

Medicare Buy-In Fix

WHAT THIS POLICY DOES NOT DO

- **Does not solve the problem of lack of insurance in America.** As stated earlier, the 55 to 65 year olds are not the most uninsured group in the nation.

But they are the sickest and probably the most discriminated against in the private market. This policy creates an affordable, decent health insurance choice for people who may not have any options.

- **Does not target a group for subsidies.** The President's 1999 budget does not include funds for additional subsidies for health insurance. This year, our priorities are:
 1. Ensuring that the largest expansion of health insurance for children -- CHIP -- gets aggressively and effectively implemented, including an aggressive public-private outreach campaign;
 2. Encouraging Congress to pass comprehensive tobacco legislation that will save millions of children's lives;
 3. Passing legislation that assures all Americans of basic patient protections from their health plans; and
 4. Give a vulnerable group of people access to insurance in fiscally responsible way.

And, if we had funding for subsidizes, we might not begin using them on this group. As you know, the President in previous budgets have included premium assistance for people in between jobs who are disproportionately uninsured.

- **Does not affect Medicare's solvency.** Temporary cost to the Medicare program from innovative premium "loan" is fully paid for by the President's proposal through a series of anti-fraud, abuse, and overpayment measures.

WHAT THIS POLICY DOES

Reduce Inequality when we can get opportunity among

- **In a fiscally constrained environment, gives some vulnerable people new choices.**
 - May not be many, but for those people this protection, which they fully pay for, is invaluable. *Wider health Trust fund*
- **May improve choices in the private market as individual insurers compete for these people.**

Provide security that does not ~~now~~ exist

Doesn't do much. But more than doing nothing

757 5000 - action
- RHP letter
early retirement

MEDICARE EARLY ACCESS ACT OF 1998

TITLE I. Access to Medicare Benefits for Individuals 62-to-65 Years of Age

Eligibility:

- People ages 62 to 65 who do not have access to employer sponsored or federal health insurance may participate.

Premium Payments:

- Participants would pay two separate premiums-- one before age 65 and one between age 65 and 85:
 - **Base premium:** The base premium would be paid monthly between enrollment and when the participant turns age 65. It is the part of the full premium that represents what Medicare would pay on average for all people in this age group. CBO estimates that this would be about \$300 per month. It would be adjusted for geographic variation, but the maximum premium would be limited to ensure participation in all areas of the country.
 - **Deferred premium:** The deferred premium would be paid monthly beginning at age 65 until the beneficiary turns age 85. It is the part of the premium that covers the extra costs for participants who are sicker than average. Participants will be told before they enroll what their deferred premium will be. CBO estimates that this would be about \$10 per month per year of participation.
- This two-part payment plan acts like a mortgage: it makes the up-front premium affordable but requires participants to pay back the Medicare "loan" with interest. It also ensures that in the long-run, this buy-in is self-financing.

Enrollment:

- Eligible people can enroll within two months of either turning 62 or losing access to employer-based or Federal insurance.

Applicability of Medicare Rules:

- Services covered and cost sharing would be, for paying participants, the same as those of Medicare beneficiaries. Participants would have the choice of fee-for-service or managed care. No Medicaid assistance would be offered to participants for premiums or cost sharing. Medigap policy protections would apply, but the open enrollment provision remains at age 65.

Disenrollment:

- People could stop buying into Medicare at any time. People who disenroll would pay the deferred premium as though they had been enrolled for a full year (e.g., a person who buys in for 3 months in 1999 would pay the deferred premium as though they participated for 12 months). This is intended to act as a disincentive for temporary enrollment.

**TITLE II. Access to Medicare Benefits for Displaced Workers 55-to-62 Years of Age
Eligibility:**

- People would be eligible if they are between ages 55 and 61 and:
 - Lost their job because their firm closed, downsized, or moved, or their position was eliminated (defined as being eligible for unemployment insurance) after January 6, 1998;
 - Had health insurance through their previous job for at least one year (certified through the process created under HIPAA to guarantee continuation coverage); and
 - Do not have access to employer sponsored, COBRA, or federal health insurance.

Spouses of these eligible people may also buy into Medicare.

Premium Payments:

- Participants would pay one, geographically adjusted premium, with no Medicare "loan". This premium represents what Medicare would pay on average for all people in this age group plus an add-on (65 percent of the age average) to compensate for some of the extra costs of participants who may be sicker than average. These premiums would be about \$400 per month.

Disenrollment:

- Like people ages 62 to 65, eligible displaced workers and their spouses must enroll in the buy-in within 63 days of becoming eligible. Participants continue to pay premiums until they voluntarily disenroll, gain access to federal or employer-based insurance or turn 62 and become eligible for the more general Medicare buy-in. Once they disenroll, they may only re-enroll if they meet all the eligibility rules again.

TITLE III. Retiree Health Benefits Protection Act

Eligibility:

- People ages 55 to 65 and their dependents who were receiving retiree health coverage but whose coverage was terminated or substantially reduced (benefits' value reduced by half or premiums increased to a level above 125 percent of the applicable premium) would qualify them for "COBRA" continuation coverage.

Premium Payments:

- Participants would pay 125 percent of the applicable premium. This premium is higher than what most other COBRA participants pay (102 percent) to help offset the additional costs of participants.

Enrollment:

- Participants would enroll through their former employer, following the same rules as other COBRA eligibles.

Disenrollment:

- Retirees would be eligible until they turn 65 years old.

COMPANION BILL: Medicare Anti-Fraud and Overpayment Act of 1998

Eliminating Excessive Medicare Reimbursement for Drugs. A recent report by the HHS Inspector General found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. For more than one-third of these drugs, Medicare pays more than double the actual acquisition costs, and in one case, pays as high as ten times the amount. This proposal would ensure that Medicare payments are provider's actual acquisition cost of the drug without mark-ups.

Eliminating Overpayments for Epogen. A 1997 HHS Inspector General report found that Medicare overpays for Epogen (a drug used for kidney dialysis patients). This policy would change Medicare reimbursement to reflect current market prices (from \$10 per 1,000 units administered to \$9).

Eliminating Abuse of Medicare's Outpatient Mental Health Benefits. The HHS Inspector General has found abuses in Medicare's outpatient mental health benefit - specifically, that Medicare is sometimes billed for services in inpatient or residential settings. This proposal would eliminate this abuse by requiring that these services are only provided in the appropriate treatment setting.

Ensuring Medicare Does Not Pay For Claims Owed By Private Insurers. Too often, Medicare pays claims that are owed by private insurers because Medicare has no way of knowing the private insurer is the primary payer. This proposal would require insurers to report any Medicare beneficiaries they cover. Also, Medicare would be allowed to recoup double the amount owed by insurers who purposely let Medicare pay claims that they should have paid, and impose fines for failure to report no-fault or liability settlements for which Medicare should have been reimbursed.

Enabling Medicare to Negotiate Single, Simplified Payments for Certain Routine Surgical Procedures. This proposal would expand HCFA's current "Centers of Excellence" demonstration that enables Medicare to pay for hospital and physician services for certain high-cost surgical procedures through a single negotiated payment. This lets Medicare receive volume discounts and, in return, enables hospitals to increase their market share, gain clinical expertise, and improve quality.

Deleting Civil Monetary Penalty Provision that Weakens Ability to Reduce Fraud and Abuse. HIPAA limited the standard used in imposing civil monetary penalties regarding false Medicare claims. It limited the duty on providers to exercise reasonable diligence to submit true and accurate claims. This provision would repeal this weakening of the standard.

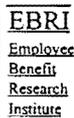
Deleting the Exceptions from Anti-Kickback Statute for Certain Managed Care Arrangements. Current law makes an exception from the anti-kickback rules for any arrangement where a medical provider is at "substantial financial risk" whether through a "withhold, capitation, incentive pool, per diem payment, or any other risk arrangement." Because of the difficulty of defining this exception, this provision may be serving as a loophole to get around the anti-kickback provisions. This provision would eliminate the exception.

Parenteral Nutrition Reform. According to the Office of the Inspector General, there is an overpayment for these services. This proposal would pay for these products at actual acquisition cost and add a requirement that the Secretary provides for administrative costs and sets standards for the quality of delivery of parenteral nutrition.

Strengthening Health Coverage for the Near Elderly: The Next Incremental Step?

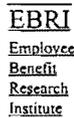
Paul Fronstin, Ph.D.
Employee Benefit Research Institute

Alliance for Health Reform
Washington, DC
April 22, 1998

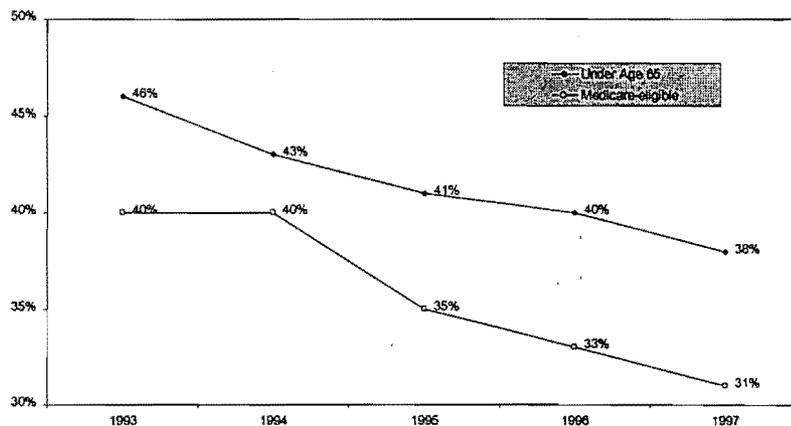


Persons Ages 55-64 by Work Status and Health Status, 1996

| | Total | Workers | Retirees | II and Disabled |
|--|-------|---------|----------|-----------------|
| (millions) | | | | |
| Total | 21.5 | 13.9 | 3.6 | 2.3 |
| Excellent | 4.2 | 3.3 | 0.6 | 0.0 |
| Very good | 5.8 | 4.4 | 0.9 | 0.1 |
| Good | 6.6 | 4.5 | 1.2 | 0.3 |
| Fair | 3.0 | 1.4 | 0.6 | 0.7 |
| Poor | 1.8 | 0.4 | 0.2 | 1.2 |
| (percentage within work status category) | | | | |
| Total | 100% | 100% | 100% | 100% |
| Excellent | 20% | 24% | 18% | 1% |
| Very good | 27% | 31% | 25% | 3% |
| Good | 31% | 32% | 34% | 14% |
| Fair | 14% | 10% | 17% | 32% |
| Poor | 9% | 3% | 6% | 50% |



