

## **Money Can't Buy Me Love, but It Might Buy Me Medicare: An Analysis of the Impact of a Medicare Buy-In Policy on Employers**

*By Jake Spiegel, Employee Benefit Research Institute*

---

### AT A GLANCE

- Policies that grant the near elderly the option to enroll or buy into Medicare prior to age 65 have been proposed periodically for over two decades. Given Congress' appetite for health care reforms, a Medicare buy-in could feasibly emerge as a bipartisan compromise. However, the effects such a regime might have on employers and the employees who remain on employer-sponsored insurance are not well understood.
- There is a wide range of ramifications on employer spending, and they depend entirely on which workers decide to switch to the Medicare buy-in. If only less-healthy, higher-spending workers — those in the top 10 percent of spenders in the 50–64 population — enroll in Medicare, then total spending on employer-sponsored plans could fall significantly. However, if only healthier, lower-spending workers — those in the bottom 10 percent of spenders in the 50–64 population — enroll in the Medicare buy-in, then the impact on total spending on employer-sponsored plans would be marginal.
- To explore which workers might switch from employer coverage to Medicare, EBRI built a simulation model. We find that, depending on plan design, the workers who switch to Medicare tend to be healthier and lower-spending workers. Thus, the impact on spending would likely not be extreme.
- Our model might suggest that expenditures incurred by employers will decrease. Workers are sensitive to the generosity of their employer-sponsored plan relative to Medicare and are particularly sensitive to monthly premiums and out-of-pocket maximums. However, providers might raise their commercial prices to offset the loss of revenue as more people are covered by Medicare.
- Further, workers switching to Medicare are likely to be lower spenders who do not reach the annual out-of-pocket maximums of their employer-sponsored plans. As such, the premiums for workers who stay with their employer-sponsored plan frequently rise.

Jake Spiegel is Research Associate at the Employee Benefit Research Institute (EBRI). This *Issue Brief* was written with assistance from the Institute’s research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF), or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

**Suggested Citation:** Jake Spiegel, “Money Can’t Buy Me Love, but It Might Buy Me Medicare: An Analysis of the Impact of a Medicare Buy-In Policy on Employers,” *EBRI Issue Brief*, no. 512 (Employee Benefit Research Institute, September 3, 2020).

**Copyright Information:** This report is copyrighted by the Employee Benefit Research Institute (EBRI). You may copy, print, or download this report solely for personal and noncommercial use, provided that all hard copies retain any and all copyright and other applicable notices contained therein, and you may cite or quote small portions of the report provided that you do so verbatim and with proper citation. Any use beyond the scope of the foregoing requires EBRI’s prior express permission. For permissions, please contact EBRI at [permissions@ebri.org](mailto:permissions@ebri.org).

**Report Availability:** This report is available on the internet at [www.ebri.org](http://www.ebri.org)

## Table of Contents

The Pros and Cons of a Medicare Buy-In Policy.....	4
History of Medicare Buy-In Proposals.....	4
Who Might Switch?.....	5
Data and Methodology.....	6
How Much Does Each Group Spend?.....	7
Switching Model.....	11
Remaining Employees Might Face Higher Costs.....	20
Medicare Advantage Puts the Buy-In at an Advantage.....	20
Conclusions and Further Considerations.....	22
References.....	23
Endnotes.....	24

## Figures

Figure 1, Estimates of Workers With Employer-Sponsored Insurance, by Buy-In-Eligible Age Group.....	7
Figure 2, Firm Size Where Eligible Workers Are Employed.....	8
Figure 3, Estimated Spending on Employer-Sponsored Insurance Plans, by Eligible Age Group.....	9
Figure 4, Share of Total Employer-Sponsored Insurance Spending, by Spending Decile, 50–64 Age Group.....	10
Figure 5, Share of Total Employer-Sponsored Insurance Spending, by Spending Decile, 55–64 Age Group.....	10
Figure 6, Share of Total Employer-Sponsored Insurance Spending, by Spending Decile, 60–64 Age Group.....	11
Figure 7, Reduction in Hypothetical Firms’ Health Care Spending Arising From Eligible 50–64 Workers Switching to Medicare, by Firm Size, Baseline Simulation.....	12

Figure 8, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, Baseline Simulation.....	13
Figure 9, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, Baseline Simulation.....	13
Figure 10, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 50–64 Workers Switching to Medicare, by Firm Size, Varying Deductible Assumptions .....	14
Figure 11, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, Varying Deductible Assumptions .....	15
Figure 12, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, Varying Deductible Assumptions .....	15
Figure 13, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 50–64 Workers Switching to Medicare, by Firm Size, Varying Out-of-Pocket-Maximum Assumptions .....	16
Figure 14, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, Varying Out-of-Pocket-Maximum Assumptions .....	17
Figure 15, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, Varying Out-of-Pocket-Maximum Assumptions .....	17
Figure 16, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 50–64 Workers Switching to Medicare, by Firm Size, Varying Premium Assumptions.....	18
Figure 17, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, Varying Premium Assumptions.....	19
Figure 18, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, Varying Premium Assumptions.....	19
Figure 19, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 50–64 Workers Switching to Medicare, by Firm Size, With Medicare Advantage Available.....	21
Figure 20, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, With Medicare Advantage Available.....	21
Figure 21, Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, With Medicare Advantage Available.....	22

# Money Can't Buy Me Love, but It Might Buy Me Medicare: An Analysis of the Impact of a Medicare Buy-In Policy on Employers

By Jake Spiegel, Employee Benefit Research Institute

## The Pros and Cons of a Medicare Buy-In Policy

The rising costs of health care have caused no shortage of consternation among politicians, perplexity among analysts, and widespread frustration among patients and human resources departments alike. There is little consensus about what should be done to contain health care cost growth, aside from a broad agreement that something *should* be done. One policy approach that has been repeatedly proposed is to extend to individuals under the age of 65 the option of enrolling in Medicare, otherwise known as a Medicare buy-in program.

Proponents tout many benefits of a Medicare buy-in regime. Medicare features a lower reimbursement rate for most health care services and goods, which, in theory and all else equal, would put a downward pressure on total national health care expenditures. Employers may benefit to the extent that older, less-healthy workers are taken out of their risk pool and shunted to public insurance. Older workers who would prefer to retire but remain attached to the labor market to receive employer-sponsored insurance may benefit from enrolling. Finally, to the extent that older employees do not currently receive job-based health care benefits and do not find the options available to them through Affordable Care Act (ACA) exchanges to be appetizing, a Medicare buy-in regime would expand insurance coverage.

However, there are numerous political and practical hurdles for proponents of such a system to navigate. Medicare is already the second-largest expenditure in the federal budget. The Medicare Hospital Insurance Trust Fund is projected for insolvency in 2026, and enrolling more prospective beneficiaries — even at less-generous premiums than traditional Medicare enrollees face — may put a strain on the program that some believe ought to be avoided (Centers for Medicare and Medicaid Studies 2019). Further, this may prove to be difficult to implement given recent contentious legislative fights.

This paper explores the implications for employers of a switch to a Medicare buy-in regime for older workers. We examine three potential buy-in-eligible cohorts — workers aged 50–64, 55–64, and 60–64 — to reflect the eligibility defined by previous legislative proposals.

## History of Medicare Buy-In Proposals

Medicare buy-in proposals are not a new phenomenon in Washington. Proposals have been periodically floated since at least the Clinton administration. In a budgetary proposal for 1999, the Clinton administration proposed allowing people aged 62 to 64 and without employment-based coverage as well as recently separated workers aged 55 to 62 who had formerly received insurance coverage through an employer-sponsored plan to buy into Medicare. The Congressional Budget Office (CBO) estimated that 320,000 people aged between 62 and 64 would take advantage of the buy-in.

Other proposals have been floated more recently. The Medicare Early Access Act of 2005 (reintroduced in 2009) would have allowed 55- to 64-year-olds without private insurance to buy into Medicare. The Medicare at 55 Act, introduced in 2017, had similar policy goals. The Medicare Buy-In and Health Stabilization Act of 2017, which would have granted individuals aged 50–64 the option to buy into Medicare, among other similar proposals, reflects an appetite to shift at least some portion of the near elderly to public insurance rolls.

The economic dislocation caused by the COVID-19 pandemic has shown the perils associated with health insurance benefits that are tied to the workplace. The Bureau of Labor Statistics estimates that there are over 14 million fewer non-farm workers employed in June 2020 than in January 2020, before the pandemic began in earnest in the United States (U.S. Bureau of Labor Statistics 2020). Many — but certainly not all — of these newly separated workers will lose

access to their employer-sponsored insurance, though proposed COBRA subsidies may provide some temporary relief. The pandemic may result in a political landscape that is more receptive to a reform of the health care market that includes a public option, like a Medicare buy-in.

Previously, Medicare buy-in proposals were focused on expanding coverage for older citizens. However, more recent proposals are targeted toward containing costs in addition to expanding coverage and increasing the choices available to those who wish to purchase health insurance coverage. With the advent of the ACA and the implementation of individual insurance exchanges, older individuals have other options to obtain health insurance coverage at their disposal than when Medicare buy-in proposals were first introduced over 20 years ago. Additionally, the elderly, who often have expensive chronic illnesses, can no longer be denied coverage on the basis of a preexisting condition. Accordingly, attention has shifted toward containing cost increases, and many believe that shifting more people to Medicare, which reimburses health care providers at lower rates than do private insurers, can help wrangle health care cost increases.

Adding to the long list of proposals to reform health care in the United States, the Democratic nominee for president, Joe Biden, recently proposed lowering the Medicare eligibility age to 60. Though the ideological composition of the upcoming session of Congress is far from clear, this policy may prove to be a nonstarter. It is entirely possible, then, that a Medicare buy-in may prove to be a palatable bipartisan compromise.

Much like the proposals themselves, there have been several analyses of the impact of a Medicare buy-in. An Urban Institute report from 2002 estimated that 37 percent of eligible individuals aged 62–64 would buy into Medicare if given the chance, but it would not significantly expand coverage to the uninsured population (Johnson et al. 2002). A RAND study estimated that between 2.8 and 7 million people would enroll in a Medicare buy-in, depending on the design of the buy-in (Eibner et al. 2019). The extant literature suggests that a Medicare buy-in would be beneficial for at least some eligible workers.

Previous research has examined the implications of a Medicare buy-in regime on issues such as coverage, total national health expenditures, and insurance premiums. This paper supplements extant analyses and furthers research into this area by focusing specifically on the implications a Medicare buy-in regime would have on spending by workers currently enrolled in employer-sponsored insurance and the effects on total health care spending experienced by employers.

