

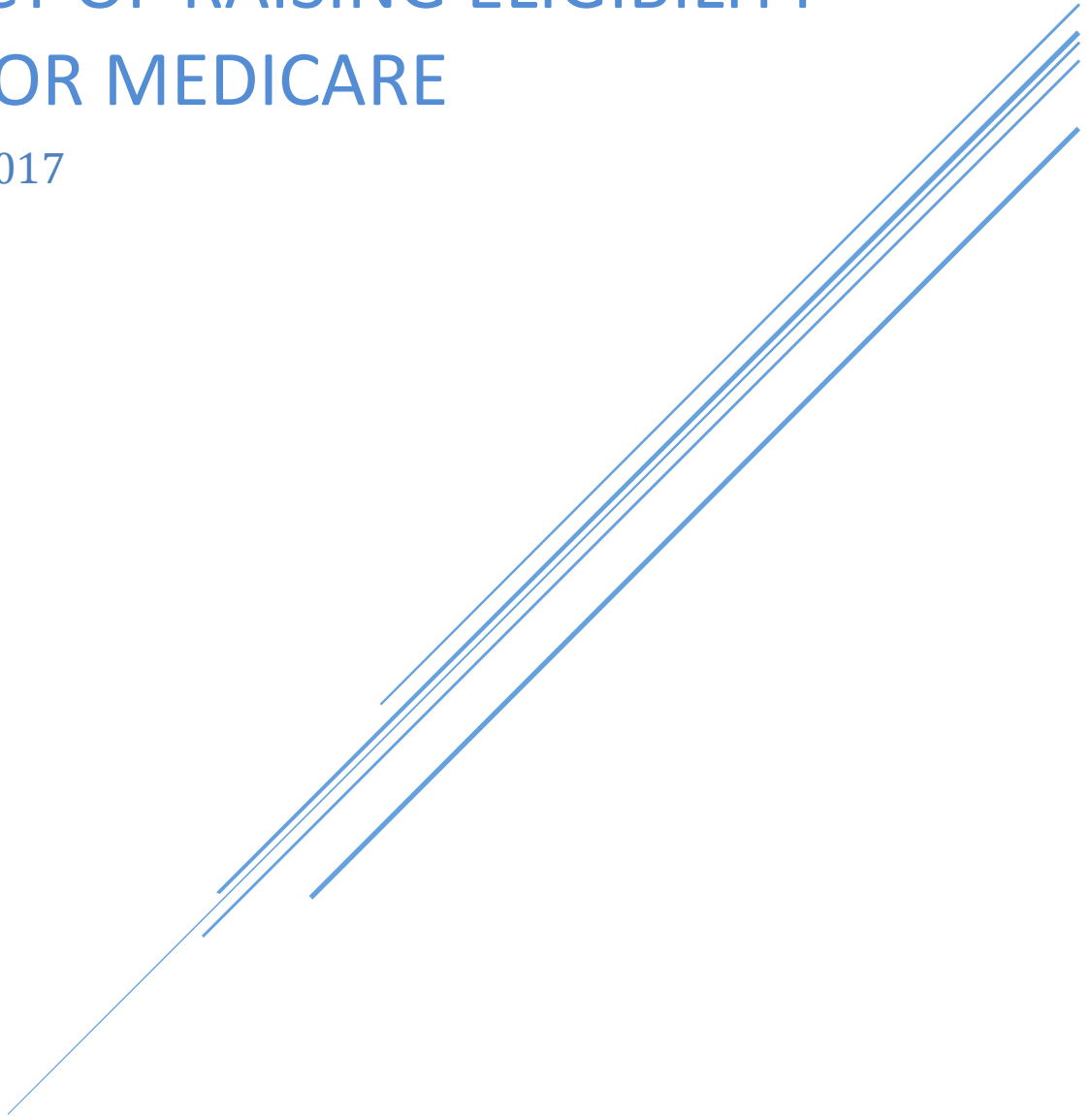


National Committee to Preserve  
**Social Security & Medicare**<sup>™</sup>  
FOUNDATION

*Insuring the Essentials for the 21st Century*

# IMPACT OF RAISING ELIGIBILITY AGE FOR MEDICARE

January, 2017



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## RESEARCH BRIEF

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### **Study Analyzes Impact of Raising Medicare’s Eligibility Age— with and without the Affordable Care Act: Result is Huge Increase in the Number of Uninsured**

Raising Medicare’s eligibility age to 67— featured in Speaker of the House Paul Ryan’s plan, “A Better Way: Health Care”—has gained renewed support in the current political environment.<sup>1</sup> Research conducted by the Actuarial Research Corporation (ARC) for the National Committee to Preserve Social Security and Medicare Foundation provides compelling evidence that suggests this would not be a “better way,” either for the health of Americans aged 65 and 66 or for the financial health of the institutions that provide care for them.

The ARC research provides a one-year snapshot of the impact of raising the eligibility age—taking a single year mid-way through the Trump administration, 2019, to illustrate the effect among people aged 65-66. The study assesses the impact of raising the eligibility age on health insurance coverage under two model scenarios: (a) assuming the Affordable Care Act (ACA) remains intact with conforming legislation to extend the premium subsidies and expand Medicaid eligibility to people aged 65-66 and, (b) assuming the ACA is repealed as proposed or is continued without conforming legislation.<sup>2,3</sup>

If the age of Medicare eligibility is raised from the current 65 years of age to 67, people aged 65 or 66 will face three alternatives: private or employer-based health insurance (for the most fortunate in that age group), public health insurance (mainly thru Medicaid),<sup>4</sup> or becoming uninsured.

