RESEARCH REPORT

Lowering the Age of Medicare Eligibility to 60

Effects on Coverage and Spending

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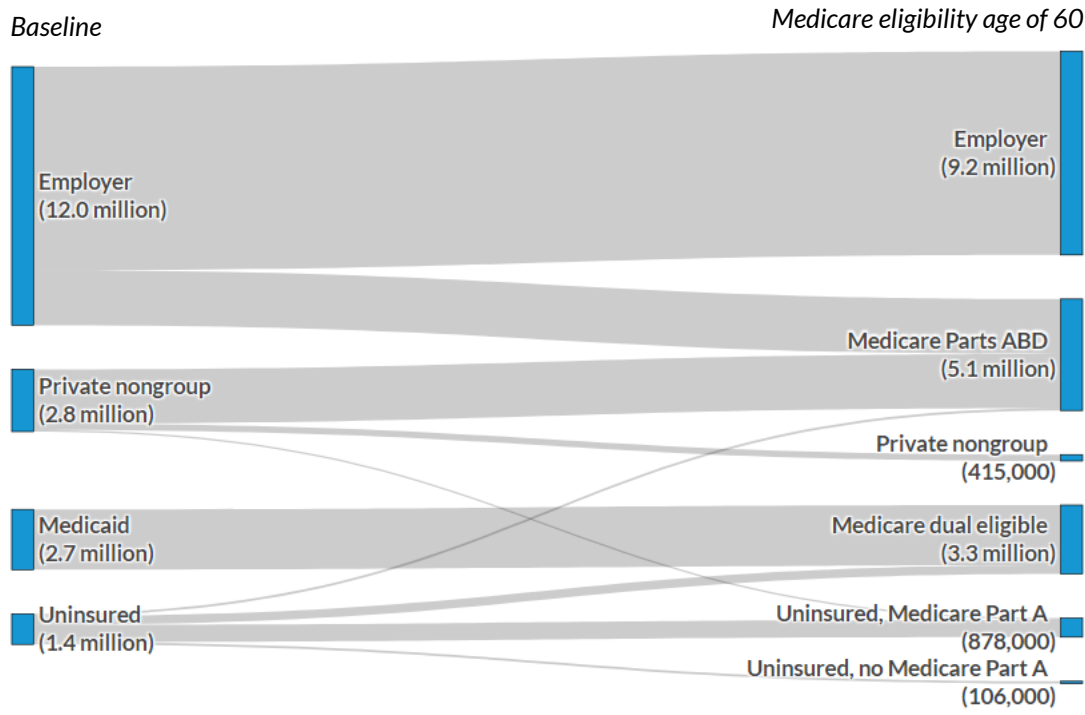
Executive Summary

This report examines the cost and coverage effects of lowering the age of Medicare eligibility from 65 to 60. We find that doing so would lead to improvements in health insurance coverage, though coverage gains would differ by enrollees' income and current coverage. However, these improvements would come with a fairly large increase in federal spending and some increase in overall spending for health care services.

If the Medicare eligibility age were lowered to 60, adults ages 60 to 64 currently enrolled in employer-sponsored insurance could choose to drop their current coverage and enroll in Medicare Parts A, B, and D (as explained below, we are not able to model Part C), or they could keep their current coverage and would be additionally enrolled in Medicare Part A as secondary insurance. We estimate that of the 12.0 million people ages 60 to 64 enrolled in employer-sponsored insurance in the baseline for 2023—which assumes the Marketplace subsidies available under the American Rescue Plan Act have been extended and made permanent—9.2 million, or 77 percent, would keep their current coverage with the added benefit of Medicare Part A (figure ES.1). The remaining 2.8 million, or 23 percent, would drop their employer-sponsored coverage, with most switching to comprehensive Medicare.

Under this policy, adults ages 60 to 64 would lose eligibility for Marketplace premium tax credits (PTCs) when they become eligible for Medicare. Of the 2.8 million people in this age group who have nongroup coverage in the baseline, the 2.4 million who currently get PTCs or are in Basic Health Program plans would lose their current coverage.[1] Nearly all of them would enroll in comprehensive Medicare instead. Marketplace PTCs are more generous than Medicare at lower incomes, however, so many of these adults would have to pay more for coverage, and a few would become uninsured. (Throughout this report, "uninsured" includes both people with no health insurance coverage and people with less than comprehensive coverage, including Medicare Part A only and noncompliant nongroup plans). Among nongroup enrollees not getting PTCs, some would switch to Medicare, while about 415,000 would remain enrolled in nongroup coverage, and almost all of the latter group would also be enrolled in Medicare Part A.

Health Insurance Coverage Transitions of the Population Ages 60 to 64 under a Policy Lowering the Medicare Eligibility Age to 60, 2023

Baseline   *Medicare eligibility age of 60*

Employer
(12.0 million)

Private nongroup
(2.8 million)

Medicaid
(2.7 million)

Uninsured
(1.4 million)

Employer
(9.2 million)

Medicare Parts ABD
(5.1 million)

Private nongroup
(415,000)

Medicare dual eligible
(3.3 million)

Uninsured, Medicare Part A
(878,000)

Uninsured, no Medicare Part A
(106,000)

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Source: Urban Institute Health Insurance Policy Simulation Model, 2022.
Notes: A small number of people with noncompliant nongroup plans are included with the uninsured. Not all coverage categories and transitions are shown here for simplicity. Current Medicare recipients ages 60 to 64 would retain their coverage under the policy; they are excluded from this figure.

The estimated 2.7 million people ages 60 to 64 enrolled in Medicaid in the baseline would become dually eligible for Medicare and Medicaid under the policy. Having Medicare could improve their access to health coverage because payment rates are generally higher in Medicare than in Medicaid. The number of uninsured people would decline by 403,000 because some people who would become eligible for both Medicaid and Medicare would newly enroll in both programs. Among the remaining 984,000 uninsured people in this age group, almost all but the 106,000 who are undocumented immigrants would become eligible for Medicare Part A, which would cover many of their hospital expenses.

New federal spending on Medicare for adults ages 60 to 64 would be $64.7 billion in 2023 if the Medicare eligibility age were lowered to 60. Largely because federal spending on Marketplace subsidies for this group would be eliminated, the net increase in federal spending would be $44.6 billion. On

balance, households' health care spending would decline; this is not true for those with incomes between 138 and 400 percent of the federal poverty level (FPL), who would pay more in premiums as they lose Marketplace subsidies and enroll in Medicare. State governments would save $1.7 billion, largely because Medicare would take over much of the cost of former Medicaid enrollees. Employers would spend $26.7 billion less on insurance premiums because many individuals would move from employer coverage to Medicare; these savings are expected to be passed back to workers in the form of higher wages, though it is unclear which workers would benefit. Higher wages would result in higher tax payments, offsetting some of the increase in federal spending (by $2.8 billion). Consequently, the impact on the federal deficit would be an increase of $41.9 billion in 2023. The increase in the deficit over 10 years, assuming no other new revenues, would be $504 billion.
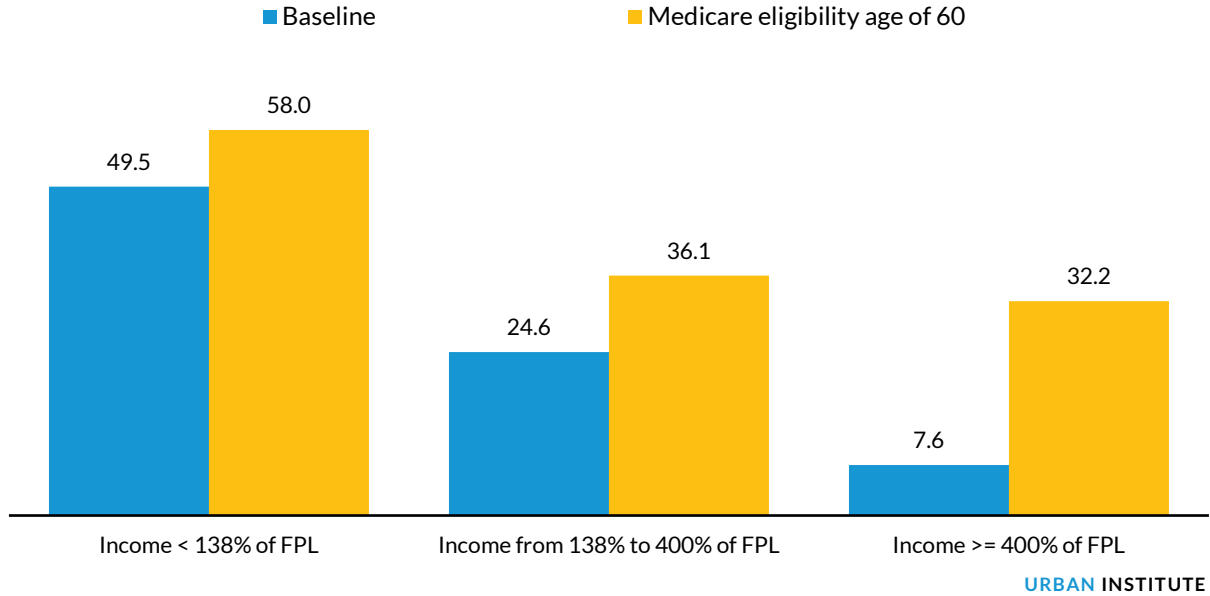
Overall health care spending for adults ages 60 to 64 would increase by $10.9 billion, or 3 percent. Medicare provider payments are generally lower than those for private coverage, but they are not lower than provider payments for Medicaid and many Marketplace plans. Still, many people would get more generous coverage in Medicare. The Congressional Budget Office has recently analyzed a similar proposal to lower the age of eligibility for Medicare to 60.[2]

