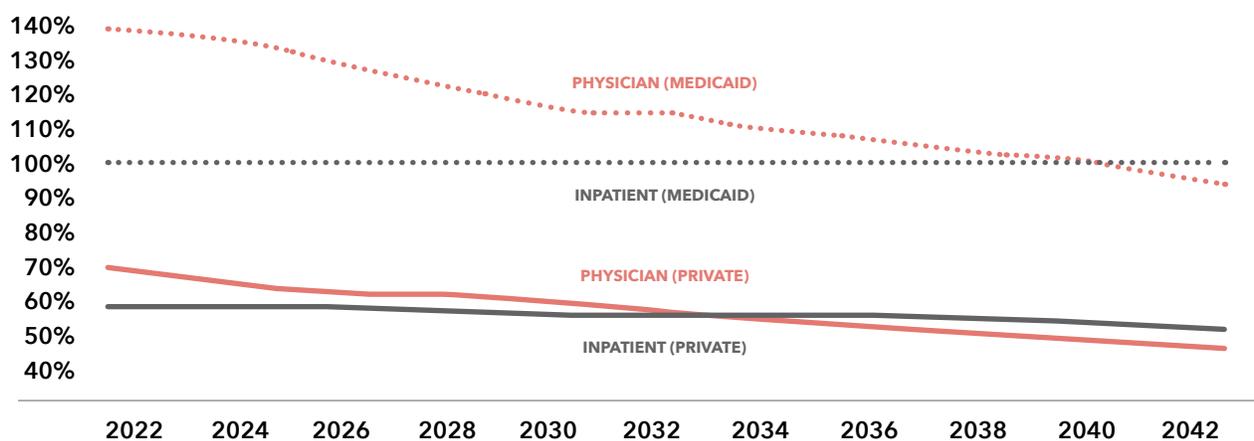
REVISED REIMBURSEMENT RATE ASSUMPTIONS

The distributional effects of Medicare at 60 depend on how payments to providers and hospitals would change for the newly enrolled. Chen, Church, and Heil assumed that reimbursement rates for inpatient hospital care would fall by 38 percent for the eligible population with private coverage or no insurance, and physician services would fall by 25 percent.²² The paper also assumed that reimbursements rates for current Medicaid recipients would not change. We have refined the reimbursement rate assumptions used for our primary estimates. These changes are discussed below.

First, we assume Medicare at 60 would increase reimbursement rates for physician services among current Medicaid recipients.²³ Payments for inpatient hospital services would be unchanged. In addition, we apply the same assumptions for uninsured population. Relative to the earlier estimates, these changes will raise the projected deficit effects and reduce the estimated loss to providers and hospitals.

Second, reimbursement rates are set to their projected current-law levels as estimated by Shatto and Clemens (2020). These projections reflect the scheduled rate changes called for by MACRA 2015 and other laws governing Medicare payments. Figure 1 shows that over the next 20 years, Medicare reimbursement rates are projected to decline relative to the rates paid by private insurers and Medicaid.

FIGURE 1. PROJECTED REIMBURSEMENT RATES FOR MEDICARE RECIPIENTS (AS A % OF PRIVATE AND MEDICAID RATES)



Notes: Projections are from Shatto and Clemens (2020).

²⁰ The earlier estimates are based on the 2018 Annual Social and Economic Supplement (ASEC) of Current Population Survey and the 2018 Medical Expenditure Panel Survey Household Component (MEPS-HC). The new estimates use the 2019 ASEC CPS and a combined spending estimate from the 2018 and 2019 MEPS-HC surveys (adjusted to match 2019 population estimates and national health expenditure totals).

²¹ Budget and economic projections from CBO are based on their July 2021 estimates.

²² These estimates were based on Shatto and Clemens (2018).

²³ All nation-wide reimbursement rate assumptions are based on Shatto and Clemens (2020).

All else equal, using the current-law projections rather than a constant rate will result in reductions in the estimated deficit effects of Medicare at 60 and increase the expected long-term loss for providers and hospitals. The projected decline in relative payments poses considerable financial risks to providers. Given past congressional behavior, these scheduled cuts may not come to fruition.²⁴ As a consequence, to better reflect the likely budget effects of Medicare at 60, Chen, Church, and Heil (2021) assumed relative reimbursement rates would remain constant. In contrast, this research is focused on the potential financial risks to hospitals and providers, which are better reflected by the current-law projections.

Given the uncertainty regarding future rate levels, we also model alternative estimates with different underlying reimbursement rate assumptions. Comparisons between the baseline and alternative estimates reveal the inevitable trade-off policymakers must make between the budget effects of Medicare at 60 and the impact the proposal would have on providers and hospitals.

IV. Results

The results of our revised model are below. We begin with an overview of the Medicare at 60 eligible population. Next, we provide updated budget estimates of Medicare at 60, outline the effects to hospitals and physicians, and consider the effects that alternative reimbursement rate assumptions would have on providers and the federal budget. We then consider the welfare effects on enrollees, paying particular attention to groups that might be worse off after transitioning to Medicare.