The first research model assumes that Medicare eligibility is raised from 65 to 67, the ACA remains intact, premium subsidies are available and current law is changed to extend expanded Medicaid eligibility to people aged 65 and 66 in tandem with the Medicare change. The second research model assumes that the ACA is repealed or is continued without conforming legislation. In this case there are no advanced premium tax credits and expanded eligibility for Medicaid remains the same as current law, ending at age 65. The study presents results for the total population affected (ages 65 and 66) by gender and by race/ethnicity.

The results are stark in both scenarios. Even with the ACA intact and modified to extend access to Medicaid to people aged 65-66, the number of people who would become uninsured rises significantly for both men and women and for all racial and ethnic groups. With repeal of the ACA the rate of uninsured increases even more dramatically.

In 2015, 98.9% of adults aged 65 or over had health insurance coverage, mainly through Medicare.<sup>7</sup> **According to ARC projections, if Medicare eligibility is raised to age 67 and the ACA remains in effect, by 2019 the percent uninsured among those aged 65 and 66 will increase more than nine-fold, from less than 2% to 18.7% (1.9 million people). If the ACA is repealed the uninsured rate will increase to 37%, more than one-third of those 65 and 66, affecting 3.8 million seniors.**

**Raising Medicare Eligibility Age from 65 to 67:  
Number Uninsured (ages 65-66) With and Without the Affordable Care Act, 2019** <sup>5</sup>

	Demographic group						
	All	Gender		Race/ethnicity			
		Men	Women	White Non-Hispanic	Black Non-Hispanic	Hispanic	Other <sup>6</sup>
<b>With ACA</b>	18.7%	18.6%	18.7%	20.3%	11.2%	13.0%	14.9%
	1,933,000	947,000	986,000	1,640,000	97,000	120,000	76,000
<b>Without ACA</b>	37.0%	34.4%	39.6%	37.3%	31.0%	42.1%	34.4%
	3,836,000	1,745,000	2,090,000	3,004,000	269,000	387,000	175,000

In 2015, 98.9% of adults aged 65 or over had health insurance coverage, mainly through Medicare.<sup>7</sup> **According to ARC projections, if Medicare eligibility is raised to age 67 and the ACA remains in effect, by 2019 the percent uninsured among those aged 65 and 66 will increase more than nine-fold, from less than 2% to 18.7% (1.9 million people). If the ACA is repealed the uninsured rate will increase to 37%, more than one-third of those 65 and 66, affecting 3.8 million seniors.**

In the first model (the ACA remains intact), the uninsured rate for people aged 65-66 does not vary much by gender (18.6% and 18.7% for men and women, respectively). However, significant disparities are apparent by race/ethnicity.<sup>8</sup> Fully one-fifth of Whites in this age group would be affected, experiencing the highest uninsured rate (20.3%); rates for Black, Hispanic and other <sup>6</sup> at 11.2%, 13% and 14.9%, respectively.

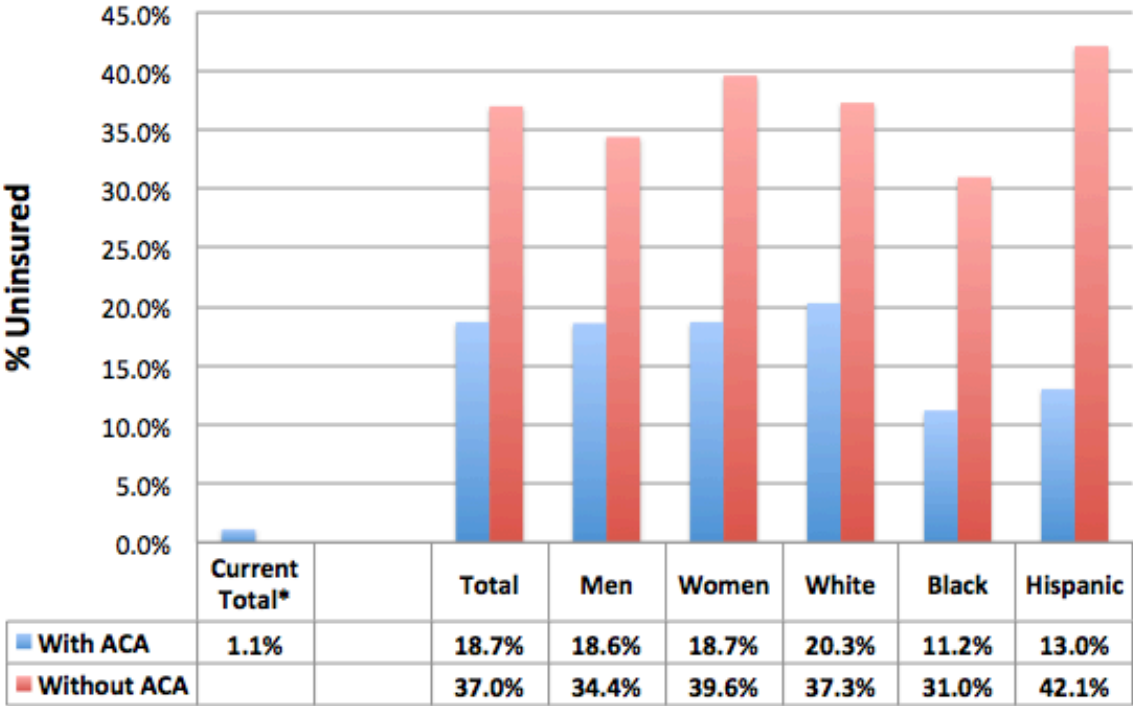
In the second model (ACA is repealed), the uninsured rate among those who are 65 and 66 rises dramatically for all groups, but affects women (39.6%) more than men (34.4%). 42.1% of Hispanics and 37.3% of Whites become uninsured and the rate among Blacks increases to 31.0%.

