Increasing the Age of Medicare Eligibility to 67

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The need for long-term reforms to Medicare and Social Security has been repeatedly raised. For example, the Republican Study Committee has recommended gradually increasing the Medicare eligibility age to 67 from 65, then indexing it to increases in longevity (RSC 2022). Paul Ryan, in *The Path to Prosperity: Restoring America's Promise*, proposed increasing the Medicare age to 67 (Ryan 2011); he has more recently suggested indexing eligibility ages to longevity.[1] In a 2023 *New York Times* editorial and a more recent *Washington Post* editorial, Eugene Steuerle and Glenn Kramon argued for reforms that would include older Americans working longer and delaying Social Security and Medicare benefits to reflect increased longevity.[2] Because of the significant popularity of these programs, these proposals have not come up in recent budget proposals.

The Congressional Budget Office (CBO) projects large US budget deficits well into the future. In their January 2025 budget and economic update, they project a 2025 budget deficit of $1.9 trillion, with outlays of $7.0 trillion (23.3 percent of GDP) and revenues of $5.2 trillion (17.1 percent of GDP). By 2035, they project a deficit of $2.7 trillion, with outlays at 24.4 percent of GDP and revenues at 18.3 percent of GDP. The US debt in 2035 in the CBO baseline was projected to be $52.1 trillion (CBO 2025) before passage of the One Big Beautiful Bill Act, which is projected to add another $3.4 trillion to the nation's debt between 2025 and 2034.[3]

Mandatory health care programs are big contributors to these deficits. Net mandatory outlays for Medicare are projected to be $910 billion in 2025 and $1.75 trillion in 2035 (CBO 2025). Thus, while major changes to Medicare do not currently appear to be on the budget-cutting table, it remains a fairly big potential budget target. The age of eligibility for full Social Security benefits has already been

increased to 67 for those born in 1960 or later. Increasing the age of Medicare eligibility would be consistent with that approach. But it would be considerably more complicated than increasing the age for full Social Security benefits and would have a wide range of effects across multiple health programs.

Under such a policy, Medicare enrollment would be eliminated for those ages 65 and 66, except for people who qualify for Medicare through disability. As a result, enrollment in employer-sponsored insurance (ESI), Marketplace insurance, and Medicaid would increase. The number of uninsured would likely rise. Employers would spend more on health insurance premiums because their health plans would have an influx of relatively expensive workers. Medicare spending would fall, but the savings would be partially offset by increased spending on Medicaid and Marketplace subsidies and possibly a reduction in income tax revenues because of the exclusion of ESI premiums from taxable income (depending on the net change in taxable wages).[4]

Marketplace premium tax credit (PTC) spending would increase as 65- and 66-year-olds move to Marketplace plans. Household spending would also be affected, depending on the source of health coverage. Most importantly, National Health Expenditures would likely increase because fewer people would be enrolled in Medicare, which generally has lower provider payment rates and lower administrative overhead than rates in private employer-sponsored commercial insurance. In this brief, we provide current estimates of each of these effects. In addition, because of changing risk pools, Medicare Parts B and D premiums would rise for those 67 and over, as would the benchmarks, likely leading to higher Part C premiums.

Key Findings

The key impacts of a change in the Medicare eligibility age to 67 from 65 are the following:

- Of the 6.9 million people ages 65 and 66 who now have Medicare, 1.5 million would remain on Medicare because of disability, while 5.4 million would leave the program.
- Of those who leave Medicare, 2.7 million would change to employer coverage, 1.2 million would have nongroup coverage, 1.0 million would have Medicaid, and 0.4 million would become uninsured.
- Federal spending would decline by $24.1 billion. Federal spending on Medicare would fall by $41.3 billion, which would be partially offset by increases of $8.0 billion in federal Medicaid spending, $8.4 billion in Marketplace subsidies, and $0.8 billion on increased demand for uncompensated care.
- Employer spending on premiums would increase by $26.6 billion, and spending by households would increase by $12.1 billion.
- National health spending would increase by $17.4 billion, driven by the shift to employer and nongroup coverage, both of which are more costly than Medicare, largely because of differences in provider payment rates.

The effects of the modeled policy are estimated for 2025, so the baseline includes enhanced Marketplace PTCs. If the enhanced PTCs are not extended, reform would likely result in smaller take-up of nongroup policies than we project, smaller subsidies for those who choose Marketplace coverage, higher take-up of ESI, and greater uninsurance. If provisions of the One Big Beautiful Bill reduce enrollment in Medicaid as expected, there will be a smaller increase in Medicaid enrollment, and more people will become uninsured than we estimate.

Prior Studies

Two main studies of this reform have been published since the passage of the Affordable Care Act (ACA). The ACA included a major expansion of Medicaid and provided subsidized coverage for those up to 400 percent of the federal poverty level (FPL); any research on this topic before the ACA would not reflect current coverage options. A KFF study was released in March 2011 and updated in July 2011 to reflect the provisions of the ACA (Neuman et al. 2011). The study assumed all states would expand Medicaid to 138 percent of FPL, and it was highly uncertain how many people would enroll in Marketplace plans. The authors found that if increasing the Medicare age was implemented in 2014, federal spending would be reduced by $5.7 billion. Medicare spending would fall by $31.1 billion, but premium and cost-sharing subsidies under the exchange would increase by $9.4 billion. Medicaid expenditures would increase by $8.9 billion. They assumed that the ACA's individual mandate would be 100 percent effective and that those losing Medicare would find other coverage. They found that 7 million people would be affected by the policy change. They estimated that 42 percent of those would take up ESI, 38 percent would enroll in the exchange, and 20 percent would become covered by Medicaid, with no estimated increase in the uninsured.