A large share of adults ages 60 to 64 (44 percent) who would enroll in comprehensive Medicare would have incomes above 400 percent of FPL and would have previously had private health insurance. Thus, the largest increase in federal spending ($24.7 billion) would be on those with incomes above 400 percent of FPL (figure ES.2);[3] much of this increase would substitute for private payments, not pay for new coverage. (Under current law, this highest-income group already benefits more than lower-income groups from the tax benefits resulting from the exclusion of employer contributions to health insurance, while lower-income groups benefit more from Marketplace subsidies and Medicaid.) Federal spending on people with incomes below 138 percent of FPL would increase by $8.5 billion, and federal spending on people with incomes between 138 and 400 percent of FPL would increase by $11.5 billion. Thus, over half of the new federal spending would be for the highest-income people. Moreover, about 69 percent of the overall increase in spending on this age group would be on people with incomes above 400 percent of FPL. The largest increase in federal spending would be among White Americans, who tend to have higher incomes. They would be more likely to enroll in comprehensive Medicare and receive full Medicare benefits; other racial and ethnic groups would be more likely to become dual eligibles, and they would have smaller increases in federal spending because their participation in federal programs (Medicaid and Marketplace coverage with PTCs) is higher under the baseline.

Federal Spending on Acute Care for Households with a Member Ages 60 to 64 under the Baseline and a Policy Lowering the Medicare Eligibility Age to 60, by Income, 2023
Billions of dollars

■ Baseline　　　　　　　■ Medicare eligibility age of 60

	Income < 138% of FPL	Income from 138% to 400% of FPL	Income >= 400% of FPL
Baseline	49.5	24.6	7.6
Medicare eligibility age of 60	58.0	36.1	32.2

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Source: Urban Institute Health Insurance Policy Simulation Model, 2022.
Notes: FPL = federal poverty level. Baseline assumes the American Rescue Plan Act subsidies are extended. Other federal government spending is Medicaid, Marketplace premium tax credit, uncompensated care, and additional spending. Spending for current Medicare recipients ages 60 to 64 would be unchanged under the policy; it is excluded from this table.

Lowering the Age of Medicare Eligibility to 60: Effects on Coverage and Spending

Introduction

This report examines a policy that would lower the age of Medicare eligibility to 60 to expand access to the Medicare program. Medicare currently provides health insurance coverage to adults ages 65 and older. It also covers some people with disabilities under age 65, including those with end-stage renal disease, but these enrollees would not be affected by this policy and are not considered in this analysis.[4] Unlike policies that offer the option to buy into Medicare, the policy we examine would lower the age of eligibility for everyone to 60. By expanding access to Medicare, this policy could help people who are uninsured or underinsured, such as those who retire early, cannot find a job with health benefits, or have coverage with high cost-sharing requirements. An additional goal is to lower health spending by taking advantage of lower Medicare provider payment rates. Legislation that would lower the age of Medicare eligibility to 60 was introduced in Congress in September 2021.[5]

The structure of Medicare is quite different than that of traditional commercial insurance. It consists of four overlapping Parts:[6]

- Part A, known as hospital insurance, or HI, covers inpatient hospital services, hospice care, skilled nursing facility services, and some home health care. Part A does not impose premiums on enrollees; instead, costs are covered by a Medicare payroll tax on all workers' earnings, half of which is paid by employers and half by employees. Medicare eligibility is conditional on a worker or a worker's spouse (current or former spouse of at least 10 years) having had at least 40 quarters of payroll tax payments. Those with insufficient work histories can buy into Part A by paying premiums. Part A has a large deductible for hospital stays, however, of about $1,550 per stay in 2022. It requires additional cost sharing after 60 days of hospitalization and cost sharing for skilled nursing facility services.

- Part B covers medical care services, like visits to the doctor's office, outpatient hospital services, and lab tests. Part B imposes on enrollees monthly premiums set to cover about 25 percent of the costs of the program, an annual deductible, and cost sharing for some services.

The standard Part B premium in 2022 is $170 per month and the annual deductible is $233. However, what individuals pay for Part B varies greatly. For people with low incomes, Medicaid covers premiums, deductibles, and cost sharing for Parts A and B, but this coverage varies by state. For people with incomes above $91,000 per year (or $182,000 for couples), Part B imposes premium surcharges that increase with income. In 2022, the maximum Part B premium is $578 per month.

- Part C, or Medicare Advantage, allows people to select private insurance plans in lieu of enrolling in Parts A, B, and D. Medicare Advantage plans can assess premiums beyond those set for Part B, but many plans choose to use their allotted Medicare funds to reduce premiums and cost sharing and provide additional benefits not covered by Medicare in exchange for a narrower network of providers.

- Medicare Part D provides coverage for prescription drugs exclusively through private prescription drug plans. Premiums are set to cover about 25 percent of the costs of prescription drugs, on average, but total premiums, deductibles, and cost sharing vary by plan. Like Part B premiums, those for Part D have additional surcharges for people with high incomes.

To cover the extensive cost sharing in Parts A, B, and D, enrollees can also purchase private supplemental insurance, called Medigap. Medigap coverage is expensive and not subsidized by Medicare. We do not model the purchase of Medigap coverage, which would add considerably to premium costs but would lower out-of-pocket spending. Nonetheless, it is attractive to many people who can afford the premiums. By not modeling Medigap policies, we likely overstate enrollment in Medicare Parts A, B, and D, particularly among people with high incomes; without Medigap, they may be more reluctant to leave their employer coverage.

On the other hand, we assume people would enroll in Parts A, B, and D but not in Part C (Medicare Advantage). This is because of the extreme complexity of modelling Part C, which varies greatly across the country. Medicare Part C offers important additional benefits in many markets, including lower Part D premiums and limited dental, vision, and hearing services coverage, but the trade-off is more limited provider networks. By excluding Part C, we likely understate Medicare enrollment, particularly among people with lower incomes.

The Goal of This Report

In this report, we examine the effects of lowering the age of eligibility for Medicare from 65 to 60. Under this policy, all eligible people would enroll, or be enrolled automatically, in Part A at age 60, and those ages 60 to 64 would have the opportunity to enroll in comprehensive coverage under Medicare, including Parts B and D. The Affordable Care Act (ACA) Marketplaces would no longer offer subsidies for this age group. People with nongroup coverage (both subsidized and unsubsidized) would have the opportunity to enroll in Medicare. Large numbers of people could see changes in coverage under the policy, depending on their current insurance coverage; spending by federal and state governments, households, and employers could change as well. The policy would have some spillover effects on younger people, but we do not show the impacts on coverage for people under 60 because those effects are extremely small.

We begin by examining how coverage would change with a Medicare eligibility age of 60. How many people would retain their employer coverage with additional Part A benefits? How many would switch from employer or nongroup coverage to comprehensive Medicare, including Parts B and D? How many people who had comprehensive subsidized Marketplace coverage would switch to full coverage under Medicare, and how many of them would become partially uninsured with only coverage for hospital services and other Part A costs? How many of those who had been completely uninsured would at least gain Medicare Part A, if not comprehensive Medicare benefits? We examine the changes in coverage overall and by income and race and ethnicity.

We then examine the costs of extending Medicare benefits to adults ages 60 to 64. What would the new federal costs of Medicare benefits be? What would the reduction in federal payments for Marketplace subsidies for people in this age range be? What would happen to states' Medicaid costs?