Medicaid protections for those with limited financial resources are particularly important for keeping up the rates of insurance coverage. Racial and ethnic minorities have dramatically lower income and asset levels compared to Whites<sup>9</sup> and thus they more easily meet the strict requirements to qualify for Medicaid. This is particularly true under the first scenario, in which Medicaid is more readily available through the ACA's expansion.<sup>10</sup>

There is little question that increasing Medicare's retirement age will demonstrably increase the number and percentage of uninsured people aged 65 and 66. Those who become uninsured will have greater difficulty accessing health care, and as a result these individuals are likely to experience worsening health status. This will also impact the Medicare system because when they do qualify for Medicare at 67, their poorer health will generate increased financial demands on the program.<sup>11,12,13</sup>

Because they would be older than other uninsured people, the 65- and 66-year olds no longer eligible for Medicare at age 65 are likely to forego needed medical care. This can not only lead to poorer health outcomes and overall well-being, but may also cause individuals to rely on costlier care, like ambulance rides, ER visits, and hospital stays.<sup>14</sup> To the extent they receive this care, those individuals are likely to experience financially crippling out-of-pocket costs. Repeal of the ACA would also eliminate the special protections that currently allow access to insurance without discrimination (pre-existing conditions clauses). Consequently, people with the most severe health problems would have the most difficulty in obtaining coverage and will generate significant costs for hospitals, providers and private insurers who experience “cost-shifting” as a hidden subsidy for care of the uninsured. **In short, raising Medicare’s eligibility age not only would undermine the health security of millions of Americans but also threatens the financial health of the institutions that care for them.**

**Raising Medicare Eligibility Age from 65 to 67:  
Percentage Uninsured (ages 65-66) With and Without the  
Affordable Care Act (ACA), 2019**



\* Current total refers to the percent of adults aged 65 or over without health insurance in 2015 (U.S. Census Bureau, <http://bit.ly/2i0P2sm>)

## References

- <sup>1</sup> Speaker of the House Paul Ryan, “A Better Way: Health Care” (June 22, 2016). <http://bit.ly/2h12vtn>
- <sup>2</sup> House Budget Resolution for Fiscal Year 2017, March 2016. <http://bit.ly/2iB9QGk>;
- <sup>3</sup> Pear R. Job No. 1 for a New Congress? Undoing Obama’s Health Law. *The New York Times*, December 31, 2016. <http://nyti.ms/2hMqWAm>
- <sup>4</sup> It should be noted that individuals who qualify for Medicare as disabled under Social Security would retain their Medicare coverage and because of their relatively high and costly medical needs would reduce any projected savings to the Medicare program.
- <sup>5</sup> Estimates were generated by analyzing patterns of health insurance coverage among people a few years younger than Medicare’s current eligibility age (60-64) and a few years older (65-69). These figures were then adjusted to account for changes in sources of health insurance coverage and participation in the labor force as people age. Projections are based on a spreadsheet-based simulation model developed from a variety of data sources, including Medicare claims and administrative data, the Medicare Current Beneficiary Survey (MCBS), the Health and Retirement Study, Medicare Trustees Reports, census data, National Health Expenditure projections of the CMS Office of the Actuary, the Medical Expenditure Panel Survey and the Current Population Survey. Sex and race/ethnicity distributions within insurance categories were obtained from the Cost and Use files of MCBS, pooling data on beneficiaries aged 65-69 from 2006-2011. For further details, see report prepared by the Actuarial Research Corporation for the National Committee to Preserve Social Security & Medicare Foundation, January 6, 2017.
- <sup>6</sup> Respondents in survey data reporting race/ethnicity other than Hispanic, non-Hispanic White, or non-Hispanic Black are included as “Other” due to small sample sizes.
- <sup>7</sup> Barnett JC, Vornovitsky MS. Health Insurance Coverage in the United States: 2015. US Census Bureau, Current Population Reports, Report. 2016 Sep (P60-257). <http://bit.ly/2iOP2sm>
- <sup>8</sup> In this report Whites refer to non-Hispanic White; Blacks refer to non-Hispanic Black.
- <sup>9</sup> Urban Institute. Nine Charts about Wealth Inequality in America, February 2015. <http://urbn.is/2ir3Ymn>
- <sup>10</sup> Blacks and Hispanics have higher Medicare disability coverage rates compared to Whites, which also contributes to lower their uninsurance rates.
- <sup>11</sup> McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Use of health services by previously uninsured Medicare beneficiaries. *New England Journal of Medicine*. 2007 Jul 12;357(2):143-53. <http://bit.ly/2hKx90e>
- <sup>12</sup> Institute of Medicine. America’s Uninsured Crisis: Consequences for Health and Health Care. 2009, National Academies Press, Washington DC. <http://bit.ly/2ib4y5z>
- <sup>13</sup> Chandra A, Gruber J, McKnight R. Patient cost-sharing and hospitalization offsets in the elderly. *The American Economic Review*. 2010 Mar 1;100(1):193-213. <http://bit.ly/2jGSRGa>
- <sup>14</sup> Swartz K. Cost-sharing: Effects on spending and outcomes. Robert Wood Johnson Foundation, The Synthesis Project, December 2010. <http://rwjf.ws/2jx0a1e>

**To:** National Committee to Preserve Social Security and Medicare Foundation  
**From:** Actuarial Research Corporation  
**Subject:** Analyzing data related to raising Medicare's eligibility age from 65 to 67  
**Date:** January 6, 2017

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## **Background**

There have been any number of studies that examine socioeconomic and demographic disparities in health insurance coverage, utilization, and health status; these disparities are well-known by now. Less attention has been paid to the disparities existing within the Medicare program, among the population nearing eligibility for the program, and whether disparities change after age 65. A question of particular interest to policymakers is whether the transition to Medicare affects disparities in access to health care and outcomes. This question takes on greater significance in light of various proposals to reform Medicare. One proposal near the top of the policy agenda is to raise the age of eligibility for Medicare, which currently stands at 65. Increasing the age of eligibility to age 67, for example, will impact people aged 65-66 and may decrease the rate of insurance coverage, increase out-of-pocket costs, and affect utilization of services among this age group. Given disparities in insurance coverage and access to care among the population under age 65, there is concern that an increase in the age of eligibility for Medicare could have a disproportionate impact on vulnerable groups such as racial and ethnic minorities and women.