In 2018, the CBO released estimates of raising the Medicare eligibility age to 67 as part of its report, *Options for Reducing the Deficit: 2019 to 2028* (CBO 2018).[5] Their estimates are hard to compare with others because they phase in raising the age of eligibility; thus, there is no spending impact in the first four years, and then it gradually increases. They provide two estimates: one for a policy that would increase the age of eligibility by two months each year, and the second by three months each year. They estimate a reduction in Medicare spending of $42 billion for the first policy and a reduction of $60 billion for the second policy (both over 10 years), with no spending changes in the first four years. They project substantial offsets through increases in spending on Medicaid and Marketplace PTCs. They also estimate a reduction in revenues, which includes increases in nonrefundable tax credits and employer shifting of compensation into nontaxable premiums.

CBO estimated that about 45 percent of the population losing Medicare coverage would obtain coverage through employers, about 20 percent in the nongroup market, about 20 percent would enroll in Medicaid, and about 15 percent would be uninsured. This would result in increases in non-Medicare health spending of $28 billion and $40 billion, respectively. This includes Medicaid and part of the payments for subsidies that are obtained through the health insurance Marketplaces. CBO assumes that eligibility for ACA-expanded Medicaid and Marketplace PTCs, which currently end at age 65, would apply up to age 67 in tandem with the change in the Medicare eligibility age. We make the same

assumption. The remaining share of the cost of subsidies in the health insurance Marketplaces is included, along with lower revenues from ESI premium tax preference, in the reduction in tax revenues over the 10 years of $3 billion and $4 billion, respectively. The net decrease in the deficit over the 10 years for the two policies is $15 billion and $22 billion, respectively, but these totals include only six years in which the policy is in effect.

CBO did not provide any estimates of the impacts on states' Medicaid spending or of state expenditures for uncompensated care. They also did not address how individuals' spending burdens would be affected, nor how employer spending on premiums would change, as they are beyond the scope of federal budgetary impacts of primary concern. They also did not estimate an effect on national health spending, suggesting the net effect is unclear. Our analysis provides estimates for these effects. Both earlier studies were done before the American Rescue Plan Act and the Inflation Reduction Act, which enhanced subsidies and widened eligibility in the Marketplaces.

Methods

Our analysis uses data from the American Community Survey (ACS) and the Medicare Current Beneficiary Survey (MCBS), augmented with data from two microsimulation models of health insurance and spending developed at the Urban Institute. The ACS is the US Census Bureau's ongoing nationwide survey that collects detailed information, including demographics and health insurance coverage, from a sample of more than 3 million households annually.[6] The Centers for Medicare and Medicaid Services' MCBS is the most comprehensive survey of Medicare beneficiaries, collecting social and medical risk factors linked to enrollment and claim data for up to 16,000 people annually.[7]

The first model, the Health Insurance Policy Simulation Model (HIPSM), was designed to address policies that affect the population younger than 65, such as changes in Marketplace subsidies, Medicaid expansion, state adoption of a Basic Health Plan, and changes in rules regarding ESI. HIPSM begins with a baseline of the coverage distribution and individual, employer, and government expenditures for individuals with each type of coverage. The model is calibrated each year to match the most recent available enrollment and spending data from administrative sources and is aligned with household survey estimates of the uninsured. In this project, the baseline for 2025 is used to calculate income distributions, payer shares, and relative risk levels for the near-elderly (age just under 65) by coverage type. We use these values to arrive at our coverage and spending projections (described below).

The second model, the Medicare Policy Microsimulation Model (MCARE-SIM), was designed to simulate policies that affect the Medicare population, e.g., adding a cap on beneficiary out-of-pocket payments or adding a dental benefit to traditional Medicare.[8] MCARE-SIM is based on the MCBS, and for this analysis uses MCBS survey years 2016–19 and projects Medicare enrollment and spending to 2025. The model provides estimates of Medicare spending, beneficiary spending on premiums, other beneficiary out-of-pocket costs, and Medigap premiums, by coverage type and income group.

We model the effect of raising the Medicare eligibility age to 67 as if it were fully implemented in 2025. In a sequence of four steps, we produce estimates for each of the following: (1) coverage distributions of individuals ages 65 and 66 by income group under current law (baseline); (2) baseline health care spending by coverage type, income group, and payer; (3) new coverage status for those who would lose Medicare under reform; and (4) new health care spending under reform.

First, we compute estimates of baseline coverage status in 2025 for individuals ages 65 and 66, including for a nontrivial number of people who do not have Medicare, using the ACS (see appendix for details).

Second, we use the Urban Institute's MCARE-SIM model to compute average Medicare spending under the current law for Medicare beneficiaries ages 65 and 66. Spending includes Medicare program spending for covered services, as well as the beneficiary cost-sharing obligations for those same services, which could be paid out-of-pocket, by an employer plan, Medigap, or Medicaid. We also capture spending for Medicare premiums (for Parts B and D, and any applicable additional Medicare Advantage premiums). We estimate average spending separately by whether beneficiaries originally qualified for Medicare through disability (through any pathway, including, e.g., Social Security Disability Insurance and end-stage renal disease) or became age-eligible at 65, and by income group. We also estimate spending for the relatively small share of 65- and 66-year-olds who do not have Medicare, as described in the appendix.

Third, we estimate the coverage for 65- to 66-year-olds if they were no longer eligible for Medicare under the modeled reform. These are beneficiaries who originally qualified as aged, not through disability. To estimate their new coverage type, we use current trends in coverage for people approaching age 65 (i.e., 61- to 64-year-olds) as a guide. From about age 60 on, labor force participation rates tend to fall, and disability rates tend to increase each year. Because employment rates show sharp declines at age 62, reflecting the availability of Social Security benefits, and at age 65, reflecting age-based Medicare eligibility, the distribution of coverage by income for those leaving Medicare coverage under reform is based on baseline HIPSM income distributions within coverage groups for those just below 65, with the age trend for 61- to 64-year-olds extended forward.