How much less would employers spend on premiums for workers who switch to Medicare? What would the effect on overall spending for this age group be? Again, we examine new federal spending overall and by income and by race and ethnicity.

As noted, people would be affected by the new availability of Medicare in different ways depending on their existing coverage.

Current coverage: Nongroup insurance. People with nongroup insurance, particularly in the Marketplaces, would be the coverage group most affected by a policy lowering the Medicare eligibility age to 60. They would no longer be eligible to receive ACA Marketplace subsidies but would be permitted to buy comprehensive coverage through Medicare by paying premiums for Parts B and D. However, Parts B and D premiums can be higher than Marketplace premiums for people with low incomes who currently benefit from the ACA's income-related premium tax credits (PTCs). People with the lowest incomes also benefit from significant cost-sharing reductions in Marketplace plans. Under the policy, Parts B and D premiums should be lower for people with higher incomes currently ineligible for significant Marketplace subsidies, at least until Medicare's income-related premium surcharges for Parts B and D coverage take effect. Full Marketplace premiums would probably be higher than full Medicare premiums because many Marketplace plans would likely pay more than Medicare provider payment rates. This would not be true for all Marketplace plans, however. On the other hand, Marketplace benchmark premiums are tied to silver plans, which have an actuarial value of 70 percent, and most enrollees are in silver plans. Medicare benefits are estimated to have an 85 percent actuarial value. This likely means Medicare costs would be higher than full Marketplace premiums, all else being equal. The higher actuarial value of Medicare benefits means lower out-of-pocket costs for most beneficiaries, but for people with low incomes, cost-sharing reductions in Marketplace plans provide actuarial values greater than 85 percent. That is, people with the lowest incomes might be worse off in Medicare because of the program's higher cost sharing.

Current coverage: Employer-sponsored insurance (ESI). People with ESI would also be affected by lowering the Medicare eligibility age to 60. They would receive Medicare Part A and could choose to have comprehensive Medicare by dropping ESI and enrolling in Parts B and D, or they could keep their current ESI coverage. If they keep ESI, Medicare Part A would provide wraparound, or secondary, coverage for hospital services. Because Part A improves affordability with no additional cost to the employee, we assume all eligible people would take up that coverage.[7] The ACA has a "firewall" that makes employees who have an affordable offer of coverage from an employer ineligible for Marketplace subsidies. However, the availability of Medicare would eliminate the employee firewall for those ages 60 to 64. This would likely mean many people would drop their ESI and enroll in Medicare,

perhaps because of Medicare's lower premiums or higher actuarial value. A consideration for those who might drop employer coverage is that traditional Medicare lacks an out-of-pocket cap in its fee-for-service program (Medicare Part C can have such caps). Most employer plans do have out-of-pocket caps. To protect themselves from catastrophic expenses, people can purchase Medigap policies, but this would increase their costs. Finally, workers gaining Medicare eligibility with family members younger than 60 who are currently covered by their employer plan would be much less likely to leave ESI. Medicare is an individual program, so family members would need to find alternative coverage (typically at an additional cost) or would become uninsured.

Current coverage: Medicaid. We assume people ages 60 to 64 currently eligible for Medicaid, including those eligible through ACA expansion, would also be eligible for Medicare under the policy, and we assume Medicaid would supplement Medicare as it does under current law for adults ages 65 and older. People who qualify for both programs are known as "dual eligibles" or "dual enrollees." Medicaid beneficiaries who gain Medicare coverage may see greater access to care because Medicare's provider payment rates generally exceed those of Medicaid. (However, if Medicare rates exceed Medicaid rates for a service by more than the amount of coinsurance, states are not required to make the coinsurance payment. This is the case for at least some services in 42 states [Roberts et al. 2020]. Thus, dual eligibles are unlikely to be as attractive to physicians as traditional Medicare beneficiaries.) Unlike those eligible for Medicare alone, dual enrollees would have protection against high expenditures.

Current coverage: Uninsured. People who are uninsured would have the option to join comprehensive Medicare or to become dual enrollees if eligible. Plus, they would be better off under the policy even if they were to remain uninsured because they would receive Part A benefits for hospital care. They would remain uninsured for other medical services, which constitute about 62 percent of expenditures for the traditional Medicare population.[8]

Methods

We produce our estimates using the Urban Institute's Health Insurance Policy Simulation Model, or HIPSM, a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new policy options such as the one considered in

this paper. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

For estimates of health coverage and costs in 2023, we updated the model on the basis of state-level Marketplace enrollment from the 2022 open enrollment period snapshot released by the Centers for Medicare & Medicaid Services. However, health coverage in 2023 will differ from coverage in 2022. More than 14 million people will likely lose Medicaid coverage after the end of the COVID-19 pandemic–related public health emergency, leading to an increase in Marketplace enrollment (Buettgens and Green 2022). For details of how we simulated 2023 coverage, see Buettgens and Banthin (2022).

The Medicare policy we simulate for this analysis, what we call "Medicare Parts ABD," would be a traditional insurance product, similar to the current Medicare fee-for-service option, sponsored by the federal government. We simplified the plan, combining Parts A, B, and D, and assumed a unified deductible of $189 and a 15 percent coinsurance rate for all services. We set the deductible and coinsurance rates at amounts that would achieve an actuarial value of 85 percent among participants in the new plan within our model; this is roughly equivalent to the actuarial value of the fee-for-service Medicare benefit under current law. For example, Milliman found that traditional Medicare has an actuarial value of 83.3 percent and Medicare Advantage's value is 89.3 percent (Mike, Friedman, and Yilmaz 2019). Our own calculations from the 2015–18 Medicare Current Beneficiary Surveys yield an estimate of 84.6 percent.[9] As is the case with the Medicare fee-for-service benefit, the Medicare plan we model would have no maximum on out-of-pocket expenditures. As noted above, we assume individuals would enroll in Medicare Parts A, B, and D but not in Part C, Medicare Advantage, because of the complexity of modelling the latter.

We do not model Medicare Savings Programs, which subsidize premiums and, in some cases, cost sharing for Medicare enrollees with low incomes. Current enrollment in Medicare Savings Programs is low (MACPAC 2017), and determining eligibility for them is complex and requires simulating assets. To the extent that new Medicare enrollees would have been enrolled in Medicare Savings Programs, our estimates may understate government costs and overstate household savings under the policy, but we expect this effect to be small.

We estimate that the vast majority of new enrollees would satisfy the requirement to have 40 quarters of hospital insurance payroll tax payments to be able to enroll in Medicare Part A without premiums.[10] For modeling purposes, we assume that all people ages 60 and older legally present in the US would satisfy this requirement. We treat people gaining eligibility for Medicare and who would

otherwise be uninsured as automatically enrolled in Medicare Part A. Currently, people becoming eligible for Medicare must sign up for the program. If automatic enrollment is not part of legislation to expand Medicare eligibility, then some people may not sign up. This would reduce the number of new Part A–only enrollees, but it probably would not reduce the costs of new Part A–only enrollees by much, because institutional providers would ensure people who incur hospital-insurance-eligible costs get enrolled in Part A.

The policy modelled here differs significantly from a Medicare buy-in policy, primarily because in a buy-in policy people would be given a choice between all available coverage options and Medicare.[11] The policy we examine would eliminate Medicaid and subsidized Marketplace coverage as options, though Medicaid would provide wraparound coverage for dual eligibles.

In this report, we examine spending and coverage changes from a baseline that assumes the American Rescue Plan Act (ARPA) subsidies, which are set to expire after 2022 under current law, have been extended and made permanent. If Congress does not extend the subsidies and they return to pre-ARPA levels, then the increases in coverage and federal spending shown here would be greater. Finally, we do not address whether the policy affects workers' retirement decisions or employers' hiring decisions.

Changes in Coverage

Table 1 and figure 1 show changes in coverage between the baseline (current law with extended ARPA subsidies) and the policy extending Medicare to 60-to-64-year-olds. A discussion of key results follows.