We first present results of some descriptive analyses examining patterns of insurance coverage by sex and race/ethnicity. We compare individuals approaching Medicare eligibility (ages 60-64) with those recently transitioning to Medicare (ages 65-69). We focus on the percent of individuals lacking health insurance and how this varies by sex and race/ethnicity. We also examine rates of uninsurance for individuals aged 60-64 and aged 65-69 before and after early implementation of reforms under the Affordable Care Act (ACA) in 2014. We use data from two sources: the Medical Expenditure Panel Survey (MEPS) and the Current Population Survey (CPS), Annual Social and Economic Supplement. These data sources are described at the end of this report.

We also present results of an analysis of the impact of raising the age of Medicare eligibility from age 65 to age 67. The results are based on a simulation using data from a variety of sources. We estimate impacts on rates of uninsurance separately for men and women and major racial/ethnic groups.

## Descriptive Results

### Comparing 60-64 and 65-69 year olds

Using 2012 MEPS Household Component data, we analyzed selected measures for 60-64 year olds and for 65-69 year olds. The tables compare men and women as well as Hispanics, non-Hispanic whites, and non-Hispanic blacks with respect to insurance status. Race and ethnicity are self-reported. Respondents reporting race/ethnicity other than Hispanic, non-Hispanic white, or non-Hispanic black are not reported separately in the tables.

Table 1 shows that uninsurance rates were similar across gender with a significant reduction in uninsurance at age 65 for both men and women due to eligibility for Medicare. Table 2 compares similar outcomes by age and race. Hispanics were much more likely to be uninsured than non-Hispanic groups in the younger age bracket (age 60-64). Uninsurance rates dropped significantly in the older age bracket (65-69 year olds) across all race categories because of the general availability of Medicare entitlement at age 65. Even though the disparities were reduced in the older age bracket, Hispanics still had a higher uninsurance rate (2.3%) compared to non-Hispanic whites (0.2%) and non-Hispanic blacks (0.3%). We do not provide further breakdowns by insurance status because of small sample sizes.

### Lack of Insurance Pre- and Post-ACA

The ACA increased the availability of health insurance through the expansion of Medicaid, the provision of insurance subsidies, and the creation of health insurance exchanges. Because many disparities in health status and outcomes are associated with a lack of insurance among people under age 65, the ACA has the potential to lessen these disparities. In order to explore how coverage expansion under the ACA may affect disparities, we examined pre- and post-ACA rates of uninsurance using the CPS March 2013 and March 2015 Supplements, which include data collected in 2012 and 2014 respectively. Tables 3a-3d show the number of people in the 60-64 and 65-69 age groups by sex, race, and insurance status.

Across age, sex and race categories we saw a decline in uninsurance with early, post-ACA data compared to pre-ACA data. Among all individuals aged 60-64 the percent uninsured declined from 13.5% to 10.2%. The decline was similar for women and men (3.4% and 3.1% respectively). Among racial/ethnic subgroups, the largest (absolute) drop in uninsurance rates was seen for Hispanics age 60-64, (from 26.6% to 20.0%); however, Hispanics continued to face lower rates of coverage compared to non-Hispanic whites and non-Hispanic blacks.<sup>1</sup> Uninsurance rates were significantly reduced once individuals reach age 65, however, disparities across race still existed, with a 6.4% uninsurance rate for Hispanics

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<sup>1</sup> This is consistent with findings from McMorrow, S., Long, S. Kenney, G. and Anderson, N. (2015). Uninsurance Disparities have narrowed for black and Hispanic adults under the Affordable Care Act. *Health Affairs* No. 10. The authors used early release data from 2014 NHIS and found uninsurance rates have narrowed for black and Hispanic adults, but Hispanics still experience larger gaps in health insurance coverage.



compared to 1.1% for non-Hispanic whites and 2.5% for non-Hispanic blacks.<sup>2</sup> The rate of uninsurance among 60-64 year old non-Hispanic blacks declined by 4.2% between 2012 and 2014 (from 14.9% to 10.7%).

We also compared rates of uninsurance in states where the Medicaid program was expanded under the ACA and states without a Medicaid expansion. Among individuals aged 60-64 rates of uninsurance decreased to a slightly greater extent in the expansion states (4.0% compared to 2.5%) but the difference was not statistically significant.

McMorrow et al. (2015) note two limitations in ACA's ability to narrow disparities. The first is a coverage gap in states that do not expand Medicaid. Without federal subsidies or access to Medicaid, many poor adults<sup>3</sup> will remain without health insurance coverage options. The second limitation is that undocumented immigrants are not eligible for Medicaid or federal subsidies. This largely affects the potential to cover Hispanics, of whom 16% are estimated to be undocumented (McMorrow et al., 2015). It will be important to continue studying the disparities for women and minorities as additional years of data are released and as the implementation of ACA continues. Expanding Medicaid eligibility, Marketplace subsidies for coverage, as well as outreach programs and enrollment simplification efforts are all aimed at increasing coverage rates and have the potential to help narrow disparities for women and minorities.

## **Impact of raising the eligibility age for Medicare**

### Overview

Recently there has been increased interest among policymakers in raising the age of eligibility for Medicare entitlement. Doing so would reflect increases in longevity and would make Medicare eligibility consistent with that for full Social Security retirement benefits. Such a change would reduce federal spending on Medicare, transferring costs to other payers such as Medicaid, employers, Health Insurance Exchanges, and individuals.<sup>4</sup> It is likely that many 65- and 66-year-old people eligible for Medicare under current law would remain uninsured for this 2-year period, which has significant implications for out-of-pocket health care costs and access to care.