Finally, for people who would no longer have Medicare under reform, we estimate what their new spending would be, given their income group and type of coverage after reform. We model their new total spending as their Medicare spending (program spending and beneficiary cost-share) before reform times a relative spending factor. The relative spending factor adjusts for relative payment rates in the new coverage type compared with Medicare, for the relative risk of people with that coverage, and any insurance loads associated with coverage. Spending for people who remain on Medicare post-reform, are eligible because of disability, and typically have high costs, would remain the same. This approach, which we apply by coverage type and income group, captures the amount spent for the care of people (and associated administrative loads) consistently for people with and without Medicare under different types of coverage.[9] The estimated new total spending amount is then assigned to payers (employers, households, federal and state governments, and providers of uncompensated care) according to

estimated shares of spending, by coverage type and income, for those nearly age 65 in the HIPSM baseline.

Findings

We begin by analyzing the changes in coverage that would result from the modeled policy: eliminating Medicare coverage for those ages 65 and 66, except for those who remain eligible because of disability. We then look at changes in spending resulting from the coverage shifts for people under new coverage, overall and by income group. Then we show how the changes in spending are distributed across payers. Finally, we show how changes in federal spending break down by component.

Coverage

Table 1 shows health insurance coverage of people ages 65 and 66 under current law and their estimated coverage if Medicare eligibility were eliminated, except for those eligible because of disability. Of an estimated 8.3 million people ages 65 and 66 in 2025, 8.1 million are insured under current law, and 0.1 million are uninsured (totals may not equal the sum of components because of rounding). Of the insured, most (6.9 million) have some Medicare coverage (including those, for example, who only have Part A).[10] Of the 1.2 million without Medicare, most (1.1 million) have employer-based coverage, and 0.1 million have nongroup coverage (i.e., individually purchased coverage that may be purchased through the ACA Marketplaces, or off the Marketplaces) that is full pay (i.e., not subsidized by the federal government through PTCs).

TABLE 1

Health Insurance Coverage of People Ages 65 and 66 under Current Law and Reform Raising Medicare Eligibility Age to 67, 2025

	Current Law		Raising Medicare Eligibility Age to 67		Difference
	Millions	%	Millions	%	Millions
Insured	**8.1**	**98%**	**7.8**	**94%**	**-0.4**
Medicare	6.9	84%	1.5	19%	-5.4
Medicare only	2.0	25%	0.6	7%	-1.5
Medicare with Medigap	1.4	17%	0.2	2%	-1.2
Medicare and ESI	2.6	31%	0.3	4%	-2.3
Medicare and Medicaid	0.9	11%	0.5	6%	-0.5
No Medicare	1.2	15%	6.2	75%	5.0
Employer	1.1	13%	3.8	46%	2.7
Subsidized nongroup	0.0	0%	0.9	11%	0.9
Nongroup full-pay	0.1	1%	0.4	4%	0.3
Medicaid	0.0	0%	1.0	12%	1.0
Other public	0.0	0%	0.2	2%	0.2
Uninsured	**0.1**	**2%**	**0.5**	**6%**	**0.4**
Total	**8.3**	**100%**	**8.3**	**100%**	**0.0**

Source: Urban Institute analysis of the American Community Survey, Medicare Current Beneficiary Survey, HIPSM, and MCARE-SIM.

Note: Medicare coverage includes individuals enrolled in any Medicare part (e.g., Part A only). ESI = employer-sponsored insurance. ESI coverage could be primary or secondary for individuals who also have Medicare coverage. People with other public coverage under reform generally have Medicare plus other public coverage, and possibly other coverage, under current law, but cannot be identified in our data. Spending on their behalf is not included in HIPSM and is not included in this analysis.

If the age of eligibility for Medicare were increased to 67, Medicare coverage for those ages 65 and 66 would decline by 5.4 million, from 6.9 million to 1.5 million people. Under current law, 2.0 million individuals in this age group have Medicare only; this would fall to 0.6 million, a decline of 1.5 million. Currently, another 1.4 million have Medicare, along with a self-purchased Medigap policy to cover most of the expenses not covered by Medicare; this would fall to 0.2 million. These are typically beneficiaries with higher-than-average incomes who can afford Medigap coverage. Currently, 2.6 million Medicare beneficiaries in this age range have Medicare and coverage offered by an employer (which could be primary or secondary, depending on the employer and policy); this would fall to 0.3 million, a decline of 2.3 million. There are 0.9 million individuals under the current law who are dually enrolled in both Medicare and Medicaid. Their number would be cut in half to 0.5 million.

With the Medicare eligibility age raised to 67, the number of people with coverage other than Medicare would increase by 5.0 million from 1.2 million under current law to 6.2 million. The majority of those who would no longer have Medicare, 2.7 million people, would take up employer coverage. This includes both those who have continued to work, or have insurance through a working spouse, after age 65 but have transitioned to Medicare, and those who return to work to retain employer coverage. The number with employer coverage would increase from 1.1 million to 3.8 million.

There would be 0.9 million individuals with nongroup coverage subsidized by Marketplace PTCs.[11] There would also be an increase in the number of people buying nongroup coverage without subsidies. This group increases from 0.1 million to 0.4 million people, mostly higher-income individuals who can afford typically expensive nongroup policies. There would also be a shift of 1.0 million people to Medicaid. These individuals have incomes sufficiently low to be Medicaid-eligible once their Medicare is eliminated. An additional 0.2 million are shown with other public coverage; these people generally have Medicare plus other public coverage under current law. Though they are captured in the ACS, we do not observe them in the MCBS. Thus, spending on other public coverage, both for people with Medicare and for those without, is not included in our models or in this analysis. Notably, the number of uninsured increases from 0.1 million to 0.5 million; 6 percent of the population in this age group would have no health insurance coverage, compared with 2 percent under current law.

