



Budgetary Effects of a Policy That Would Lower the Age of Eligibility for Medicare to 60

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In this report, the Congressional Budget Office discusses an estimate of the federal budgetary costs of a policy that would lower the age of eligibility for Medicare, largely reflecting current program rules for people who would be newly eligible. The estimate was prepared in conjunction with the staff of the Joint Committee on Taxation (JCT). This report also describes the resulting changes in the number of people with health insurance coverage and the sources of that coverage.

CBO and JCT estimate that lowering the age of Medicare eligibility to 60 would increase federal budget deficits by \$155 billion over the 2026–2031 period through the effects of that policy on federal revenues and mandatory spending.¹

Enacting the policy would have a significant effect on primary sources of health insurance coverage, and it would increase the number of people insured. According to CBO's estimate, in 2031:

- About 7.3 million more people would be enrolled in both Medicare Part A and Medicare Part B as their primary source of coverage.
- About 3.2 million fewer people would have employment-based insurance as their primary source of coverage; most of those people would enroll in Medicare.
- About 1.8 million fewer people would have Medicaid as their primary source of coverage; almost all of them would enroll in Medicare.

- About 2.0 million fewer people would be enrolled in nongroup coverage, and almost all of them would enroll in Medicare instead.
- About 0.4 million fewer people would be without health insurance.

Those changes in health insurance coverage under the policy would cause federal deficits to increase for three main reasons:

- Although spending on health care would decrease, on average, for people with employment-based coverage under current law (largely because Medicare generally has lower payment rates for medical services), federal costs would increase because a larger share of that spending would be paid by the federal government rather than employers.
- Some people who are projected to be uninsured or enrolled in unsubsidized nongroup coverage under current law would instead have health insurance coverage subsidized by the federal government.
- Federal costs for people with Medicaid coverage under current law would increase, primarily because of greater spending on health care for people dually eligible for Medicaid and Medicare and because a greater share of those costs would be paid for by the federal government rather than state governments. Those costs would be partially offset by reductions in Medicaid spending for people who would lose their eligibility for Medicaid under the policy.

Description of the Policy

CBO and JCT analyzed a policy that would lower the age of Medicare eligibility from 65 to 60. The policy would be fully implemented beginning in calendar year 2026, and it would largely maintain the current program rules for those who would be newly eligible.

1. Mandatory, or direct, spending includes outlays for some federal benefit programs and for certain other payments to people, businesses, nonprofit institutions, and state and local governments. Such outlays are generally governed by statutory criteria and are not normally constrained by the annual appropriation process.

One difference from current-law rules is that, under the policy, people could become eligible for premium-free Medicare Part A before becoming eligible for Social Security. Under current law, people are generally eligible for premium-free Part A only if they are also eligible to receive Social Security benefits.

The estimated effects of the policy reflect several key features of current law:

- Individuals or a qualifying family member must have worked 40 quarters (10 years) and must meet residency requirements to receive premium-free Part A.
- People who receive Social Security benefits are automatically enrolled in Medicare Parts A and B when they become eligible for Medicare. Under the policy, people under age 62, who are ineligible for those retirement benefits, and people ages 62 and over who are not yet claiming or receiving those benefits would have to actively choose to enroll in Medicare.²
- People who are uninsured or who remain enrolled in certain types of coverage—including nongroup and retiree coverage but excluding coverage from a current employer—instead of enrolling in Medicare Part B when they become eligible for Medicare may be subject to a late-enrollment penalty when they eventually enroll in Part B. Similarly, people who are not enrolled in creditable prescription drug coverage and who do not enroll in Medicare Part D when they become eligible may be subject to a late-enrollment penalty when they eventually enroll in Part D.
- Under Medicare’s secondary-payer rules, small firms—those with fewer than 20 employees—are not required to offer Medicare-eligible employees and other employees the same health plans. Additionally, Medicare is the primary payer for eligible employees at small firms and for people with retiree coverage.
- Once people become eligible for Medicare, they lose their eligibility for the premium tax credits and cost-sharing reductions that subsidize nongroup coverage through the marketplaces established by the Affordable Care Act (ACA).³
- Adults with low income who became eligible for Medicaid through the ACA lose their Medicaid

2. People who are eligible for Social Security benefits can claim them as early as age 62.

3. People who are eligible for an alternative source of minimum essential coverage, including Medicare Part A, are not eligible for subsidized marketplace coverage.

eligibility when they become eligible for Medicare, but they may qualify for financial support through a Medicare Savings Program.⁴ When people who are otherwise eligible for Medicaid become eligible for Medicare, they retain their Medicaid eligibility and are dually eligible for both programs.

- Newly enrolled Medicare beneficiaries have access to medigap coverage for supplemental insurance.

Changes to those key features of current law or to the policy specifications would affect the budgetary and coverage estimates discussed in this report, and those effects could be significant.