MEDICARE AT 60 ELIGIBLE POPULATION

In 2023, 17.7 million 60- to 64-year-olds not currently enrolled in Medicare would be eligible for Medicare at 60. Policymakers must weigh the budget effects of Medicare at 60 and its likely effect on hospitals and medical providers against the potential benefits that would accrue to this newly eligible populations. A key question then is who would be eligible for Medicare at 60?

Table 1 compares the insurance status of non-senior adults who would be eligible for Medicare at 60 versus the ineligible population. Generally, those eligible for Medicare at 60 are less likely to be uninsured than other non-senior adults. Approximately 13.2 percent of adults aged 18 to 59 not currently enrolled in Medicare are uninsured. In comparison, only 9.0 percent of the Medicare at 60 eligible population currently lacks insurance.

TABLE 1. CURRENT INSURANCE STATUS OF ELIGIBLE AND INELIGIBLE POPULATIONS

	Ineligible	Eligible
Uninsured	13.2%	9.0%
Government Coverage		
Medicaid	16.7%	14.5%
Exchange	4.7%	9.1%
Military Health Care	2.7%	3.2%
Private Coverage		
ESI - Smaller Employer	5.2%	4.7%
ESI - Large Employer	47.8%	40.7%
Retiree Plan	8.4%	17.1%
Other Individual Coverage	1.4%	1.6%

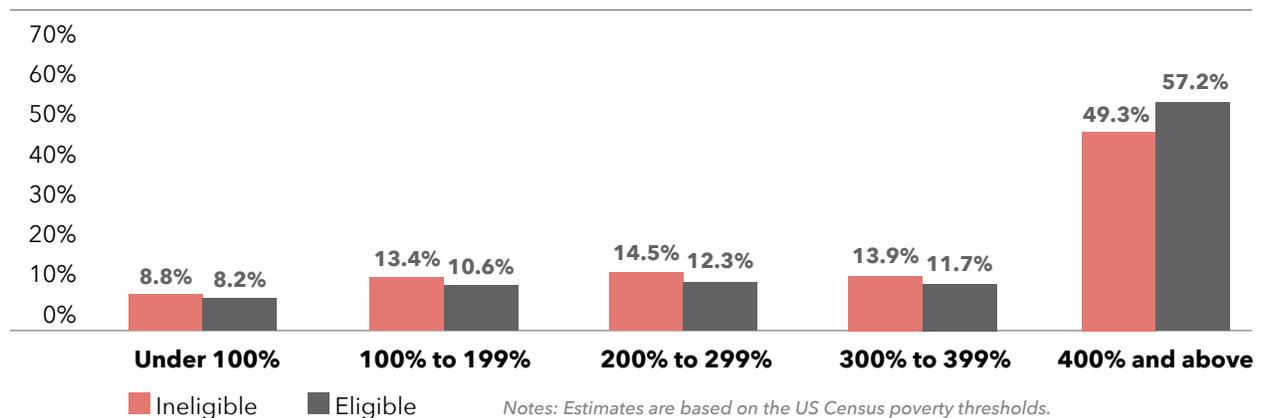
Notes: Ineligible population includes all adults aged 18 to 59 not enrolled on Medicare.

²⁴ Shatto and Clemens (2018), for example, argue that the large financial impact of the projected declines would create "substantial pressure" for Congress "to override the productivity adjustments [in MACRA], much as they did to prevent reductions in physician payment rates while the SGR was in effect."

²⁵ This group includes some individuals that would likely be ineligible due to immigration status.

Likewise, the Medicare at 60 eligible population tends to have higher incomes relative to US Census poverty thresholds than ineligible adults. As shown in figure 2, poverty rates for the groups are broadly similar, with the ineligible population slightly more likely to be considered in poverty than the eligible group. The eligible population, however, is far more likely to have family incomes above 400 percent of the Census poverty thresholds. In 2023, 57 percent of the eligible population would exceed that threshold compared to 49 percent of the ineligible group. Consistent with the insurance data, these figures suggest that Medicare at 60 may poorly target those in need of assistance.

FIGURE 2. POVERTY STATUS OF INELIGIBLE AND ELIGIBLE POPULATIONS



ENROLLMENT AND FISCAL EFFECTS OF MEDICARE AT 60

Of the 17.7 million of those who would be newly eligible, 13.7 million would enroll in Part A; this includes 4.6 million individuals covered by large-employer ESI plans.²⁶ Enrollment in Part B would total 8.4 million and 6.8 million would enroll in Part D.²⁷ Table 2 divides this sample by current insurance status and Medicare part.