It is unclear a priori whether non-Hispanic white males would be affected more by raising the age of Medicare entitlement than would be women or members of other racial and ethnic groups. On one hand, as noted previously, black and Hispanic individuals are considerably more likely to be uninsured at ages

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<sup>2</sup> We observed a difference in the rate of uninsurance for Hispanics, age 65-69 in the CPS compared to MEPS. The higher rate of uninsurance for Hispanics in CPS is likely due to differences in survey respondents (i.e. CPS could have a larger number of undocumented respondents compared to MEPS).

<sup>3</sup> McMorrow et al. (2015) suggest that this disproportionately affects the black population and estimate that 1.4 million more blacks will remain uninsured because of states not choosing to expand Medicaid.

<sup>4</sup> Neuman T., Cubanski J., Waldo D. et al. Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform. The Henry J. Kaiser Family Foundation. Wash. D.C. March 2011.

60-64. Women are also somewhat more likely than men to be uninsured. Postponing the age of Medicare eligibility might therefore have adverse consequences for women

and minorities by preserving pre-Medicare insurance arrangements past age 65. On the other hand, access to other programs and low-income subsidies in insurance Exchanges could soften the effect of delayed eligibility on average for these individuals, compared to higher-income white males. The nature of alternate insurance is crucial in determining the relative effects of the delay: if conforming legislation is not enacted to extend Exchange subsidies to people over the age of 65 the loss of Medicare eligibility would have a profound effect on lower-income groups.

For this report we simulated the impact of raising the age of Medicare eligibility from 65 years of age to 67 and examined the effects on men and women and on four racial/ethnic groups: non-Hispanic whites, non-Hispanic blacks, Hispanics, and members of all other racial/ethnic groups. We estimated impacts on rates of uninsurance in 2019, under the assumption that an increase in the age of Medicare eligibility would be phased in over several years.

We produced two sets of estimates reflecting two possible scenarios regarding health insurance subsidies and Medicaid expansion provided under the ACA. Currently, insurance subsidies are available to individuals under age 65 with incomes below 400% of the poverty level who obtain insurance through the health Exchanges. These subsidies are crucial to the take-up rate for insurance and resulting health care expenditures. Under current law, these subsidies would not be available to individuals age 65-66 if the age of Medicare eligibility were raised to 67. Similarly, the expansion of Medicaid eligibility under the ACA, which was adopted by 30 states and the District of Columbia, is limited under current law to individuals under age 65. We provide one set of results obtained under the assumption that these ACA conditions would continue to hold if the age of Medicare eligibility were raised. These results would also likely apply if the ACA were repealed. It is possible, however, that an increase in the age of Medicare eligibility could be accompanied by conforming legislation that would extend the Exchange subsidies and expanded Medicaid eligibility to people age 65-66. This would significantly affect consumers' decisions regarding enrollment through Exchanges. We provide a second set of results under the assumption of conforming legislation.

### **Findings – assuming conforming legislation**

Under current law, most people age 65 and over have Medicare coverage. If the age of eligibility were raised, nearly 19 percent of people age 65-66 would likely be uninsured (Table 4). Equal proportions of men and women would lack insurance, with more men covered under Medicare (through disability) and active employment, and more women receiving coverage through Medicaid, health Exchanges, and retiree insurance. There would be significant changes by race/ethnicity. Non-Hispanic whites would be covered disproportionately by retiree plans and plans acquired through the health Exchanges. The rate of uninsurance would be highest for non-Hispanic whites assuming that many will choose to forgo purchasing plans through the health Exchanges. Non-Hispanic blacks show a high rate of coverage under Medicare disability and a relatively low rate of uninsurance. Hispanics show a high rate of coverage under Medicaid and a relatively high rate of participation in Medicare through disability. The Exchanges established under the ACA would also be an important source of coverage for individuals affected by an increase in the age of Medicare eligibility (Table 4). Overall, an estimated 21.7% of 65-66 year olds

would receive coverage through the Exchanges, with approximately equal percentages of men and women participating. Coverage is estimated to be slightly greater for non-Hispanic whites (22.6%) than for non-Hispanic blacks and Hispanics (19.1% and 18.3% respectively).

### **Findings – assuming no conforming legislation or repeal**

The group most affected by a lack of conforming legislation would be people without access to employer-sponsored insurance, Medicaid, or Medicare through disability. Such people would have the choice of obtaining private insurance through the health Exchanges, (if the ACA exchanges were retained), the individual insurance market, or forgoing insurance altogether. In the previous section, we assumed certain take-up rates under the assumption that subsidies through the health Exchanges would be available to people age 65-66. If such subsidies are not available, the take-up rate for insurance through the Exchanges would presumably be far lower, as suggested by our review of the literature. We also assume in this analysis that Medicaid expansion will not be available to those age 65-66. For purposes of this analysis we estimated take-up rates using MEPS data for 2011-2013, which are pre-ACA years. We divided the MEPS respondents aged 50-64 into income groups and calculated take-up rates for private, non-employer sponsored insurance among persons not otherwise covered by public or employer-sponsored insurance. We based the take-up rates in our simulation on these findings.

Without subsidies and a Medicaid expansion the number of uninsured is expected to increase substantially (Table 5). With no enrollment in the health Exchange program, the percent uninsured among 65-66 year olds is expected to grow to 37 percent. Uninsurance is expected to be about 5% higher among women than among men and higher among Hispanics than among other racial and ethnic groups. The high rate of uninsurance among Hispanics reflects their lack of coverage under private retiree insurance. The relatively high rate of uninsurance among whites is attributable to their greater reliance on employer-based insurance and lower participation rates in Medicaid and Medicare through disability.