## **Who Might Switch?**

Some analysts suspect that higher-spending eligible workers will be tempted to switch to a Medicare buy-in. While Medicare Part A — which covers inpatient services such as hospital care and hospice care — features a deductible of \$1,408, after which coinsurance kicks in, Medicare Part B — which covers doctors' visits and outpatient services — features a deductible of \$198 for most beneficiaries, after which coinsurance kicks in. Additionally, Medicare features lower reimbursement rates for health care goods and services, and so a prospective beneficiary's out-of-pocket expenditures may end up being lower than with employer-sponsored insurance coverage. If higher-spending workers in the eligible population move to a Medicare buy-in, then the ramifications for health care spending could be large. And employers could potentially benefit from shifting a higher-cost population onto public insurance rolls. To the extent that higher spenders enroll in a Medicare buy-in, premiums in employer-sponsored plans could fall, benefitting workers who remain on the employer-sponsored plans.

However, other analysts suspect that only systematically healthier older workers will be tempted to switch to a Medicare buy-in. After all, those with an expensive chronic condition might be better served by staying with an employer-sponsored plan that has a defined out-of-pocket maximum, above which private insurance pays for 100 percent of health expenditures. Workers who suspect that they might brush up against that limit will probably not switch to a Medicare regime in which their yearly health care expenses are not capped. Indeed, previous research has shown that some health care consumers, particularly those with chronic conditions such as high blood pressure and diabetes, hit their plan's out-of-pocket maximums consistently (Fronstin and Roebuck 2019). In such cases, those

workers would likely be best served by staying enrolled in their employer’s plan, assuming they do not change their health care consumption patterns.

The impact on employers is somewhat less clear. Some analysts predict that transitioning older workers to Medicare will decrease employer spending on health benefits, since older workers tend to consume more health care than their younger counterparts. Others predict that a Medicare buy-in option might increase costs to employers, or at least result in lower potential savings, and expect that insurance premiums will simply get more expensive for privately insured workers as insurers seek to recoup the revenue lost by older workers switching to a public insurance option.

A Medicare buy-in regime may also nudge workers to retire early. Health care costs are a daunting prospect for many households to face, and even with the advent of individual exchanges and health insurance reforms implemented by the ACA, health care can be costly. As a result, while current employment-based health care plans can act as a powerful retention tool, a Medicare buy-in regime could blunt the effectiveness of that tool. While buy-in proposals ought to consider the impact on employment, calculating this effect lies outside the scope of this paper.

## Data and Methodology

To examine the impact of a Medicare buy-in on employers, we conducted two main sets of analyses. For the first set of analyses, we made naïve assumptions about who would switch from employer-sponsored insurance to the Medicare buy-in. We calculated the ramifications on total health care spending when systematically higher, but not lower, spenders switched, and also when systematically lower, but not higher, spenders switched. For the second set of analyses, we built a simulation model to develop a better understanding of the ramifications of a Medicare buy-in for workers who choose to stay on the employer-sponsored insurance plan.

### About the Data

This study uses medical claims data collected in the IBM Health Analytics MarketScan® Commercial Claims and Encounters Databases (copyright © IBM Health Analytics, all rights reserved). The MarketScan Database is comprised of administrative medical claims data from workers covered by employer-sponsored health insurance, and the dataset contains records for over 20 million patients from 2018. The database contains data on the gross spending on inpatient and outpatient services as well as on prescription drugs.<sup>1</sup>

This analysis focuses on the primary beneficiary of the health insurance plan. The data do not allow us to discern whether spouses covered by an employer-sponsored plan could enroll through their own employer (or if they are even employed at all), and so we focus our analysis on workers with health insurance in their own name. Given that health care spending by spouses and dependents of the named beneficiary comprise a large chunk of health care spending, any Medicare buy-in proposal ought to take into consideration the coverage impact on spouses and dependents of an older worker with employer-sponsored insurance choosing to enroll in a Medicare buy-in. However, specific policy proposals to address the coverage options for spouses and dependents of workers who choose to buy into Medicare early are outside the scope of this paper.

For the simulation model, we used the IBM Health Analytics MarketScan data to build spending distributions and created a synthetic firm comprised of hypothetical workers. Workers in the model seek to minimize their health care costs. While some health care users — the very healthy or the very sick, for instance — may have a rough idea of their future health expenditures, this is admittedly an inherently unrealistic assumption, since health care users will not know their total expenditures over the course of a year until the year is over. Also, some workers may exhibit some degree of risk aversion. Workers who anticipate large expenditures may wish to stay with their employer-sponsored plan, even if they do not end up spending enough to hit their plan’s out-of-pocket maximum at the end of the year.

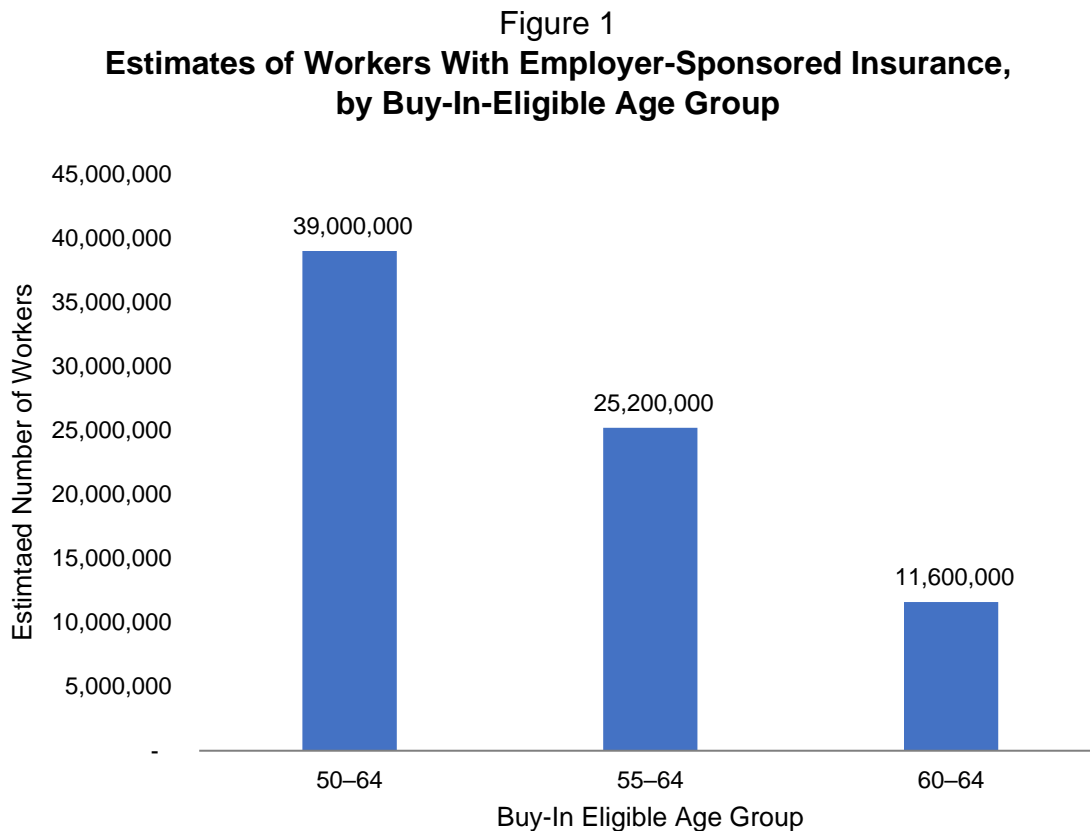
To examine the impact on the total spending and premiums faced by a firm, we summed the health care expenditures by their employee population and estimate premiums. We then calculated the total spending of workers whose expenditures would be minimized by switching to Medicare, and we compared the total sums of spending incurred by

both the remaining workers and also the workers who benefit from switching to Medicare. We then estimated the firm's total health insurance premiums per remaining worker.

Medicare reimbursement rates tend to be lower than those of private insurance, sometimes significantly so. An analysis by the CBO found that, on average, private insurance reimbursement rates were 89 percent higher than Medicare Fee-for-Service rates but noted there is substantial variation by geography (CBO 2017). As a result, total national health care expenditures may decrease under a Medicare buy-in regime, assuming similar patterns of health care consumption after enrolling in the buy-in.<sup>2</sup> However, this may not prove to be a realistic assumption. More generous health benefits can induce health care consumers to spend more than they otherwise would, first established in the seminal RAND Health Insurance Experiment and subsequently confirmed by other researchers (Brook et al. 1984, Aron-Dine et al. 2013).

### How Much Does Each Group Spend?

To estimate the impact of a Medicare buy-in regime on employers, we first calculated the size of each hypothetical buy-in cohort. Using data from the 2019 Current Population Survey (CPS) Annual Social and Economic Supplement to create an estimate of eligible workers with health insurance in their own name, we estimated that there are roughly 39 million buy-in-eligible workers in the 50–64 age cohort, 25 million buy-in-eligible workers in the 55–64 age cohort, and 12 million buy-in-eligible workers in the 60–64 age cohort, shown below in Figure 1.

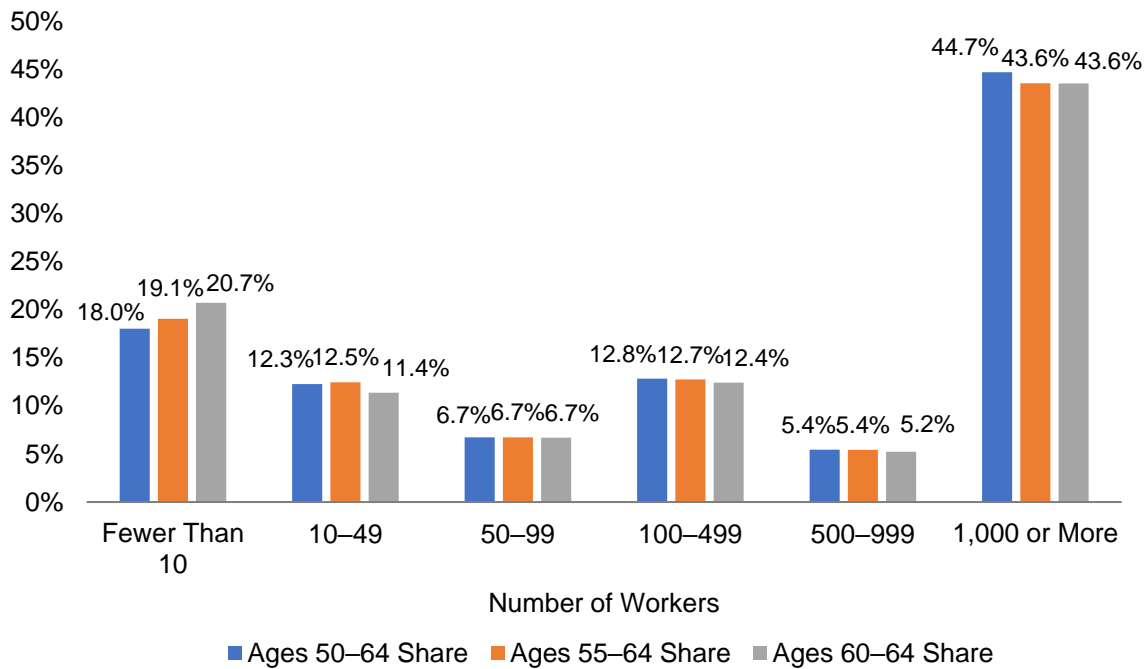


Source: Author's estimates from Current Population Survey.