TABLE 2. ESTIMATED 2023 ELIGIBLE POPULATION AND ENROLLMENT IN MEDICARE AT 60 (MILLIONS)

	Eligible Population	Part A	Part B	Part D
Uninsured	1.6	1.2	1.1	0.9
Government Coverage				
Medicaid	2.6	2.6	2.6	2.2
Exchange	1.6	1.6	1.4	1.1
Military Health Care	0.6	0.6	0.5	0.3
Private Coverage				
ESI - Smaller Employer	0.9	0.5	0.3	0.2
ESI - Large Employer	7.2	4.6	0.2	0.2
Retiree Plan	3.0	2.4	2.1	1.7
Other Individual Coverage	0.3	0.2	0.2	0.2
Total	17.7	13.7	8.4	6.8

Notes: Enrollment by part includes those who would enroll in Medicare Advantage. Sums may not match totals due to rounding.

²⁶ As Medicare would act as the secondary payer, we assume Medicare outlays for this group would be zero.

²⁷ These estimates include individuals that would enroll in Medicare Advantage.

Table 3 reports the budget effects of Medicare at 60 with projected current-law reimbursement rates. Gross Medicare spending would rise by \$1.2 trillion over the 10-year window. Non-interest federal deficits would rise by \$42.6 billion in 2023 and \$452 billion from 2023 to 2032.²⁸ Budget savings would come from reductions in ACA premium subsidies, military health care programs, and increased tax revenue. States would see a \$8.7 billion decline in 2023 Medicaid outlays because most spending for new enrollees with current Medicaid coverage would shift to Medicare.

TABLE 3. EFFECTS OF MEDICARE AT 60 ON THE FEDERAL BUDGET WITH PROJECTED CURRENT-LAW REIMBURSEMENT RATES (BILLIONS OF NOMINAL DOLLARS)

	Medicare Expenditures				Offsets			Federal Deficit
	Part A	Part B	Part D	Total	Premiums	Taxes	Outlays	
2023	\$36.4	\$55.0	\$11.4	\$102.8	\$18.5	\$2.4	\$39.3	\$42.6
10-Year Effects	\$431.7	\$598.9	\$137.4	\$1,168.0	\$215.8	\$28.1	\$471.9	\$452.2

Notes: Premiums are for Part B and Part D (we assume all Part A recipients are offered premium-free hospital insurance). Tax increases include reductions in tax expenditure from ESI premiums and the revenue savings from ACA tax credits. Outlay reductions include net savings from the ACA, military health care, and Medicaid.

IMPACT ON PHYSICIANS AND HOSPITALS

The effects on medical providers and hospitals from lower reimbursement rates would be significant. If Medicare at 60 were enacted for 2023, aggregate payments for hospitals and doctors would fall by \$15.1 billion under the projected current-law rates. In the short-term, the decline in revenue is primarily for inpatient hospital services. Payments for inpatient hospital services would fall by \$12.3 billion in 2023, or about 0.78 percent of the projected total hospital expenditures for 2023.²⁹ In addition, reductions in outpatient revenue would further affect hospital revenues. We estimate that payments for outpatient procedures would decline by \$2 billion in 2023.³⁰

The size of the cuts may jeopardize the profitability of many hospitals. The median margin for hospitals was estimated at 2.8 percent in 2021 before accounting for temporary federal subsidies under the Coronavirus Aid, Relief, and Economic Security Act of 2021.³¹ Thus, absent cost-cutting measures by hospitals, reductions in inpatient hospital service payments from Medicare at 60 could reduce annual profits by about 25 percent for the median hospital and by even larger amounts for hospitals with below-average margins.

If reimbursements follow their projected path, the decline in revenue for inpatient hospital services would grow by an annual real rate of 2.9 percent over the next 20 years. Given the steep projected declines in physician payments under Medicare, the long-term revenue loss for physician and other providers services would grow even faster at 14.3 percent annually, after accounting for inflation. Figure 3 shows the 20-year trend of real losses (in 2022 dollars) for inpatient hospital and physician services.