**Tables**

**Table 1: Percent Uninsured, Medical Expenditure Panel Survey 2012, by sex and age**

	Total		Men		Women	
	60-64	65-69	60-64	65-69	60-64	65-69
N	1,828	1,510	831	677	997	833
% uninsured	12.1%	0.5%	11.9%	0.6%	12.3%	0.5%

N represents the number of respondents. Percents are weighted using MEPS survey weights.

**Table 2: Percent Uninsured, Medical Expenditure Panel Survey 2012, by Race/Ethnicity**

	Non-Hispanic White		Non-Hispanic Black		Hispanic	
	60-64	65-69	60-64	65-69	60-64	65-69
N	936	825	376	303	322	235
% uninsured	9.6%	0.2%	12.4%	0.3%	30.3%	2.3%

N represents the number of respondents. Percents are weighted using MEPS survey weights.

**Table 3a: Percent uninsured by sex, age 60-64, CPS**

		2012			2014		
		Non-Expansion States	Expansion States	Total	Non-Expansion States	Expansion States	Total
Male	N	2,050	2,661	4,711	2,379	2,723	5,102
	% uninsured	13.9%	12.2%	12.9%	11.4%	8.5%	9.8%
Female	N	2,352	2,926	5,278	2,551	2,912	5,463
	% uninsured	14.6%	13.3%	13.9%	12.1%	9.0%	10.5%
Total	N	4,402	5,587	9,989	4,930	5,635	10,565
	% uninsured	14.3%	12.7%	13.5%	11.8%	8.7%	10.2%

Notes: Expansion states include those with coverage under the Medicaid expansion effective January 1, 2014. Medicaid Expansion Decision accessed 12April2016 at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#table>

N represents the number of respondents. Percents are weighted using CPS survey weights.

Source: Current Population Survey, Annual Social and Economic Supplement, 2013 & 2015

		2012			2014		
		Non-Expansion States	Expansion States	Total	Non-Expansion States	Expansion States	Total
Non-Hispanic White	N	3,134	3,638	6,772	3,381	3,595	6,976
	% uninsured	12.4%	9.9%	11.1%	10.0%	7.6%	8.7%
Non-Hispanic Black	N	639	584	1,223	795	596	1,391
	% uninsured	14.8%	15.1%	14.9%	12.2%	8.4%	10.7%
Hispanic	N	396	725	1,121	503	768	1,271
	% uninsured	29.0%	25.1%	26.6%	25.1%	16.2%	20.0%
Total	N	4,169	4,947	9,116	4,679	4,959	9,638
	% uninsured	14.0%	12.1%	13.0%	11.7%	8.7%	10.1%

Notes: Expansion states include those with coverage under the Medicaid expansion effective January 1, 2014. Medicaid Expansion Decision accessed 12April2016 at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#table>;  
Excludes "other" race category  
N represents the number of respondents. Percents are weighted using CPS survey weights.

Source: Current Population Survey, Annual Social and Economic Supplement, 2013 & 2015

		2012			2014		
		Non-Expansion States	Expansion States	Total	Non-Expansion States	Expansion States	Total
Male	N	1,718	2,114	3,832	1,875	2,225	4,100
	% uninsured	1.8%	2.3%	2.1%	2.0%	1.7%	1.9%
Female	N	1,914	2,211	4,125	2,151	2,513	4,664
	% uninsured	2.5%	2.4%	2.5%	1.8%	1.7%	1.8%
Total	N	3,632	4,325	7,957	4,026	4,738	8,764
	% uninsured	2.2%	2.4%	2.3%	1.9%	1.7%	1.8%

Notes: Expansion states include those with coverage under the Medicaid expansion effective January 1, 2014. Medicaid Expansion Decision accessed 12April2016 at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#table>  
N represents the number of respondents. Percents are weighted using CPS survey weights.

Source: Current Population Survey, Annual Social and Economic Supplement, 2013 & 2015

**Table 3d: Percent uninsured by race, age 65-69, CPS**

		2012			2014		
		Non-Expansion States	Expansion States	Total	Non-Expansion States	Expansion States	Total
Non-Hispanic White	N	2,647	2,835	5,482	2,855	3,057	5,912
	% uninsured	1.3%	1.2%	1.3%	1.2%	1.0%	1.1%
Non-Hispanic Black	N	471	482	953	609	533	1,142
	% uninsured	2.5%	3.3%	2.8%	2.5%	2.3%	2.5%
Hispanic	N	322	521	843	357	613	970
	% uninsured	9.8%	7.8%	8.6%	7.0%	6.0%	6.4%
Total	N	3,440	3,838	7,278	3,821	4,203	8,024
	% uninsured	2.1%	2.0%	2.0%	1.8%	1.7%	1.7%

Notes: Expansion states include those with coverage under the Medicaid expansion effective January 1, 2014.

Medicaid Expansion Decision accessed 12April2016 at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#table>;

Excludes "other" race category

N represents the number of respondents. Percents are weighted using CPS survey weights.