Spending Per Capita

Average spending per person ages 65 to 66 varies by current coverage type, and changes in coverage types under reform would affect overall average spending. Current law spending for all people ages 65 to 66 in the US, including those with and without Medicare, averages $14,000 per person; this increases to $16,100 when age eligibility for Medicare under 67 is eliminated (table 2). The main reason for the increase is that many individuals shift from Medicare to more expensive ESI or nongroup coverage.

Figure 1 and table 2 show spending per capita by the type of coverage people have before and after reform. Figure 1 shows that the 1.5 million who remain on Medicare spend $29,600 both before and after reform. Of those who stay on Medicare the most expensive groups are those who also have Medigap coverage as well as those who have both Medicare and Medicaid (dual eligibles); spending averages $38,700 and $42,600 for these groups respectively, likely reflecting a combination of worse health status (among those who originally qualified for Medicare through disability); and limited exposure to out-of-pocket costs because of the supplemental coverages.

TABLE 2

Average Health Spending for People Ages 65 and 66 by Coverage under Current Law and Reform Raising Medicare Eligibility Age to 67, 2025

	Current Law		Raising Medicare Eligibility Age to 67	
	Coverage (millions)	Spending ($)	Coverage (millions)	Spending ($)
Insured	**8.1**	**14,100**	**7.8**	**16,700**
Medicare	*6.9*	*13,900*	*1.5*	*29,600*
Medicare only	2.0	12,000	0.6	20,500
Medicare with Medigap	1.4	16,600	0.2	38,700
Medicare and ESI	2.6	8,300	0.3	20,100
Medicare and Medicaid	0.9	29,500	0.5	42,600
No Medicare	*1.2*	*15,100*	*6.2*	*13,500*
Employer	1.1	15,700	3.8	15,500
Nongroup	0.1	10,900	1.3	11,600
Medicaid	0.0	n/a	1.0	10,900
Other Public	0.0	n/a	0.2	n/a
Uninsured	**0.1**	**7,500**	**0.5**	**6,700**
Total	**8.3**	**14,000**	**8.3**	**16,100**

Source: Urban Institute analysis of the American Community Survey, Medicare Current Beneficiary Survey, HIPSM, and MCARE-SIM.

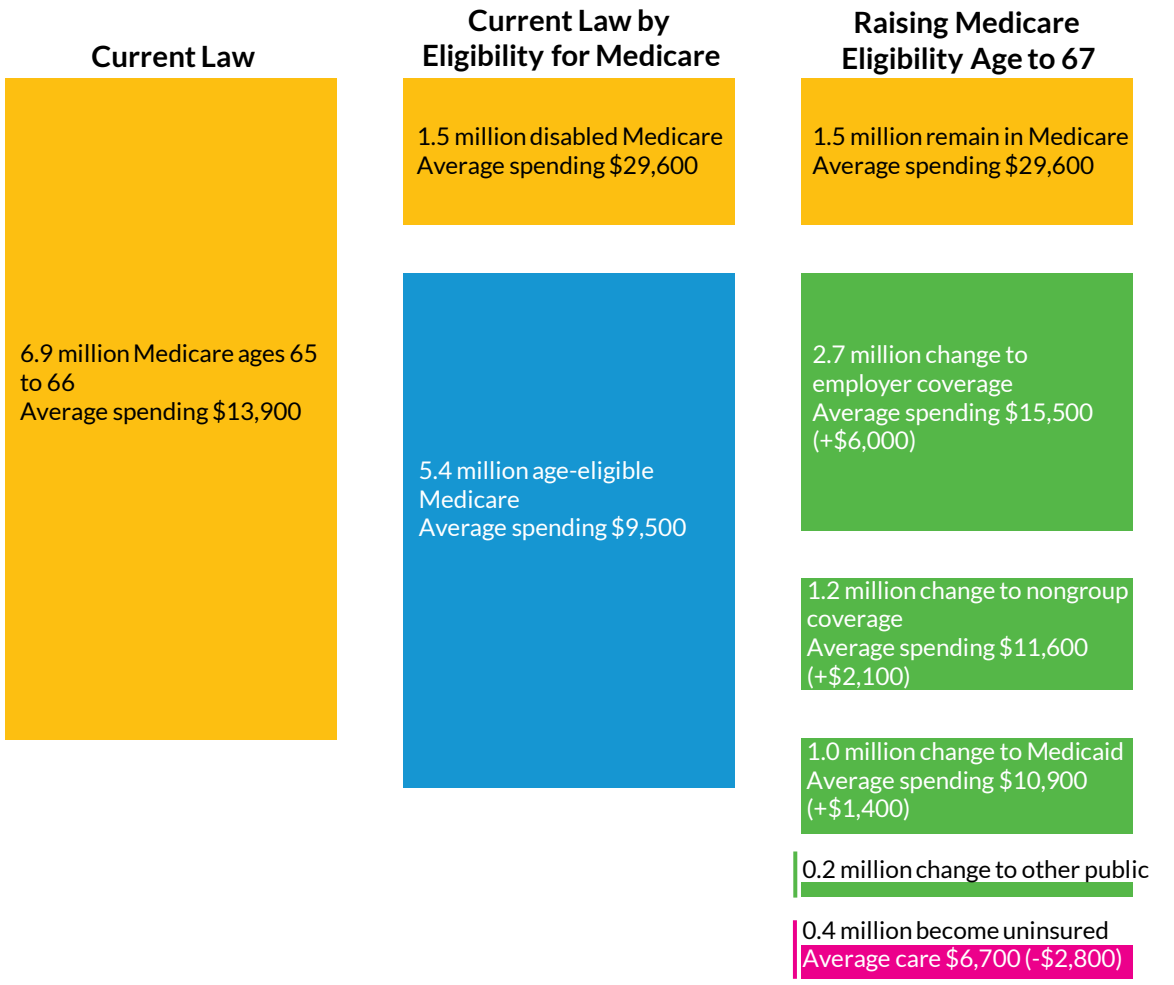
Note: Medicare coverage includes individuals enrolled in any Medicare part (e.g., Part A only). ESI = employer-sponsored insurance. ESI coverage could be primary or secondary for individuals who also have Medicare coverage. People with other public coverage under reform generally have Medicare plus other public coverage, and possibly other coverage, under current law, but cannot be identified in our data. Spending on their behalf is not included in HIPSM and is not included in this analysis.