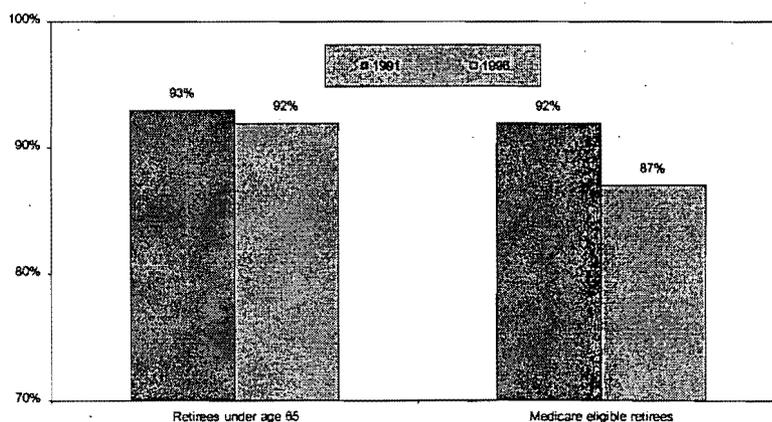
Percentage of Large Employers Offering Retiree Health Benefits, 1993-1997 (Higgins/Mercer)



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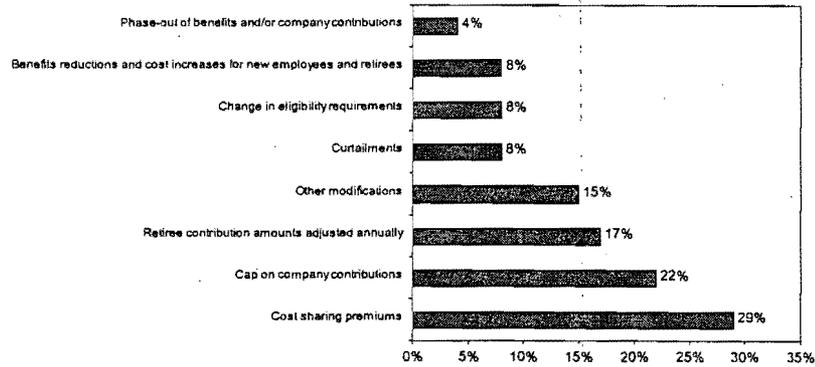
Percentage of Employers Offering Health Benefits to Retirees, 1991 and 1996 (Hewitt - constant sample)



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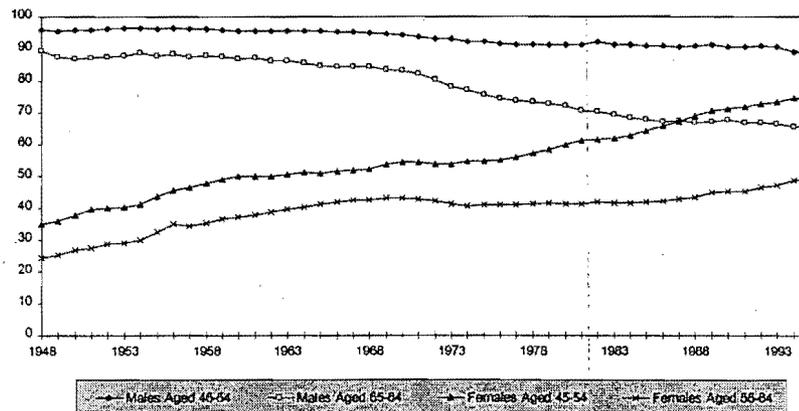
Postretirement Nonpension Benefit Modifications (Buck Consultants, 1995)



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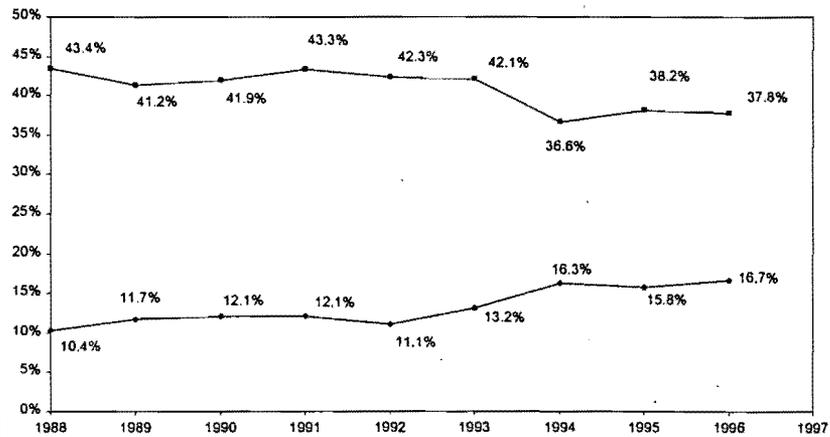
Labor Force Participation Rate, by Age and Gender, 1948-1995



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Retirees, Ages 55-64, Percentage with Retiree Health Benefits and Percentage Uninsured 1988-1996



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Nonelderly Population, Percentage Uninsured, 1996

| | |
|---------------|-------------------|
| Children 0-17 | 14.8% (10.6 mil.) |
| Ages 18-24 | 28.9% (7.2 mil.) |
| Ages 25-34 | 22.5% (9.0 mil.) |
| Ages 35-44 | 16.4% (7.2 mil.) |
| Ages 45-54 | 13.7% (4.5 mil.) |
| Ages 55-64 | 13.9% (3.0 mil.) |

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The Harris Poll

THE HARRIS POLL #6

Wednesday, February 4, 1998

STRONG SUPPORT FOR PRESIDENT'S PROPOSAL ALLOWING SOME PEOPLE AGED 55-64 TO BUY INTO MEDICARE, ALTHOUGH MAJORITY DO NOT BELIEVE IT WOULD BE SELF-FINANCING

Only 54% of the public have heard about the proposal.

by Humphrey Taylor

The president's proposal to allow some people aged 55-64 to buy into the Medicare health insurance program is popular with most people who have heard about it. And the two main elements of the proposal, allowing retired workers aged 62 to 64, and laid-off workers aged 55 to 64, to buy into Medicare are strongly supported by most people, whether or not they have heard about the proposal. The majority support the proposals even though – by an equally large majority – most people do not believe the president's claim that it will be paid for in full by those insured. They believe that the government and taxpayers will eventually pay a substantial part of the cost.

Some of the major findings of this Harris survey, conducted among a nationwide survey of 1,000 adults between January 14 and 18, 1998 are:

- Just over half of all adults (54%) say they have seen, heard or read about the president's proposal to allow some people aged 55 to 64 to buy into Medicare.
- Among this 54% who have heard about it, a substantial 63%-28% favor it. A virtually identical 63%-26% of people aged 55 to 64 feel this way.
- A substantial 68%-27% majority of the public (and a 67%-29% of those who have heard about the proposal) support the proposal "that people aged 62 to 64 who have retired should be allowed to buy into Medicare if they pay the full cost."

- A virtually identical 67%-29% majority also supports the proposal to "allow laid-off workers aged 55 to 64 to buy into Medicare" if they also pay the full cost.
- A majority of the public accepts one criticism of the plan (by 68%-29%) that "the government and taxpayers will eventually pay a substantial part of the cost."
- However, only a 44% minority agrees with another criticism that "this is an undesirable increase in the government's involvement with health insurance."

The survey is not large enough to provide accurate data about how many people might actually buy into Medicare if these proposals become law. However, it suggests that the number would be small. Only about one out of every five people aged 55 to 65 does not have health insurance now, and only about a quarter of those without health insurance (i.e. 4% of all people aged 55 to 64) say they would buy it.

Nevertheless, the poll suggests that, at least initially, the president's proposals sound attractive to most people, whether or not they have heard about them.

Humphrey Taylor is the Chairman and CEO of Louis Harris and Associates, Inc.

TABLE 1

**SEEN, HEARD, READ ABOUT PRESIDENT'S PLAN TO
ALLOW PEOPLE TO BUY INTO MEDICARE**

Base: All Adults

"President Clinton has proposed that some people aged 55 to 64, who wish to do so, should be able to buy into the Medicare health insurance program for the elderly. Have you seen, read or heard about this proposal or not?"

| | Total | People Aged 55-64 |
|------------------------------|--------------|----------------------------------|
| | % | % |
| Seen, read or heard about it | 54 | 75 |
| Not done so | 46 | 25 |

TABLE 2

SUPPORT/OPPOSE PRESIDENT'S PROPOSAL

Base: Seen, read or heard about President Clinton's plan

"On balance, do you support or oppose this idea?"

| | Total | People Aged 55-64 |
|--------------------|--------------|----------------------------------|
| | % | % |
| Support | 63 | 63 |
| Oppose | 28 | 26 |
| Don't know/Refused | 9 | 11 |

TABLE 3

**SUPPORT/OPOSE ALLOWING RETIRED WORKERS
AGED 62-64 TO BUY INTO MEDICARE**

Base: All Adults

“Under this proposal, people aged 62 to 64 **who have retired** would be allowed to buy into Medicare if they paid the full cost, so that it would not increase the cost of the Medicare program to taxpayers. Do you support or oppose this idea?”

| | Adults | Familiar with Clinton's Proposal | People Aged 55-64 |
|--------------------|---------------|---|----------------------------------|
| | % | % | % |
| Support | 68 | 67 | 56 |
| Oppose | 27 | 29 | 39 |
| Don't know/Refused | 5 | 3 | 5 |