Large firms are likely to be the most impacted by a Medicare buy-in regime. Among workers in the different eligible cohorts, between 44 and 45 percent work for very large firms with 1,000 or more employees. Relatively few of the eligible population work for smaller firms with between 50 and 99 employees or for medium-sized firms with between 500 and 999 employees. Among buy-in-eligible cohorts, the distribution of buy-in-eligible workers did not vary significantly by firm size; the largest difference in work force composition existed among very small firms. Workers in the oldest age cohort (60–64) were slightly disproportionately more likely to work for very small firms compared with workers in the youngest age cohort (50–64) — 21 percent compared with 18 percent. Smaller differences were observed in smaller and medium-sized firms, shown below in Figure 2.

Figure 2  
Firm Size Where Eligible Workers Are Employed



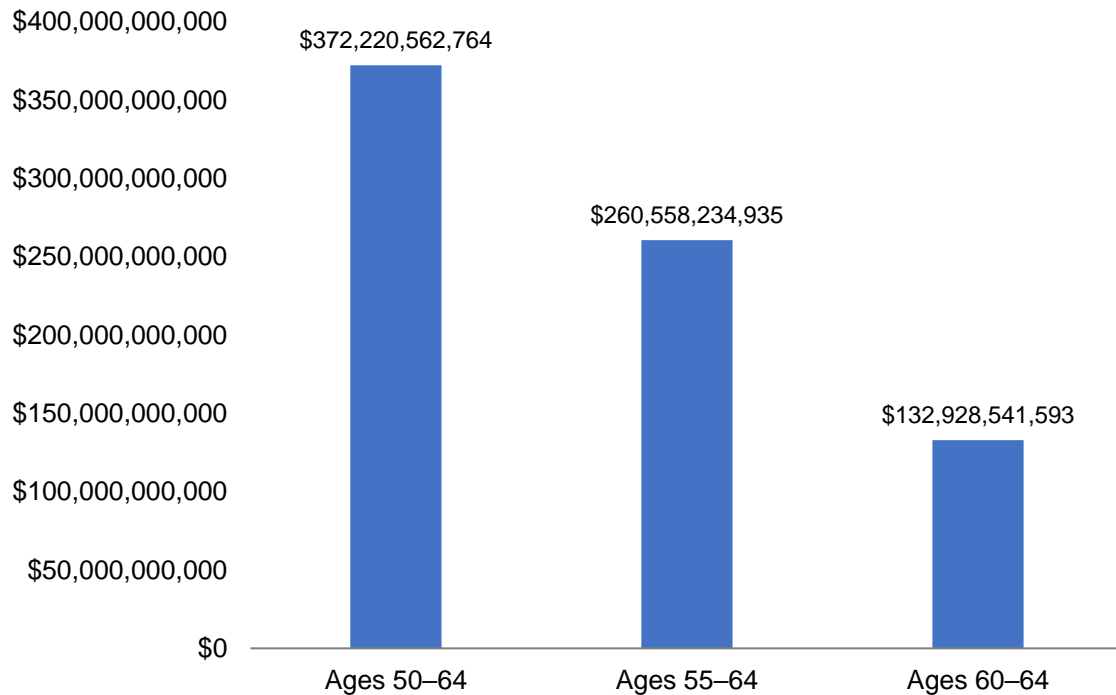
Source: Author’s estimates from Current Population Survey.

The ramifications for total health care spending vary dramatically depending on who chooses to switch to the Medicare buy-in. If all eligible workers switch to the Medicare buy-in regime, the total amount of health care expenditures shifting from private to public insurance vastly outweighs the shift if, say, only 10 percent of eligible workers decide to switch.

We thus present results describing a wide variety of potential outcomes. Specifically, we show the spending ramifications if the top 10 percent, 20 percent, and 50 percent of spenders switch to the buy-in as well as the spending ramifications if the bottom 10 percent, 20 percent, and 50 percent of spenders switch. Estimates for the total spending by each age cohort (50–64, 55–64, and 60–64) were estimated by summing the total expenditures observed in the Marketscan database and extrapolating over each age cohort’s share of the total work force. Using this method, we estimated that the 50–64 age cohort accounts for about 30 percent of total private health care spending. The 55–64 age cohort accounts for about 21 percent of private health care spending, and the 60–64 age cohort accounts for about 11 percent of total private health care spending, shown below in Figure 3.



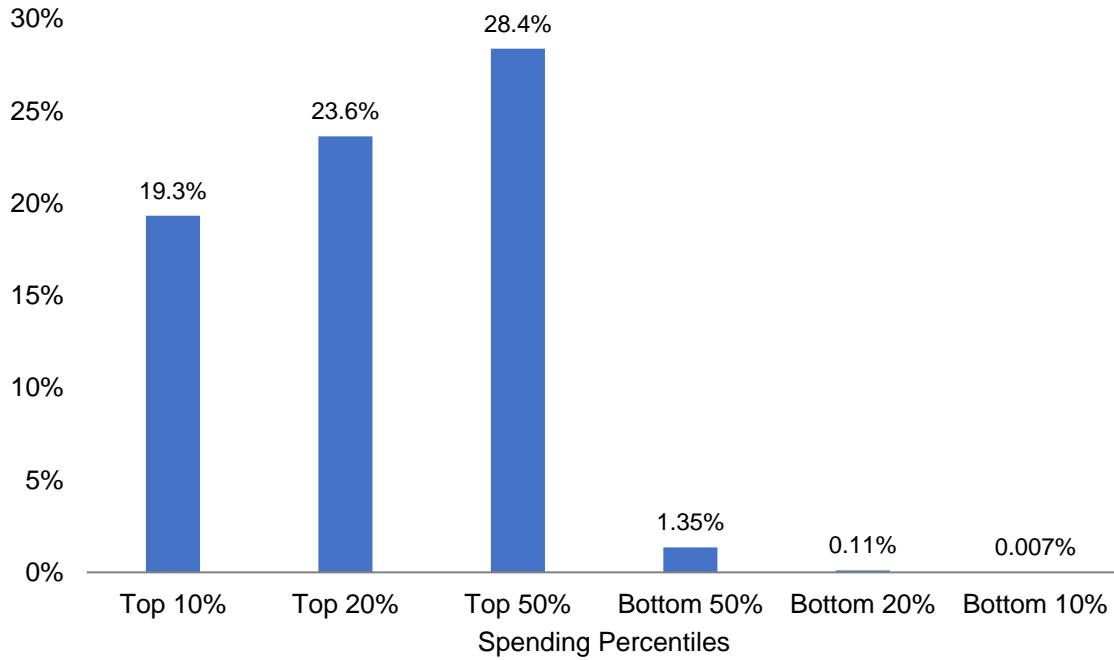
**Figure 3**  
**Estimated Spending on Employer-Sponsored Insurance Plans,**  
**by Eligible Age Group**



Source: Author's estimates from Current Population Survey and IBM Health Analytics MarketScan Database.

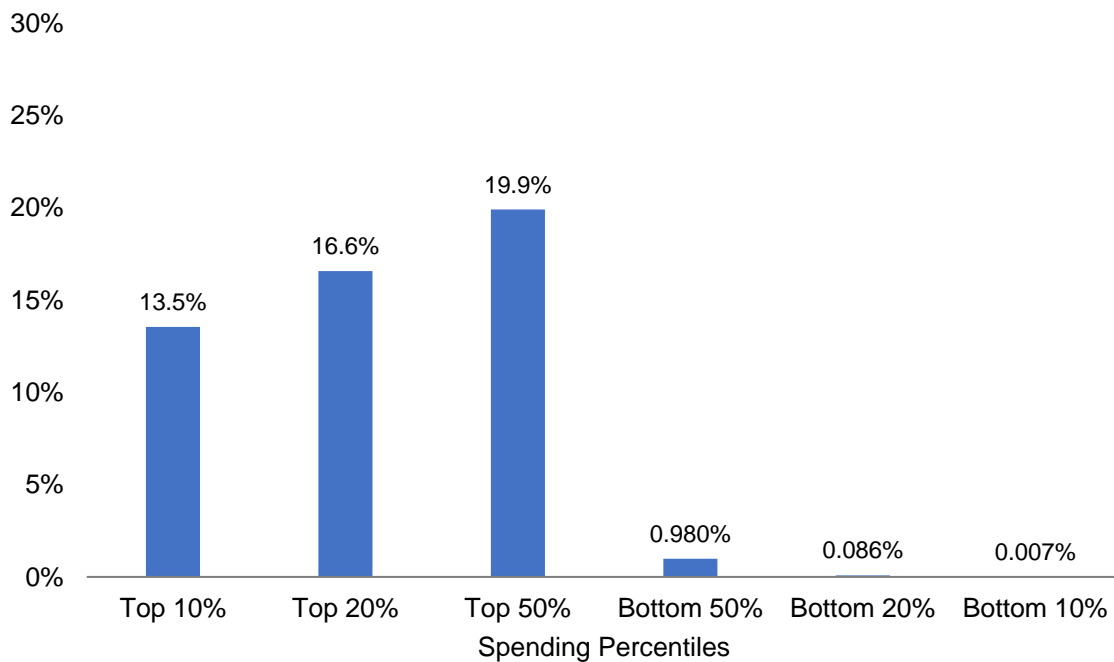
Next, we estimated the total health care spending by high spenders to approximate the effects on total spending if only systematically less-healthy and higher-spending workers switched to the Medicare buy-in. The impact on total employer-sponsored spending would be significant if only the highest-spending workers switch. To illustrate, those in the top 10 percent of spending in the ages 50–64 cohort represent 65 percent of that cohort's spending and 19 percent of total employer-sponsored insurance spending. If, for instance, all workers aged 50–64 with above-median health care expenditures switched to the Medicare buy-in, then 28.4 percent of total spending by all workers covered by employer-sponsored insurance would be transferred to public insurance. Full results are shown below in Figure 4. The ages 55–64 and ages 60–64 cohorts are smaller and therefore represent a smaller share of total spending by workers with employer-sponsored insurance, shown below in Figures 5 and 6.