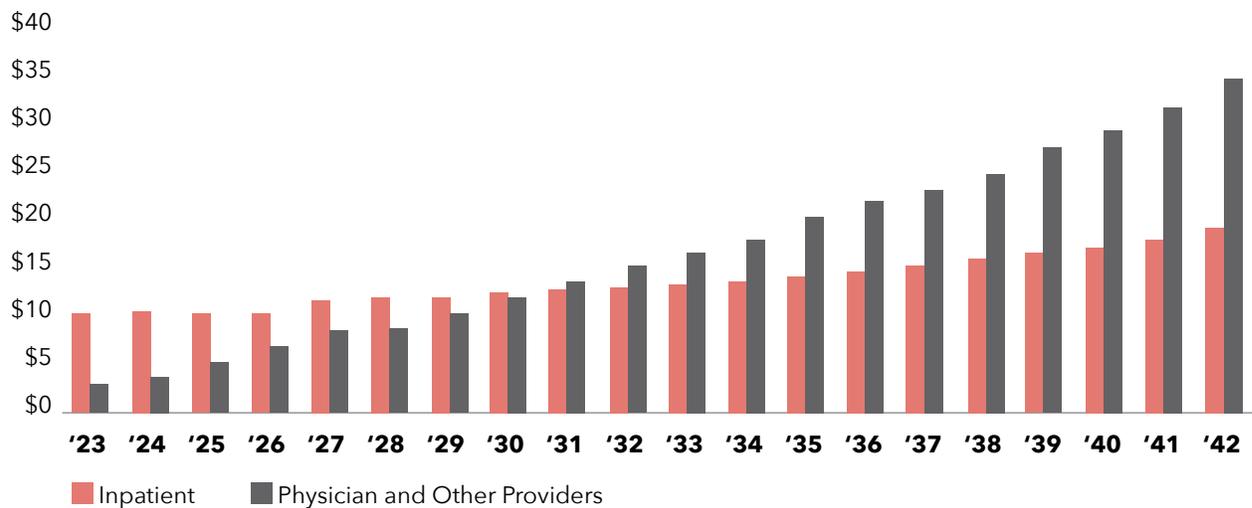
²⁸ Similar to Chen, Church, and Heil (2021), these figures do not include any increase in the Part D claw-back payments provision. See footnote 30 in Chen, Church, and Heil for a discussion of why we did not include these payments in our primary estimates. If claw-back payments were required for the new Medicare at 60 enrollees, the 2023 budget outlays would be \$2.3 billion lower than estimated here and the 10-year deficit effects would fall by \$27.7 billion.

²⁹ This calculation understates the effect on hospitals, as it does not include additional loss in revenue to hospitals from declines in outpatient, emergency, physician, and other services.

³⁰ There is some evidence that relative reimbursement rates for outpatient procedures are significantly lower than inpatient or physician services, thus our estimates here likely serve as a lower bound on the effects to hospitals. See CBO (2022b) for a further discussion.

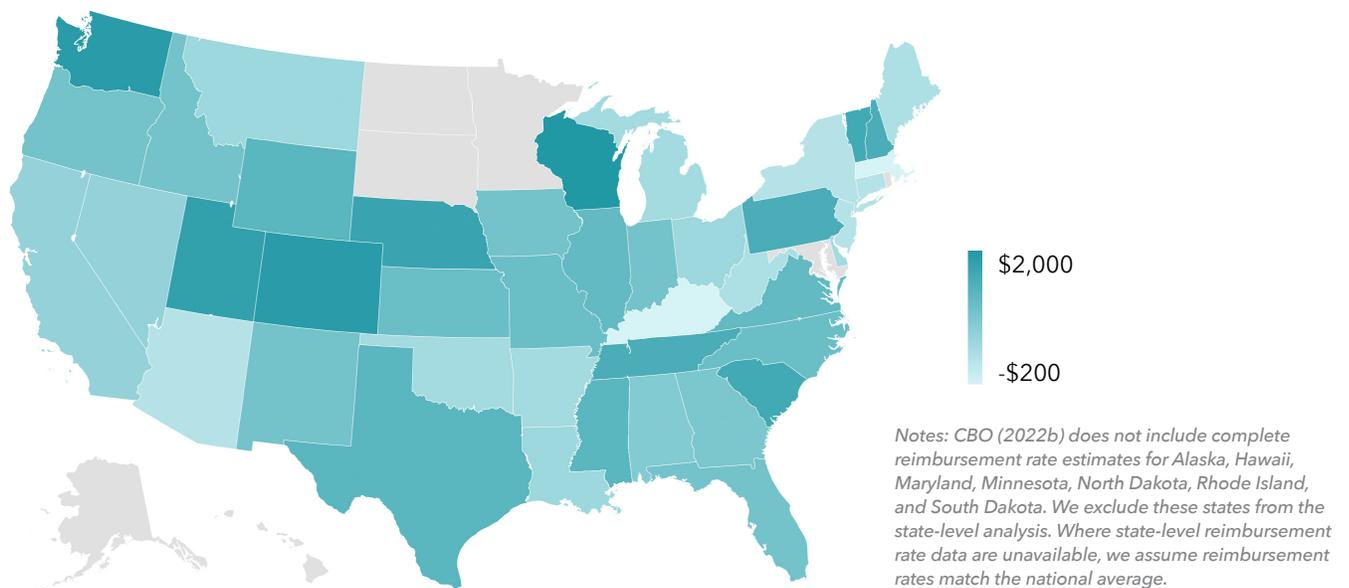
³¹ See Kaufmann Hall (January 2022).

FIGURE 3. INFLATION-ADJUSTED LOSSES TO PROVIDERS UNDER PROJECTED CURRENT-LAW RATES (2022 DOLLARS)



As discussed above, CBO (2022b) found significant interstate variation in the rates paid by private insurers versus Medicare. These effects were particularly large for inpatient hospital services. We incorporate these state level variations in our estimates.³² Figure 4 shows the per enrollee revenue loss by state in 2023. The microsimulation’s small state-level sample size means each state’s estimate is subject to considerable noise. The point estimates, however, suggest Medicare at 60 would have particularly large effects per enrollee for hospitals in Wisconsin, Washington, and Colorado.