The 5.4 million who lose Medicare had an average spending under the current law of $9500 (figure 1). Of those who lose Medicare, 2.7 million move to employer coverage and have an average spending of $15,500, reflecting generous benefits at higher payment rates. Another 1.2 million change to nongroup coverage and have an average spending of $11,600, again higher than their average spending under Medicare before reform. Another 1.0 million moved to Medicaid and had an average spending of $10,900; these people have higher spending than the average person losing Medicare, and their spending reflects that they have greater health needs than those going to other coverage. As noted above, 0.2 million changed to other public coverage for which we have no spending data. Finally, 0.4 million people become uninsured, and we project average out-of-pocket spending and uncompensated care totaling $6,700 per person because of lower utilization, given the lack of coverage and risk that is lower than average for their age. In summary, most people who change coverage obtain employer or nongroup coverage, and their spending is considerably higher relative to coverage under current law.

FIGURE 1

Changes in Coverage and Spending under Reform Raising Medicare Eligibility Age to 67, for People Age 65 and 66 Who Have Medicare under Current Law

(Millions of people; dollars per person)



Source: Urban Institute analysis of the American Community Survey, Medicare Current Beneficiary Survey, HIPSM, and MCARE-SIM.

Note: Spending changes shown in "()" are dollars per person compared with the average spending for all people ages 65 to 66 losing Medicare coverage under reform. People with other public coverage under reform generally have Medicare plus other public coverage, and possibly other coverage, under current law, but cannot be identified in our data. Spending on their behalf is not included in HIPSM or in this analysis.

Table 3 shows the changes in per capita spending by income. Health care spending can be high among older people with lower incomes because lower income is associated with a higher likelihood of disability and poor health (De Nardi et al. 2015).[12] There are 2.2 million individuals ages 65 and 66 with incomes below 150 percent of FPL. Many of these are dually enrolled in Medicare and Medicaid. With the elimination of Medicare age eligibility for those ages 65 and 66, many remain covered by Medicare

(because their eligibility is through disability, not age) or switch to coverage through Medicaid. Some obtain coverage through the Marketplace or through employers, both of which pay providers more than Medicare. On average, spending for people in this income group grows from $15,700 to $17,600, an increase of 12 percent.

TABLE 3

Health Spending for People Ages 65 and 66 by Income Group under Current Law and Reform Raising Medicare Eligibility Age to 67, 2025

		Current Law	Raising Medicare Eligibility Age to 67	Difference	Difference
	People (millions)	Per capita spending ($)	Per capita spending ($)	($)	(%)
<150% of FPL	2.2	15,700	17,600	1,900	*12%*
150-250% of FPL	1.2	19,100	20,700	1,600	*8%*
250%-400% of FPL	1.5	11,100	13,100	2,000	*18%*
>400% of FPL	3.4	12,400	14,900	2,500	*20%*
Total	**8.3**	**14,000**	**16,100**	**2,100**	***15%***

Source: Urban Institute analysis of the American Community Survey, Medicare Current Beneficiary Survey, HIPSM, and MCARE-SIM.
Notes: FPL = federal poverty level.

For those with incomes between 150 and 250 percent of FPL, average spending under current coverage is $19,100; this increases by 8 percent to $20,700 when people ages 65 and 66 who lose Medicare under reform take up different coverage. Many of these individuals have offers of coverage through an employer; those who do not are typically eligible for Marketplace tax credits with cost-sharing reductions.

For those with incomes between 250 and 400 percent of FPL, average spending is $11,100 under current law; this increases to $13,100, or by 18 percent. Large numbers of these individuals would switch to ESI or receive coverage in the Marketplace with limited premium subsidies; both of these coverages have higher spending than Medicare, largely because they pay higher rates to providers.

For those with incomes above 400 percent of FPL, average spending is $12,400. With the elimination of Medicare for this age group, average spending increases to $14,900, or by about 20 percent. Most of these individuals obtain coverage through employers or purchase it through the nongroup market.

Spending by Payer

Table 4 shows changes in health spending by payer. Overall health spending for this population increases from $115.7 billion to $133.1 billion, a 15 percent increase. This is primarily because of individuals shifting to more expensive forms of coverage. Federal spending on health for 65- and 66-year-olds falls from $82.6 billion to $58.5 billion, a decrease of $24.1 billion, while state spending,

mostly for Medicaid but including some uncompensated care for the uninsured, increases by $2.2 billion to $3.9 billion.

The savings to the federal government, $24.1 billion, are surprisingly small, given that 5 million people no longer have Medicare. The federal savings are small because Medicare continues to cover a relatively expensive population that qualifies through disability; the 1.5 million 65- to 66-year-olds remaining in Medicare have average annual costs of over $29,600 each. Individuals losing Medicare would have been less costly to the program under current law, but their spending increases on average with the new policy. When they move to Marketplace coverage, they face high premiums because of their age. Because most people moving to the Marketplace will have PTCs, their household portion of the premium is limited, so most of the premium will be paid by the government, and federal savings are limited. Some individuals move to Medicaid, which is paid for by both the federal and state governments. The population leaving Medicare and enrolling in Medicaid is more expensive than the typical nondisabled Medicaid adult, largely because they are older. Thus, Medicaid costs for this group are relatively high. This not only affects the federal government but also state governments.