**Figure 4**  
**Share of Total Employer-Sponsored Insurance Spending, by Spending Decile, 50–64 Age Group**



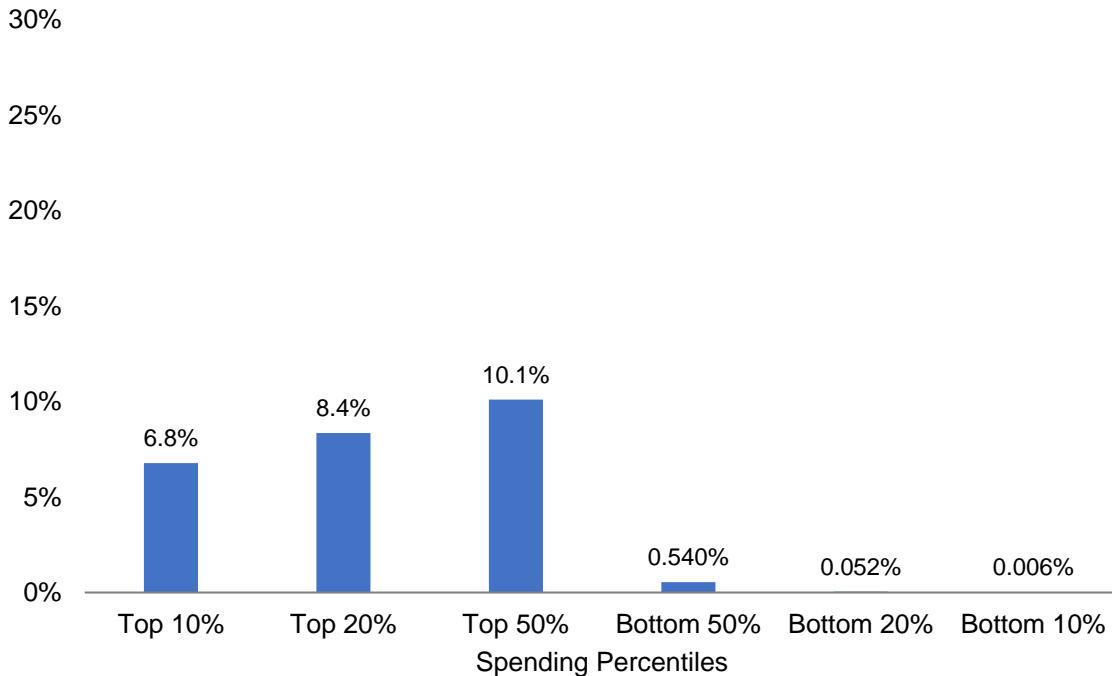
Source: Author's estimates from Current Population Survey.

**Figure 5**  
**Share of Total Employer-Sponsored Insurance Spending, by Spending Decile, 55–64 Age Group**



Source: Author's estimates from Current Population Survey.

**Figure 6**  
**Share of Total Employer-Sponsored Insurance Spending, by Spending Decile, 60–64 Age Group**



Source: Author's estimates from Current Population Survey.

Estimating the change in total health care spending by low spenders who are covered by employer-sponsored insurance switching to Medicare reveals a significantly smaller impact on total health care expenditures. To illustrate, the bottom 10 percent of spenders in the ages 50–64 cohort switching to a Medicare buy-in represents 0.02 percent of total spending by 50–64 year old workers and 0.007 percent of all employer-sponsored insurance spending, as shown above in Figure 4. Even if *a*ll 50–64-year-old workers with below-median health care expenditures switched to the Medicare buy-in model, their spending only represents about 1.35 percent of all employer-sponsored insurance expenditures. Again, since the ages 55–64 and ages 60–64 cohorts are smaller, they represent an even smaller share of spending by workers covered by employer-sponsored insurance.

This exploratory analysis establishes that the impact on employers depends crucially on which workers decide to enroll in the Medicare buy-in plan. Particularly high-spending workers in the 50–64 cohort represent 19 percent of spending by those covered by employer-sponsored insurance; particularly low spenders in that same cohort represent essentially a rounding error. To examine which workers might switch and how employers might be impacted, we turn to the simulation model.

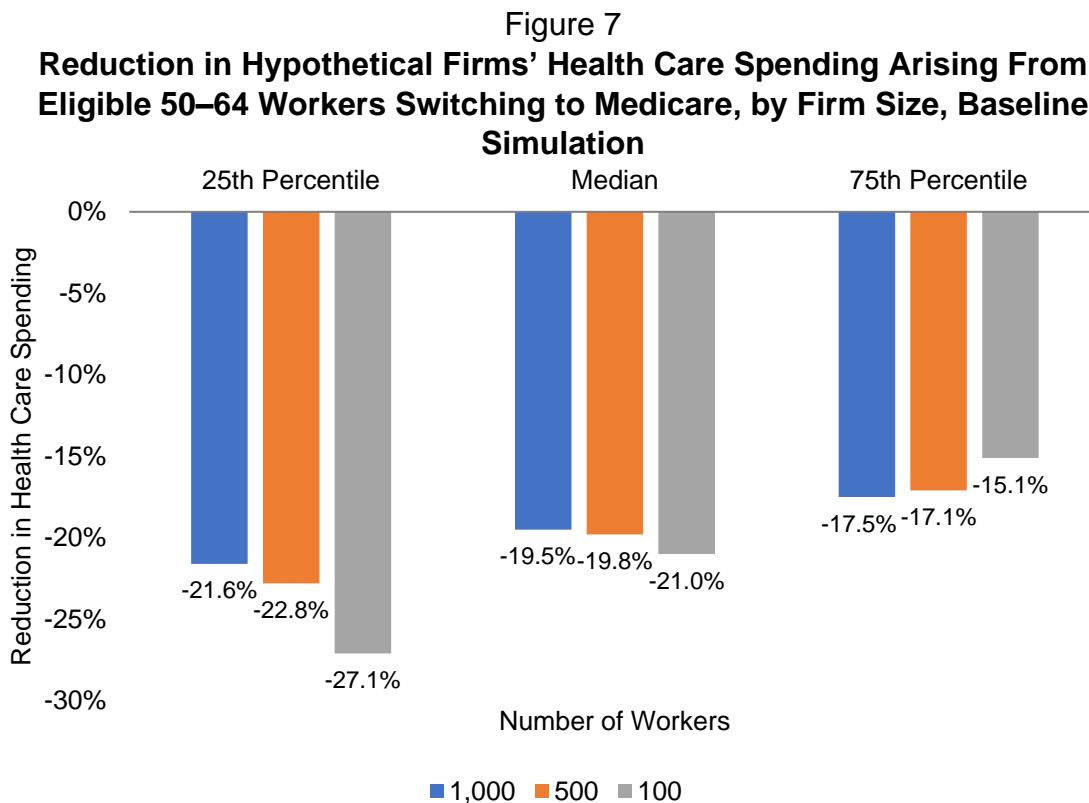
## Switching Model

In the switching model, we constructed synthetic firms of varying sizes using the techniques described in the Methodology section. The total health care expenditures incurred by workers of these synthetic firms were calculated by randomly sampling without replacement from a distribution of health care expenses that approximates those observed in the IBM Health Analytics MarketScan claims database. We then calculated the total health care expenditures incurred by all workers as well as by workers who would minimize their health care expenditures by switching to Medicare. We similarly calculated premiums for all workers as well as for the workers who remain on the

employer-sponsored plan after eligible workers have switched.<sup>3</sup> We created synthetic firms of 100, 500, and 1,000 workers as illustrative examples. The IBM Health Analytics Marketscan database disaggregates spending by inpatient and outpatient services, which we used as an estimate for the spending that would be covered by Medicare Part A and Medicare Part B.

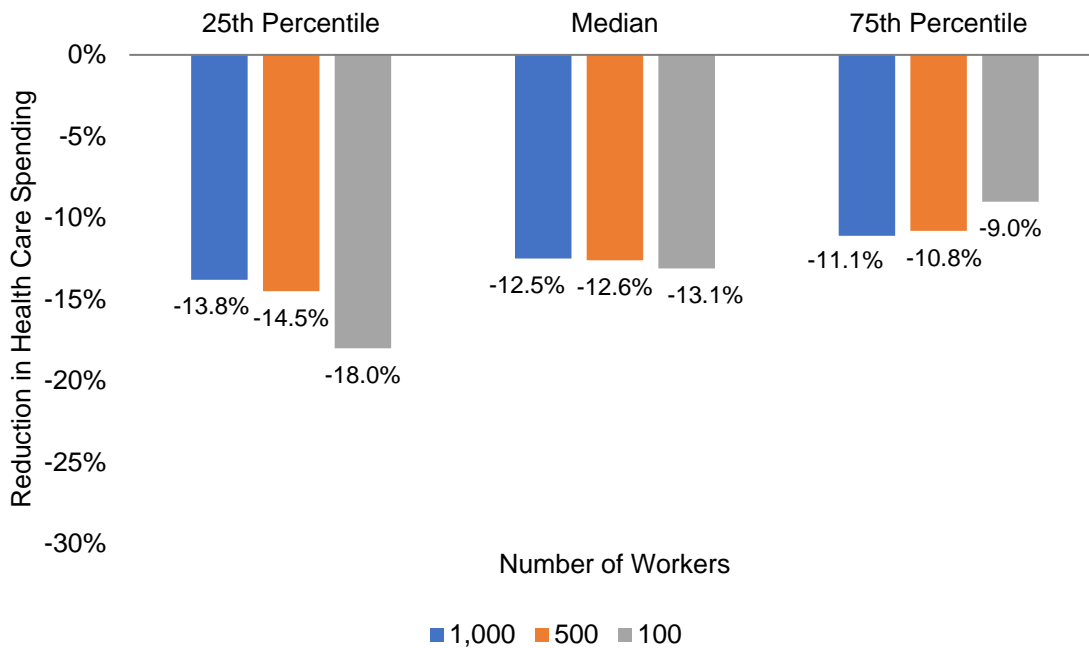
The results from the simulation model indicate that lower-spending eligible workers tended to be better off switching to the Medicare buy-in. And since under all but the most extreme inputs for the sensitivity analyses we conducted, some portion of the buy-in-eligible population switched to the buy-in, the total health expenditures incurred by workers using employer-sponsored insurance decreased. Our baseline analysis assumed a \$1,000 deductible for the private plan, a \$4,000 maximum out-of-pocket, and no cost difference in premiums between the employer-sponsored plan and the buy-in. We varied these assumptions to test the sensitivity of our results. Unsurprisingly, the results are sensitive to the generosity of the private health insurance relative to the Medicare buy-in. For instance, lower out-of-pocket maximums, lower private insurance premiums, and lower deductibles all increased the attractiveness of the employer-sponsored plan relative to the Medicare buy-in and resulted in more eligible workers staying with their employer-sponsored plan, and vice versa.

In our baseline simulation, we found firms can realize cost savings from workers switching to the buy-in. The cost savings are greater when the buy-in population is larger (e.g., the ages 50–64 cohort compared with the 60–64 cohort) and when the Medicare buy-in is more attractive relative to the employer-sponsored plan (e.g., the employer-sponsored plan has a particularly high deductible, a high out-of-pocket maximum, or high premiums relative to the Medicare buy-in). For the ages 50–64 cohort, shown below in Figure 7, the baseline simulation indicates that the median 1,000-employee firm saw a 19.5 percent decrease in health care spending as a result of eligible workers switching to the buy-in and taking their spending with them. A hypothetical firm of the same size at the 25<sup>th</sup> percentile, meanwhile, saw a 21.6 percent reduction, and a hypothetical firm at the 75<sup>th</sup> percentile saw a 17.5 percent reduction. Smaller firms saw similarly sized reductions, and the ages 55–64 cohort and ages 60–64 cohort saw smaller reductions in spending, in accordance with the smaller pool of eligible workers, shown below in Figures 8 and 9.