TABLE 4

**SUPPORT/OPOSE ALLOWING LAID-OFF WORKERS
AGED 55-64 TO BUY INTO MEDICARE**

Base: All Adults

“Another part of the proposal would allow **laid-off workers** aged 55 to 64 to buy into Medicare, also paying the full cost so that there would be no cost to the taxpayers. Do you support or oppose this idea?”

| | Adults | Familiar with Clinton's Proposal | People Aged 55-64 |
|--------------------|---------------|---|----------------------------------|
| | % | % | % |
| Support | 67 | 68 | 61 |
| Oppose | 29 | 29 | 36 |
| Don't know/Refused | 3 | 3 | 3 |

TABLE 5

**AGREE/DISAGREE WITH TWO CRITICISMS OF
PRESIDENT'S PROPOSALS**

Base: All Adults

"Critics of the proposal make two points, please tell me if you agree or disagree with them."

| <u>AGED 55-64</u> | | <u>TOTAL</u> | | | <u>PEOPLE</u> | | Not | |
|-------------------|---|-------------------|------------------|-------------|---------------|----|-----|----|
| | | Agree Disagree | Disagree Sure | Not Sure | Agree | | | |
| | This is an undesirable increase of the government's involvement with health insurance | % | 44 | 52 | 4 | 42 | 47 | 10 |
| | Even though the president denies it, the government and taxpayers will eventually pay a substantial part of the costs | % | 68 | 29 | 3 | 72 | 21 | 7 |

TABLE 6

**HOW MANY PEOPLE HAVE OR DO NOT HAVE
HEALTH INSURANCE**

Base: Aged 55 to 64

"Do you have health insurance or not?"

| | Total % |
|-------------|------------|
| Yes, have | 81 |
| Do not have | 19 |

NOTE: Approximately one-third of those without health insurance say they would buy it if it cost "\$5,000 a year or just over \$400 a month." However, this is based on a very small sample and should be treated with great caution.

Methodology

This Harris Poll was conducted by telephone within the United States between January 14 to 18, among a nationwide cross section of 1,000 adults. Figures for age, sex, race, education and number of adults in household were weighted where necessary to bring them into line with their actual proportions in the population.

In theory, with a sample of this size, one can say with 95 percent certainty that the results have a statistical precision of plus or minus 3 percentage points of what they would be if the entire adult population had been polled with complete accuracy. Unfortunately, there are several other possible sources of error in all polls or surveys that are probably more serious than theoretical calculations of sampling error. They include refusals to be interviewed (non-response), question wording and question order, interviewer bias, weighting by demographic control data and screening (e.g., for likely voters). It is difficult or impossible to quantify the errors that may result from these factors.

These statements conform to the principles of disclosure of the National Council on Public Polls.

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Contact Louis Harris and Associates, Inc. 111 Fifth Avenue, New York, NY 10003, (212) 539-9697, for complete demographic details for the questions in this release.

FAX (212) 539 - 9669
Compuserve address: 76702,2063
Other E-mail: achurch@lha.gsbc.com

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Medicare as an Option for Americans Ages 55-64: Issues to Consider

by Paul Fronstin, EBRI

Introduction

Medicare is by far the largest public health care financing program, with expenditures of \$200 billion on health care in 1996, mostly for the elderly (ages 65 and older). As a percentage of national health care spending, Medicare has increased from 11.4 percent in 1970 to 20.9 percent in 1995.¹ The Balanced Budget Act of 1997 (BBA '97) contained the first major Medicare changes in many years. BBA '97 is expected to reduce Medicare spending by \$115 billion between 1998 and 2002, and by \$386 billion between 1998 and 2007. The Medicare provisions contained in BBA '97 were largely a response to the financial situation of the Medicare Part A trust fund, which was expected to be depleted in late 2000 or early 2001. The provisions are expected to extend the fund's solvency until 2010, according to actuaries at the Health Care Financing Administration.

Increasing the Medicare eligibility age to 67 was not included in BBA '97's Medicare provisions, although it was heavily debated. The Senate-passed legislation would have increased

the Medicare eligibility age to 67, but did not include legislation that would have provided for some other health insurance for people in that age bracket. However, the Clinton administration's FY 1999 budget proposal includes provisions that would allow individuals to buy into the Medicare program starting at age 55 for individuals laid off or displaced and at age 62 for all individuals.² The age 62 provision would effectively bring consistency to the Medicare and Social Security programs in that *both* would provide for early retirement benefits before age 65 and full retirement benefits at age 65. The ultimate goal of the program, however, is not consistency between Social Security and Medicare, but to provide affordable access to health insurance coverage for individuals ages 55-64 who have trouble obtaining coverage. Unlike individuals under age 55, this population may have more difficulty obtaining health insurance coverage because of their age and health status.

While the Clinton administration's proposal would help some uninsured people ages 62-64, and will undoubtedly be strongly debated by both advocates and opponents, it would have very limited impact on the aggregate number of people without health insurance coverage, as discussed below. Allowing the buy-in for Medicare starting at age 55 for laid-off and displaced workers would also have a limited effect.

Table 1
PERSONS AGES 35-64 WITH SELECTED SOURCES OF HEALTH INSURANCE, BY MAIN ACTIVITY AND AGE, 1996

| | Total | Total Private | Employment-Based | | | Other Private | Total Public | Medicare | Medicaid | Uninsured |
|--|------------|---------------|------------------|------------|-----------|---------------|--------------|-----------|-----------|-----------|
| | | | Total | Own name | Dependent | | | | | |
| Ages 35-44 | 43,694,159 | 33,336,479 | 31,122,096 | 22,574,828 | 8,547,269 | 2,214,383 | 4,391,424 | 766,618 | 3,109,114 | 7,151,596 |
| Working | 37,436,727 | 30,607,684 | 28,762,647 | 22,231,533 | 6,531,114 | 1,845,037 | 2,103,067 | 165,607 | 1,299,724 | 5,610,688 |
| Retired | 82,311 | 30,319 | 18,324 | 15,919 | 2,404 | 11,996 | 30,982 | 8,281 | 11,216 | 30,924 |
| Ill or disabled | 1,949,210 | 381,574 | 310,063 | 120,987 | 189,077 | 71,511 | 1,344,878 | 543,112 | 1,029,769 | 388,498 |
| Home or family | 3,323,230 | 2,057,679 | 1,846,249 | 164,378 | 1,681,870 | 211,431 | 638,493 | 12,289 | 537,803 | 722,008 |
| Other ^a | 902,681 | 259,222 | 184,815 | 42,011 | 142,804 | 74,408 | 274,005 | 37,330 | 230,601 | 399,478 |
| Ages 45-54 | 32,955,087 | 26,232,801 | 24,298,969 | 18,233,136 | 6,065,833 | 1,933,832 | 3,647,348 | 947,683 | 1,872,916 | 4,509,139 |
| Working | 27,760,782 | 23,703,099 | 22,126,866 | 17,674,810 | 4,452,056 | 1,576,233 | 1,616,395 | 119,592 | 621,779 | 3,415,032 |
| Retired | 447,188 | 290,059 | 246,274 | 99,590 | 146,684 | 43,785 | 126,661 | 54,364 | 38,350 | 76,019 |
| Ill or disabled | 2,123,128 | 665,631 | 566,652 | 259,592 | 307,061 | 98,978 | 1,491,090 | 744,848 | 957,614 | 278,535 |
| Home or family | 2,094,155 | 1,343,302 | 1,181,579 | 143,026 | 1,038,553 | 161,723 | 306,973 | 16,209 | 184,468 | 522,094 |
| Other ^a | 529,834 | 230,710 | 177,597 | 56,118 | 121,479 | 53,113 | 106,229 | 12,671 | 70,707 | 217,458 |
| Ages 55-64 | 21,466,474 | 16,249,626 | 14,022,612 | 10,568,642 | 3,453,970 | 2,227,014 | 3,907,804 | 1,822,000 | 1,576,593 | 2,973,759 |
| Working | 13,853,602 | 11,845,073 | 10,509,326 | 8,706,523 | 1,802,804 | 1,335,746 | 1,087,876 | 185,916 | 342,199 | 1,591,507 |
| Retired | 3,595,774 | 2,593,023 | 2,088,530 | 1,357,875 | 730,655 | 504,493 | 829,058 | 531,900 | 147,120 | 601,219 |
| Ill or disabled | 2,314,895 | 789,759 | 585,231 | 315,000 | 270,231 | 204,529 | 1,703,545 | 1,040,011 | 943,963 | 281,740 |
| Home or family | 1,442,093 | 881,689 | 746,940 | 141,310 | 605,629 | 134,750 | 248,671 | 57,890 | 126,099 | 402,202 |
| Other ^a | 260,109 | 140,081 | 92,585 | 47,934 | 44,650 | 47,496 | 38,654 | 6,282 | 17,213 | 97,091 |
| (percentage within main activity category) | | | | | | | | | | |
| Ages 35-44 | 100.0% | 76.3% | 71.2% | 51.7% | 19.6% | 5.1% | 10.1% | 1.8% | 7.1% | 16.4% |
| Working | 100.0 | 81.8 | 76.8 | 59.4 | 17.4 | 4.9 | 5.6 | 0.4 | 3.5 | 15.0 |
| Retired | 100.0 | 36.8 | 22.3 | 19.3 | 2.9 | 14.6 | 37.6 | 10.1 | 13.6 | 37.6 |
| Ill or disabled | 100.0 | 19.6 | 15.9 | 6.2 | 9.7 | 3.7 | 69.0 | 27.9 | 52.8 | 19.9 |
| Home or family | 100.0 | 61.9 | 55.6 | 4.9 | 50.6 | 6.4 | 19.2 | 0.4 | 16.2 | 21.7 |
| Other ^a | 100.0 | 28.7 | 20.5 | 4.7 | 15.8 | 8.2 | 30.4 | 4.1 | 25.5 | 44.3 |
| Ages 45-54 | 100.0 | 79.6 | 73.7 | 55.3 | 18.4 | 5.9 | 11.1 | 2.9 | 5.7 | 13.7 |
| Working | 100.0 | 85.4 | 79.7 | 63.7 | 16.0 | 5.7 | 5.8 | 0.4 | 2.2 | 12.3 |
| Retired | 100.0 | 64.9 | 55.1 | 22.3 | 32.8 | 9.8 | 28.3 | 12.2 | 8.6 | 17.0 |
| Ill or disabled | 100.0 | 31.4 | 26.7 | 12.2 | 14.5 | 4.7 | 70.2 | 35.1 | 45.1 | 13.1 |
| Home or family | 100.0 | 64.1 | 56.4 | 6.8 | 49.6 | 7.7 | 14.7 | 0.8 | 8.8 | 24.9 |
| Other ^a | 100.0 | 43.5 | 33.5 | 10.6 | 22.9 | 10.0 | 20.0 | 2.4 | 13.3 | 41.0 |
| Ages 55-64 | 100.0 | 75.7 | 65.3 | 49.2 | 16.1 | 10.4 | 18.2 | 8.5 | 7.3 | 13.9 |
| Working | 100.0 | 85.5 | 75.9 | 62.8 | 13.0 | 9.6 | 7.9 | 1.3 | 2.5 | 11.5 |
| Retired | 100.0 | 72.1 | 58.1 | 37.8 | 20.3 | 14.0 | 23.1 | 14.8 | 4.1 | 16.7 |
| Ill or disabled | 100.0 | 34.1 | 25.3 | 13.6 | 11.7 | 8.8 | 73.6 | 44.9 | 40.8 | 12.2 |
| Home or family | 100.0 | 61.1 | 51.8 | 9.8 | 42.0 | 9.3 | 17.2 | 4.0 | 8.7 | 27.9 |
| Other ^a | 100.0 | 53.9 | 35.6 | 18.4 | 17.2 | 18.3 | 14.9 | 2.4 | 6.6 | 37.3 |