TABLE 4

Health Care Spending by Payer for People Ages 65 and 66 under Current Law and Reform Raising Medicare Eligibility Age to 67, 2025

	Current Law (billions of $)	Raising Medicare Eligibility Age to 67 (billions of $)	Difference (billions of $)
Household	20.1	32.2	12.1
Federal government	82.6	58.5	-24.1
State government	1.7	3.9	2.2
Employer premiums	11.1	37.7	26.6
Providers uncompensated care	0.3	0.9	0.6
Total	**115.7**	**133.1**	**17.4**

Source: Urban Institute analysis of the American Community Survey, Medicare Current Beneficiary Survey, HIPSM, and MCARE-SIM.

Employers see spending on premiums increase from $11.1 billion to $37.7 billion because of 2.7 million additional individuals receiving employer coverage. The cost of employer coverage is relatively expensive compared with Medicare. There is some uncertainty in our allocation of health care spending between Medicare and ESI for two reasons. First, those who we show as having Medicare and ESI could have ESI as their primary coverage or as supplementary coverage, but the MCBS does not allow us to reliably distinguish the two. We therefore treat Medicare as primary, which could somewhat overstate Medicare spending and understate employer spending. Likewise, those who we show as having employer coverage without Medicare could be eligible for Medicare Part A when they become eligible for full Social Security benefits. In this case, we could be overstating employer spending and understating Medicare. We do not expect these measurement issues to have large effects on our findings.

Household spending increases from $20.1 billion to $32.2 billion because, under the reform, individuals would be responsible for more in premium payments and cost sharing than under Medicare. Because the number of uninsured increases from 0.1 million to 0.5 million, the amount of uncompensated care demanded from providers is expected to increase by $0.6 billion; increased uninsurance also increases spending for federal and state governments. Overall, as noted above, spending from all sources increases by 15 percent.

Changes in Federal Spending by Component

Table 5 shows how the overall change in federal spending is allocated across components. Medicare spending for people ages 65 and 66 falls from $80.0 billion under current law to $38.7 billion under the modeled reform; again, savings are limited because an expensive population remains on Medicare. In addition, Medicare premiums paid to the federal government offset Medicare spending. We estimate premiums will fall by $12.0 billion, which, with respect to the deficit, would offset more than one-quarter of the Medicare savings (data not shown). There would also be a relatively small spillover effect that increases payments for people who remain on Medicaid (not estimated): Part B and Part D premiums are shares of their respective total Medicare spending, and their dollar amounts would increase as less costly younger beneficiaries leave Medicare. Medicaid spending increases by $8.0 billion. Marketplace subsidies of $8.4 billion would also now be paid to this group for individuals newly receiving subsidized coverage. These individuals are also expensive to the government because Marketplace premiums are high for older people, and most are paid through federal PTCs.

Taken together, federal health spending for 65- to 66-year-olds declines from $82.6 billion to $58.5 billion, or by 29 percent. This is a large drop in percentage terms for the target population, but it is relatively small compared with the overall size of the Medicare program, about $1.0 trillion in 2025. The savings to Medicare are more than offset by increased spending elsewhere. Thus, while a Medicare-to-67 policy would aim to lower federal spending, its impact is relatively small, and the overall societal cost of health care would increase.

TABLE 5

Federal Health Spending for People Ages 65 and 66 under Current Law and Reform Raising Medicare Eligibility Age to 67, 2025

	Current Law (billions of $)	Raising Medicare Eligibility Age to 67 (billions of $)	Difference (billions of $)
Medicare	80.0	38.7	-41.3
Medicaid	2.2	10.2	8.0
Marketplace subsidies	0.0	8.4	8.4
Uncompensated care	0.3	1.1	0.8
Total	**82.6**	**58.5**	**-24.1**

Source: Urban Institute analysis of the American Community Survey, Medicare Current Beneficiary Survey, HIPSM, and MCARE-SIM.

Discussion

This paper examined a policy that would eliminate Medicare eligibility for those ages 65 and 66, except for those eligible for Medicare because of disability. The result is a decline of over 5 million Medicare beneficiaries, or 78 percent of those in the affected age group who have Medicare under current law. About 1.5 million retain Medicare because of disability. Those who would lose Medicare tend to take up employer coverage (54 percent). This would include those who enroll in Medicare while continuing to work, then return to their employer's plan under the reform, as well as those who choose not to retire and keep employer coverage. About 0.9 million would enroll in Marketplace plans (18 percent) and receive income-related subsidies (PTCs).[13] Another one million would enroll in Medicaid (20 percent). We find an increase in the number of uninsured of 0.4 million; about 6 percent of the population in this age range would now be uninsured.

We find that this policy would result in a $24.1 billion decline in federal spending and reduced Medicare premiums. This is less than might have been anticipated because a relatively expensive group of Medicare beneficiaries keeps their Medicare coverage. Moreover, the federal government must pay its share of an increased Medicaid caseload and the full cost of Marketplace subsidies. The decline in federal spending is more than offset by increases in spending elsewhere. Employer premiums would increase by about $26.6 billion; we expect this would be passed on to workers in the form of lower wages, which in turn would reduce federal tax payments (not reflected in our estimates). It is not clear that the workers who newly take up employer coverage will be those who experience lower compensation—the wage reductions could be spread across the workforce. Household spending increases by about $12 billion because of greater spending on premiums, deductibles, and coinsurance, amounting to $2,241 per person losing Medicare. Although the policy would reduce federal spending, national health spending on this age group would increase by around 15 percent. Accordingly, although the policy would produce modest savings for the federal government, it would be at the expense of increased health care costs for the US at large.

Our analysis has some limitations. For example, those who we show as having Medicare and ESI could have ESI as their primary coverage or as supplementary coverage, but the MCBS does not allow us to reliably distinguish the two. In this case, we may be overstating Medicare spending and understating employer spending. Likewise, those who we show as having employer coverage could be eligible for Medicare Part A when they become eligible for full Social Security benefits. In this case, we could be overstating employer spending and understating Medicare. We do not expect these effects to be large.