TABLE 1
Health Insurance Coverage Distribution of the Population Ages 60 to 64 under the Baseline and under a Policy Lowering the Medicare Eligibility Age to 60, 2023

	Baseline		Medicare Eligibility Age of 60		Change
Coverage	1,000s of people	%	1,000s of people	%	1,000s of people
Insured	19,921	93.5	20,324	95.4	403
Employer	12,011	56.4	9,244	43.4	-2,767
Private nongroup	2,837	13.3	415	1.9	-2,423
Basic Health Program	105	0.5		0.0	-105
Marketplace with PTC	2,259	10.6		0.0	-2,259
Full-pay nongroup	474	2.2	415	1.9	-59
Medicaid	2,734	12.8		0.0	-2,734
Disabled	1,115	5.2		0.0	-1,115
Medicaid expansion	1,094	5.1		0.0	-1,094
Traditional nondisabled adult	525	2.5		0.0	-525

| Coverage | Baseline | | Medicare Eligibility Age of 60 | | Change |
	1,000s of people	%	1,000s of people	%	1,000s of people
Dual eligible		0.0	3,274	15.4	3,274
Other public	2,337	11.0	2,337	11.0	
Medicare Parts A, B, and D		0.0	5,053	23.7	5,053
Uninsured	1,387	6.5	984	4.6	-403
No Medicare Part A	1,387	6.5	106	0.5	-1,281
With Medicare Part A		0.0	878	4.1	878
Total	21,308	100.0	21,308	100.0	

Source: Urban Institute Health Insurance Policy Simulation Model, 2022.

Notes: PTC = premium tax credit. The baseline assumes American Rescue Plan Act subsidies are extended. "Uninsured" includes people with no coverage and people with less than comprehensive coverage, including Medicare Part A only and noncompliant nongroup plans. The full-pay nongroup category includes people who pay full price for Marketplace coverage and those who purchase nongroup plans outside the Marketplace. Current Medicare recipients ages 60 to 64 would retain their coverage under the policy; they are included under "other public" coverage.

Health Insurance Coverage Transitions of the Population Ages 60 to 64 under a Policy Lowering the Medicare Eligibility Age to 60, 2023
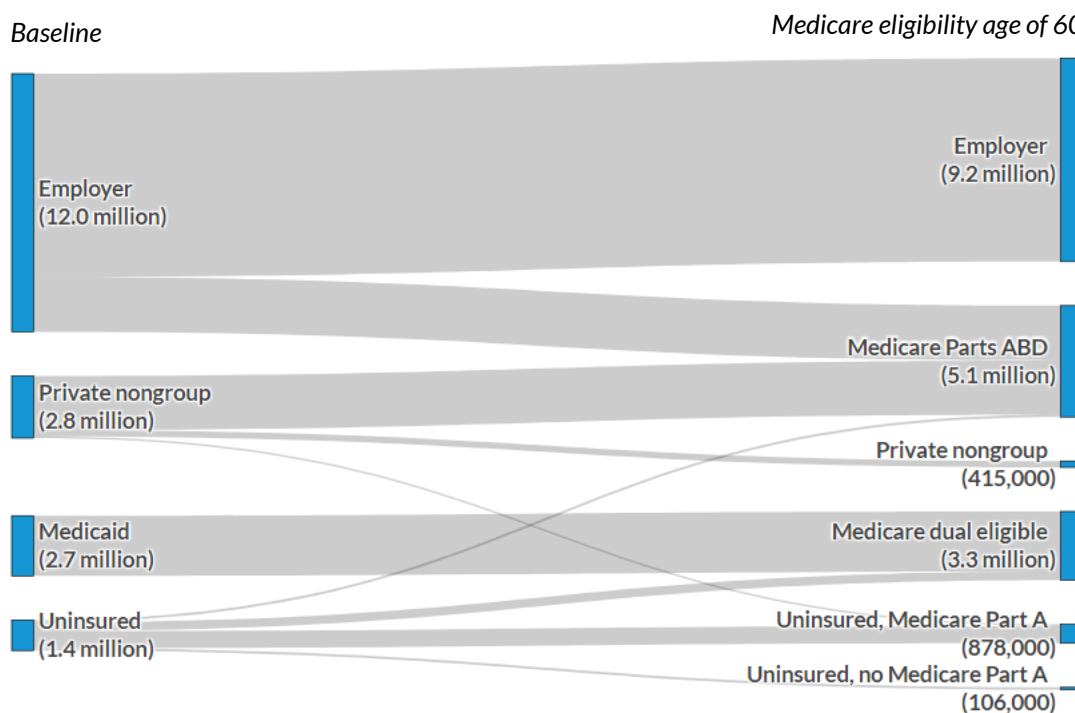

Baseline

Medicare eligibility age of 60

Employer (12.0 million)

Private nongroup (2.8 million)

Medicaid (2.7 million)

Uninsured (1.4 million)

Employer (9.2 million)

Medicare Parts ABD (5.1 million)

Private nongroup (415,000)

Medicare dual eligible (3.3 million)

Uninsured, Medicare Part A (878,000)

Uninsured, no Medicare Part A (106,000)

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Source: Urban Institute Health Insurance Policy Simulation Model, 2022.

Notes: A small number of people with noncompliant nongroup plans are included with the uninsured. Not all coverage categories and transitions are shown here for simplicity. Current Medicare recipients ages 60 to 64 would retain their coverage under the policy; they are excluded from this figure.

A large share of the 12.0 million people ages 60 to 64 with ESI, 77 percent (9.2 million), would retain their current coverage, but about 23 percent (2.8 million) would leave their employer coverage, with most enrolling in Medicare Parts ABD. As is the case under current law for people ages 65 and older, those who would keep ESI would also receive Medicare Part A coverage under the policy. (As noted above, almost all legally present Americans ages 60 to 64 have the required number of calendar quarters of work history to be eligible for Medicare.) Those who would leave their ESI would be better off with Medicare because of lower premiums, lower out-of-pocket costs, or better benefits. An additional 151,000 people who have ESI under the baseline but are entitled to Medicaid would become dual eligibles.

Most of the 2.8 million people ages 60 to 64 who currently have nongroup coverage would join Medicare Parts ABD. About 2.4 million people who currently receive Marketplace PTCs or are enrolled in a Basic Health Program would lose such coverage when they become eligible for Medicare. Many of them, particularly those with incomes below 250 percent of the federal poverty level (FPL), would pay higher premiums in Medicare than they did under the baseline, but they would value health coverage enough to pay higher costs. People with higher incomes who leave nongroup coverage and enroll in Medicare would save on out-of-pocket health costs and sometimes premiums. A small number (415,000) would remain in private nongroup coverage. For this group, keeping private nongroup coverage is advantageous; these people are presumably those with high incomes who would be required to pay significant income surcharges if they enroll in Medicare Parts ABD under the policy we examine. Another small share of people who currently have nongroup coverage would become uninsured, presumably because Medicare costs substantially more than their previously subsidized coverage.

The current Medicaid population (2.7 million people ages 60 to 64) would become dual eligible, and 389,000 currently uninsured people eligible for Medicaid would newly enroll in Medicare as dual enrollees. Under the policy, dual enrollees would have Medicare as primary coverage and would find Medicare more attractive than they find Medicaid under the baseline.

All but 106,000 of the 1.4 million people ages 60 to 64 who are currently uninsured would obtain either comprehensive Medicare coverage or Part A coverage. A small share of the uninsured population would become dual eligibles because they would be newly eligible for Medicare under the policy. Another very small share would enroll directly in Medicare, again because they would find Medicare Parts ABD more attractive than the alternatives that were available under the baseline. Consequently, the number of uninsured people would fall from 1.4 million to 984,000. Of these,

878,000 would have coverage for Medicare Part A, and a very small number, about 106,000, would remain completely uninsured (no Part A); they are primarily undocumented immigrants.

Medicare Parts ABD would have 5.1 million new beneficiaries among people ages 60 to 64, whose total population is 21.3 million. Most of these new enrollees would come from employer or nongroup coverage. Another 3.3 million would become dual eligibles.

Changes in Coverage by Income

We briefly discuss coverage changes for three income groups: those with incomes below 138 percent of FPL (25 percent of those ages 60 to 64), with incomes between 138 and 400 percent of FPL (31 percent), and with incomes above 400 percent of FPL (44 percent).

People ages 60 to 64 with incomes below 138 percent of FPL currently have the highest Medicaid and uninsurance rates of any income group (44.3 and 13.9 percent) and the lowest rate of employer coverage (16.6 percent; table 2). Consequently, most of the new dual eligibles (2.9 million) and nearly all currently uninsured people who would gain coverage under the policy (385,000) would have incomes in this range. Although the percent reduction in ESI would be larger among this group (36 percent) than among higher-income groups, only 16.6 percent of this income group currently has ESI. Thus, only 316,000 people in this group would drop ESI and take up other coverage.