Source: Employee Benefit Research Institute estimates from the March 1997 Current Population Survey.

^aOther includes going to school, unemployed, and other.

Note: Numbers less than 75,000 should be interpreted with caution, as they are based on a relatively small sample.

The remainder of this paper provides data on Americans ages 55-64 and discusses issues surrounding a Medicare buy-in program.

Background Data

Although individuals ages 55-64 have lower labor force

participation rates than other age groups, the majority (65.3 percent) get their health insurance coverage through an employment-based plan (table 1). This compares with 71.2 percent for individuals ages 35-44 and 73.7 percent for individuals ages 45-54. Individuals ages 55-64 are more likely than other age groups to have purchased

health insurance directly from an insurance company. Almost 10.5 percent have such a policy, compared with 5.1 percent among individuals ages 35-44 and 5.9 percent among individuals ages 45-54. The near elderly's high rate of privately purchased coverage is a result of their weak attachment to the labor force and their increased

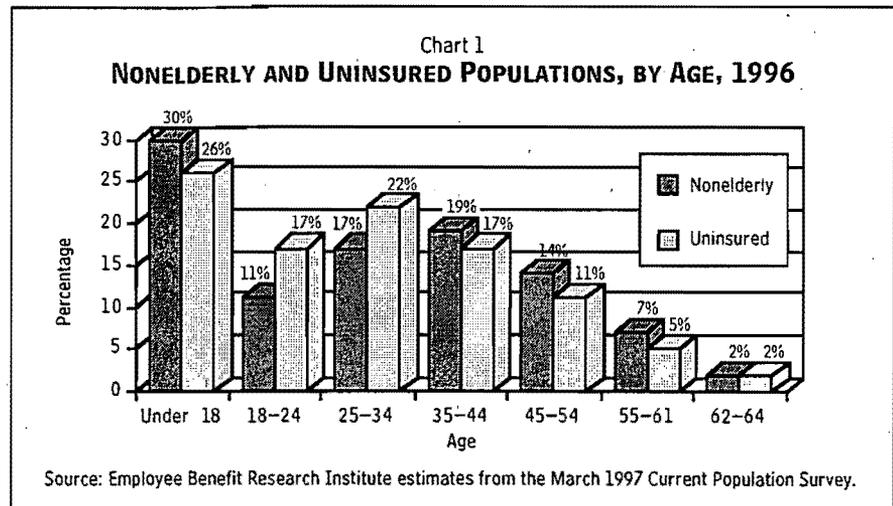
likelihood of being retired or disabled. They are less likely to have employment-based health insurance, yet they are more likely than others to need some form of health insurance.

Individuals ages 55–64 were not significantly more likely than other age groups to be uninsured. Almost 14 percent of individuals ages 55–64 were uninsured in 1996, compared with 16.4 percent of individuals ages 35–44 and 13.7 percent of those ages 45–54. The higher rates of insurance coverage, however, can be attributed to higher rates of Medicare coverage among the retired and disabled populations.

Issues to Consider

When designing effective public policy, policymakers need to understand the policy's potential impact. Allowing individuals to buy into the Medicare program before age 65 raises a number of issues that should be considered during the ensuing policy debate.

Potential Impact—Increasing access to health insurance coverage among individuals ages 55–64 is a primary goal of allowing them to buy into the Medicare program before age 65. It can be justified because these individuals may have the most difficulty purchasing insurance in the individual market because of their age and health status. However, the Medicare buy-in program would



have a minimal effect on the overall uninsured population.

According to Employee Benefit Research Institute (EBRI) estimates from the March Current Population Survey, between 1987 and 1996, the percentage of nonelderly (under age 65) Americans without health insurance increased from 14.8 percent to 17.7 percent, and now represents 41.4 million individuals.³ Individuals ages 55–61 account for 5 percent of the uninsured, representing 2.1 million individuals, and individuals ages 62–64 account for 2.2 percent of the uninsured and represent 900,000 individuals (chart 1). Furthermore, there are only 800,000 uninsured individuals in the population ages 55–61 who are unemployed and would potentially qualify for the Medicare program. If the Clinton administration's estimate that 300,000 individuals would benefit from the proposal is accurate, over 41 million individuals would remain uninsured. However, the program's primary goal is to provide access to health insurance for individuals ages 55–64 who do not have access to employment-based health insurance, not to reduce the uninsured population.

Affordability—The potential impact of allowing individuals to buy into the Medicare program would be hampered by the program's cost. Initial estimates are \$300 per month for individuals ages 62–64, and \$400 per month for individuals 55–61, representing annual premiums of \$3,600 to \$4,800, respectively. In addition, persons ages 62–64 would be required to pay between \$10 and \$20 per month extra for Medicare once they turn age 65 in order to pay back the early buy-in subsidy. While the majority of uninsured individuals would be able to afford this premium, many would not be able to participate because it would be unaffordable. In 1996, 24 percent of the population ages 55–61 and 25 percent of the population ages 62–64 were in families with income below the federal poverty level (table 2). In addition, 22.7 percent of the population ages 55–61 and 18.2 percent of the population ages 62–64 were in families with income at or above 300 percent of the federal poverty level. A couple at the poverty level would have \$10,507 in gross income per year, while a couple at 300 percent of poverty would have \$31,521 in gross income. The cost for a couple to buy

Table 2
**UNINSURED PERSONS AGES 55-64, BY MAIN ACTIVITY AND
 POVERTY LEVEL, 1996**

| Main Activity and Poverty Level | Ages 55-61 | | Ages 62-64 | |
|------------------------------------|------------|--------------|------------|--------------|
| | (number) | (percentage) | (number) | (percentage) |
| Total | 2,071,800 | 100.0% | 901,959 | 100.0% |
| Below poverty level | 505,569 | 24.4 | 229,517 | 25.4 |
| 100%-149% of poverty | 319,990 | 15.4 | 161,208 | 17.9 |
| 150%-199% of poverty | 220,892 | 10.7 | 110,887 | 12.3 |
| 200%-299% of poverty | 326,540 | 15.8 | 141,619 | 15.7 |
| 300%-399% of poverty | 228,477 | 11.0 | 94,305 | 10.5 |
| 400% of poverty or more | 470,332 | 22.7 | 164,424 | 18.2 |
| Working | 1,247,115 | 100.0 | 344,393 | 100.0 |
| Below poverty level | 154,483 | 12.4 | 44,599 | 13.0 |
| 100%-149% of poverty | 162,773 | 13.1 | 52,572 | 15.3 |
| 150% of poverty or higher | 929,859 | 74.6 | 247,222 | 71.8 |
| Retired | 256,983 | 100.0 | 344,235 | 100.0 |
| Below poverty level | 78,980 | 30.7 | 100,706 | 29.3 |
| 100%-149% of poverty | 58,449 | 22.7 | 71,937 | 20.9 |
| 150% of poverty or higher | 119,554 | 46.5 | 171,592 | 49.8 |
| Ill or Disabled | 186,060 | 100.0 | 95,679 | 100.0 |
| Below poverty level | 95,587 | 51.4 | 41,667 | 43.5 |
| 100%-149% of poverty | 33,734 | 18.1 | 21,146 | 22.1 |
| 150% of poverty or higher | 56,740 | 30.5 | 32,866 | 34.4 |
| Homemaker | 300,468 | 100.0 | 101,733 | 100.0 |
| Below poverty level | 113,311 | 37.7 | 32,904 | 32.3 |
| 100%-149% of poverty | 53,657 | 17.9 | 10,800 | 10.6 |
| 150% of poverty or higher | 133,500 | 44.4 | 58,030 | 57.0 |
| Other* | 81,173 | 100.0 | 15,918 | 100.0 |
| Below poverty level | 63,209 | 77.9 | 9,640 | 60.6 |
| 100%-149% of poverty | 11,377 | 14.0 | 4,753 | 29.9 |
| 150% of poverty or higher | 6,587 | 8.1% | 1,526 | 9.6 |

Source: Employee Benefit Research Institute estimates from the March 1997 Current Population Survey.
 Note: Numbers less than 75,000 should be interpreted with caution, as they are based on a relatively small sample.