Effects on the Federal Budget

CBO and JCT estimate that the policy would increase federal deficits by \$155 billion over the 2026–2031 period through its effects on federal revenues and mandatory spending (see Table 1).⁵ The net increase in deficits would result from increases in mandatory spending for Medicare, the Medicare Savings Program, the Military Health System, and Social Security, partially offset by decreases in Medicaid outlays, federal subsidies for insurance purchased through the marketplaces, and a shift in employees’ compensation from tax-favored health insurance to taxable wages. Those estimated changes reflect increases of \$222 billion in mandatory spending that are partly offset by a \$67 billion increase in revenues.

Enrollment in Medicare Among Newly Eligible People

CBO estimates that there will be 19.8 million people between the ages of 60 and 64 in the United States in 2031. Of those, 2.6 million people who are eligible for Medicare under current law because of disability or end-stage renal disease are expected to enroll in the program. Of the remainder, an estimated 15.6 million people would meet work history and residency requirements and would therefore be newly eligible for Medicare

4. For the adult eligibility category established by the ACA, the Medicaid statute includes only people who are “not entitled to, or enrolled for, benefits under part A of title XVIII [of Medicare], or enrolled for benefits under part B of title XVIII.” Medicaid enrollees who qualify for Medicaid through the eligibility categories available before the implementation of the ACA retain their Medicaid eligibility. See sec. 2001(a)(1) of the Patient Protection and Affordable Care Act, Public Law 111-148 (codified at 42 U.S.C. §1396a(a)(10)(A)(i)(VIII) (2018)).

5. The policy would also affect discretionary spending, which is subject to future appropriations. Some discretionary spending would increase, and some would decrease. CBO has not estimated the net effect.

Table 1.

Budgetary Effects of a Policy to Lower the Medicare Age of Eligibility to 60

Billions of Dollars, by Fiscal Year

	2026	2027	2028	2029	2030	2031	2026–2031
Net Increases or Decreases (-) in the Deficit							
Changes in Federal Subsidies for Health Insurance							
Medicare outlays ^a	43.5	60.4	62.4	65.1	67.8	72.1	371.4
Medicare Savings Program outlays ^b	1.9	2.7	2.9	3.2	3.5	3.8	17.9
Medicaid outlays	-12.4	-17.6	-18.7	-19.8	-21.0	-22.2	-111.8
Subsidies for employment-based coverage	-6.0	-8.6	-8.9	-9.4	-10.0	-10.6	-53.5
Subsidies for nongroup coverage	-10.9	-15.7	-16.3	-16.9	-17.5	-18.2	-95.5
Military Health System outlays	1.0	1.5	1.5	1.5	1.6	1.6	8.7
Subtotal	17.1	22.7	22.9	23.7	24.5	26.4	137.3
Change in Social Security Outlays	1.3	2.3	3.2	3.6	3.8	3.6	17.6
Total Increase in the Deficit	18.3	25.0	26.1	27.3	28.2	30.0	154.9
Memorandum:							
Total Increase in Mandatory Outlays	25.9	35.8	37.4	39.1	40.6	43.1	221.8
Total Increase in Revenues^c	7.5	10.8	11.3	11.8	12.4	13.1	66.9

Data sources: Congressional Budget Office; staff of the Joint Committee on Taxation. See www.cbo.gov/publication/57918#data.

Numbers may not add up to totals because of rounding.

These estimates are relative to CBO's July 2021 baseline budget projections. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2021 to 2031* (July 2021), www.cbo.gov/publication/57218.

CBO assumed that the policy would take effect beginning in calendar year 2026. The agency estimates that the policy would also affect discretionary spending, which is subject to future appropriations by lawmakers, as a result of two offsetting effects: lower discretionary spending on the Federal Employees Health Benefits program, the Military Health System, and the Veterans Health Administration and higher discretionary spending on implementation and ongoing administrative costs for Medicare. CBO has not produced an estimate of the net effect.

a. Medicare outlays are net of offsetting receipts and have been adjusted for timing shifts. Offsetting receipts include premiums, amounts paid to providers and later recovered, and phased-down state contribution ("clawback") payments from the states to Part D.

b. Medicare reimburses Medicaid for some outlays for the Medicare Savings Programs.

c. The \$66.9 billion total increase in revenues over the 2026–2031 period is the net effect of \$53.5 billion less in tax subsidies for employment-based coverage and \$13.5 billion less in premium tax credits (which are included as a component of subsidies for nongroup coverage).

under the policy (see Table 2). CBO estimates that about 13.6 million, or 87 percent, of those newly eligible people would enroll in some form of Medicare.⁶

More specifically, 53 percent of people newly eligible for Medicare would enroll in Parts A and B, 34 percent would enroll in Part A only, and 13 percent would not enroll in any Medicare coverage. By comparison, in 2019, about 82 percent of people ages 65 to 69 enrolled in Parts A and B, about 15 percent enrolled in Part A only, and 3 percent had no Medicare coverage.⁷

6. Of the people newly eligible for Medicare, 7.3 million would enroll in Parts A and B with Medicare as the primary payer, 0.9 million would enroll in Parts A and B with Medicare as the secondary payer, 4.8 million would enroll in Part A only and keep their current-law coverage, and 0.5 million would enroll in Part A only and would be categorized as uninsured by CBO.