In addition, Marketplace PTCs were enhanced (made more generous) by the American Rescue Plan Act of 2021 and extended by the Inflation Reduction Act. The effects of the modeled policy are estimated for 2025, so the baseline includes those enhanced PTCs. If the enhanced PTCs are not extended, we expect policies to increase the age of Medicare eligibility, effective in 2026 and beyond, to have smaller take-up of nongroup policies, smaller subsidies for those who do choose Marketplace coverage, higher take-up of ESI, and greater uninsurance. Our estimates of new coverage types under reform assume 2025 Medicaid enrollment patterns. If the One Big Beautiful Bill reduces enrollment in

Medicaid as expected, there will be a smaller increase in Medicaid enrollment, and more people will become uninsured than we estimate.

This paper examined the changes in coverage and spending that would be expected under a policy raising the Medicare eligibility age from 65 to 67. This work provides updated estimates relative to two prior studies we described, using much more recent data and reflecting how ACA implementation has unfolded, which differs from the original design (e.g., no individual coverage mandate and not all states expanding Medicaid). The US faces severe fiscal challenges, as we summarized above. Medicare is a significant part of the federal budget and would necessarily need to be part of any discussion to solve the nation's deficit and debt problems. But unfortunately, there would be relatively little net contribution to the federal budget deficit from increasing the Medicare age of eligibility (a gross reduction in 2025 of $41.3 billion and a net reduction of $24.1 billion or 2.6 percent of Medicare spending). National Health Expenditures are also a significant problem, with the US spending significantly more as a percentage of gross domestic product than other Western nations. A policy to increase the age of Medicare eligibility to 67 would exacerbate this problem.

Appendix: Additional Methodological Detail

Coverage

The total number of people ages 65 and 66 is estimated from the 2023 ACS population, with those ages 63 and 64 in 2023 aging forward to ages 65 and 66 in 2025, and adjusted for mortality using death rates from the 2024 Social Security Administration Trustees' Report.[14] So, for example, a 63-year-old from the 2023 ACS becomes a 65-year-old in 2025, unless, according to SSA life tables, they die before reaching age 65. As a check, we compared the implied populations to CBO's projected population by age (which has a somewhat broader scope than the ACS) and found the totals to be consistent.[15]

When assigning coverage, we first split ACS observations into people who report Medicare coverage and those who do not. Within both groups (Medicare or no Medicare), coverage is assigned in a hierarchy so each person can have only one (or no) non-Medicare coverage, either with or without Medicare (those without Medicare or any non-Medicare coverage are uninsured). A person is first assigned to Medicaid, then ESI, other public coverage, or nongroup coverage in that order. The number of people in each coverage group under the baseline—current law in 2025—is the share of each type of coverage for 65-and 66-year-olds from the 2023 ACS, multiplied by the estimated 2025 population of 65-and 66-year-olds.

Under the modeled policy of raising the Medicare eligibility age to 67, we estimate what shares of coverage would be for those losing Medicare by extending existing trends for each type of coverage from age 61 to 64 in the 2023 ACS. The numbers of people in each Medicare coverage group under 67 are the trended shares multiplied by the estimated number of 65- and 66-year-olds. This approach assumes that under reform, opportunities for coverage for 65- and 66-year-olds losing their Medicare eligibility will be similar to those currently afforded to the near-elderly. It would also capture trends in

coverage by age before age 65, including slowing labor force participation and increasing likelihood of disability, but not the discrete jump that occurs at age 65 because of current Medicare eligibility, since this would not be available until age 67 under the reform policy.

Income

The distribution by income group for people with Medicare under current law and reform is from MCARE-SIM, based on MCBS data for 2016 to 2019, updated to 2025. For people not covered by Medicare, shares of people in each of the four income groups are tallied by coverage type from the 2025 HIPSM baseline, and those shares are applied to the totals by coverage described above.

Spending

Spending for people with Medicare, both in the baseline and under reform, is taken from MCARE-SIM. Average spending is computed separately by beneficiary income and reason for Medicare eligibility. People who qualify for Medicare because of disability have much higher spending on average than those who qualify as eligible at age 65. Our modeling assumes those who originally qualified for Medicare through disability remain on Medicare under reform.

Spending for people without Medicare, both those who lose it under reform and those who do not have Medicare under current law, is computed by applying a relative cost factor to their current Medicare spending, by income group. This method, which we apply by coverage and income group, captures the amount spent for the care of people (and associated administrative loads) under different types of coverage. The factors include insurance loads, ratios of provider payment rates for non-Medicare coverage to Medicare, and the average relative risk of people ages 62 to 64 with each specific type of coverage (or no coverage), based on diagnosis-based risk scores from HIPSM (which come from the Medical Expenditure Panel Survey) and coverage in the HIPSM baseline. Relative spending factors range from 0.62 for the uninsured to 1.78 for people with ESI; factors for people with nongroup insurance and Medicaid are 1.19 and 0.91, respectively. Our sources and methods for computing these spending factors are as follows:

- ***ESI.*** For the ESI spending factor, we relied on Blavin and Holahan's (2025) analysis of factors associated with commercial relative to Medicare prices. They estimate hospital payments will be 246 percent of Medicare, and professional services will be 124 percent (we do not assume differences in prices paid for prescription drugs). We combine these with the estimates of what share of spending goes to each of these providers for people ages 62 to 64 with ESI in the HIPSM baseline, the average ESI load for those people (9.3 percent), and the relative risk of people ages 62 to 64 with ESI to all people ages 62 to 64 without Medicare from the HIPSM baseline (98 percent) to arrive at the overall ESI factor of 1.78 (178 percent).
- ***Nongroup.*** For the nongroup insurance factor, we assume that premiums in highly competitive ACA Marketplace rating areas—those with low concentration in hospital markets and at least four insurers in the nongroup market—pay approximately Medicare rates to providers. See