Because most people eligible for Marketplace PTCs have incomes between 138 and 400 percent of FPL, this income group has the highest share with nongroup coverage (22 percent). Consequently, the number of people who would switch from nongroup coverage to Medicare is larger among this group (1.3 million) than any other income group. The number of uninsured people in this income range would increase slightly because some people losing PTC eligibility would be worse off with Medicare, leading some to drop coverage altogether. However, nearly all of the people remaining uninsured would be eligible for Medicare Part A. The share of people in this income group who have employer coverage (53 percent) is larger than at lower incomes, so a larger number would drop ESI (890,000), with most enrolling in Medicare ABD.

TABLE 2

Health Insurance Coverage Distribution of the Population Ages 60 to 64 under the Baseline and a Policy Lowering the Medicare Eligibility Age to 60, by Income, 2023

	Baseline		Medicare Eligibility Age of 60		Change
	1,000s of people	%	1,000s of people	%	1,000s of people
Income < 138% of FPL					
Insured	4,551	86.1	4,937	93.4	385
Employer	878	16.6	562	10.6	-316
Private nongroup	605	11.4	122	2.3	-483
Medicaid	2,344	44.3		0.0	-2,344
Dual eligible		0.0	2,877	54.4	2,877
Other public	724	13.7	724	13.7	
Medicare Parts ABD		0.0	652	12.3	652
Uninsured	735	13.9	349	6.6	-385
No Medicare Part A	735	13.9	68	1.3	-667
With Medicare Part A		0.0	282	5.3	282
Total	*5,286*	*100.0*	*5,286*	*100.0*	
Income of 138% to < 400% of FPL					
Insured	6,253	94.9	6,216	94.3	-37
Employer	3,475	52.7	2,585	39.2	-890
Private nongroup	1,457	22.1	152	2.3	-1,305
Medicaid	297	4.5		0.0	-297
Dual eligible		0.0	302	4.6	302
Other public	1,024	15.5	1,024	15.5	
Medicare Parts ABD		0.0	2,153	32.7	2,153
Uninsured	339	5.1	376	5.7	37
No Medicare Part A	339	5.1	30	0.5	-310
With Medicare Part A		0.0	346	5.3	346
Total	*6,592*	*100.0*	*6,592*	*100.0*	
Income >= 400% of FPL					
Insured	9,117	96.7	9,171	97.3	55
Employer	7,658	81.2	6,097	64.7	-1,561
Private nongroup	775	8.2	141	1.5	-634
Medicaid	94	1.0		0.0	-94
Dual eligible		0.0	96	1.0	96
Other public	590	6.3	590	6.3	
Medicare Parts ABD		0.0	2,248	23.8	2,248
Uninsured	313	3.3	258	2.7	-55
No Medicare Part A	313	3.3	9	0.1	-304
With Medicare Part A		0.0	250	2.6	250
Total	*9,430*	*100.0*	*9,430*	*100.0*	

Source: Urban Institute Health Insurance Policy Simulation Model, 2022.

Notes: FPL = federal poverty level. Baseline assumes American Rescue Plan Act subsidies are extended. "Uninsured" includes people with no coverage and people with less than comprehensive coverage, including Medicare Part A only and noncompliant nongroup plans. Current Medicare recipients ages 60 to 64 would retain their coverage under the policy; they are included under "other public" coverage.

A large majority of people with incomes above 400 percent of FPL (81 percent) is enrolled in employer coverage. Consequently, the number of people in this income group who would switch from ESI to Medicare (1.6 million) is larger than such numbers among the lower-income groups. In addition, more than 600,000 of these high-income people would switch from nongroup coverage to Medicare. Few people with incomes in this range are enrolled in Medicaid or uninsured, so these changes would be small under the policy.

Changes in Health Care Spending

Under a policy lowering the Medicare eligibility age to 60, new Medicare spending would amount to $64.7 billion in 2023 (table 3 and figure 2). Table 3 shows that new Medicare spending would be somewhat offset by savings in Marketplace PTCs of $23.6 billion and a reduction of $1.3 billion in federal spending for uncompensated care. Relative to federal spending on Medicaid under the baseline, federal spending on Medicare for dual enrollees would increase by $4.7 billion, because many people currently uninsured would choose to become dual enrollees. Thus, the net result would be an increase in federal spending of $44.6 billion. This new spending would be offset somewhat by additional federal revenue; overall taxable wages would increase as employers pay less in premiums for workers, so tax revenues would increase by $2.8 billion. Deducting this from new federal spending, **the federal deficit would increase by $41.9 billion in 2023. Over 10 years, this would amount to $504 billion.**

States would save $1.7 billion under the policy, largely because of reduced Medicaid costs resulting from Medicare picking up some of the costs formerly borne by states. States would pay $1.2 billion less for Medicaid and save money on uncompensated care because of the small reduction in the number of people uninsured.

Households would save on out-of-pocket costs but face small increases in premiums. Table 3 shows that households with a member ages 60 to 64 would see a reduction in spending ($3.2 billion). Household premiums would increase slightly ($0.6 billion), but out-of-pocket costs would decline significantly ($3.8 billion).

Employer health insurance premium contributions would fall by $26.7 billion, but most of this would eventually be passed back on to workers in the form of higher wages.

Across all payers, acute care spending on households with members ages 60 to 64 would increase by $10.9 billion, or 3 percent. The increase is driven by higher Medicare costs; these grow because the higher actuarial value of Medicare would drive increased use of health care and thus increased health

care costs. Though Medicare's lower provider payment rates would generate savings, they would not be enough to offset the costs of increased health care use.

Spending on Acute Care for Households with a Member Ages 60 to 64 under the Baseline and a Policy Lowering the Medicare Eligibility Age to 60, by Payer
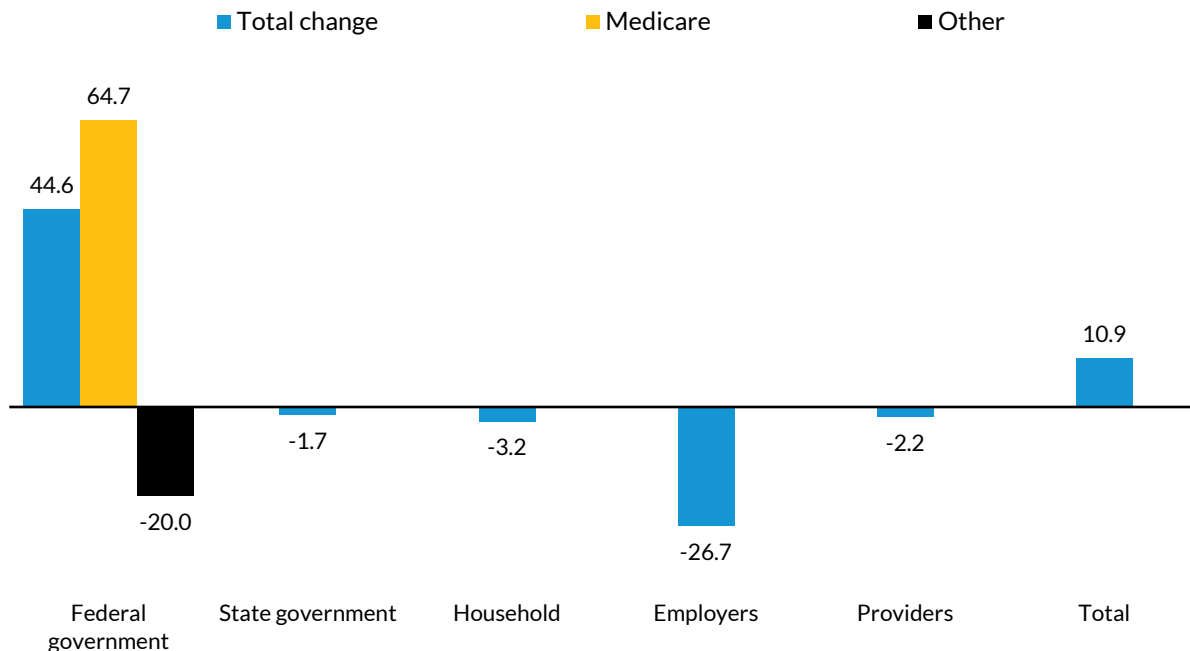
Millions of dollars

Total Spending, 2023			
		Medicare eligibility	
	Baseline	**age of 60**	**Change**
Federal government	81,701	126,342	44,641
Medicare	0	64,666	64,666
Other	81,701	61,676	-20,025
State government	28,822	27,157	-1,665
Household	97,780	94,612	-3,168
Employers	123,732	97,033	-26,700
Providers	4,766	2,519	-2,248
Total	**336,802**	**347,664**	**10,861**