Source: Current Population Survey, Annual Social and Economic Supplement, 2013 & 2015

**Table 4: Simulated effects on insurance coverage of raising the age of Medicare eligibility to 67, assuming health insurance subsidies and Medicaid expansion under the ACA will be extended to people aged 65-66, by sex and race, 2019**

Measure	Demographic group						
	All	Sex		Race/ethnicity			
		Men	Women	Non-Hispanic white	Non-Hispanic black	Hispanic	Other
<i>Number (000s)</i>							
Population aged 65-67	10,359	5,081	5,278	8,061	868	920	510
<b>Health insurance</b>							
Medicare (disabled)	1,404	727	677	983	208	146	67
Private active employer	1,759	1,034	725	1,333	157	172	97
Private retired worker	1,936	920	1,016	1,642	126	89	79
Medicaid	1,084	390	693	646	115	224	99
Exchange	2,244	1,063	1,181	1,818	166	168	91
Uninsured	1,933	947	986	1,640	97	120	76
<i>Percent</i>							
Health insurance	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Medicare (disabled)	13.6%	14.3%	12.8%	12.2%	24.0%	15.9%	13.1%
Private active employer	17.0%	20.4%	13.7%	16.5%	18.1%	18.7%	19.0%
Private retired worker	18.7%	18.1%	19.2%	20.4%	14.5%	9.7%	15.5%
Medicaid	10.5%	7.7%	13.1%	8.0%	13.2%	24.3%	19.4%
Exchange	21.7%	20.9%	22.4%	22.6%	19.1%	18.3%	17.8%
Uninsured	18.7%	18.6%	18.7%	20.3%	11.2%	13.0%	14.9%

Note: The analysis covers individuals aged 65-66.

**Table 5: Simulated effects on insurance coverage of raising the age of Medicare eligibility to 67, assuming health insurance subsidies and Medicaid expansion under the ACA are not extended to people aged 65-66, by sex and race, 2019**

Measure	Demographic group						
	Sex			Race/ethnicity			
	All	Men	Women	Non-Hispanic white	Non-Hispanic black	Hispanic	Other
	<i>Number (000s)</i>						
Population aged 65-67	10,359	5,081	5,278	8,061	868	920	509
Health insurance							
Medicare (disabled)	1,404	727	677	983	208	146	67
Private active employer	1,759	1,034	725	1,333	157	172	97
Private retired worker	1,936	920	1,016	1,642	126	89	79
Medicaid	235	69	166	92	45	55	42
Exchange or other private insurance	1,191	586	604	1,008	64	70	49
Uninsured	3,836	1,745	2,090	3,004	269	387	175
	<i>Percent</i>						
Health insurance	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Medicare (disabled)	13.6%	14.3%	12.8%	12.2%	24.0%	15.9%	13.2%
Private active employer	17.0%	20.4%	13.7%	16.5%	18.1%	18.7%	19.1%
Private retired worker	18.7%	18.1%	19.2%	20.4%	14.5%	9.7%	15.5%
Medicaid	2.3%	1.4%	3.1%	1.1%	5.2%	6.0%	8.3%
Exchange or other private insurance	11.5%	11.5%	11.4%	12.5%	7.4%	7.6%	9.6%
Uninsured	37.0%	34.4%	39.6%	37.3%	31.0%	42.1%	34.4%

Note: The analysis covers individuals aged 65-66.



## **Selected Data Sources**

### Medical Expenditure Panel Survey (MEPS)

MEPS has been conducted annually since 1996,<sup>5</sup> and collects data on the medical expenditures and sources of payment of a sample of households. The survey also includes basic economic and demographic information about the respondents and their health insurance coverage by month. For this reason, many analysts believe that MEPS provides a more reliable source of information on insurance coverage than does the CPS. Because it is a household survey, it excludes most of the institutionalized. Cross-sectional data on MEPS respondents who participated in the survey at ages 60-64 and/or 65-69 can be found in Tables 1a-1e (by sex) and Table 2 (by race).

### Current Population Survey (CPS)

The CPS is probably one of the best-known sources of socio-demographic information. Conducted jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, the CPS – especially the Annual Social and Economic (March) Supplement – is a widely used source for studying the impact of changes in Medicaid and SCHIP eligibility criteria. The CPS also includes information on family structure, income, and tax filings. Because the March Supplement to the CPS has become the standard source of data for estimating health insurance coverage, it has received considerable scrutiny. Most analysts agree that it undercounts Medicaid and SCHIP enrollees.

### Health and Retirement Study (HRS)

HRS is a longitudinal panel study that surveys a representative sample of more than 26,000 Americans over the age of 50 every two years. Since its launch in 1992, the study has collected information about income, work, assets, pension plans, health insurance, disability, physical health and functioning, cognitive functioning, and out-of-pocket costs for health care. The HRS explores the changes in labor force participation and the health transitions that individuals undergo toward the end of their work lives and in the years that follow.

### Medicare Current Beneficiary Survey (MCBS)

The MCBS is a cross-sectional survey of people enrolled in the Medicare program – a survey with longitudinal aspects. It is a continuous survey of a nationally representative sample of about 12,000 of the Medicare population; each beneficiary selected for the survey is included for three consecutive years. The survey collects not only self-reported health care use and expenditures but also administrative data from the participant's date of entry into the survey until date of death.<sup>6</sup> The survey has been conducted each year since 1991.

The MCBS combines survey information with administrative data for Medicare enrollees. The survey provides information on supplemental health insurance carried by Medicare enrollees

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<sup>5</sup> Earlier household expenditure surveys had been conducted in 1977, 1980, and 1987.

<sup>6</sup> A limitation of the data is that information on use and expenditures for Medicare Advantage and PACE enrollees are obtained from the survey rather than administrative data and are thus likely to be underreported. This problem will be accentuated further in future years due to new capitated federal programs such as the Financial Alignment Demonstration for dual eligibles.

plus their Medicaid involvement. The MCBS is coordinated with program claims and enrollment data to improve reliability. As a result, MCBS expenditure data closely reconcile with Medicare aggregate expenditures. Because a large proportion of people institutionalized in medical institutions are Medicare eligible, the MCBS fills a major gap in the knowledge of expenditures that is left by household surveys that exclude the institutionalized. The MCBS provides data on beneficiary sources of public and private wraparound coverage, so MCBS has been used to study the effect of changes in Medigap offerings.