*Other includes going to school, unemployed, and other.

into the Medicare program would be at least \$7,200, or 69 percent of their gross income for those at the poverty level, and 23 percent of their income for those at 300 percent of the poverty level.

Labor Market Dynamics—The availability of Medicare prior to age 65 could affect both workers and employers. Some workers might choose to retire before age 65 because of the availability of Medicare. An EBRI/Gallup poll reveals a strong link between a worker's decision to retire early and the availability of subsidized health insurance.⁴ In 1993, 61 percent of workers reported

that they would not retire before becoming eligible for Medicare if their employer did not offer retiree health benefits. Yet the same survey shows that 47 percent planned to retire before age 65, with a planned mean age of retirement younger than age 61. Hence, a Medicare buy-in program would inevitably allow some workers to retire early. However, affordability will continue to be an issue, especially because retiree health benefits tend to be partly subsidized by employers and the Medicare buy-in option will be unsubsidized.

Employers might respond to

the Medicare buy-in program by cutting back or completely eliminating retiree health benefits, accelerating an already existing trend.⁵ However, the number of employers who would completely eliminate their programs might be minimal for a number of reasons. First, most employers do not offer retiree health benefits. Second, there is a public image problem associated with eliminating retiree health benefits that most employers would like to avoid because it can affect employee-employer relations. With the unemployment rate as low as it is now, employers may start to look for workers by rehiring retired workers, with the promise of retiree health benefits as an incentive to bring them back to the labor force. Third, if an employer completely eliminated retiree health benefits, its retirees would still be eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) until they were eligible for Medicare benefits, under the Clinton administration proposal. In fact, 55-year-old retirees would be eligible for COBRA for 10 years under the proposal. Past research indicates that the claims for health care services incurred by COBRA-covered individuals are on average 50 percent higher than those for active workers.⁶ As a result, even though COBRA beneficiaries are required to pay 102 percent of the premium, they cost employers on average 150 percent of the premium. Likewise, if COBRA beneficiaries were required to pay between 120 percent and 125 percent of the premium, as proposed in the Clinton administration's FY 1999 budget for the small group of retirees whose employer eliminated retiree health benefits, they would still be both a financial and admin-

istrative burden for employers. Hence, employers will examine the trade-off between dropping retiree health benefits and increasing their COBRA exposure before making a decision.

Adverse Selection—The goal of the Clinton administration is to design a program that completely pays for itself in five years. Premiums before and after age 65 would be adjusted to accomplish this. For individuals ages 62–64, the monthly premium is expected to be \$300 for both Medicare Part A and Part B. The current monthly premium for individuals over age 65 who do not qualify for Medicare is \$309.⁷ Medicare Part B would cost an individual an additional \$43.80 per month, which only covers 25 percent of the cost of Medicare Part B. The average cost for health insurance under Medicare is higher for the population ages 65 and older than it is for the under age 65 population. However, it is possible that \$300 per month, combined with the proposed \$10–\$20 monthly premium surcharge for individuals once they turn age 65, would not cover the expected expenditures of the average person under age 65. If the buy-in program suffers from adverse selection, meaning unhealthy individuals are more likely to participate in the program than the healthy, it would be even more difficult for the program to pay for itself at \$300 per month. Adverse selection will be minimized, however, since individuals will be required to sign up for

the buy-in program within a certain amount of time after the qualifying event. For example, individuals may have only one or two months to be eligible for the buy-in program after becoming displaced or turning age 62. This provision would reduce adverse selection because individuals could not wait until they became sick to sign up for coverage. This would effectively reduce adverse selection, but would not eliminate it.

Conclusion

While it is unlikely that the Medicare buy-in program would have a major impact on the uninsured population, it would help people obtain health insurance. The proposal is in large part consistent with recent health care legislation in that it guarantees access to health insurance coverage for people who can afford it. The proposal also moves toward consistency between the Medicare program and the Social Security program. The Social Security program currently provides for full benefits at age 65 and reduced benefits at age 62. While the reduced benefits at age 62 allow workers to retire before age 65, many do not because of the lack of availability of health insurance. Because people are living longer, the full benefit Social Security age is going to increase to 67, but the early benefit age of 62 will remain the same. Policymakers may want to consider examining the effects of

complete consistency in the programs by raising the age for full Medicare benefits to age 67 (as the Medicare commission will undoubtedly recommend) while at the same time allowing for reduced benefits at age 62. In designing any changes to Medicare eligibility age, policymakers should understand the advantages and the issues involved in implementing such a program.

Endnotes

- ¹ Katherine R. Levit et al., "National Health Expenditures, 1995," *Health Care Financing Review (Fall 1996)*: 175–214.
- ² The proposal includes a third provision that would allow retirees to continue retiree health benefits through COBRA when an employer drops retiree health benefits. See Paul Fronstin, "Health Insurance Portability: COBRA Expansions and Job Mobility," *EBRI Issue Brief no. 194 (Employee Benefit Research Institute, February 1998)*.
- ³ Paul Fronstin, "Sources of Health Insurance Coverage and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey," *EBRI Issue Brief no. 192 (Employee Benefit Research Institute, December 1997)*.
- ⁴ *EBRI/The Gallup Organization, Inc., "Public Attitudes on Medicare and Retiree Health, 1993," Summary Report G-51 (Employee Benefit Research Institute, November 1993)*.
- ⁵ Paul Fronstin, "Retiree Health Benefits: What the Changes May Mean for Future Benefits," *EBRI Issue Brief no. 175 (Employee Benefit Research Institute, July 1996)*.
- ⁶ See Fronstin, "Health Insurance Portability."
- ⁷ There are actually two premiums for individuals who do not qualify for premium-free Medicare benefits. If an individual has fewer than 30 qualifying quarters of Social Security income, the premium is \$339.90 per month. For individuals with between 30 and 39 qualifying quarters of Social Security income, the premium is \$187 per month.

HEALTH INSURANCE TRANSITIONS OF OLDER WORKERS

Lynn A. Karoly and Jeannette A. Rogowski
RAND
DRU-1797-DOL/AHCPR

EXECUTIVE SUMMARY

Labor force transitions at the end of the work career may be complex, including not only retirement but movements to part-time work and self-employment. The prior literature has focused on the role of financial factors such as pensions in affecting the path towards complete labor force withdrawal. In this study, we consider the role of health insurance availability and the cost of health insurance on labor force transitions of older workers. We study various aspects of the pathway towards complete labor force exit, including movements from full-time work to part-time work or retirement, as well as shifts from wage and salary jobs to self employment. The findings of this study are important for understanding the effects of policies that change access to post-retirement health insurance, as well as understanding the impact of the trend toward decreased generosity of retiree health insurance offers among employers.

BACKGROUND AND MOTIVATION

Access to health insurance is an important consideration for older workers contemplating reduced labor force participation. Employers are a primary source of health insurance while working. Some employers offer post-retirement health insurance for their former employees, paying all, part or none of the insurance premium. The 1993 Employee Benefits Survey conducted by the Bureau of Labor Statistics reveals that 45 percent of full-time workers in medium and large firms with health insurance coverage can continue their health benefits upon retirement, with the premium either wholly or partially paid by the employer. While nearly half of current retirees age 55 and older rely upon a former employer for health insurance coverage,

that fraction is likely to decline in the future as employers are increasingly unwilling to provide post-retirement health benefits. Employers are either scaling back the generosity of their plans—by requiring, for example, greater premium cost sharing with the former employee—or eliminating the benefit all together. These trends are in part due to the change in accounting rules mandated by the Financial Accounting Standards Board (FASB) in 1990, requiring employers to treat the present value of the unfunded retiree health liabilities as a cost against current earnings. As a result of these rules, many employers have institute changes aimed at decreasing their retiree health liability.

For workers without employer-provided post-retirement health insurance, options for obtaining an affordable policy can be limited. Persons under age 65 are not eligible for public insurance (Medicare or Medicaid) except under certain circumstances such as being disabled. Individual insurance can be prohibitively expensive, especially when there are preexisting health conditions. Given the increases in health care costs at older ages, and the association of retirement with poor health status, it seems reasonable to expect that the ability to obtain affordable group-rate health insurance coverage would enter into the decision to transition out of the labor market.

Given the potential for labor force transitions to result in the loss of health insurance coverage at group rates, a number of public policies have been enacted to ensure continued access to health coverage. While these initiatives are often motivated by job transitions for prime age workers, they are equally relevant for retirees who leave the work force before age 65 and who work for an employer that does not offer retiree health benefits. Since 1986, the COBRA (Consolidated Omnibus Budget Reconciliation Act, 1985) legislation offers one way to obtain bridge coverage until Medicare eligibility. For individuals with employer coverage as active workers (in firms with 20 or more employees), COBRA allows a former employee to purchase eighteen months of continuation coverage from their former employer at 102 percent of the group rate.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) further expands the potential to obtain continuation coverage. Under the new legislation, continuation coverage is available to persons after exhausting their 18-months of COBRA coverage, or immediately for workers not covered by COBRA who meet other eligibility requirements. For these individuals, insurers in the individual market are required to write individual health insurance policies without pre-existing condition exclusions. However, the legislation places no restrictions on the premiums that insurers can charge. Instead, premium determination is regulated according to existing laws in each state. Thus, while HIPAA guarantees access to insurance after retirement for persons who have health insurance while working, the premiums charged by private insurers may be higher than those paid for under COBRA coverage.

Policies currently under consideration may further affect the availability of post-retirement health insurance in the future. In order to increase access to health insurance among the near elderly, the Clinton Administration has proposed allowing persons aged 62 to 64 to buy into Medicare coverage, regardless of their current employment or insurance status. The premium payments would be set to cover the full cost of insuring these individuals before the age of Medicare eligibility, currently estimated at about \$300 per month (plus a monthly surcharge to the regular Medicare premium when the individual reaches age 65). Other proposals, motivated by concern over the solvency of the Medicare program, would extend the age of Medicare eligibility for future cohorts from 65 to 67.