7. CBO's analysis uses the Medicare Beneficiary Summary File and CBO's population estimates. See Centers for Medicare &

The projected share of newly eligible people who would enroll in Medicare under the policy is lower than the recent historical share for people ages 65 to 69 for two main reasons. First, people ages 60 to 64 are more likely to be employed and, therefore, to have access to health insurance through their employment. For many workers, particularly those needing coverage for younger spouses and dependents ineligible for Medicare, employment-based coverage would cost less than the cost of both Medicare and nongroup insurance for any younger family members. Second, people eligible for Medicare at age 60 would not be automatically enrolled and would not have their Medicare premiums withheld because they would be too young to claim Social Security retirement benefits.

Medicaid Services, "Master Beneficiary Summary File, Limited Data Set" (December 1, 2021), <https://go.usa.gov/xu4uM>.

Table 2.

Insurance Coverage Among People Who Would Be Newly Eligible for Medicare Under a Policy to Lower the Medicare Age of Eligibility to 60, 2031

Millions of People

	Current Law ^a	Insured Under the Policy				Uninsured Under the Policy			
		Medicare Parts A and B, Medicare Primary Payer	Medicare Parts A and B, Medicare Secondary Payer	Medicare Part A Only and Current-Law Coverage	Current-Law No Medicare	Total	Medicare Part A Only	No Medicare	Total
Employment-Based Coverage									
Current employer coverage, firms with fewer than 20 employees	1.0	0.5	0	0.4	0.1	1.0	0	0	0
Current employer coverage, firms with 20 employees or more	7.1	0.5	0.9	4.3	1.4	7.1	0	0	0
Retiree coverage	1.9	1.9	0	0	0	1.9	0	0	0
Subtotal	10.0	2.8	0.9	4.8	1.5	10.0	0	0	0
Medicaid	2.3	1.7	0	0.1	0.4	2.1	0.2	0	0.2
Nongroup Coverage	2.0	1.9	0	0	0	1.9	0.1	0	0.1
Subtotal, insured	14.4	6.5	0.9	4.8	1.8	14.1	0.3	0	0.3
Uninsured	1.3	0.9	0	0	0	0.9	0.2	0.1	0.4
Total	15.6	7.3	0.9	4.8	1.8	15.0	0.5	0.1	0.7

Data source: Congressional Budget Office. See www.cbo.gov/publication/57918#data.

Numbers may not add up to totals because of rounding.

CBO considers people uninsured if they are not covered by an insurance plan or enrolled in a government program that provides financial protection from major medical risks. For additional information, see Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094. Therefore, because Part A alone does not provide comprehensive medical coverage, CBO categorized people with Medicare Part A only (without any other form of coverage, including Medicare Part B, employment-based coverage, or Medicaid) as uninsured.

a. Current-law coverage among people newly eligible under the policy.

CBO expects that a large share of people newly eligible for Medicare would enroll in at least Part A because that coverage would not require a premium. However, because Part A alone does not provide comprehensive medical coverage, CBO would categorize anyone enrolled in only Part A without any other form of coverage (such as Medicare Part B, employment-based coverage, or Medicaid) as uninsured.⁸

Changes for People Enrolled in Employment-Based Coverage Under Current Law

Among the 8.2 million people newly eligible for Medicare with coverage from a current employer under current law, CBO estimates that 23 percent, or 1.9 million people, would enroll in Medicare Parts A and B

in 2031. That enrollment is the result of four separate effects:

- About 150,000 people would be induced to retire earlier than they would under current law because eligibility for Medicare would substantially decrease their cost of health insurance in retirement.
- About 170,000 people would enroll in Medicare after losing their offer of employment-based coverage.⁹
- About 330,000 people would decline an offer of employment-based coverage and instead enroll in Medicare.

8. For additional information, see Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

9. CBO anticipates that workers might lose an offer of employment-based coverage under the policy for two reasons: Some small employers would stop offering coverage to employees newly eligible for Medicare, and some employers with particularly large shares of employees between the ages of 60 and 64 would choose to stop offering health insurance altogether because many of their workers would become eligible for Medicare.