Federal Spending, 2023			
		Medicare eligibility	
	Baseline	**age of 60**	**Change**
Spending on health care services			
Medicaid and CHIP	47,228	51,939	4,711
Marketplace PTC	28,338	4,723	-23,615
Reinsurance	392	555	163
Uncompensated care	5,744	4,459	-1,285
New Medicare spending	0	64,666	64,666
Total	*81,701*	*126,342*	*44,641*
Changes in revenue			
Income and payroll tax effect of ESI change	nc	nc	2,753
Total effect on the deficit	*nc*	*nc*	*41,888*

Federal Spending, 2023–32			
		Medicare eligibility	
	Baseline	**age of 60**	**Change**
Spending on health care services			
Medicaid and CHIP	567,022	623,584	56,562
Marketplace PTC	340,223	56,703	-283,520
Reinsurance	4,710	6,665	1,955
Uncompensated care	65,847	51,122	-14,726
New Medicare spending	0	776,390	776,390
Total	*977,802*	*1,514,463*	*536,661*
Changes in revenue			
Income and payroll tax effect of ESI change	nc	nc	33,048
Total effect on the deficit	*nc*	*nc*	*503,613*

Source: Urban Institute Health Insurance Policy Simulation Model, 2022.

Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. ESI = employer-sponsored insurance. nc = not calculated; only tax differences (income and payroll) due to changes in ESI spending are reported (not overall tax levels). Baseline

assumes American Rescue Plan Act subsidies are extended. Other federal government spending is Medicaid, Marketplace PTC, uncompensated care, and additional spending. At the federal level, the change in spending for uncompensated care represents lower payments to Medicare disproportionate share hospitals resulting from lower uninsurance. Spending for current Medicare recipients ages 60 to 64 would be unchanged under the policy; it is excluded from this table.

Changes in Spending on Acute Care for Households with a Member Ages 60 to 64 under a Policy Lowering the Medicare Eligibility Age to 60, by Payer, 2023
Billions of dollars

■ Total change   ■ Medicare   ■ Other

	Federal government	State government	Household	Employers	Providers	Total
Total change	44.6	-1.7	-3.2	-26.7	-2.2	10.9
Medicare	64.7					
Other	-20.0					

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Source: Urban Institute Health Insurance Policy Simulation Model, 2022.
Note: Other federal government spending is Medicaid, Marketplace premium tax credit, uncompensated care, and additional spending.

Changes in Health Care Spending by Income

Overall acute care spending on the lowest-income group (below 138 percent of FPL) would increase by $1.6 billion, or 2 percent, under a policy lowering the Medicare eligibility age to 60. Table 4 shows that new Medicare spending would be $10.1 billion. On the other hand, other federal spending (Marketplace PTCs, uncompensated care) would fall by $1.6 billion. New federal spending on this income group would total $8.5 billion, but most of this would be offset by a reduction in other spending. Household spending would fall by $1.0 billion. Spending on premiums would increase, but other household spending would decline. States would save $1.2 billion, primarily because of lower spending

on Medicaid and uncompensated care. Employers would spend $3.1 billion less on health insurance for this group.

Spending on Acute Care for Households with a Member Ages 60 to 64 under the Baseline and a Policy Lowering the Medicare Eligibility Age to 60, by Income and Payer, 2023
Millions of dollars

	Baseline	Medicare eligibility age of 60	Change
Income < 138% of FPL			
Federal government	49,490	58,001	8,511
Medicare	0	10,132	10,132
Other	49,490	47,869	-1,620
State government	22,029	20,872	-1,157
Household	9,532	8,499	-1,034
Employers	7,386	4,293	-3,093
Providers	2,413	830	-1,583
Total	*90,851*	*92,495*	*1,645*
Income of 138% to < 400% of FPL			
Federal government	24,621	36,095	11,474
Medicare	0	26,367	26,367
Other	24,621	9,727	-14,893
State government	4,431	4,076	-354
Household	29,399	29,715	316
Employers	37,558	28,044	-9,514
Providers	931	749	-182
Total	*96,939*	*98,679*	*1,740*
Income >= 400% of FPL			
Federal government	7,591	32,247	24,656
Medicare	0	28,167	28,167
Other	7,591	4,080	-3,512
State government	2,362	2,209	-153
Household	58,849	56,399	-2,451
Employers	78,788	64,696	-14,092
Providers	1,422	939	-483
Total	*149,013*	*156,490*	*7,477*

Source: Urban Institute Health Insurance Policy Simulation Model, 2022.
Notes: FPL = federal poverty level. Baseline assumes the American Rescue Plan Act subsidies are extended. Other federal government spending is Medicaid, Marketplace premium tax credit, uncompensated care, and additional spending. Spending for current Medicare recipients ages 60 to 64 would be unchanged under the policy; it is excluded from this table.

For people with incomes between 138 and 400 percent of FPL, the net increase in acute care spending would be $1.7 billion, or 2 percent. Federal spending on this group would increase by $11.5 billion. Medicare spending would increase by $26.4 billion, but this would be partially offset by a decline of $14.9 billion in spending on Marketplace PTCs. State spending would fall by $354 million mostly because the federal government would absorb Medicaid costs as people become dual eligible.

Household spending would increase by $316 million because of the shift from subsidized Marketplace coverage to Medicare. Many in this group would have previously benefited from PTCs and cost-sharing reductions that would no longer be available. Employers would spend about $9.5 billion less on health insurance for this group.

For people with incomes above 400 percent of FPL, the net increase in acute care spending would be $7.5 billion, or 5 percent. Federal government spending on this income group would increase by $24.7 billion, far more than for the other two income groups. New Medicare spending would be $28.2 billion; this would be offset by a reduction of $3.5 billion in other federal spending. States would save $153 million because of lower spending on Medicaid and uncompensated care. Household spending would fall by $2.5 billion, because a portion of this income group would transition from employer coverage to Medicare and those remaining in ESI would gain Medicare Part A coverage. Employers would spend $14.1 billion less on health insurance, a greater difference than that for the other two income groups combined. More than half of the increased federal spending and most of the net increase in spending under the policy would be on behalf of this income group.

Effects on Coverage and Spending by Race and Ethnicity

Higher-income racial and ethnic groups would be more likely to receive comprehensive Medicare benefits under a policy lowering the Medicare eligibility age to 60, and lower-income racial and ethnic groups would be more likely to become dual eligibles. The impacts of the policy on different racial and ethnic groups would largely result from income effects. Higher-income groups are more likely to have employer coverage in the baseline. The number of people dropping this coverage and enrolling in Medicare under the policy would be large if the share of people within a racial or ethnic group with employer coverage is large. For example, 61 percent of White adults have employer coverage, whereas 50 percent of Asian or Pacific Islander adults, 44 percent of Black adults, and 40 percent of Hispanic adults have such coverage.[12] Consequently, the share of people leaving ESI would be largest for White adults, as would the share of people joining Medicare Parts ABD (26 percent). Fewer Black and Hispanic adults have employer coverage under current law and thus would have smaller shares of people enrolling in Medicare Parts ABD (17 and 19 percent). Asian or Pacific Islander adults fall in the middle; relative to Black and Hispanic adults, they have more employer coverage under current law, and thus more of them would join Medicare Parts ABD (20 percent). Medicare Parts ABD would be heavily subsidized, and, as noted, the share of adults switching from employer coverage to Medicare would be largest among White adults. Thus, White adults would benefit more from Medicare subsidies than any

other racial or ethnic group examined. Those switching from ESI to Medicare would largely be substituting Medicare for private coverage.