The trend among employers toward decreasing retiree health benefit offers, combined with public policies that would change access to post-retirement health insurance, imply that an understanding of the labor force effects of health insurance access and cost will be critical to understanding the future retirement behavior of older workers. This will become increasingly important as the baby boom generation nears retirement age. In this study, we explore the effect of access to employer-based retiree health benefits, as well as cost sharing provisions for that insurance, on the labor force behavior of workers who are under age 65.

DATA AND METHODS

Data from the first two waves (1992 and 1994) of the Health and Retirement Survey (HRS) are used to estimate multinomial logit models of transitions in labor force status. The HRS is a nationally-representative, longitudinal survey of older Americans, who were aged 51 to 61 in 1992. Our study focuses on men who worked-full time at the start of the survey. By observing the change in labor force status between the first and second waves of the survey, we estimate models of the transition from full-time to part-time work or retirement, as well as from wage and salary employment to self-employment or retirement. Full-time work is defined as working 35 hours or more and part-time work as less than 35 hours. Retirement is defined by being out of the labor force and reporting being retired.

The HRS contains detailed information on health insurance held by survey respondents, including information on access to retiree health benefits from employers and the associated cost sharing provisions. Key covariates in the analyses include access to employer-based retiree health insurance and whether premium cost sharing is higher, lower or the same after retirement compared to active employees. The models also control for demographic, health and economic covariates included in other models of retirement behavior.

FINDINGS

The empirical models demonstrate that transitions to retirement as well as transitions to part-time employment are determined by both traditional demographic and economic variables, as well as the measures of access to health insurance and premium cost sharing arrangements. Specifically, having access to retiree health benefits increases the likelihood of a transition from full-time work to either part-time work or retirement. However, for movements to part-time work, if out-of-pocket premiums increase upon retirement, this effect is largely offset. Increased premiums for health insurance, however, appear to have little dampening effect on transitions that involve complete withdrawal from the labor force. The source of the retiree health benefit plan—as a benefit through the worker's own employer or spouse's employer—also appears to determine the type of labor force transition that we observe. The results suggest that access to

retiree health benefits through any employment-based plan may first facilitate the transition to part-time work as a stepping stone to full retirement from the labor force.

We also found that those without employment based coverage—either because their coverage was through the private market or a public program or because the worker was uninsured—were also more likely to transition to part-time work but not to retirement. These workers appear to have more flexibility to make labor market transitions than their counterparts who would lose the health insurance coverage they have as active workers. At the same time, they are not able to entirely leave the labor force, perhaps due to the financial obligations associated with paying for private coverage or to protect against high medical costs when uninsured.

While we gain insight from the models into the determinants of labor market transitions based on hours worked, we see little evidence in the HRS data, perhaps due to insufficient sample sizes, that transitions from wage and salary to self-employment status are driven by any of the financial or health insurance measures included in our model. The one exception is the effect of having no health insurance, and possibly health insurance that is nonemployment based, which appear to raise the likelihood of making a change in employment status. Nevertheless, the most likely transition for these workers is to self-employment, not retirement, suggesting the need to work in order to finance private market health insurance premiums or out-of-pocket costs for health care when uninsured.

IMPLICATIONS FOR POLICY

The findings in this analysis, as well as our previous research, indicate that access to and cost sharing provisions of health insurance after retirement affect the labor force decisions of older workers. In general, policy initiatives that make post-retirement health insurance more available would be expected to increase transitions out of full-time work and into part-time work and retirement, while the reverse would be true of changes that reduce access to health insurance upon partial or full retirement. The magnitude of this effect, however, appears to depend upon the extent of premium cost sharing. The data we analyze in this paper indicate that making post-

retirement health insurance available, with premium payments that cost more than what is paid as a full-time employee, will diminish the propensity to move to part-time employment as a result of greater access to post-retirement health insurance. The transition to full retirement appears to be less sensitive to the cost sharing provisions of post-retirement health insurance.

Among recent policy changes, HIPAA, and previously COBRA, have increased access to post-retirement health insurance among workers who do not already have continuation coverage through their former employer. But, for most workers without employer-provided retiree health benefits, premium payments under either program would be higher than what they pay as active workers (even if they pay the full cost of their employer-provided plan) but less than what they would pay in the private market prior to the implementation of the policies. For example, for workers in firms of 20 or more employees, COBRA provides for 18 months of continuation coverage at 102 percent of the employer's group rate. HIPAA guarantees that insured workers can purchase an individual insurance policy without pre-existing conditions exclusions after the COBRA period (or immediately for those not covered by COBRA), although premiums are set in the individual market. In most states, these premiums will be at least age rated, and thus more expensive than the typical employer-provided plan. Given that COBRA coverage restricts premium payments more than under HIPAA, we would expect COBRA to have had a larger effect on early retirement behavior than we will see under HIPAA.

The current proposal to allow individuals aged 62 to 64 to buy into Medicare will also increase access to post-retirement health insurance. While the Medicare buy-in option increases access to health insurance after retirement, our research suggests that the size of the out-of-pocket premium will determine the fraction of the workforce that experiences an increased financial incentive to move to part-time employment or complete retirement. Since individuals, as currently proposed, will pay a Medicare premium that is designed to be actuarially fair, the premium is likely to exceed the typical cost of an employer-provided policy as an active worker, as a retiree health benefit or under COBRA. Workers with employment-based health insurance options, therefore, are not likely to face an incentive to move to part-time work or complete

retirement. Depending upon the state regulatory environment, the Medicare buy-in premium may or may not exceed the cost of an individual plan under HIPAA provisions or in the individual market for those without employment-based coverage. For retirees in poor health or with pre-existing conditions, the Medicare premium will probably be less than an individual plan in states that do not mandate community rating. The Medicare buy-in option should therefore be most attractive to older workers in poorer health who are insured on the job and who would exhaust their COBRA coverage (or would not be eligible for COBRA because they work in a small firm). There may also be changes in labor force behavior for workers without employment-based coverage because they would face lower insurance premiums under Medicare compared with the individual market, thereby reducing their out-of-pocket medical expenses both as workers or retirees. Our research to date does not address the magnitude of the effect for workers without employment-based coverage.

Other policy changes may reduce access to affordable health insurance upon early retirement. For instance, proposed reforms to Medicare include raising the age of full Medicare eligibility for future cohorts to age 67. Trends among employers have also been towards decreasing the generosity of retiree health benefits, due in part to changes in the FASB regulations that were enacted in 1990. These changes would serve to decrease access to affordable post-retirement health insurance, a trend that would be expected to increase job lock among older workers and reduce the number of individuals who leave full-time employment prior to Medicare eligibility.

While our analysis suggests that access to and generosity of post-retirement health insurance will affect labor force behavior at older ages, this empirical relationship merits further exploration. First, the offsetting effects of premium cost sharing on movements out of full-time work may be larger than those implied by our study. The amount of increased cost sharing in our data is limited to 100 percent of the employer's group rate. The premium increases in policies such as HIPAA and actuarially-fair Medicare buy-ins may be considerably higher. Thus, the offsetting labor force effects due to higher premiums associated with these policies

may be even larger than those estimated in our analysis. Second, we have not been able to examine the effect of providing access in retirement to health insurance plans with varying plan provisions, for example, the types of services covered or the level of copayments and deductibles. Many employer-provided plans cover more services than those offered by Medicare or the private market. Plans also differ in the extent of out-of-pocket cost sharing through deductibles and copayments. Ultimately, we would expect policy changes to increase or decrease labor force transitions at older ages depending upon whether they lower or raise the expected total out-of-pocket costs of insurance premiums plus medical care. The magnitude of this effect has yet to be measured empirically.

**Retiree Health Benefits:
Availability from Employers
and Participation by Employees**

by

Pamela Loprest

October 1997

**The Urban Institute
2100 M Street, NW
Washington, DC 20037**

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Executive Summary

Health insurance coverage can be a key concern for early retirees who are not yet eligible for Medicare. For the 4.5 million early retirees ages 55 to 64, retiree health insurance from a previous employer (RHI) can be an important source of coverage because of it costs less than COBRA or nongroup coverage. However, not all early retirees have access to this coverage and not all that have access take it up. Knowing what types of firms and early retirees are more likely to have offers and which early retirees are most likely to accept offers allows for potential targeting of reforms.

This study uses data from the 1994 September supplement to the Current Population Survey to examine the following questions:

- What characteristics of jobs and individuals are associated with an increased probability of having an offer of retiree health insurance?
- What characteristics of jobs and individuals are associated with an increased probability of accepting an offer of coverage?
- To what extent are differences in RHI coverage across groups of early retirees due to differences in rates of RHI offers versus differences in rates of accepting offers? What would the rate of acceptance be if access to offers were increased?

In 1994, 76 percent of all early retirees ages 55 to 64 had own-employer insurance on their last job and 39 percent have RHI coverage at the time of the survey. Only about half of early retirees were offered RHI. This means that almost a third of employees with health insurance on the job who retire early do not have the option of RHI coverage. This represents a substantial decrease since 1988. At that time, 84 percent of early retirees had own-employer insurance on their last job, 57 percent had RHI coverage, and 67 percent were offered RHI.

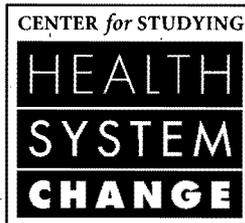
We find large differences in offer rates for different groups of early retirees. Those retirees with pensions, long tenure, and who worked in large firms are substantially more likely to have offers of RHI. Nonwhites and women are less likely to have access to this benefit, even after controlling for differences in job and demographic characteristics.

But even those with RHI offers do not always accept these offers. Of those that are offered RHI coverage, we find that more than a quarter do not accept the offer of RHI. For some it is because they have access to coverage through a spouse. But almost half of those who do not accept the offer say the coverage was too expensive. We find that early retirees with lower incomes and lacking pensions are significantly less likely to accept an offer of RHI than other early retirees.