- About 1.3 million people would keep their employment-based coverage and enroll in Medicare Parts A and B. That Medicare coverage would be the primary payer for workers at small firms and the secondary payer for workers at larger firms.¹⁰

Most of the remaining people with employment-based coverage who do not enroll in Medicare Part B would enroll in Part A because they would not pay a premium and could receive some limited benefits with Medicare as secondary coverage. However, CBO anticipates that others would not enroll in Part A because of a lack of awareness that they could enroll or the effort required to do so.

Among those with retiree coverage from a former employer under current law who would be newly eligible for Medicare under the policy, CBO estimates that all 1.9 million people would enroll in Medicare Parts A and B in 2031.¹¹ Since employment-based health insurance for early retirees generally covers former employees until they are eligible for Medicare, CBO expects that such coverage would no longer be available to those retirees when they became eligible for Medicare under the policy.¹² Because that group probably has a strong demand for health insurance and because Medicare premiums would be comparable to those paid for retiree coverage, the agency estimates that anyone with early retiree coverage under current law would enroll in Medicare Parts A and B.

Employment-based health insurance plans typically require enrollees to share some costs for care through deductibles, copayments, or coinsurance. Although cost sharing in Medicare can differ from that in employment-based insurance in several ways, the share of total health care costs required to be paid through

10. CBO based its estimate of the share of workers who would enroll in both employment-based coverage and Medicare Parts A and B on its analysis of the share of workers with that concurrent coverage separately for small and larger firms using data from the Health and Retirement Study. See University of Michigan, “The Health and Retirement Study” (Institute for Social Research, 2020), <https://hrs.isr.umich.edu/about>.

11. Some employers also provide their retirees with supplemental coverage after they enroll in Medicare, which typically covers some cost sharing and may provide additional benefits.

12. CBO expects that employers that offer retiree health insurance under current law would continue to offer that coverage to former employees under age 60, who would not be eligible for Medicare under the policy.

cost sharing is, on average, similar in both sources of coverage. However, the amount any individual enrollee would pay in cost sharing in employment-based coverage or Medicare would vary substantially depending on the characteristics of the plan and the person’s utilization of medical care.

Changes for People Enrolled in Medicaid Under Current Law

Among the 2.3 million current-law Medicaid enrollees who would be newly eligible for Medicare, 74 percent, or 1.7 million people, would enroll in Medicare Parts A and B under the policy in 2031. Of those who would not enroll in Part B, 60 percent would choose to remain enrolled in Medicaid only, 11 percent would choose to enroll in both Medicaid and Medicare Part A, and 29 percent would be uninsured, enrolling in Part A only after losing Medicaid eligibility.

Qualifying for a Medicare Savings Program would significantly affect coverage outcomes for current-law Medicaid enrollees. Many of those enrollees would find that Part B premiums were a substantial fraction of their income without assistance from those programs. Under those programs, which are jointly funded by the federal government and state governments, Medicaid pays for Medicare premiums and, in some cases, cost sharing.¹³ (Being eligible for a Medicare Savings Program is different from being eligible to have Medicaid cover medical services as a supplement to Medicare.)

Most current-law Medicaid enrollees would be eligible for a Medicare Savings Program because they have low income and few assets.¹⁴ CBO expects that most people who are eligible for such programs would switch to

13. People with income below 100 percent of the federal poverty guidelines (commonly known as the federal poverty level, or FPL) receive payment for Part B premiums and for Parts A and B deductibles, coinsurance, and copayments (Medicare cost sharing). People with income between 100 percent and 120 percent of the FPL receive payment for Part B premiums and, at the states’ discretion, Medicare cost sharing. People with income between 120 percent and 135 percent of the FPL receive payments for Part B premiums only. Eligibility for all the programs that cover Part B premiums is limited to people with financial assets below a specified level (\$8,400 for an individual and \$12,600 for a couple in 2022), although states may elect to eliminate those asset requirements.

14. Under current law, a person could have income below the threshold for Medicaid eligibility but have assets that exceed eligibility thresholds for a Medicare Savings Program.

Medicare as their primary coverage. CBO also expects that people who retained Medicaid eligibility but would not qualify for a Medicare Savings Program would maintain Medicaid as their primary source of coverage; 0.4 million of those people would choose not to enroll in any Medicare coverage, and 0.1 million would choose to enroll in Part A as secondary coverage. Among current-law Medicaid enrollees made eligible by the ACA (who would lose their Medicaid eligibility when they became eligible for Medicare), those who would not qualify for a Medicare Savings Program would either pay for their Medicare Part B premiums out of pocket or go without Part B coverage, becoming uninsured.