FIGURE 4. REVENUE LOSS FOR INPATIENT HOSPITAL SERVICES PER ENROLLEE (2023)

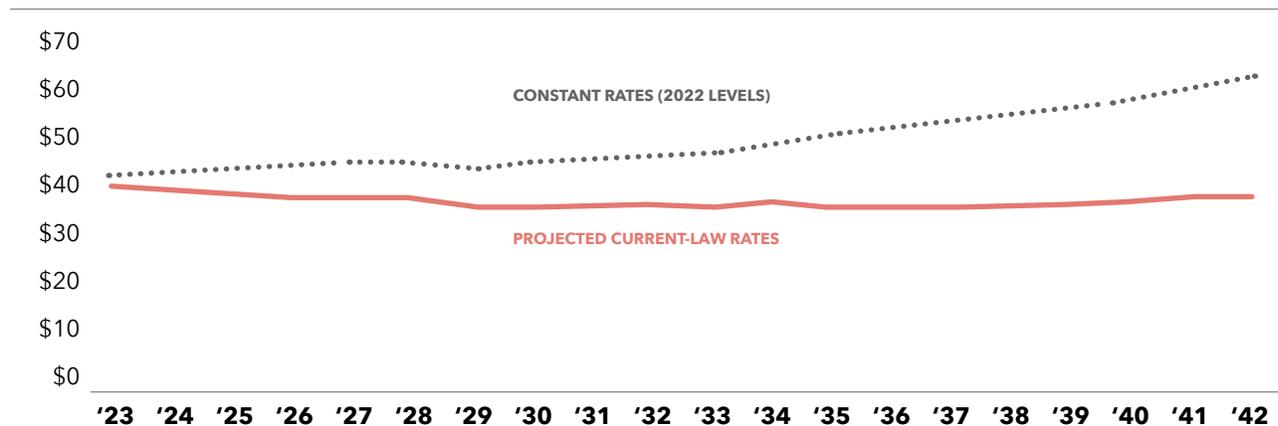


³² We use the ratio of reimbursement rate changes found in CBO (2022b), while maintaining the nation-wide reimbursement rate assumptions found in Shatto and Clemens (2020).

EFFECTS OF ALTERNATIVE RATE ASSUMPTIONS

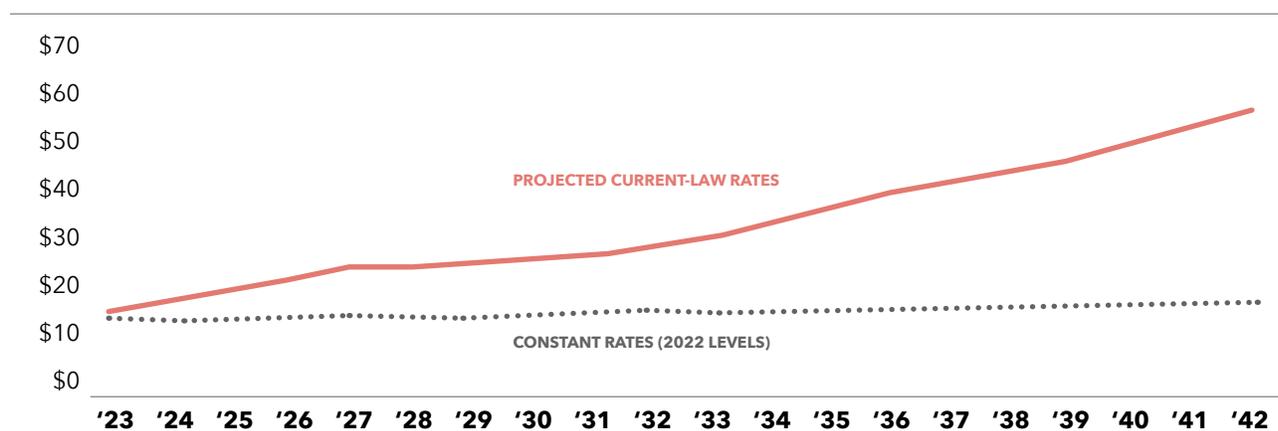
The long-term effects of Medicare at 60 depend heavily on the chosen reimbursement rate assumptions. If relative reimbursement rates remained at their 2022 levels, the nominal 10-year deficit effects of Medicare at 60 would be 16.1 percent higher than if rates fall as current law requires. By 2042, maintaining current reimbursement rates would increase federal deficits by 64 percent more than if reimbursement rates were allowed to fall as scheduled. Figure 5 compares the effect Medicare at 60 would have on annual non-interest deficits under the projected current-law rates compared to a constant rate set to 2022 levels.