We also examined what is the dominant factor in being without RHI coverage, lacking an

offer or not accepting an offer. Decomposing differences in RHI coverage rates across subgroups of early retirees shows that for the most part, differences in RHI offers are the dominant factor in differences in RHI coverage. For example, men are more than twice as likely to have RHI coverage than women. After controlling for a variety of job and individual characteristics, we find that 72 percent of this difference is due to differences in RHI offer rates and 28 percent is due to differences in accepting RHI offers. For the characteristics considered, offer rate differences make up one-half to three-quarters of the differences in RHI coverage. However, differences in accepting RHI coverage are still substantial, making up a quarter to a third of the difference in rates of coverage.

The impact of declining RHI could mean even greater differences across groups of early retirees in their access to RHI offers in the future. One way to increase RHI coverage among this age group is to implement targeted policies that increase access to employer group coverage for early retirees. These include tax or other incentives for employers who offer this coverage. However, increased access does not directly lead to increased coverage. Although almost 75 percent of those early retirees with RHI offers accept, a simple prediction of acceptance rates if all those without offers were given access shows a much lower acceptance rate of 43 percent. This suggests that other ways to increase RHI coverage for this age group that could increase acceptance rates may be important. Examples of these policies include reforms such as direct subsidies to retirees for RHI or allowing retirees to buy into a public program with subsidies.



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Ann Greiner
(202) 484-3475

**NEW STUDY FINDS THAT MOST UNINSURED NEAR ELDERLY
WOULD HAVE SEVERE DIFFICULTY AFFORDING COVERAGE UNDER
THE PRESIDENT'S MEDICARE BUY-IN PLAN**

*The Average Uninsured Near Elderly Person in Fair or Poor Health Would Have to
Spend Between One Third and One Half of Their Income on Medicare Premiums*

WASHINGTON – The Center for Studying Health System Change, an independent non-partisan research group, released a study today, including a finding that most uninsured near elderly persons (ages 55-64) would have problems affording coverage under the President's Medicare Buy-in plan, but that those in the poorest health would have the most difficulty of all. Specifically, the average uninsured near elderly person would have to spend 20 to 25 percent of his or her income on Medicare premiums, while their counterparts in poor or fair health would have to spend between one third to one half of their income to obtain coverage. These findings come from a study that compares insurance coverage, access to care, and health status by age group.

According to the Center's findings, the uninsured near elderly are among the poorest and sickest of all uninsured persons – one fourth to one third of the near elderly characterize themselves in poor or fair health, as compared to 16 percent of all uninsured. These sicker near elderly have average annual incomes of less than \$10,000, while overall the near elderly have average incomes of about \$46,000 a year.

-more-

"This study is an important contribution to the Medicare policy debate, in that it clearly demonstrates that a significant gap exists between the cost of coverage and the ability to pay of the uninsured near elderly," said Robert Reischauer, Ph.D., Senior Fellow, Brookings Institution. "The findings also suggest that 65 and 66 year olds would face even greater difficulty if the eligibility age for Medicare was raised."

The report from the Center is based on a telephone survey of 33,000 households across the country conducted between July 1996 and July 1997, and are part of a much larger effort by the Center for Studying Health System Change to track changes in health care over a multi-year period. The Center has also conducted surveys of physicians (12,000) and employer establishments (23,000), and conducted intensive case study research in 12 U.S. communities. See the Center's web site for more information (www.hschange.com).

Other key findings released by the Center today include a comparison of the near elderly population to other age groups, such as young adults (ages 19-24). While the uninsured near elderly as a group may be the most difficult to extend coverage to because they are among the poorest and sickest, young adults actually have higher rates of uninsurance – 29 percent in comparison to 10 for the uninsured near elderly. Young adults have high uninsurance rates for a variety of reasons, including losing eligibility under public programs and dependent coverage under their parent's insurance, lower labor force participation, working at jobs where benefits are not offered, and the fact that they are less likely to accept coverage when it is offered to them.

The Center for Studying Health System Change, an independent research organization funded entirely by the Robert Wood Johnson Foundation and based in Washington D.C., provides objective analyses about changes in the nation's health care system and their impact on consumers to both policy makers and the public at large.

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**Health Insurance Coverage
Transitions of Older Americans**

by

Pamela J. Loprest

Sheila R. Zedlewski

May 30, 1997

The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037

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Health Insurance Coverage Transitions of Older Americans

Abstract

Health insurance coverage can be a significant factor in determining older individuals' economic and health security. This paper uses data from the Health and Retirement Survey to examine the health insurance transitions of two groups: those who move into retirement between 1992 and 1994 and those who were retired in both years. For a quarter of full-time workers in 1992 who move to retirement, this work transition also involves a change in health insurance coverage. The percentage who are uninsured increases from 7 percent to 13 percent. Although the majority of full-time workers with own-employer health insurance keep this coverage when they retire, not all do. Fully a third of workers who became uninsured when they retired between 1992 and 1994 had insurance through an employer while working, although 43 percent of retirees becoming uninsured had no health insurance while they were working. Our results also indicate a much lower rate of employer group coverage for those already retired in wave 1992. While insurance coverage for those with employer group insurance (whether through their own employer or their spouse) remains quite stable, we observe considerable churning in health insurance coverage among those who retired with nongroup coverage or without health insurance. Transitions into government coverage are important for this group, as some complete the two-year waiting period for Medicare eligibility for the disabled and others qualify for Medicaid. Overall, health insurance coverage is a problem for the most vulnerable persons in this age group; the rates of uninsurance are much higher for low-income persons, the disabled, and single persons. Many lack options for purchasing affordable insurance to tide them over until they are eligible for Medicare at age 65.

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GAO

Report to the Honorable
Jerry Kleczka, House of Representatives

July 1997

RETIREE HEALTH INSURANCE

Erosion in Employer-Based Health Benefits for Early Retirees



**Health, Education, and
Human Services Division**

B-276540

July 11, 1997

**The Honorable Jerry Kleczka
House of Representatives**

Dear Mr. Kleczka:

In August 1996, the Pabst Brewing Company notified about 750 retirees of its Milwaukee plant that it planned to terminate their health benefits within a month. Concerned about this abrupt cancellation, especially for early retirees—those who are not yet eligible for Medicare, you asked us to examine a number of issues related to the private sector's provision of health benefits to retirees:

- Has the number of private sector early retirees with health coverage declined since the late 1980s?
- How are retirees affected by an employer's decision to terminate health benefits?
- Do federal laws (1) prevent employers from reducing or terminating retirees' health benefits or (2) provide for continued group health coverage for retirees under age 65 years whose health plans are terminated?

Beyond the specific questions raised by Pabst's termination of retiree health benefits, you expressed concern about the fragility of the current system for providing retiree health coverage. Several factors suggest that retiree coverage is becoming an important national issue. These factors include the downward drift in employers' commitment to retiree coverage, the need to trim Medicare cost growth, and the dramatic near-term increase in the number of retirees as millions of baby-boomers approach retirement age.

To address your specific questions, we reviewed (1) available private sector and government surveys of changes in retiree access to and participation in employer-based health coverage; (2) the Pabst health benefit plan in effect during 1996; (3) data from health insurance carriers on the cost of alternative sources of coverage for early retirees in Wisconsin, where Pabst is located, and other selected states; (4) applicable federal and state laws and legal precedents; and (5) earlier GAO work. Appendix I contains a discussion of the sources of data on employer-sponsored coverage, the patchwork nature of the evidence on retiree health care trends, and a cautionary note on the strict

comparability of the data. We performed our work during April and May 1997 in accordance with generally accepted government auditing standards.

Results in Brief

The available data on employer-based retiree health benefits paints a limited but consistent picture of eroding coverage. The data, primarily from employer or retiree surveys, demonstrate a steady decline in the number of retirees with coverage through a former employer—both for early retirees and those who are Medicare eligible. Foster Higgins, a benefit consulting firm, reported in 1996 that only 40 percent of large employers with more than 500 employees offered health benefits to early retirees—a 6 percentage point decline since 1993. Even fewer small and medium-sized firms offered retiree coverage. Earlier employer survey data suggest that since 1988 the decline in the number of large employers who offer retiree coverage has been significant. It is important to point out that the decline in the availability of employer-based coverage has not resulted in as large an increase in early retirees without private health insurance. Among the reasons are that (1) the decision to retire is often predicated on the availability of health coverage and (2) access to other sources of private coverage appear to be filling a significant portion of the gap created by fewer employers offering retiree health benefits. For example, if employer-based coverage is not available, early retirees may purchase coverage themselves or obtain insurance through a working or retired spouse.

Retiree surveys provide another important perspective on the erosion in retiree health coverage. Comparing 1988 and 1994 data for all retirees aged 55 and older, the Labor Department reported that the number of individuals who continued to receive employer-based health benefits into retirement declined by 8 percentage points; in addition, the number still covered sometime after retirement dropped by 10 percentage points. There are several explanations for the erosion in coverage during retirement. First, some employers, much like Pabst, have ceased to offer retiree health benefits. Escalating health care costs have spurred employers to look for ways to control their benefit expenditures. Among the cost-control techniques adopted by employers are eliminating retiree coverage, increasing cost sharing, and requiring those covered to choose more cost-effective delivery systems. In addition, a new financial accounting standard developed in the late 1980s has changed employers' perceptions of retiree health benefits and may have acted as a catalyst for reductions in retiree coverage. The new rule makes employers much more

aware of the future liability inherent in retiree health benefits by requiring them to account for its estimated value as a cost against earnings. A second contributor to the erosion in employer-based health coverage during retirement is retirees' responses to changes in their coverage. According to the Labor Department, fewer retirees are choosing to participate in employer-based coverage when offered because firms are asking them to shoulder more of the costs. At the same time, retirees who decline employer-based benefits may have access to less expensive coverage through a working or retired spouse.