Eligibility for supplemental Medicaid coverage and for a Medicare Savings Program would also affect the medical services that would be covered and the cost-sharing amounts that current-law Medicaid enrollees would pay under the new policy. People who enrolled in Medicare but did not retain eligibility for supplemental Medicaid benefits would lose coverage for certain services that are covered by Medicaid but not Medicare, such as non-emergency medical transportation and long-term services and supports. Additionally, current-law Medicaid enrollees typically pay little or no cost sharing for covered services. Some current-law Medicaid enrollees who qualified for a Medicare Savings Program under the policy would have their Medicare cost sharing paid by that program. Others who did not qualify for such assistance would pay higher cost sharing for their care than under their current-law Medicaid coverage.

Changes for People Enrolled in the Nongroup Market Under Current Law

Among the 2.0 million current-law enrollees in nongroup coverage who would be newly eligible for Medicare, 95 percent, or 1.9 million people, would enroll in Medicare Parts A and B under the policy in 2031.¹⁵ Those who are ineligible for premium tax credits through the health insurance marketplaces under current law would typically pay substantially lower premiums for comparable Medicare coverage under the policy. Those who are eligible for premium tax credits under current law who gained eligibility for Medicare under the policy

would become ineligible for those credits. Depending on their income, some might pay more for Medicare coverage than for their current-law coverage, some would pay less, and some would pay roughly the same amount.

However, CBO expects that factors other than premiums, including the attractiveness of Medicare and the late-enrollment penalty, would induce most of those who would pay more than they do for their current-law nongroup coverage to enroll in Medicare. The agency estimates that 5 percent of current-law nongroup enrollees, predominantly those who pay very low premiums for nongroup coverage, would lose eligibility for premium subsidies under the policy, enroll only in Medicare Part A, and be considered uninsured under the policy.

Like employment-based insurance, nongroup plans typically have a deductible and coinsurance or copayments. The amount of cost sharing required by a plan depends on its metal tier (such as bronze, silver, or gold) and whether an enrollee is eligible for cost-sharing reductions through the health insurance marketplaces. Although CBO expects that current-law enrollees in bronze and silver plans who are not eligible for those reductions would probably pay less in cost sharing if they enrolled in Medicare, the difference in cost sharing between Medicare and nongroup plans could vary substantially for any given enrollee, and some nongroup enrollees would end up paying more in cost sharing under Medicare.

Changes for People Without Insurance Under Current Law

Under the policy, 70 percent of the 1.3 million people who are uninsured under current law and would be newly eligible for Medicare would take up Medicare Parts A and B in 2031. Roughly 80 percent of those that would take up coverage under the policy are not eligible for Medicaid or a subsidized nongroup plan under current law and would pay substantially less for insurance through Medicare than they would for unsubsidized current-law coverage.

In CBO's estimation, the policy would halve the uninsured rate for the newly eligible group, from 8 percent to 4 percent (including people who had insurance under current law but would not have it under the policy). The agency expects that most people who remained uninsured would enroll in premium-free Medicare Part A and have coverage for services such as inpatient care in

15. CBO's definition of nongroup coverage excludes policies that do not provide comprehensive major medical insurance. For additional information, see Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

hospitals, skilled nursing facility care, and hospice care. In the event of a hospitalization, they would probably face substantial medical costs because they would not have coverage for physicians' services (which are covered under Part B). They would also not have coverage for services such as outpatient care, durable medical equipment, and many preventive services.

The projected uninsured rate for people ages 60 to 64 is higher than the current uninsured rate of 2 percent for people age 65 or older for several reasons, but two are particularly significant.¹⁶ First, people ages 60 to 64 have somewhat lower demand for health insurance because they are younger and generally healthier. Second, newly eligible people would have to expend greater effort to enroll because automatic enrollment and automatic deduction of premiums under current law would not apply to those aging into Medicare eligibility at age 60.

Changes in Primary Sources of Health Insurance Coverage

CBO estimated the effect of the policy on primary sources of coverage—defined as the insurer that is the primary payer—for people newly eligible for Medicare as well as for those not newly eligible for Medicare, who would be indirectly affected.

Changes for People Newly Eligible for Medicare

In CBO's estimate, the number of people with Medicare as their primary health insurance coverage would increase by 7.3 million in 2031 (see Table 3). That figure is lower than the 13.6 million people that CBO estimated would enroll in any part of Medicare, because it does not include the 4.8 million people projected to enroll only in Part A in addition to having some other primary coverage, the 0.9 million people projected to enroll in Parts A and B but for whom Medicare would be a secondary payer, and the 0.5 million people who would have only Medicare Part A and would be considered uninsured. The estimated decline in the number of uninsured people is the net result of people who would be uninsured under current law enrolling in Medicare Parts A and B and of some people who would be insured under current

law forgoing insurance because they would no longer be eligible for Medicaid or nongroup premium subsidies.

Of the 7.3 million people newly enrolled in Medicare as their primary source of health insurance coverage under the policy, 2.8 million would have previously had employment-based coverage, 1.9 million would have been covered by Medicaid, 2.0 million would have had nongroup coverage, and 0.6 million would otherwise have been uninsured.