FIGURE 5. DEFICIT EFFECTS OF MEDICARE AT 60 UNDER DIFFERENT REIMBURSEMENT RATES (2022 DOLLARS)



Conversely, maintaining current reimbursement rates would shield providers and hospitals from the steep cuts predicted in section III. As shown in figure 6, maintaining 2022 reimbursement rates would reduce the loss to hospitals and providers by 65 percent in 2042.

FIGURE 6. LOSS TO PROVIDERS FROM MEDICARE AT 60 UNDER DIFFERENT REIMBURSEMENT RATES (2022 DOLLARS)



As the above figures demonstrate, Medicare at 60 brings an unavoidable trade-off between revenue cuts to physicians and hospitals, or higher costs to taxpayers (through higher federal deficits).

WELFARE EFFECTS AMONG RECIPIENTS

Even among the newly eligible, the benefits of Medicare at 60 might prove illusory for some recipients. Chen, Church, and Heil (2021) discussed the possibility that many recipients would be worse off under the proposal. This would occur if their new Medicare premiums (including income-related payments) and cost-sharing requirements exceed their existing premiums and cost-sharing payments. Here, we focus on ACA recipients as an illustrative example of how new enrollees may not universally benefit from Medicare at 60.

Enrollee premiums for ACA recipients depend on the recipient's family income and the marketplace insurance plan they select. A family's required contribution share rises as their income as a share of the federal poverty

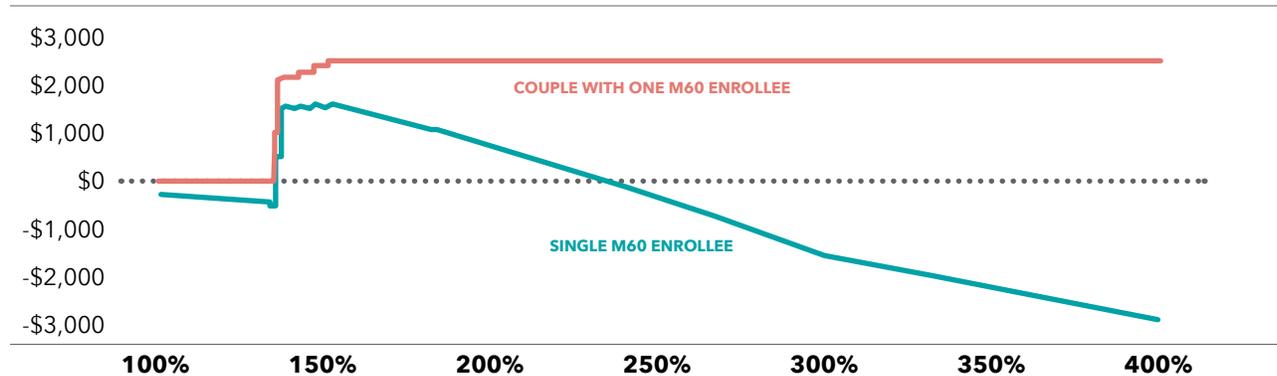
A family's required contribution share rises as their income as a share of the federal poverty guideline rises.

guideline rises. Marketplace plans are divided by metal tiers that indicate the approximate actuarial value of a plan. Bronze plans provide enrollees with a plan that covers an average of 60 percent

of an enrollee's covered health expenditures, silver plans have a 70 percent actuarial value, and gold plans must have an 80 percent actuarial value.³³ The size of the ACA subsidy is equal to their second-cheapest silver plan (the "benchmark plan") less the enrollees' required family contribution.

Figure 7 displays the change in premiums for two stylized families who are enrolled in the benchmark ACA silver plan before the eligibility age expansion. The first is a single individual, aged 60, who would transition from the ACA to Medicare. The second is a married couple where one spouse is 60 years old and would move to Medicare while the other spouse is 59 years old and would maintain current ACA coverage. A positive value indicates the family's required premiums for Medicare and the ACA are greater after enrolling in Medicare at 60. We use 2022 nationwide average premiums for the benchmark plan.³⁴ We assume individuals below 135 percent of the federal poverty guideline would be covered by their state's Medicare Savings Programs and thus owe no Part B premiums.³⁵ We also assume enrollees below 150 percent of poverty would enroll in Part D's Low-Income Subsidy program.

FIGURE 7. CHANGE IN TOTAL PREMIUMS FOR ACA RECIPIENTS WITH BENCHMARK PLAN AFTER MEDICARE AT 60 (BY FAMILY TYPE)



Notes: Data are based on ACA and Medicare premium data for 2022. We use KFF (2022) for the average benchmark premium (\$438 monthly premium for a 40-year old) and adjust using HHS age ratios. Required ACA contribution rates do not include the temporary changes made in the American Rescue Plan of 2021. New Medicare enrollees are assumed to be 60 years old and the non-enrolling spouse in the couple family is assumed to be 59 years old.