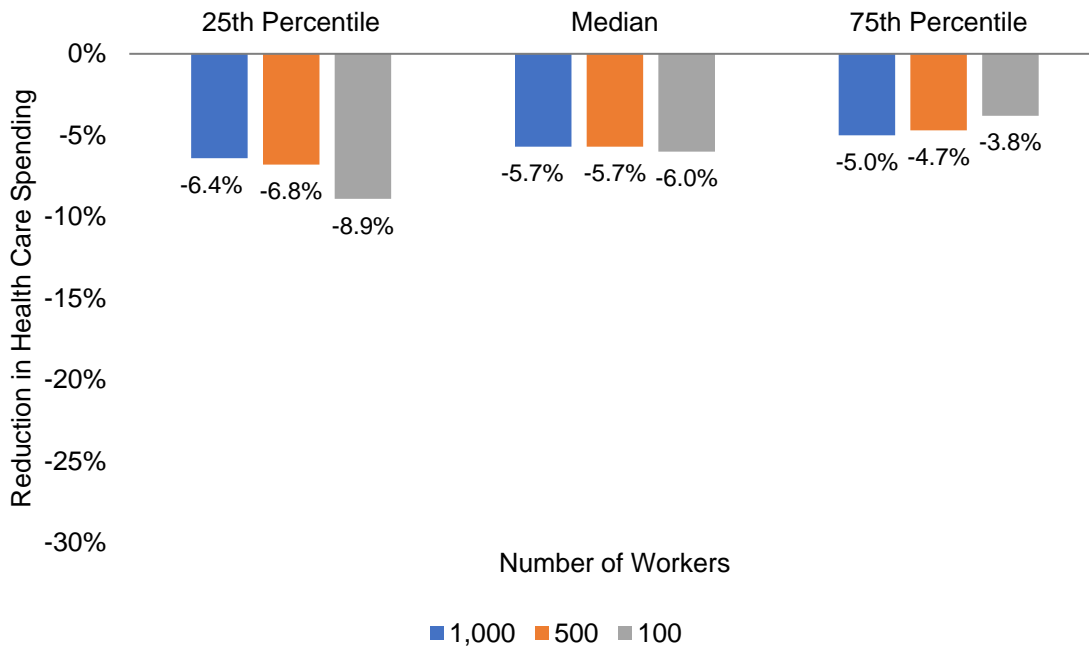
Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

**Figure 8**  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, Baseline Simulation**



Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

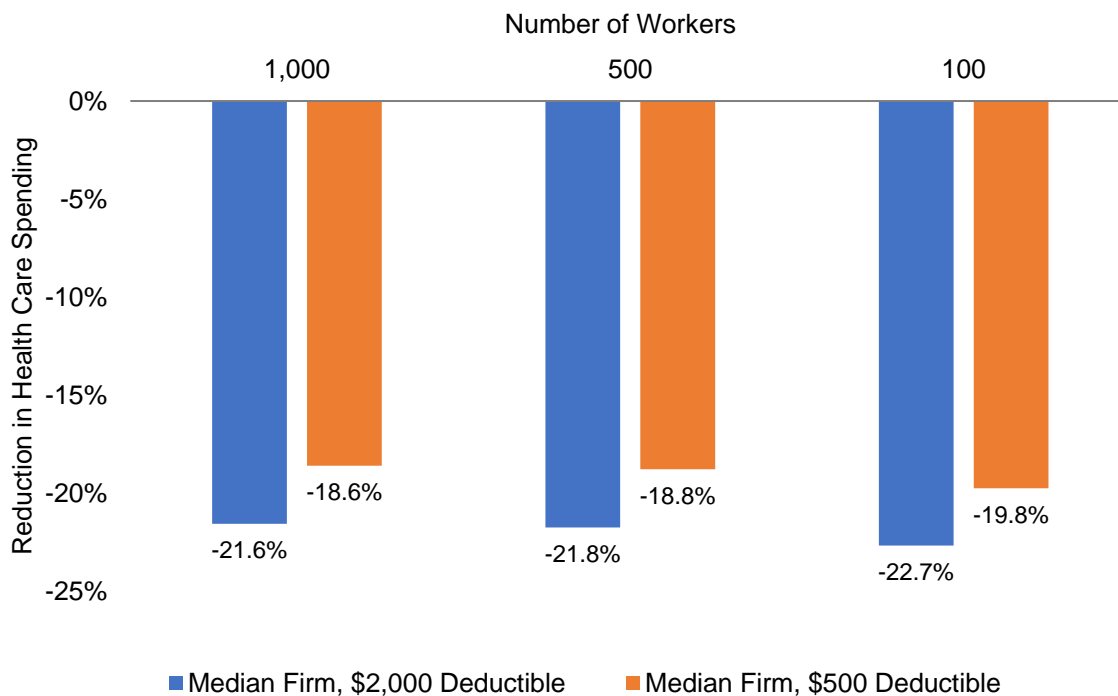
**Figure 9**  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, Baseline Simulation**



Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

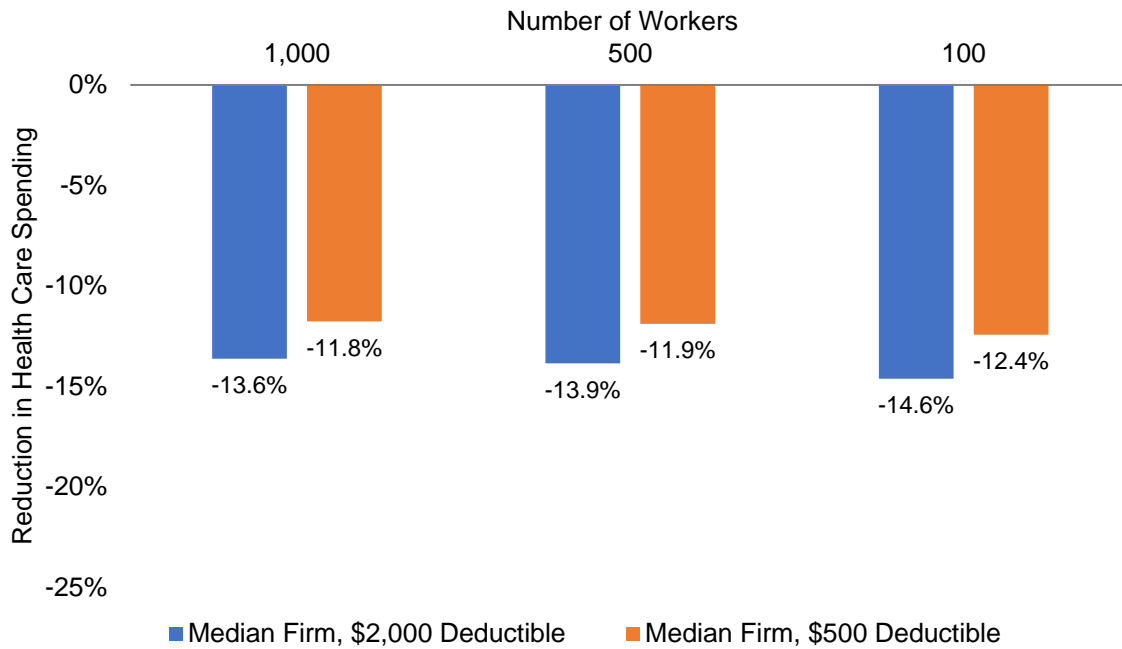
Varying the employer-sponsored insurance deductible to make it more or less attractive relative to the buy-in results in lower and higher decreases in firm spending, respectively. For the ages 50–64 cohort, the simulation model indicates that the median 1,000-employee firm saw a 21.6 percent decrease in spending when the deductible was raised to \$2,000 (compared with a 19.5 percent reduction with a \$1,000 deductible) and an 18.6 percent reduction when the deductible was lowered to \$500, shown below in Figure 10. More eligible workers will enroll in the Medicare buy-in when the workplace plan is made to be less generous, which leads to a higher reduction in the firm’s spending on health care, and vice versa. Similar results hold for the ages 55–64 and ages 60–64 cohorts, shown below in Figures 11 and 12.

Figure 10  
**Reduction in Hypothetical Firms’ Health Care Spending Arising From Eligible 50–64 Workers Switching to Medicare, by Firm Size, Varying Deductible Assumptions**



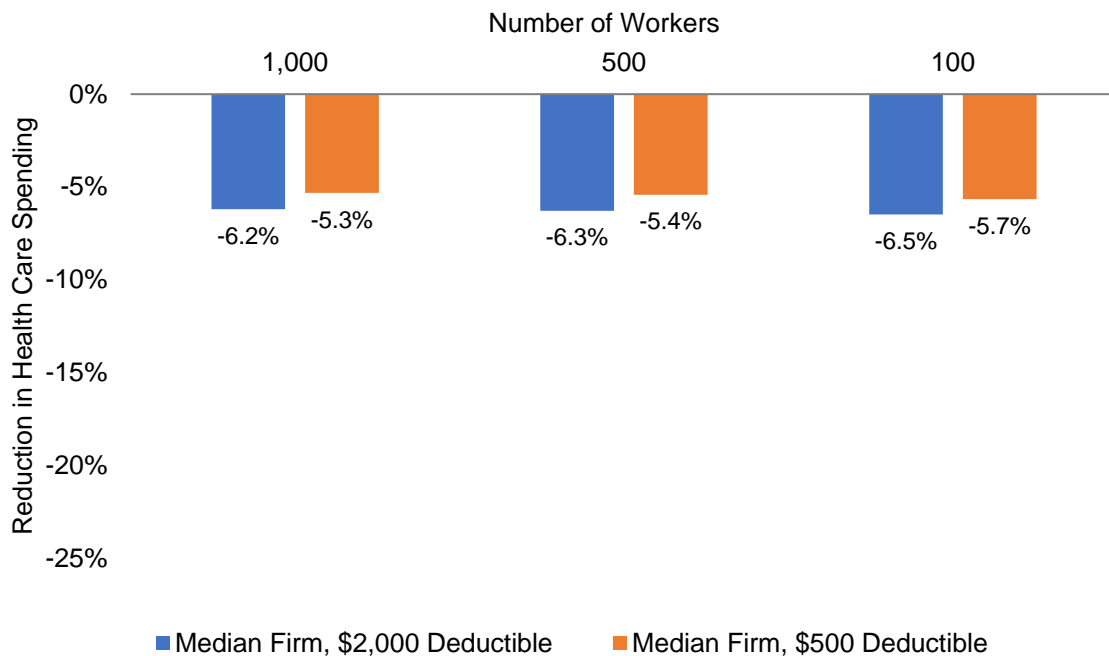
Source: Author’s estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

Figure 11  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, Varying Deductible Assumptions**



Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

Figure 12  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, Varying Deductible Assumptions**