Changes for People Not Newly Eligible for Medicare

In 2031, CBO estimates, about 0.4 million people not newly eligible for Medicare who would have employment-based coverage under current law would no longer have that coverage for two main reasons. Some younger workers would lose their coverage because their employer had a large share of employees newly eligible for Medicare and discontinued offering coverage. In addition, some younger family members would lose their coverage if a newly eligible person who had previously purchased a family plan discontinued that coverage and enrolled in Medicare instead. Some of those people would enroll in Medicaid or nongroup coverage, but CBO estimates that the policy discussed here would, on net, increase the number of uninsured people not newly eligible for Medicare by about 0.2 million relative to current law.

Effects on Medicare Spending and Receipts

Lowering the age of Medicare eligibility would increase Medicare outlays by \$371 billion, on net, between 2026 and 2031 (see Table 1 on page 3). CBO estimates that higher enrollment in Medicare would increase outlays by \$449 billion: Outlays for Part A would increase by \$146 billion, outlays for Part B would increase by \$240 billion, and outlays for Part D would increase by \$63 billion.¹⁷ Those increases in Medicare outlays would be somewhat offset by an increase in receipts (which are

16. The rate of uninsurance for people 65 or older is based on CBO's analysis of the 2019 National Health Interview Survey. Because enrollees in only Part A or only Part B of Medicare would not have comprehensive major medical insurance, the agency defined those survey respondents as uninsured. See Centers for Disease Control and Prevention, National Center for Health Statistics, "National Health Interview Survey" (March 7, 2022), www.cdc.gov/nchs/nhis/index.htm.

17. Part D is a voluntary, federally subsidized prescription drug benefit delivered to beneficiaries by private-sector plans. CBO's spending estimates reflect the expectation that new enrollees would enroll in private managed care plans (known as Medicare Advantage, or MA) to the same extent that 66-year-old Medicare beneficiaries are projected to enroll in MA plans. CBO has not analyzed how the policy would affect the financial operations of the Hospital Insurance Trust Fund. However, greater spending under Part A, with no other policy changes, would tend to place financial strain on the trust fund.

Table 3.

Effects on Primary Health Insurance Coverage Among People Under 65 of a Policy to Lower the Medicare Age of Eligibility to 60, 2031

Millions of People

	People Newly Eligible for Medicare	People Not Newly Eligible for Medicare	Total
Number of People Under a Policy to Lower the Medicare Age of Eligibility to 60 Minus Number of People Under Current Law			
Medicare ^a	7.3	n.a.	7.3
Employment-Based Coverage	-2.8	-0.4	-3.2
Medicaid	-1.9	0.1	-1.8
Nongroup Coverage	-2.0	0.1	-2.0
Uninsured	-0.6	0.2	-0.4
Memorandum:			
Total Population	15.6	263.4	279.0
Number of Insured People			
Under current law	14.4	235.8	250.1
Under policy	15.0	235.6	250.5
Insured as a Percentage of the Population			
Under current law	91.9	89.5	89.6
Under policy	95.8	89.4	89.8

Data source: Congressional Budget Office. See www.cbo.gov/publication/57918#data.

Numbers may not add up to totals because of rounding.

CBO considers people uninsured if they are not covered by an insurance plan or enrolled in a government program that provides financial protection from major medical risks. For additional information, see Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094. Therefore, because Part A alone does not provide comprehensive medical coverage, CBO categorized people with Medicare Part A only (without any other form of coverage, including Medicare Part B, employment-based coverage, or Medicaid) as uninsured.

n.a. = not applicable.

a. Denotes people who would enroll in Medicare Parts A and B with Medicare as the primary payer.

recorded as negative outlays)—including premiums paid in part by Medicare beneficiaries and in part by states and the federal government on behalf of people who are also enrolled in Medicaid—and a decrease in disproportionate share hospital (DSH) payments, which together total \$78 billion over the period.¹⁸

CBO estimates that receipts would increase by \$74 billion, the net result of two effects: an increase in receipts because of increased enrollment and a decline in receipts because of lower premiums. Much of that increase in receipts, \$61 billion, would result from increases in Part B premium receipts. Part D premium receipts and state contributions toward Medicare Part D (often called the “clawback”) would increase by \$13 billion, according to CBO’s estimates. The agency expects that premiums per person, which are set to cover 25 percent of expected

Part B costs and 25.5 percent of certain expected Part D costs, would decline because average Medicare spending would be lower than under current law since new enrollees would have lower average spending.¹⁹

Lastly, lower DSH payments would reduce Medicare outlays by \$3 billion. Those payments would decrease because the number of people who are uninsured or enrolled in Medicaid would fall under the policy.

Effects on Federal Subsidies for Health Insurance Outside Medicare

CBO and JCT estimated the effect of the policy on revenues and outlays for other sources of health insurance.