TABLE 5

Health Insurance Coverage Distribution of the Population Ages 60 to 64 under the Baseline and a Policy Lowering the Medicare Eligibility Age to 60, by Race or Ethnicity, 2023

	Baseline		Medicare Eligibility Age of 60		Change
	1,000s of people	%	1,000s of people	%	1,000s of people
Asian or Pacific Islander					
Insured	881	90.1	912	93.3	31
Employer	493	50.4	410	42.0	-82
Private nongroup	139	14.2	20	2.0	-119
Medicaid	185	18.9		0.0	-185
Dual eligible		0.0	220	22.6	220
Other public	65	6.6	65	6.6	
Medicare Parts ABD		0.0	197	20.2	197
Uninsured	97	9.9	65	6.7	-31
No Medicare Part A	97	9.9	21	2.1	-76
With Medicare Part A		0.0	45	4.6	45
Total	*977*	*100.0*	*977*	*100.0*	
Black					
Insured	2,057	92.8	2,107	95.1	50
Employer	977	44.1	778	35.1	-199
Private nongroup	236	10.7	35	1.6	-201
Medicaid	508	22.9		0.0	-508
Dual eligible		0.0	576	26.0	576
Other public	336	15.2	336	15.2	
Medicare Parts ABD		0.0	383	17.3	383
Uninsured	159	7.2	109	4.9	-50
No Medicare Part A	159	7.2	9	0.4	-149
With Medicare Part A		0.0	99	4.5	99
Total	*2,216*	*100.0*	*2,216*	*100.0*	
Hispanic					
Insured	1,646	87.0	1,709	90.3	63
Employer	759	40.1	639	33.8	-119
Private nongroup	271	14.3	29	1.5	-242
Medicaid	446	23.6		0.0	-446
Dual eligible		0.0	516	27.2	516
Other public	170	9.0	170	9.0	
Medicare Parts ABD		0.0	355	18.7	355
Uninsured	247	13.0	184	9.7	-63
No Medicare Part A	247	13.0	63	3.3	-183
With Medicare Part A		0.0	120	6.4	120
Total	*1,892*	*100.0*	*1,892*	*100.0*	
White					
Insured	14,970	94.6	15,215	96.2	244
Employer	9,611	60.7	7,283	46.0	-2,328
Private nongroup	2,145	13.6	325	2.1	-1,820
Medicaid	1,504	9.5		0.0	-1,504
Dual eligible		0.0	1,854	11.7	1,854
Other public	1,710	10.8	1,710	10.8	

	Baseline		Medicare Eligibility Age of 60		Change
	1,000s of people	%	1,000s of people	%	1,000s of people
Medicare Parts ABD		0.0	4,043	25.6	4,043
Uninsured	852	5.4	607	3.8	-244
No Medicare Part A	852	5.4	11	0.1	-841
With Medicare Part A		0.0	597	3.8	597
Total	*15,822*	*100.0*	*15,822*	*100.0*	

Source: Urban Institute Health Insurance Policy Simulation Model, 2022.

Notes: Baseline assumes American Rescue Plan Act subsidies are extended. Asian or Pacific Islander, Black, and White adults are not Hispanic. American Indian / Alaska Native adults and adults of additional races and ethnicities are not shown because of small sample sizes. "Uninsured" includes people with no coverage and people with less than comprehensive coverage, including Medicare Part A only and noncompliant nongroup plans. Current Medicare recipients ages 60 to 64 would retain their coverage under the policy; they are included under "other public" coverage.

Compared with other racial and ethnic groups, fewer White adults have Medicaid under current law, so only 12 percent would become dual eligible under the policy. Black and Hispanic adults have larger shares of people with Medicaid under current law (23 and 24 percent), and thus 26 percent of Black adults and 27 percent of Hispanic adults would be dual eligible under the policy. A large share of Asian or Pacific Islander adults would also become dual eligible (23 percent). Thus, larger shares of Asian or Pacific Islander, Black, and Hispanic adults would become dual eligible instead of becoming full Medicare beneficiaries. Having Medicare as a primary payer should increase the value of coverage for dual enrollees, but the value of new subsidies for dual enrollees would be smaller than the value of full Medicare coverage.

Spending by the federal government on White adults would increase by 70 percent ($36.3 billion) under the policy, a much larger percentage than that for other groups (table 6). Spending by states, employers, and providers on White adults would decrease somewhat under the policy. The reduction in spending by employers would be especially large, because these adults would largely be switching coverage, not gaining new coverage. Federal spending on Asian or Pacific Islander adults would increase by $1.8 billion, or 43 percent; this would be offset somewhat by reduced state government, employer, and provider spending. Federal spending on Black adults would increase by $3.1 billion, or 26 percent; again, spending on this group by state governments, employers, and providers would decline. The increase in federal government spending on Hispanic adults would be smaller at $2.7 billion, or 25 percent; again, state government, employer, and provider spending on this group would decline.

Under the policy, White adults would have bigger increases in federal spending because they have a higher share of people switching from ESI to Medicare and newly benefiting from comprehensive subsidized coverage in Medicare. The increases in federal spending among Asian or Pacific Islander, Black, and Hispanic adults would be lower than that for White adults because these racial and ethnic

groups have lower incomes than White adults. Because of this, they have higher baseline Medicaid and Marketplace coverage and federal spending and therefore benefit less from the policy. Overall, White adults would receive 81 percent of all new federal spending, largely because adults ages 60 to 64 are predominantly White (74 percent), much more so than younger groups. In the long term, the 60-to-64 age group will become more diverse, and the overall share of spending going to White adults under the policy will fall, even if other income and program effects remain unchanged.

Spending on Acute Care for Households with a Member Ages 60 to 64 under the Baseline and a Policy Lowering the Medicare Eligibility Age to 60, by Race or Ethnicity and Payer, 2023
Millions of dollars

	Baseline	Medicare eligibility age of 60	Change
Asian or Pacific Islander			
Federal government	4,069	5,838	1,769
Medicare	0	2,537	2,537
Other	4,069	3,301	-768
State government	1,346	1,238	-109
Household	4,069	3,910	-160
Employers	5,169	4,473	-696
Providers	222	159	-63
Total	*14,875*	*15,618*	*742*
Black			
Federal government	12,010	15,157	3,147
Medicare	0	4,927	4,927
Other	12,010	10,230	-1,780
State government	4,966	4,705	-260
Household	6,842	6,566	-276
Employers	9,409	7,460	-1,949
Providers	243	134	-110
Total	*33,470*	*34,022*	*552*
Hispanic			
Federal government	10,835	13,517	2,682
Medicare	0	4,573	4,573
Other	10,835	8,945	-1,890
State government	4,259	4,013	-246
Household	6,204	6,100	-104
Employers	7,948	6,818	-1,129
Providers	367	258	-109
Total	*29,613*	*30,707*	*1,094*
White			
Federal government	51,970	88,224	36,254
Medicare	0	51,582	51,582
Other	51,970	36,643	-15,327
State government	17,144	16,139	-1,005
Household	79,249	76,707	-2,543
Employers	99,466	76,914	-22,552
Providers	3,766	1,884	-1,882
Total	*251,595*	*259,867*	*8,272*

Source: Urban Institute Health Insurance Policy Simulation Model, 2022.

Notes: Baseline assumes American Rescue Plan Act subsidies are extended. Asian or Pacific Islander, Black, and White adults are not Hispanic. American Indian/Alaska Native adults and adults of additional races and ethnicities are not shown because of small sample sizes. Other federal government spending is Medicaid, Marketplace premium tax credit, uncompensated care, and additional spending. Spending for current Medicare recipients ages 60 to 64 would be unchanged under the policy; it is excluded from this table.

Discussion

Reducing the age of eligibility for Medicare to 60 would have several effects on coverage that would mostly make people better off. The number of uninsured people would fall slightly because some of this population would gain Medicare coverage and Medicaid wraparound coverage.

Most people with employer coverage under current law would keep their employer coverage (77 percent), but 23 percent would drop ESI, with most switching to Medicare Parts ABD because of lower premiums, lower out-of-pocket costs, or better benefits. Those who keep their employer coverage would also have Medicare Part A as secondary insurance. People with nongroup coverage under the baseline would largely switch to Medicare. In some cases, they would have to pay more because the cost of Medicare would exceed the subsidized costs of Marketplace premiums and cost sharing. A small number of them would become uninsured because of these higher costs. However, most would decide to enroll in Medicare; they may face higher household expenses because of the value they place on better insurance.

People currently enrolled in Medicaid would become dual enrollees under the policy, perhaps gaining greater access to providers because Medicare, with its higher provider payment rates, would become their primary payer. Most people who would remain uninsured would gain Part A coverage for hospital care. A small share would remain uninsured without Part A; they are largely undocumented immigrants. Overall household spending would decline, with a small increase in premium spending but a larger decline in spending on out-of-pocket costs.

These benefits of the policy do, however, come with higher federal and overall spending on health care. Spending by the federal government would increase by $44.6 billion. This includes new Medicare spending of $64.7 billion that would be partially offset by reductions in Marketplace premium expenditures and spending on uncompensated care. Of particular note, the bulk of the additional spending would go to adults ages 60 to 64 with the highest incomes.