³³ Individuals with incomes below 250 percent of the federal poverty guidelines may be eligible for cost-sharing reductions. These reductions raise the actuarial value of silver plans up to 94 percent.

³⁴ Premium estimates are from KFF (2022). We impute age-adjusted premiums using marketplace community rating age ratios. Note, while we use 2022 premiums and poverty guidelines for our calculation, we use the required contribution shares as they were in 2020 to avoid the effects of the American Rescue Plan of 2021, which temporarily lowered the required contribution rates for 2021 and 2022.

³⁵ Many individuals eligible for premium support under the Medicare Savings Programs do not enroll. See Caswell and Waidmann (2017) for details.

...premiums would initially be far higher than an individual's ACA premiums, which were set at 2.07% of their income in 200.

A single individual with an income below 135 percent of the poverty line would see their premiums fall as they would no longer pay any ACA premiums while their Medicare premiums could be covered by low-income assistance programs (if they enrolled).

Above 135 percent, individuals would be required to pay their Part B premiums and at least a portion of their standard Part D premiums.³⁶ These premiums would initially be far higher than an individual's ACA premiums, which were set at 2.07%

of their income in 2020. We estimate that single individuals with incomes up to 233 percent of the poverty line would pay higher premiums under Medicare at 60 than they do under the ACA. A married couple with one Medicare at 60 enrollee faces a larger premium increase. Their required ACA contribution would remain the same across all income levels, while they would also be required to pay Medicare premiums beginning at 135 percent of the poverty line.

Among ACA recipients, the cohort that is most likely to benefit from Medicare at 60 are single individuals with incomes above 233 percent of the federal poverty line. As shown in figure 7, single individuals with incomes above 233 percent of poverty will see their combined premiums fall if they shift from the ACA to Medicare. The savings are particularly large for single individuals with incomes above 400 percent of the federal poverty line; under current law, this group would not be eligible for any ACA subsidies in 2023.³⁷

Premiums are not the only dimension to contemplate in determining the welfare effects of Medicare at 60. Medicare and the ACA offer vastly different cost-sharing rules and reimbursement rates paid to physicians and hospitals that make direct comparisons challenging. Using our microsimulation, we estimate that most ACA marketplace participants that enroll in Medicare at 60 would see their combined out-of-pocket spending plus premiums paid fall. Nevertheless, a significant share—about 36 percent—of individuals would see their combined costs rise. As expected, those most likely to see their combined costs rise are those with incomes between 150 percent and 250 percent of the poverty line.

This group is disproportionately affected for two reasons. First, as shown above, their required premiums rise after moving to Medicare. Second, this group is currently eligible for ACA cost-sharing reductions that reduce out-of-pocket payments for those with silver plans, which they would lose when they move to Medicare. Conversely, we estimate that about 90 percent of ACA recipients with incomes above 400 percent of the poverty line would see their combined out-of-pocket spending plus premiums fall after shifting to Medicare. This is a further indication that Medicare at 60 poorly targets those most in need of assistance.

Beyond low-income ACA recipients, there are other new enrollees that may find limited value from Medicare enrollment. Individuals that are required to pay income-related premiums are particularly likely to discover the downsides of Medicare at 60. We estimate that 20.3 percent of the eligible population would owe income-related premiums. Many of this group are currently enrolled in current-employer ESI plans and thus would choose to forego Medicare coverage without triggering late-enrollment penalties. Those with coverage from a former employer, however, would be required to enroll or face permanent late-enrollment penalties. Among this group, 20.4 percent would be required to pay income-related premiums.

³⁶ Premium subsidies for the LIS program are reduced beginning at 135 percent of the poverty line and fully phased out at 150 percent.

³⁷ The nationwide average benchmark monthly premium for a 60-year-old is \$726 in 2022—significantly higher than the \$203 in premiums a typical recipient would pay for Medicare Parts B and D. Even if we include Medicare's highest income-related premiums (\$408.20 for Part B and \$77.90 for Part D), a 60-year-old ACA single recipient with an income above \$500,000 would still pay less in premiums on Medicare than the ACA.

V. Limitations

There are several limitations to our model. Many of the model's limitations were discussed in the results section of Chen, Church, and Heil (2021). Here, we focus on limitations that are relevant to our new findings.

First, we assume no change in utilization for any group. If Medicare at 60 leads to increased utilization (due to reduced cost-sharing requirements) the budget effects would be larger. This effect could be particularly large for the uninsured population. Conversely, the effects to providers' revenue would be smaller, although whether this would improve the financial outlook for providers depends on the marginal cost from the additional services being provided.