18. Medicare makes DSH payments to providers whose share of low-income and uninsured patients exceeds a certain threshold.

19. Monthly premiums for Part B are set by the Secretary of Health and Human Services to finance one-quarter of the expected average monthly Part B spending for all enrollees age 65 or older, rounded to the nearest multiple of 10 cents.

Medicaid

CBO estimates that lowering the age of Medicare eligibility would decrease outlays for Medicaid and Medicare Savings Programs by \$94 billion between 2026 and 2031.²⁰ That effect is the net result of a \$112 billion net reduction in spending on Medicaid benefits that would be partially offset by a \$18 billion increase in spending on Medicare premiums and cost sharing under Medicare Savings Programs. Much of the decrease in spending on Medicaid benefits would result from reduced Medicaid enrollment among people who had been made newly eligible for Medicaid by the ACA.²¹ Among people who retained their Medicaid eligibility and enrolled in Medicare, spending on Medicaid benefits would decrease because Medicaid would become a secondary payer for services that are covered by Medicare. Those decreases in Medicaid spending would be slightly offset because some people who lost employment-based coverage but did not become eligible for Medicare would enroll in Medicaid instead.

Medicaid outlays for Medicare premiums and cost sharing would increase because more people would enroll in Medicare Savings Programs. That increased spending would be slightly offset by lower spending by Medicare Savings Programs on Medicare Part B premiums among people who are dually enrolled under current law (because of lower premiums).

Employment-Based Coverage

CBO and JCT estimate that reductions in employment-based coverage attributable to the policy would increase federal tax revenues by \$53 billion over the 2026–2031 period by shifting employees' compensation from tax-favored health insurance to taxable wages. That increase in revenues has four components:

- A 0.8 percent decrease in average health insurance premiums for employment-based coverage would increase revenues by \$25 billion. Those premiums would decrease because of the reduced enrollment of people ages 60 to 64, who have relatively higher health care spending.
- People with coverage from a former employer would switch to Medicare as their primary source of

coverage. As with active employment-based coverage, CBO and JCT expect that, in response to decreased spending on retiree coverage, employers would shift compensation toward taxable wages of existing workers, resulting in an estimated \$12 billion increase in revenues.

- A reduction in employment-based coverage among people whose employer stopped offering coverage in response to the policy would contribute \$8 billion to the increased revenues.
- A reduction in employment-based coverage among people who became eligible for Medicare would also contribute \$8 billion to the increased revenues.

Nongroup Coverage

CBO and JCT estimate that premium tax credits (PTCs) for health insurance obtained through the marketplaces established by the ACA would decrease by \$95 billion between 2026 and 2031, the net effect of an \$82 billion decrease in outlays and a \$13 billion increase in revenues. Most of that effect would result from the loss of subsidy eligibility and the corresponding decrease in enrollment among people newly eligible for Medicare who would receive subsidies under current law, which CBO and JCT estimate would decrease PTC costs by \$99 billion. The agencies also estimate that there would be a net decrease in subsidized enrollment among people who would not be eligible for Medicare under the policy, which would decrease PTC costs by \$1 billion. That decrease would result from reduced enrollment for some people whose total family contribution to health insurance premiums increased after a family member gained Medicare eligibility, which would more than offset increased enrollment for people newly receiving premium tax credits after their employer stopped offering coverage.

An estimated 2.2 percent increase in nongroup premiums over the 2026–2031 period would increase PTCs by \$5 billion. That is because premiums in the nongroup market are tied to age: CBO and JCT's analysis suggests that even though older enrollees spend more, on average, on health care, their premium payments (including individual premium contributions and any applicable PTCs) would exceed insurers' claims and administrative spending under current law.²² Since those older enrollees would leave the nongroup market under the policy,

20. Medicare reimburses Medicaid for some outlays for the Medicare Savings Programs.

21. For those people, the federal government pays 90 percent of Medicaid costs, so most of the expected reductions in Medicaid spending would accrue to the federal government.

22. Insurers in most states are allowed to vary adult premiums using a 3:1 ratio; that is, the premium for a 64-year-old is three times the premium for a 21-year-old.

premiums would increase. Because premium tax credits are determined by the second-lowest-cost silver plan available in the marketplace in any given area, premium increases result in higher PTCs.