The federal government would spend $8.5 billion more on people with incomes below 138 percent of FPL. Medicare spending on this income group would increase by $10.1 billion, but other federal

spending (largely Marketplace PTCs) would fall by $1.6 billion. Federal spending on current Medicaid enrollees would increase because they would become dual enrollees, making Medicare their primary payer. Federal government spending on adults with incomes between 138 and 400 percent of FPL would increase by $11.5 billion. This reflects $26.4 billion in new Medicare spending offset by a reduction of $14.9 billion in Marketplace PTCs. The biggest increase in federal spending by far would be on adults with incomes above 400 percent of FPL ($24.7 billion); this reflects $28.2 billion in new Medicare spending offset by a $3.5 billion reduction in other federal spending. Thus, the largest increases in federal spending, 55 percent of the total increase in such spending, would be on this high-income group.

State governments would save $1.7 billion under the policy, largely because Medicaid enrollees would switch to dual enrollment, thus reducing state spending on this population; states would only be responsible for their share of wraparound services because Medicare would be dual enrollees' primary payer.

Employers would also spend considerably less on health insurance: $26.7 billion overall. As noted, most of this will be passed back to workers in the form of higher compensation, though it is unclear which workers would benefit. Most of the reduction in employer premium contributions—$14.1 billion—would go to the highest-income group. Employers would spend $9.5 billion less on insurance for the middle-income group and $3.1 billion less for the lowest-income group.

The overall increase in spending on adults ages 60 to 64 would be $10.9 billion, or 3 percent. Spending on people with incomes below 138 percent of FPL would increase by $1.6 billion. Increased federal spending on this income group would be largely offset by reductions in spending by households, states, providers, and employers.

Spending on people with incomes between 138 and 400 percent of FPL would increase by $1.7 billion. Households in this income range would have a small increase in spending because of the elimination of Marketplace subsidies; some would have to pay somewhat more to enroll in Medicare. Nonetheless, much of new Medicare spending on this group would be offset by lower spending on Marketplace PTCs. States and employers would both spend less on health care for this group, also offsetting some of the increase in federal spending.

The increase in Medicare spending on people with incomes above 400 percent of FPL would be only slightly offset by reductions in PTC spending. States would save somewhat on expenditures for this group, and employers would spend less, too. Because of fewer offsets to the increase in federal

spending for this income group, the change in overall spending on this group would be $7.5 billion, accounting for more than two-thirds of the total $10.9 billion increase.

Under the policy, overall acute health care spending for adults 60 to 64 would increase by 3 percent largely because the actuarial value of Medicare exceeds that of most people's current coverage. The impact of provider payment rates is somewhat complicated. Many people becoming dual enrollees would have provider payments set by Medicare. Previously, they would have had Medicaid, which has payment rates generally lower than those in Medicare, especially for physicians (Zuckerman, Skopec, and Aarons 2021). Other new dual eligibles would previously have had Marketplace plans. Many Marketplace plans have narrow networks and pay low provider payment rates. Thus, in many cases, the reduction in spending would be low because of lower Medicare payment rates. The opposite is true for people who leave employer coverage. In most cases, commercial payment rates are above Medicare's. On balance, the savings from lower Medicare payment rates will likely be small for people switching from ESI to Medicare. Thus, the main reason for the increase in overall spending is the increased richness of the Medicare benefit package.

Notes

1   The Basic Health Program is an optional health insurance program states may offer to people with incomes up to 200 percent of FPL as an alternative to purchasing coverage through the Marketplace. Only Minnesota and New York have implemented Basic Health Programs.

2   As we neared completion of this paper, the Congressional Budget Office (CBO) released a report on the implications of lowering the Medicare eligibility age to 60. The two reports are difficult to compare because they rely on different data sources, have different modeling and policy assumptions, and provide estimates for different time periods. The bottom line results—a small effect on the uninsured and a relatively large increase in federal spending—are the same. CBO provides coverage estimates for 2031, the Urban Institute for 2023. The population aged 60 to 64 is projected to be smaller in 2031 than in 2023 because of the aging of the baby boom. The reports have relatively similar estimates of the percent dropping employer coverage. CBO assumes the nongroup market will completely be eliminated for this age group; the Urban Institute assumes that a small percentage of people, primarily those with income sufficient to pay the Medicare surcharges, would choose the nongroup market. The Urban Institute assumes that all those on Medicaid would become dual eligibles, while CBO assumes a small number would remain enrolled in Medicaid only, and that those who gained Medicaid eligibility through the ACA's Medicaid expansion would lose Medicaid eligibility. The number of uninsured gaining coverage would be similar between the two models. The CBO has a lower estimate of the increase in federal spending because of differences in population size, different assumptions about how Medicaid eligibility would be affected by the policy, and because they estimate higher new federal tax revenues because of the wage increases occurring from the loss of employer coverage.

3   Throughout this report, totals may not match the sums of parts presented because of rounding.

4   Current Medicare beneficiaries under age 65 are included in coverage tables in the "other public" row. We exclude spending on their behalf from our cost estimates because their spending would not change under the reform.

5   Improving Medicare Coverage Act, H.R. 5165, 117th Cong. 1st Sess. (Sep. 3, 2021).

6   "What Does Medicare Cost?" Medicare.gov, accessed April 28, 2022, https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/what-does-medicare-cost.

7   In addition, health care providers and small firms would have incentives to encourage participation in Part A.

8   Urban Institute calculations from the Medicare Current Beneficiary Survey; see "Medicare Current Beneficiary Survey (MCBS)," Centers for Medicare & Medicaid Services, updated December 3, 2021, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS.

9   "Medicare Current Beneficiary Survey," Centers for Medicare & Medicaid Services.

10   Most people ages 65 and older are automatically entitled to premium-free Part A coverage because they or their spouse paid payroll taxes for at least 40 quarters of work (Davis et al. 2020); premium payments by beneficiaries make up only 1 percent of Part A revenues (see Table II.B.1. in Medicare Trustees [2021]). Data on fully insured status for Social Security (Old-Age and Survivors Insurance), which has similar eligibility rules to but more coverage exemptions and taxation of wages than Medicare, show little, if any, additional gain in eligibility after age 55. See Table 4.C5 in SSA (2021).

11   See Garrett and colleagues (2020) for an analysis of Medicare buy-in policies.

12   The racial and ethnic terms used in this analysis are from the American Community Survey, the data on which HIPSM is built. We acknowledge this language may not reflect how people describe themselves. We remain committed to employing respectful and inclusive language.

American Indian/Alaska Native people and people of additional races and ethnicities are not shown because of small sample sizes.

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About the Authors

John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

Matthew Buettgens is a senior fellow in the Health Policy Center, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

Andrew Green is a research analyst in the Health Policy Center. His work focuses on developing and using Urban's Health Insurance Policy Simulation Model to evaluate the coverage and cost effects of health insurance reform proposals. Green holds a bachelor's degree in business administration from the University of Michigan and a master's degree in data science and public policy from Georgetown University.

Michael Simpson is a principal research associate in the Health Policy Center with 25 years of experience developing economic models and using survey and administrative data. His current work focuses on using Urban's Health Insurance Policy Simulation Model to project health insurance coverage and spending both in the baseline and under policy alternatives. Before joining Urban, Simpson developed the Congressional Budget Office's long-term dynamic microsimulation model. He analyzed numerous policy reform proposals, investigated differences between various projections of Social Security finances and benefits, quantified the importance of Monte Carlo variation in model results, and created multiple methods to demonstrate uncertainty in projections.

Jessica Banthin is a senior fellow in the Health Policy Center, where she studies the effects of health insurance reform policies on coverage and costs. Before joining the Urban Institute, she served more than 25 years in the federal government, most recently as deputy assistant director for health at the Congressional Budget Office. During her eight-year term at the Congressional Budget Office, Banthin directed the production of numerous major cost estimates of legislative proposals to modify the Affordable Care Act. Banthin has contributed to Congressional Budget Office reports and written about how reform proposals affect individuals' and families' incentives to enroll in coverage, influence employers' decisions to offer coverage to their employees, and affect insurance market competitiveness. In her recent work, Banthin has written on competition in insurer markets and the accuracy of various data sources used in modeling health reforms. Banthin has also conducted significant work on the financial burden of health care premiums and out-of-pocket costs on families, published in scientific journals. She has special expertise in the design of microsimulation models for analyzing health insurance coverage and a deep background in the design and use of household and employer survey data. Banthin's experience in estimating the effects of health reform on cost and coverage extend back to her service on the President's Task Force on National Health Care Reform in 1993. She earned her PhD in economics from the University of Maryland, College Park, and her AB from Harvard University.

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