Blumberg et al. (2019) for a discussion of the assumption that efficient rating areas approach Medicare payment rates. Current factors are based on data from Holahan, O'Brien, and Wengle (2024) and show, when weighted by nongroup participants ages 62 to 64, an average increase from Medicare of 4.8 percent. We assume an average load for nongroup coverage of 15.3 percent (from HIPSM estimates for 62- to 64-year-olds) and that the relative risk of people with nongroup insurance is 98 percent of the average. The total gross up for nongroup coverage relative to Medicare is 1.19 (119 percent). Nongroup coverage also includes ACA noncompliant (short-term limited-duration) plans, which have low enrollment compared with the total market. The risk adjustment includes both coverages; the insurance load is a weighted average of both; and the payment rate adjustment for compliant nongroup is applied to all nongroup coverage.

- ***Medicaid and the uninsured.*** Spending for people with Medicaid and for the uninsured is based on relative risk and on assumed payment ratios consistent with the literature. We estimate spending for Medicaid to be 91 percent of Medicare spending, for people not entitled to Medicare through a disability, which is a combination of an assumed payment ratio to Medicare of 80 percent and a relative risk of Medicaid enrollees of 114 percent.[16] Similarly, spending for the uninsured is 62 percent of Medicare spending for those leaving Medicare, a combination of an assumed payment ratio of 70 percent and a relative risk of 89 percent.[17]

After computing the total per capita spending amounts, by new coverage type and income group, of Medicare beneficiaries ages 65 and 66 who would no longer have Medicare under reform, we distribute the spending to payers (federal government, states, employers, and households) according to the shares paid by the near-elderly in the 2025 HIPSM baseline.

Notes

[1] Denise Myshko, "Paul Ryan Proposes Risk Pools and Medicare Overhaul to Reform Healthcare," *Managed Healthcare*, October 28, 2025, https://www.managedhealthcareexecutive.com/view/paul-ryan-proposes-risk-pools-and-medicare-overhaul-to-reform-healthcare-amcp-nexus-2025.

[2] C. Eugene Steuerle and Glenn Kramon, "For the Good of the Country, Older Americans Should Work More and Take Less," *The New York Times*, October 26, 2023, https://www.nytimes.com/2023/10/26/opinion/social-security-medicare-aging.html; and C. Eugene Steuerle and Glenn Kramon, "Another winner from the new federal budget: Older Americans," *The Washington Post*, July 14, 2025, https://www.washingtonpost.com/opinions/2025/07/14/old-americans-federal-budget-social-security/.

[3] "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline" Congressional Budget Office, July 21, 2025, https://www.cbo.gov/publication/61570.

[4] Shifting of compensation from wages to health insurance premiums typically reduces income tax revenue because wages are taxable, while premiums typically are not. However, to the extent that taxable wages increase overall, which could occur if people losing eligibility for Medicare work more under reform (and their additional labor is not offsetting labor losses by younger workers), revenues could increase.

[5] See option "Raise the Age of Eligibility for Medicare to 67," in CBO (2018).

[6] Additional information on the ACS can be found at "American Community Survey (ACS)," United Census Bureau, accessed November 7, 2025, https://www.census.gov/programs-surveys/acs.html.

[7] Additional information on the MCBS can be found at "Medicare Current Beneficiary Survey (MCBS)," CMS.gov, accessed November 7, 2025, https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey.

[8] For further applications of MCARE-SIM to Medicare policy reforms, see "Medicare Policy Microsimulation Model (MCARE-SIM)," Urban Institute, accessed November 7, 2025, https://www.urban.org/tags/medicare-policy-microsimulation-model-mcare-sim.

[9] This accounting of spending differs somewhat from that used in HIPSM's computation of costs, which sums spending on premiums by households, employers, and government (in the form of PTCs), other government spending on health care, other out-of-pocket health spending by households, and uncompensated care by providers and governments.

[10] With very rare exceptions, all Medicare beneficiaries have Part A coverage. A small share have Part A but do not enroll in Part B. While the large majority of Medicare beneficiaries have Part D, a substantial share do not.

[11] The number of people with nongroup coverage and the share with PTCs would be smaller without the enhanced tax credits available in the Marketplaces in 2025. These enhanced credits are due to expire at the end of 2025, but an extension of the credits is currently under discussion by Congress. See Sigi Ris, "Tillis: Short-Term Extension Of Enhanced PTCs Has GOP Support," September 3, 2025, https://insidehealthpolicy.com/daily-news/tillis-short-term-extension-enhanced-ptcs-has-gop-support.

[12] "Social Determinants of Health and Older Adults," OASH, accessed November 7, 2025, https://odphp.health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults.

[13] As is listed in the methods section, our analysis is based on 2025 and includes enhanced PTCs. Estimates under standard PTCs would have smaller take-up of nongroup policies, smaller subsidies for those who do choose Marketplace coverage, higher take-up of ESI, and greater uninsurance.

[14] "The 2024 OASDI Trustees Report," Social Security, accessed November 14, 2025, https://www.ssa.gov/oact/tr/2024/.

[15] CBO publishes projected population by age and sex; see "Demographic Projections" in "Key Budget and Economic Data," CBO, accessed November 14, 2025, https://www.cbo.gov/data/budget-economic-data.

[16] For more detail on Medicaid-Medicare payment ratios, see Clemens-Cope et. al. (2023), CBO (2022), Hwang and Kesselheim (2020), Selden et al. (2015), Skopec, Pugazhendhi, and Zuckerman (2025), Zuckerman, Skopec, and Epstein (2017), and Cindy Mann and Aiden Striar, "How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity and Costs," Commonwealth Fund (blog), August 17, 2022, https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact.

[17] See Hadley and Holahan (2003a,b) for more on spending for the uninsured.

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