Second, our results are highly sensitive to chosen reimbursement rate assumptions. As discussed above, there is considerable variation in the literature regarding differences between Medicare and private insurer payment rates. There is also considerable uncertainty over whether current-law projected rates are sustainable, or if Congress will succumb to political pressure and enact new "doc fixes" to keep physician rates from falling any further. Similarly, we assume prescription drug spending remains the same after enrolling in Medicare at 60. This is largely due to data limitations. CBO (2022c) describes a lack of available data for retail drug prices for the US population not enrolled in Medicare or Medicaid, but they "find the average net price of a given brand-name drug is probably lower in Medicare Part D than in commercial plans."³⁸ If payments for drugs do fall (with no offsetting increase in utilization), the budgetary costs would decline while drug makers would experience revenue losses.³⁹

Third, we do not assume any change in premiums for Medicare, private insurance, or the Affordable Care Act. In the case of Medicare, Part B premiums are set to finance approximately 25 percent of total expenditures. Thus, if the new group is less costly than current Medicare recipients, projected premiums may be lower than currently anticipated.

In a similar vein, the Kaiser Family Foundation (2021) argued that moving relatively costly ESI enrollees to Medicare would improve ESI risk pools and allow premiums—which are typically the same regardless of an employee's age—to fall for remaining ESI recipients. As noted above, however, most current-employer ESI recipients would

continue to have their private coverage act as the primary payer. Many more individuals with retiree coverage would enroll, but the effects of this transition are less obvious. In the short run, employers would likely benefit from transitioning

Over the long-term, declining retirement health costs could lead to rising wages or other benefits for employees in competitive labor markets.

retirees to Medicare. Over the long-term, declining retirement health costs could lead to rising wages or other benefits for employees in competitive labor markets.

Changes to the Affordable Care Act's risk pool are more complicated. Chen, Church, and Heil posited that removing older ACA recipients may improve risk pools and lead to reductions in premiums: "The ACA community rating rules limit the variation in premiums by age. Thus, average premiums on the exchanges could fall if insurers no longer have to provide coverage for 60- to 64-year-olds."⁴⁰ This could result in even larger reductions in ACA subsidies than estimated above. An analysis of ACA recipients who would enroll in Medicare at 60 reveals that

³⁸ See pages 14 and 15 of CBO (2022c) for a discussion of the relevant factors affecting difference in drug payments by payer.

³⁹ Medicare at 60 would increase gross Part D outlays over the 10-year budget window by \$137 billion. Thus, if prescription drug spending fell by 20 percent for new enrollees, the estimated deficit effect of the proposal would fall by \$27 billion or about 6 percent of our estimated 10-year deficit effect.

⁴⁰ Chen, Church, and Heil (2021), page 16.

their estimated (pre-subsidy) premiums are larger than their expected expenses. This suggests that our earlier hypothesis is incorrect. This finding is consistent with NASI (2020):

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.⁴¹

Finally, we do not account for the effect Medicare at 60 would have on the retirement decisions among the newly eligible. If the policy increases retirement rates, enrollment in Medicare would likely be higher than projected here. Beyond the direct budget effects to Medicare, early retirement decisions would also affect tax revenue and potentially increase Social Security outlays if individuals choose to collect benefits sooner.

VI. Conclusions

Expanding the Medicare eligibility age to 60 would likely lead to large cuts for health care providers, while simultaneously increasing federal deficits. The typical enrollee would see their combined premiums plus out-of-pocket payments fall, but many enrollees—particularly those with subsidized ACA plans—would see an increase in their combined health expenditures. In addition, the data suggest that Medicare at 60 would poorly target many of its intended recipients. The newly eligible are more likely to be insured and have incomes above 400 percent of the federal poverty line than ineligible adults.

The magnitude of these results depends on projected reimbursement rates for Medicare and Medicaid services relative to the payments made by private insurers. It remains an open question if Congress will permit payments for medical services by Medicare to lag further behind private insurers. The Office of the Actuary of Centers for Medicare and Medicaid Services suggests the projected rates may not be sustainable:

Over time, unless providers could alter their use of inputs to reduce their cost per service correspondingly, Medicare's payments for health services would fall increasingly below providers' costs. Providers could not sustain continuing negative margins and would have to withdraw from serving Medicare beneficiaries or (if total facility margins remained positive) shift substantial portions of Medicare costs to their non-Medicare, non-Medicaid payers. Under such circumstances, lawmakers might feel substantial pressure to override the productivity adjustments, much as they did to prevent reductions in physician payment rates while the sustainable growth rate (SGR) was in effect.

If the projected rates prove unsustainable, the fiscal costs of Medicare at 60 would balloon.

Other proposed government health care expansions, such as a government-run public option, a Medicare Buy-In, or Medicare for All, face a similar trade-off. Underpinning optimistic budget scores of these proposals is an assumption that Medicare reimbursement rates will fall even further relative to rates paid by private insurers. If the rates do fall as scheduled, hospitals and providers will face steep cuts. Conversely, if Congress succumbs to political pressure and keeps rates from falling, the effect on the federal budget will be far larger than what optimistic budget scores predict.

⁴¹ NASI (2020), page 45.

⁴² Shatto and Clemens (2020), page 7.

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