The Military Health System

CBO estimates that the policy would also increase mandatory spending from the Department of Defense's Medicare-Eligible Retiree Health Care Fund (MERHCF) by about \$9 billion between 2026 and 2031. Retirees from the uniformed services and their dependents are eligible for lifetime health benefits from the government. Before those beneficiaries become eligible for Medicare, the benefits are paid from annual discretionary appropriations. Once the beneficiaries become eligible for Medicare, it becomes the primary payer, and all additional costs, including wraparound coverage and pharmacy benefits, are paid from the MERHCF. In 2031, lowering the Medicare eligibility age to 60 would, therefore, transfer the costs for about 500,000 military retirees and dependents to Medicare and the MERHCF.²³

Effects on Social Security Outlays

CBO estimates that the policy would increase Social Security outlays by \$18 billion over the 2026–2031 period. Spending on Social Security benefits would increase during that period because the agency expects that about 110,000 of the people newly eligible for Medicare under the policy would choose to retire and claim Social Security retirement benefits earlier than they would under current law. However, people who claimed benefits earlier under the policy would also receive a smaller monthly benefit amount, so that in later years, benefit outlays for people who claimed benefits earlier would be lower than under current law.

Effects on Discretionary Spending

CBO estimates that there would be two offsetting effects on discretionary spending, which is subject to future appropriations by lawmakers. First, lowering the age of eligibility would reduce discretionary spending mainly by reducing such spending for the Federal Employees Health Benefits program, the Military Health System, and the Veterans Health Administration, because some of the care provided through those programs under current law would instead be paid for through the Medicare program. Second, spending on implementation and ongoing administrative costs for Medicare would

increase discretionary spending. CBO has not produced an estimate of the net effect.

Uncertainty About the Estimates

The largest sources of uncertainty in the estimated budgetary effects include the number of people who would enroll in each part of Medicare and the types of coverage those new enrollees have under current law. It is unclear how newly eligible people would weigh several factors when deciding whether to enroll in Medicare, including ease of enrollment, premiums, cost sharing, late-enrollment penalties, and perceived coverage quality. Additionally, the health care utilization of new Medicare enrollees is uncertain. Those new enrollees might be more or less healthy than CBO anticipates, resulting in lower or higher health care utilization.

Another source of substantial uncertainty is whether and how medical providers would respond to people's shifting from private coverage, Medicaid, or being uninsured to Medicare. Medicare typically pays less for medical services than employment-based and nongroup coverage but more than uninsured patients and more than Medicaid for physicians' services. Payment rates could decline for some providers and increase for others, which could affect the supply of care available to people newly insured by Medicare and other patients as well. Changes in the supply of providers, which could result from those changes in payment rates, were not included in the modeling and could increase or decrease the estimate of federal spending. Finally, there is considerable uncertainty in the actions that the federal government, states, and employers might take to encourage enrollment in Medicare among newly eligible people.

Other Analyses of Policy Changes to the Age of Medicare Eligibility

CBO generally expects that policies that raise the age of eligibility would lower budget deficits, whereas policies that lower the age of eligibility would increase budget deficits.²⁴ However, CBO does not expect that raising

23. There would also be a reduction in discretionary appropriations for the Military Health System.

24. For past estimates of policies that would increase the age of Medicare eligibility to 67, see Congressional Budget Office, *Options for Reducing the Deficit: 2019 to 2028* (December 2018), p. 68, www.cbo.gov/publication/54667. CBO also analyzed a related policy—the establishment of a single-payer system—that would eliminate the eligibility age. See CBO's Single-Payer Health Care Systems Team, *How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program*, Working Paper 2020-08 (Congressional Budget Office, December 2020), www.cbo.gov/publication/56811.

the eligibility age by the same number of years would result in symmetric budgetary effects—effects of opposite sign and same size—because the factors that determine enrollment and spending for federally subsidized insurance under current law and under the policy vary for people younger or older than 65. In particular, people younger than 65 are estimated to enroll in Medicare to a lesser extent than those over age 65 and are estimated to have lower average health care costs.

Similarly, CBO does not expect that policies that change the age of eligibility for Medicare to a different age—to age 55 or 50, for example—would result in budgetary effects that are proportional to the change in the age of eligibility. That is, lowering the age of eligibility to 55 instead of 60 would result in larger increases in budget deficits than those estimated in this report, though not necessarily deficits that were twice as large. That is because factors that determine enrollment and spending for federally subsidized insurance under the policy and under current law vary by age group. Such factors would be more similar for policies that lower the age of eligibility to around 60 and less similar for policies that lower the age of eligibility farther away from 60.

This report was prepared at the request of the Chairman of the Senate Committee on the Budget. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, the report makes no recommendations.

The analysis discussed in this report was produced by Alice Burns, Ru Ding, Noelia Duchovny, Cornelia Hall, Stuart Hammond, Caroline Hanson, Ben Hopkins, Nadia Karamcheva, Sean Lyons, Noah Meyerson, Eamon Molloy, Asha Saavoss, Rebecca Sachs, Sarah Sajewski, Matt Schmit, Emily Stern, Robert Stewart, and Emily Vreeland. The staff of the Joint Committee on Taxation provided analysis of revenue effects.

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CBO seeks feedback to make its work as useful as possible. Please send comments to communications@cbo.gov.



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