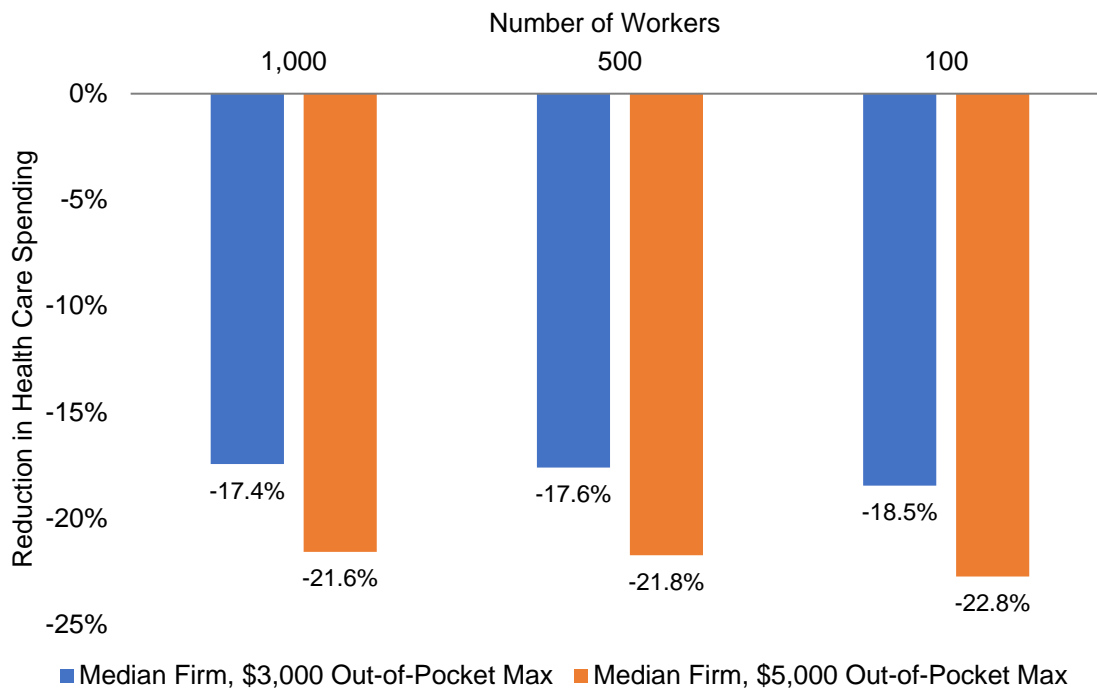


Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.



Next, we vary the plan’s out-of-pocket maximum and find that, similar to varying the deductible, a more generous out-of-pocket maximum encourages more eligible workers to stay on their employer’s plan, and vice versa. With a \$3,000 maximum out-of-pocket, our model suggests that the median firm sees a 17.4 percent decrease in spending with the ages 50–64 cohort (compared with a 19.5 percent decrease with a \$4,000 maximum out-of-pocket) and a 21.6 percent decrease in the case of a \$5,000 out-of-pocket maximum, shown below in Figure 13. As was the case with deductibles, making an employer-sponsored plan more generous — i.e., lowering the maximum out-of-pocket at which insurance covers spending above that level at 100 percent — leads to more eligible workers staying on that plan. We see directionally similar results for the ages 55–64 and ages 60–64 cohorts, seen in Figures 14 and 15. Again, their impact on overall spending is smaller, owing to their smaller share of the employee population.

Figure 13  
**Reduction in Hypothetical Firms’ Health Care Spending Arising From Eligible 50–64 Workers Switching to Medicare, by Firm Size, Varying Out-of-Pocket-Maximum Assumptions**



Source: Author’s estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

Figure 14  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, Varying Out-of-Pocket-Maximum Assumptions**

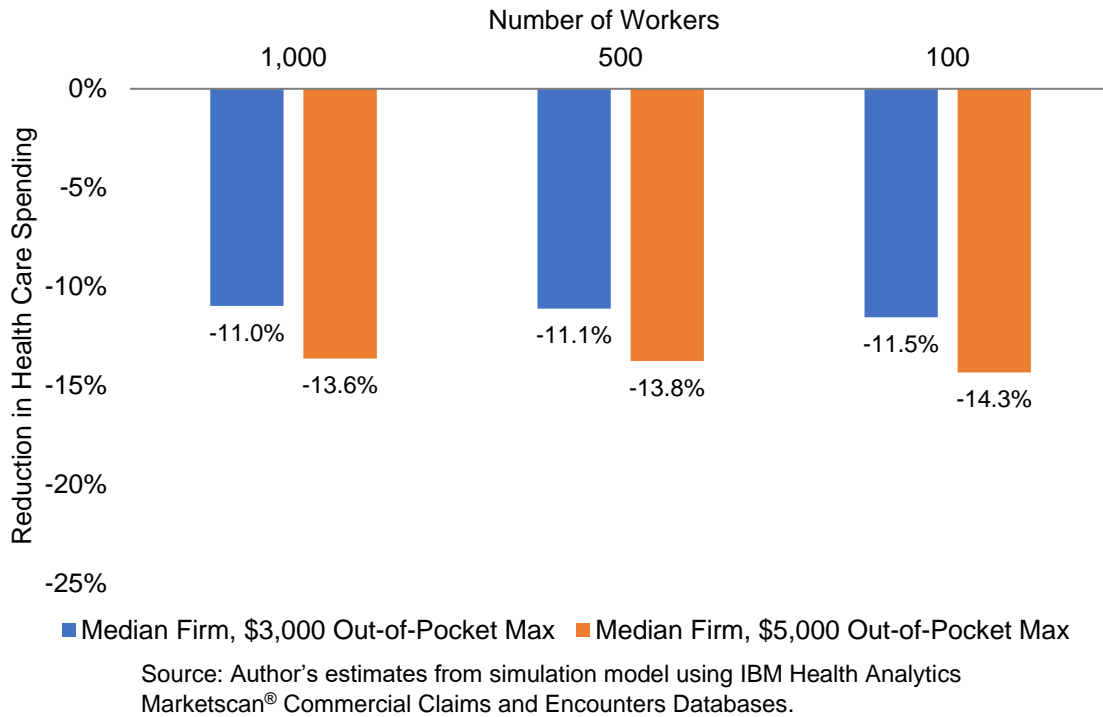
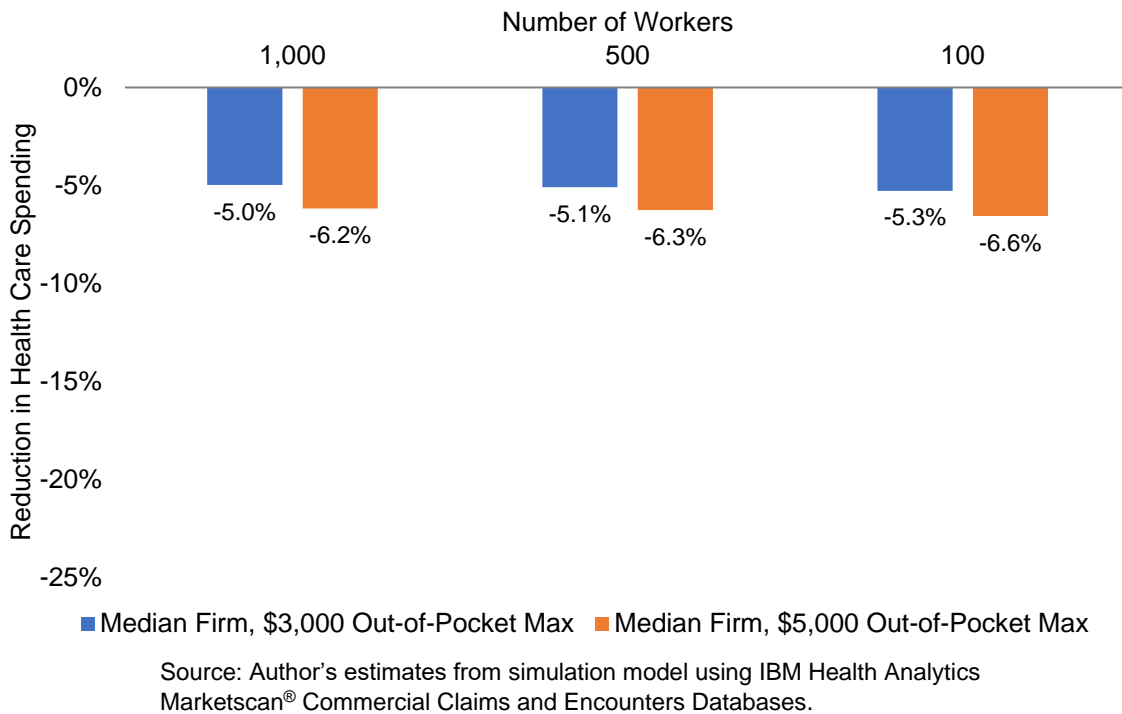
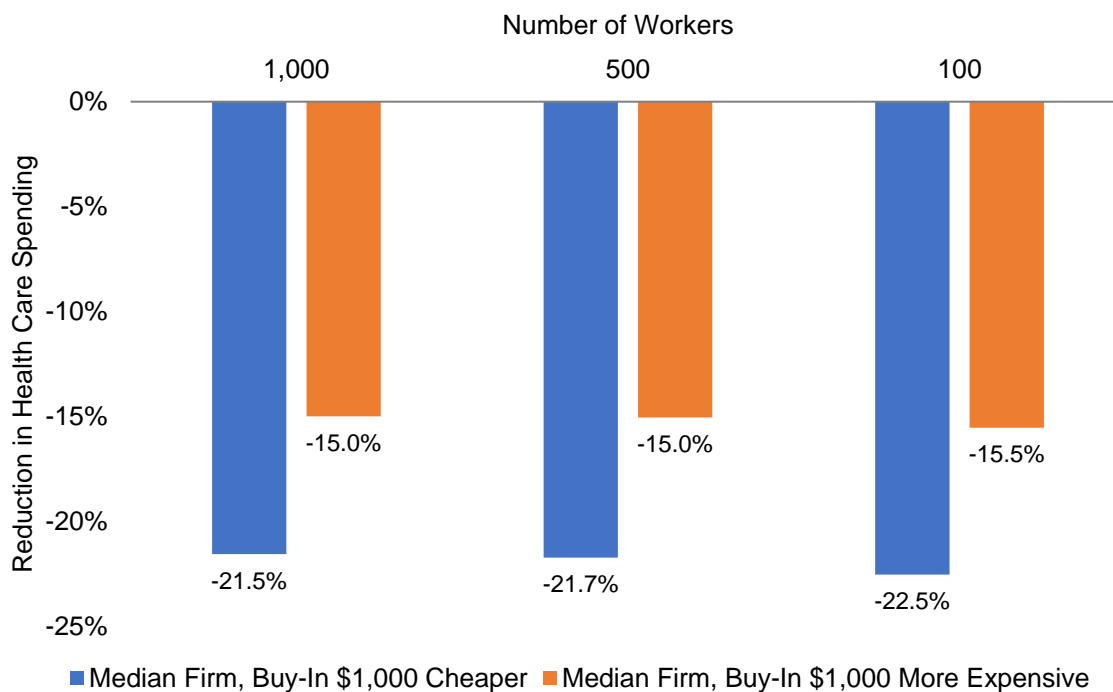