#### Medicare Claims and Other Administrative Data

Another source of information about utilization under the Medicare program is the claims data themselves. Through an anonymized 5-percent national sample of enrollees, claims data for inpatient, outpatient, physician, home health, Skilled Nursing Facility, hospice, and durable medical equipment were summarized at several levels; information from Medicare's enrollment files about the beneficiary's age, sex, and (to some extent) race and ethnicity were added to the analysis. The race and ethnicity markers on these data are good for White and Black enrollees, but less accurate for Hispanic enrollees and for American Indians and enrollees of Asian descent (an algorithm has been developed to identify Hispanic enrollees on the basis of name, but are not available in the anonymized sample.)

#### **Simulation methods**

Our methods closely follow those of an earlier study in which we simulated the effects of raising the age of Medicare eligibility.<sup>7</sup> The current study differs from the previous one in two key respects. First, we incorporate new assumptions about the availability of health insurance based on state implementation of Medicaid expansion under the ACA and on the experience of health insurance Exchanges. This has implications for insurance take-up rates. Second, we stratify our analysis by sex and race/ethnicity, providing separate sets of findings for each group.

Our findings are based on a spreadsheet-based simulation model developed from a variety of data sources, including Medicare claims and administrative data, the Medicare Current Beneficiary Survey (MCBS), the Health and Retirement Study (HRS), Medicare Trustees Reports, Census data, and National Health Expenditure projections of the CMS Office of the Actuary. Sex and race/ethnicity distributions within Insurance and income categories were obtained from the Cost and Use files of MCBS, pooling data on beneficiaries aged 65-69 from 2006-2011.

We began with tabulation from Medicare administrative records of enrollees aged 65 and 66 years. Thus, our figures exclude people of this age who were not enrolled in Medicare; our assumption is that these people would not be affected by a change in the age of eligibility.

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<sup>7</sup> Neuman T., Cubanski J., Waldo D. et al. Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform. The Henry J. Kaiser Family Foundation. Wash. D.C. March 2011.

We used census population projections to move the enrolled population to calendar year 2019, and then used Medicare administrative data and HRS to divide these people into strata, according to the following hierarchy:

- People originally entitled to Medicare through disability. These people would continue to have Medicare coverage, regardless of a change in the age of Medicare eligibility.
- Active workers currently receiving health insurance through their employer. We assumed these workers would continue to receive insurance through their employer at ages 65-66. This group was proxied in our data by Medicare beneficiaries with Part A coverage only.
- People dually eligible for full Medicaid and Medicare. We assumed Medicaid would become the primary insurer if Medicare were no longer available.
- Individuals with generous private supplemental insurance provided by a former employer or union. We assumed the retiree plan would become the primary source of coverage at ages 65-66. These individuals were proxied by the proportion of 65- and 66-year old enrollees with a Part D retiree drug subsidy or other creditable drug coverage in 2008.

The remaining enrollees were divided into strata depending upon their income as a percentage of the federal poverty level (FPL). They include people with no insurance supplemental to Medicare; with Medigap; or with employer-sponsored insurance that we considered unlikely to extend early-retiree benefits to this newly-uncovered population. They also include people who rely on programs such as Indian Health Service or Veterans Administration benefits.

- Those with income below 139 percent of the FPL who live in a Medicaid expansion state. We assumed these individuals would have Medicaid as primary insurance.
- Those with income below 139 percent of the FPL who do not reside in an expansion state. We assumed that these people would choose between enrolling in an Exchange plan or becoming uninsured.
- Those with income between 139 and 150 percent of the FPL. These people would choose between an Exchange plan or uninsurance.
- Those with income between 150 and 200 percent of the FPL. These people would choose between an Exchange plan or uninsurance.
- Those with income between 200 and 300 percent of the FPL. These people would choose between an Exchange plan or uninsurance.
- Those with income between 300 and 400 percent of the FPL. These people would choose between an Exchange plan or uninsurance.
- Those with income of 400 percent or more of FPL. These people would choose between an Exchange plan or uninsurance.

The decision to enroll in an Exchange plan or to remain uninsured is difficult to model. We had some early estimates of the proportion of Exchange-eligible people who actually enrolled in 2014,<sup>8</sup> which we increased to allow for growing familiarity with the program over time.

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<sup>8</sup> Marketplace Enrollment as a Share of the Potential Marketplace Population. (2015, September 30). Retrieved January 15, 2016, from <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/>

This proportion was not differentiated by income, so we used evidence from a study of the take up of employer-sponsored worker insurance (ESI)<sup>9</sup> to create artificial take-up rates by income group that reproduced the aggregate rate while preserving the pattern of ESI take-up. We assumed that in the absence of Exchange subsidies, the group of displaced Medicare enrollees would enroll in insurance exchanges or private non-employer sponsored insurance plans at a pre-ACA rate.

Each stratum was subdivided by sex and race/ethnicity using MCBS data. Absent other firm information, we assumed that each individual in a cell had the mean level of spending and income for the cell.

Our methods incorporate several additional simplifying assumptions:

- Insurance take-up rates, service demand, average costs, and other factors do not vary with sex and race within an insurance or income stratum.
- Employers providing coverage to active workers and retirees under age 65 would extend that coverage to people age 65-66 under a change in Medicare eligibility.
- Workers and retirees would continue to avail themselves of this coverage if it were available.
- Individuals affected by the change would not postpone retirement due to a delay in acquiring Medicare coverage.
- The number of people becoming eligible for Medicare at age 65 or 66 due to disability would not increase because of the change.

Additional methodological details are contained in a previous report on this model.<sup>10</sup>

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<sup>9</sup> Marquis, M. Susan and Long, Stephen H., (1995), Worker demand for health insurance in the non-group market, *Journal of Health Economics*, 14, issue 1, p. 47-63, <http://EconPapers.repec.org/RePEc:eee:jhecon:v:14:y:1995:i:1:p:47-63>.

<sup>10</sup> Neuman T., Cubanski J., Waldo D. et al. Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform. The Henry J. Kaiser Family Foundation. Wash. D.C. March 2011.