Figure 15  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, Varying Out-of-Pocket-Maximum Assumptions**



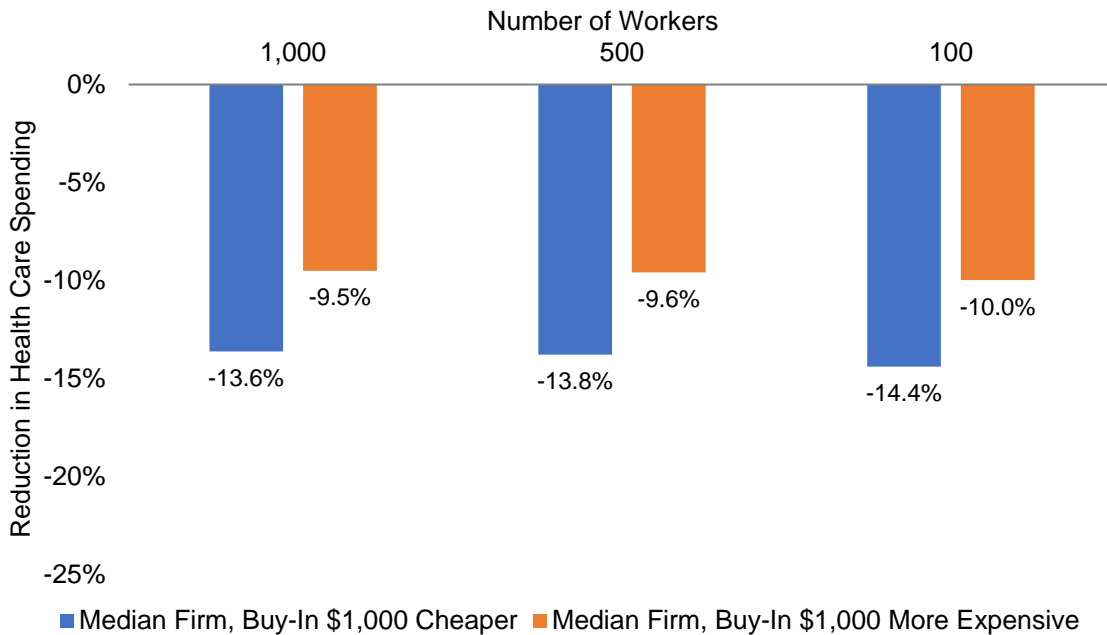
In our final sensitivity analysis, we varied the premiums associated with the buy-in relative to the hypothetical firms' insurance offering and found that eligible workers are particularly sensitive to monthly premiums. We returned to our baseline assumption of a \$1,000 deductible and a \$4,000 out-of-pocket maximum but instead made the Medicare buy-in \$1,000 more expensive over the course of the year (which translates to about \$83.33 per month), and vice versa. Our model suggests that a 1,000-employee firm will see a 21.5 percent reduction in spending when the buy-in is \$1,000 cheaper than the employer-sponsored plan and a 15 percent reduction in spending when the buy-in is \$1,000 more expensive than the employer-sponsored plan, shown below in Figure 16, with results for the ages 55–64 and ages 60–64 cohorts shown in Figures 17 and 18. Varying the assumptions about plan premiums produced larger differences in take-up and spending changes than the previous sensitivity analyses we conducted. This is an important implication for policymakers, as it demonstrates the importance of calibrating an appropriate premium for a Medicare buy-in regime.

**Figure 16**  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 50–64 Workers Switching to Medicare, by Firm Size, Varying Premium Assumptions**



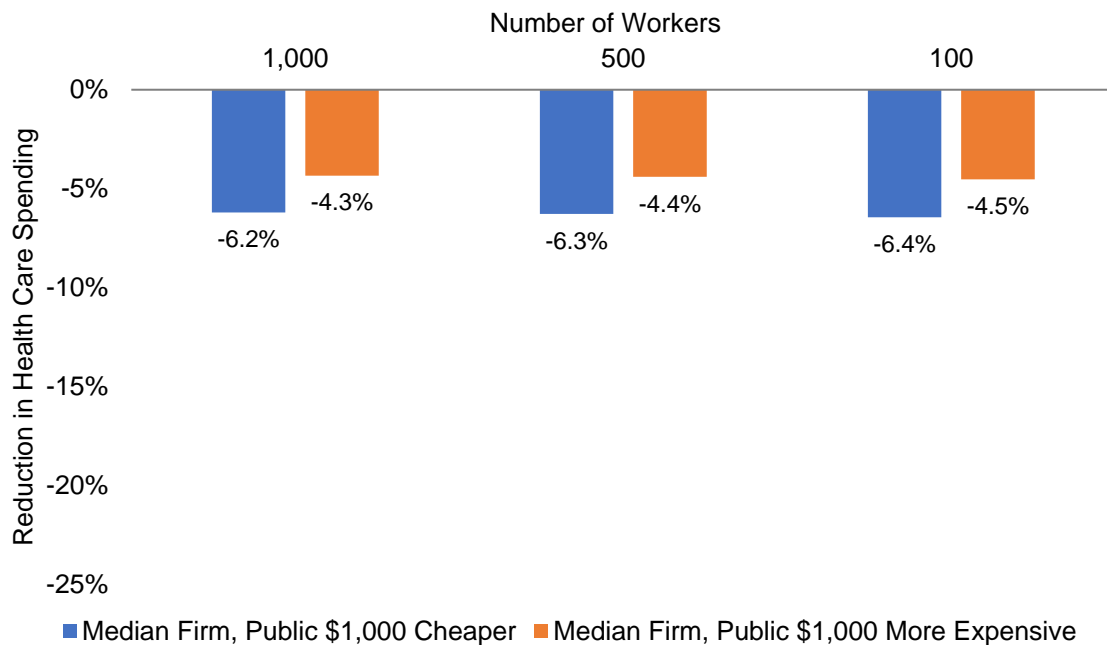
Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

Figure 17  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, Varying Premium Assumptions**



Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

Figure 18  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, Varying Premium Assumptions**



Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

## **Remaining Employees Might Face Higher Costs**

Though employers will likely face lower health care costs after some eligible workers switch to a Medicare buy-in, the remaining employees might face higher premiums. Our model indicates that very high spenders will likely stay on their employer-sponsored plan since they benefit from the out-of-pocket maximum. Thus, for most firms, the average spending per employee will go up, on account of high spenders staying and at least some portion of low-spending buy-in-eligible workers leaving the employer-sponsored insurance plan.

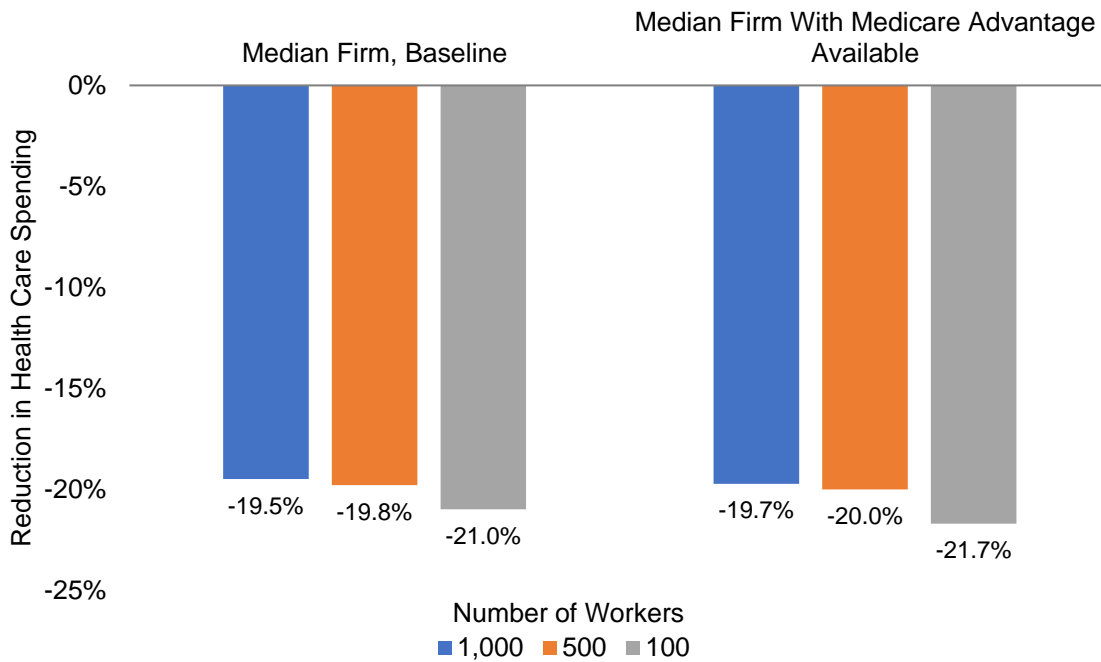
In a few uncommon cases, premiums for employees remaining on the employer-sponsored plan decreased. Premiums for an employer-sponsored plan would decrease if total spending per person for those remaining on the employer-sponsored plan were lower than the spending per person by those switching to the buy-in. As an illustrative case, consider a firm where young workers are unusually healthy, and there are no (or very few) eligible older workers who are very high spenders and would be better off staying on the employer-sponsored plan. Again, very high spenders who bump up against an out-of-pocket maximum tend to stay with the employer-sponsored plan. And so cases in which premiums decreased were not particularly common and are not illustrative of the broader trend represented in the model that a Medicare buy-in would likely increase premiums for workers remaining on the employer-sponsored plan. In the baseline simulation model, this happens in about 1 percent of cases among large firms with 1,000 employees, 7 percent of cases among firms with 500 employees, and 19 percent of cases among firms with 100 employees.

## **Medicare Advantage Puts the Buy-In at an Advantage**

Medicare Advantage plans are supplementary insurance plans available to Medicare beneficiaries. These plans tend to have high actuarial values. For a relatively small monthly premium, enrollees benefit from a defined maximum out-of-pocket, which, as our analysis indicates, is an important part of the calculations workers might make when deciding whether or not to buy into Medicare. Thus, workers who choose to stay with their employer-sponsored plan on account of the out-of-pocket maximum may be tempted to switch to Medicare if they may also purchase a Medicare Advantage plan.

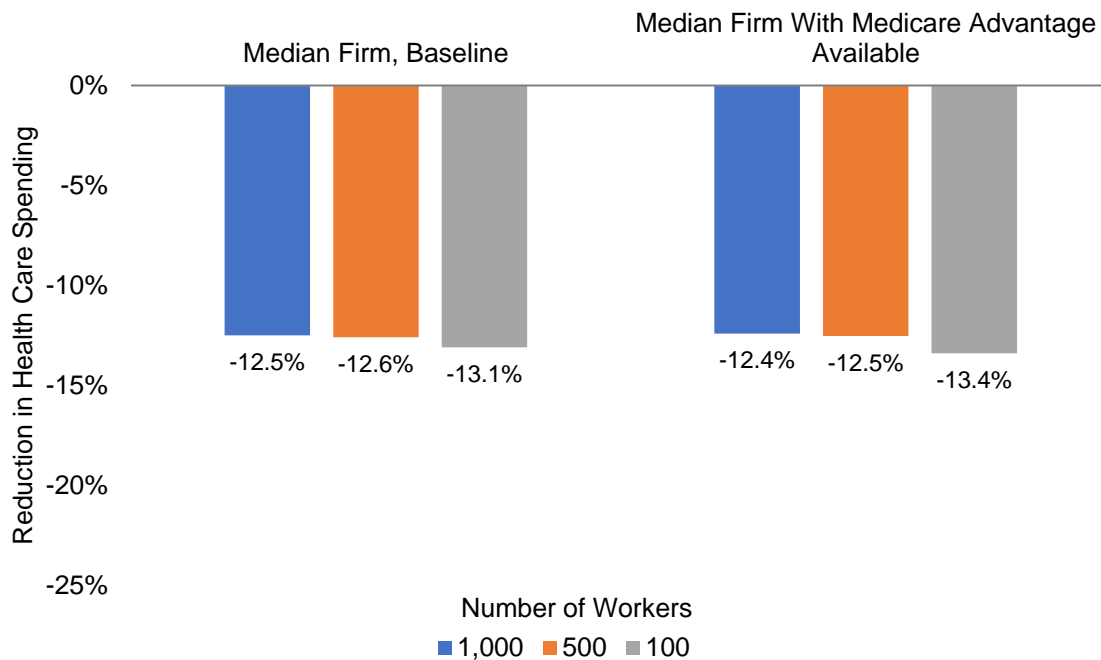
The average Medicare Advantage plan has a monthly premium of about \$40 and an out-of-pocket maximum on in-network services of about \$5,000.<sup>4</sup> Using these values in the simulation model, we found that enrollment in Medicare increases and total firm spending decreases, even relative to the baseline assumption of a \$4,000 out-of-pocket maximum for employer-sponsored plans, seen below in Figures 19, 20, and 21. Note that employer spending tends to decrease with the availability of Medicare Advantage plans relative to the baseline model, despite the baseline model featuring an out-of-pocket maximum \$1,000 lower than the theoretical Medicare Advantage plan.

Figure 19  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 50–64 Workers Switching to Medicare, by Firm Size, With Medicare Advantage Available**



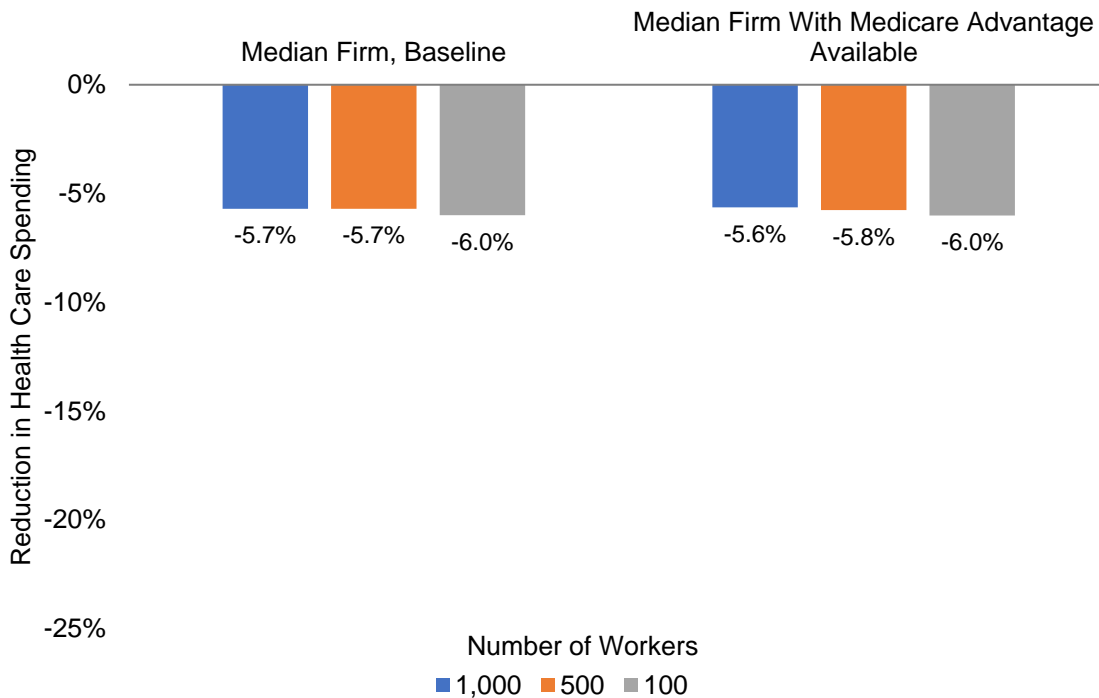
Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

Figure 20  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 55–64 Workers Switching to Medicare, by Firm Size, With Medicare Advantage Available**



Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

Figure 21  
**Reduction in Hypothetical Firms' Health Care Spending Arising From Eligible 60–64 Workers Switching to Medicare, by Firm Size, With Medicare Advantage Available**



Source: Author's estimates from simulation model using IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases.

## Conclusions and Further Considerations

Medicare buy-ins have been floated for over two decades now as a means of expanding coverage to older workers without access to health insurance and as a means to help wrangle health care cost inflation. However, the effects of such a plan on employers are less understood. Additionally, there are numerous political hurdles to navigate for a Medicare buy-in to be implemented. As such, research such as EBRI's — which quantifies the possible impacts on both employer and employee costs — is essential.

As mentioned previously, Medicare buy-in policy proposals should take into consideration the treatment of the spouses and dependents of workers who had previously received coverage through a full-time worker who decided to enroll in a Medicare buy-in policy. Such an examination, however, is outside the scope of this paper. Also, there is no such thing as a free lunch. Despite the cost savings realized from transitioning older eligible workers to public insurance rolls, employers may find that they have no appetite for such a regime if it comes with additional levies that wipe out whatever savings they realize.

We conclude that there is a broad range of possible outcomes on employer spending, depending on who enrolls in the buy-in. If only systematically very high-spending eligible workers decide to buy into Medicare — for example, due to the relative generosity of the employer-sponsored plan — a very large shift in cost could move from private insurance to the public insurance rolls. However, if only systematically very low-spending workers enroll in the Medicare buy-in, then only a very small share of spending could be shifted from private insurance to public insurance.

Our second analysis found that lower-spending eligible workers are the ones to switch and that employers' total spending falls accordingly. Eligible workers are sensitive to the generosity of the employer-sponsored plan relative to



the Medicare buy-in, and when more eligible workers switch to the buy-in, the total health care spending by remaining employees falls.

We also found that while firms' total health expenditures generally fall, the premiums faced by remaining employees often increase, since lower-spending buy-in eligible workers switch to Medicare. Passing along the higher costs of premiums to employees may be unpopular. Employers could use some of the savings they reap from their older workers moving to public insurance to offset the higher premiums that their employees who remain on the employer-sponsored plan may experience. And since a Medicare buy-in may nudge workers to retire earlier than they would absent the buy-in, employers could realize additional cost savings — of course, at the cost of retaining older (and potentially more experienced) workers.

A buy-in regime could be even more appealing to prospective enrollees if Medicare Advantage plans were available. Employer-sponsored insurance features an out-of-pocket maximum, and so very high spenders will often find that their expenditures are minimized when staying with their employer's plan. However, Medicare Advantage plans and Medigap Plans K and L feature an out-of-pocket maximum that prospective enrollees will find familiar. Since our model suggests that workers are sensitive to out-of-pocket maximums — that is, they more frequently stay with their employer's plan when there is a relatively more generous out-of-pocket maximum — then Medicare Advantage plans could nudge more eligible workers to enroll in the buy-in.

## References

Aron-Dine, Aviva, Liran Einav, and Amy Finkelstein, "The RAND Health Insurance Experiment, Three Decades Later," *Journal of Economic Perspectives*, Winter 2013.

Brook, Robert H., John E. Ware, William H. Rogers, Emmett B. Keeler, Allyson Ross Davies, Cathy Donald Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patti Camp, and Joseph P. Newhouse, "The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment," RAND Corporation, 1984.

Centers for Medicare and Medicaid Studies, "2019 Annual Report of the Boards of Trustees and Federal Supplementary Trust Funds," 2019.

Centers for Medicare and Medicaid Studies, "2020 CMS Medicare Advantage Landscape," 2020.

Congressional Budget Office, "An Analysis of the President's Budgetary Proposal for Fiscal Year 1999," Washington, DC: U.S. Congressional Budget Office, 1998.

Congressional Budget Office, "An Analysis of Hospital Prices for Commercial and Medicare Advantage Plans," U.S. Congressional Budget Office, 2017.

Eibner, Christine, Raffaele Vardavas, Sarah A. Nowak, Jodi L. Liu and Preethi Rao, "Medicare for 50-64 Year Olds: Assessing the Effects of Allowing Older Adults to Buy Into the Medicare Program," RAND Corporation, 2019.

Fronstin, Paul and M. Christopher Roebuck, "Persistency in High-Cost Health Care Claims: 'It's Where the Spending is, Stupid,'" *EBRI Issue Brief*, no. 493 (Employee Benefit Research Institute, October 2019).

Johnson, Richard W., Marilyn Moon, and Amy J. Davidoff, "A Medicare Buy-In for the Near Elderly," The Urban Institute, 2002.

U.S. Bureau of Labor Statistics "Current Employment Statistics," <https://www.bls.gov/ces> (accessed July 2020).

## Endnotes

---

<sup>1</sup> The IBM Health Analytics MarketScan database is compiled from a convenience sample, and as a result there is a chance that the estimates produced using this data are biased since the sample may not necessarily be nationally representative.

<sup>2</sup> Additionally, doctors and hospitals, in order to maintain similar revenues to those under the pre-Medicare-buy-in regime, may bill private insurers at higher rates to compensate for receiving lower reimbursements for giving care to workers who switch to Medicare and would otherwise be covered by employer-sponsored insurance. Estimating the extent to which this might happen is outside the scope of this paper.

<sup>3</sup> We use the Medical Loss Ratio (MLR) as an estimate for how premiums might be affected by eligible workers switching to a Medicare buy-in regime. The MLR, codified by the ACA, is a requirement for insurers to spend at least 80 percent of premiums on health care costs. Insurers could spend more than 80 percent of health plan premiums on health care costs, so estimates based on this assumption reflect an upper bound on the premium increases that might be passed on to workers who stay with their employer-sponsored insurance.

<sup>4</sup> The author's analysis of the Center for Medicare and Medicaid Services' 2020 Medicare Advantage Landscape data indicates that the lowest nonzero out-of-pocket maximum was \$400, and the highest out-of-pocket maximum is statutorily set at \$6,700 for 2020.