Losing access to employer-based coverage poses three major challenges for retirees: (1) higher costs in purchasing individual coverage on their own; (2) a related problem, the potential for less comprehensive coverage because of higher premiums; and (3) until recently, the possibility that coverage will be denied or restricted by a preexisting medical condition. The impact of the termination of health benefits on retirees varies from state to state, depending on the nature of state laws governing the purchase of insurance by individuals. The cost impact is starkly illustrated for affected Pabst early retirees by the nearly \$8,200 annual cost of purchasing standard family coverage in the individual insurance market—an enormous increase given that the former Pabst plan required no contribution on the part of the retiree for most plan options. Beginning July 1, 1997, the implementation of the Health Insurance Portability and Accountability Act (HIPAA) will provide uniform federal standards to ensure that individuals leaving employer-based group plans can purchase insurance on their own if they can afford to do so.

A key characteristic of America's voluntary, employer-based system of health insurance is an employer's freedom to modify the conditions of coverage or to terminate benefits. While federal law (the Employee Retirement Income Security Act of 1974 or ERISA) requires that the terms of an employee's health benefits be in writing, the intent was not to prevent an employer from changing or terminating those benefits for either active workers or retirees. In cases involving the termination of health benefits by an employer, federal courts have turned to the nature of the written agreements and extrinsic evidence covering the provision of retiree benefits. In essence, the issues before the court often come down to a matter of contract interpretation. If the employer has explicitly reserved the right in plan documents to modify health benefits, the courts have generally upheld the termination of coverage. On the other hand, if the contract leaves some doubt, courts will look to evidence such as collective bargaining agreements and other written and oral representations to

determine the rights and obligations of the parties. Today, most companies have reserved the right in plan documents to modify health benefits for current and future retirees. Finally, the right to purchase continuation coverage from an employer is only guaranteed to workers in certain circumstances, for example, if an employee is fired, laid off, quits, or retires. Individuals who are already retired when an employer terminates coverage are not eligible to continue that firm's health plan at their own expense.

**Retiree Health Trends and
Implications of Possible Medicare Reforms**

Prepared by:
Hewitt Associates LLC

Prepared for:
Kaiser Medicare Policy Project

September 1997

Preparation of this report was supported by The Henry J. Kaiser Family Foundation Grant Number 96-1710B. The study consists of a review and analysis of recent trends in the provision of employer-sponsored health benefits to retirees, as well as an assessment of potential changes to employer-sponsored retiree health plans in the future, including the effects of certain proposed changes to Medicare. The views expressed in this paper are solely the responsibility of the authors and do not necessarily represent those of The Henry J. Kaiser Family Foundation.

Acknowledgments

This report was prepared by Frank B. McArdle, Ph.D., and Dale H. Yamamoto, F.S.A., of Hewitt Associates, a global management consulting firm specializing in human resource solutions. Saline Leckman prepared the tables allowing for a comparison of trends between 1991 and 1996. Libby Terry and Nancy Newman collaborated on many aspects of this report.

For Further Information Contact:

Frank B. McArdle, Ph.D.
Hewitt Associates LLC
2401 Pennsylvania Avenue, N.W.
Suite 450
Washington, DC 20037
(202) 331-1155

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Executive Summary

Retiree Health Benefits Play an Important Role

Employer-sponsored retiree health benefits are a source of valuable coverage to individuals, both through the provision of coverage to early retirees before they become eligible for Medicare and as a supplement to Medicare for retirees age 65 and over. More than a third (approximately 12 million) of Medicare aged and disabled beneficiaries have employer-sponsored coverage.

In 1996, most large employers (1,000 or more employees) provided some form of retiree health benefits, of which the vast majority provided coverage both before and after age 65. However, because of rising health care costs and changes in accounting rules, and after years of expanding coverage and benefits, the prevalence of employers offering such coverage has been declining since the early 1990s; eligibility has been tightened; and more of the costs have been shared with retirees.

In addition, because Medicare pays a large portion of the costs for post-65 retirees, certain proposed changes to Medicare could potentially accelerate the decline in retiree health coverage by shifting financial liability to employers and to retirees.

The purpose of this study is twofold:

- Document trends in retiree health benefits using an extensive database that annually tracks benefit provisions of major employers, and
- Analyze the potential impact on retiree health plans of major Medicare reform proposals, such as increasing the age of eligibility.

Key Trends

Part I of this report analyzes key trends in retiree health plans for a constant sample¹ of large companies in the Hewitt database, finding that between 1991 and 1996, the vast majority of large employers continued to provide retiree health benefits, but there were significant changes in coverage, eligibility rules, and beneficiary contribution requirements. (Figure 1 summarizes selected key findings with respect to coverage of retirees.)

¹ Using a constant sample of large companies is a better indicator of key trends than just reporting the percentages for a changing group of companies in the entire database. For the constant sample, the percentage of employers offering retiree health benefits is higher than for a changing base of companies in the database that includes more newer companies with no retiree coverage.

- *Availability of coverage declined for retirees ages 65 and over*
 - For retirees age 65 and over, the share of large employers offering retiree benefits declined from 92 percent in 1991 to 87 percent in 1996.²
- *More retirees charged premiums*
 - The share of large employers requiring pre-65 retirees to pay premiums increased from 85 percent in 1991 to 95 percent in 1996, and increased for post-65 retirees from 72 percent in 1991 to 88 percent in 1996.
- *Eligibility for postretirement medical coverage tightened through higher age and service requirements*
 - The percentage of large employers setting minimum eligibility requirements for benefits at age 55 and 10-15 years of service (versus age 50 and shorter years of service) increased from 31 percent in 1991 to 35 percent in 1996.
- *Financial caps placed on future retiree health obligations*
 - Virtually no large employers had financial caps on their future benefit obligations in 1991. By 1996, 39 percent of large employers have some form of dollar cap on the employer's contribution for post-65 retiree coverage, and 36 percent had caps on pre-65 coverage.
- *More employers encourage use of managed care for retirees*
 - The number of large employers offering Medicare risk HMOs has grown sharply from 7 percent in 1993 to 38 percent in 1996, according to other survey data.³

Implications of Medicare Reforms

Changing our focus from existing trends to possible future changes in retiree health plans, Part II of this report considers another potential wave of changes that might result from three significant Medicare reform proposals.

Option #1: Proposed increase in the Medicare age of eligibility

During the recent Medicare reform debate in connection with the Balanced Budget Act of 1997, the Senate included a provision that would have gradually raised the Medicare age of eligibility from 65 to 67, in tandem with the already scheduled increase in the Social Security eligibility age. Although dropped from the final bill, this issue will likely be revisited, and if enacted, could have a significant impact on retiree health plans. A few examples of the impact of raising the eligibility age include:

² By comparison, 80 percent of all the 1,006 employers in the full 1991 Hewitt database offered some form of retiree health coverage for post-65 retirees, compared to 71 percent of the 1,050 employers in the full 1996 database, a larger percentage difference that reflects turnover among the companies in the database and the addition of newer companies without retiree coverage.

³ Foster Higgins, *National Survey of Employer-Sponsored Health Plans*, 1996.

- *Raising the Medicare eligibility age to 67 would mean that plan costs for a 65-year-old retiree could be two to four times higher (depending on plan design) for each year of coverage without Medicare.*
- *For a typical large company with a predominately younger workforce, the employer's actuarial cost for lifetime retiree health benefits would rise about 16 percent (18 percent for a large employer with an older workforce).*
- *Employer response to the eligibility age increase will vary, but the increased costs could encourage them to reduce (or eliminate) their retiree health financial commitment to active employees, while preserving coverage for current retirees, along with plan design changes.*

— For example, eliminating Medicare eligibility may increase the retiree health plan costs for a 66-year old from \$1,000 per person per year to \$4,000. To keep the cost effect neutral, the employer could require the retiree to pay the extra \$3,000 for coverage, or redesign the plan to offset the increased cost. A cost-neutral plan redesign might include, for example, a \$10,000 deductible, 50 percent coinsurance, with a \$50,000 out-of-pocket limit on the retiree's obligations.

Option #2: Changes in Medicare payments to Medicare HMOs

With employers increasingly moving toward Medicare managed care to keep costs down and provide comprehensive coverage to retirees, the favorable financial impact of that strategy could be significantly affected by changes in the way Medicare pays health plans in the future.

The Balanced Budget Act of 1997 makes significant changes in payments to Medicare managed care plans, in part to increase payment rates in rural areas but also to reduce future Medicare spending increases. Employers will soon begin the process of assessing what the specific financial impact of these changes may be. The revised payment formulas may significantly alter the geography of Medicare managed care plan offerings to retirees, as well.

Smaller payment increases in certain areas of the country as a result of the 1997 legislation could potentially make managed care plans less attractive to employers and to retirees in those areas if HMO benefits are reduced or premiums rise. Alternatively, payment and other policies that support the expansion of Medicare managed care may help to stabilize retiree health benefit coverage by helping to manage employer costs over the long term.

Option #3: Proposed shift to a defined contribution program

Another option for reforming Medicare, supported by some experts in the health care community, is to shift away from having Medicare pay the cost of each beneficiary's care, e.g., a defined benefit approach, toward a defined contribution approach in which Medicare would pay a fixed sum for each beneficiary, who would then use that sum, e.g., through a voucher-like mechanism, to select coverage from competing health plans. In fact, the Balanced Budget Act of 1997 creates a private fee-for-service option under Medicare+Choice. The conferees note

that this private fee-for-service option “represents the first defined contribution plan in which beneficiaries may enroll in the history of the [Medicare] program.”⁴

Broad-based use of a defined contribution approach, while empowering retirees to choose their own health plan, also shifts financial risk to employers sponsoring retiree health plans and to retirees. In addition, that cost shift could grow over time if the defined contribution rate increases yet fails to keep pace with medical inflation. This is particularly worrisome to employers because Medicare coverage is already less generous than what large employers typically offer active employees. Comparing the plan value of Medicare benefits to those of 250 large employers participating in the 1996 Hewitt Health Value InitiativeTM database, 82 percent of the indemnity plans offered to active employees provide higher benefit levels than Medicare.

A broad-based defined contribution scheme for Medicare could also create administrative complexities for employers, in terms of the difficulty of coordinating the retiree plan with the specific Medicare health plans retirees choose, and determining an appropriate price for them.

The combination of financial and administrative impacts could thus lead employers to reassess the manner and the extent of coverage they offer to future retirees.

Summary

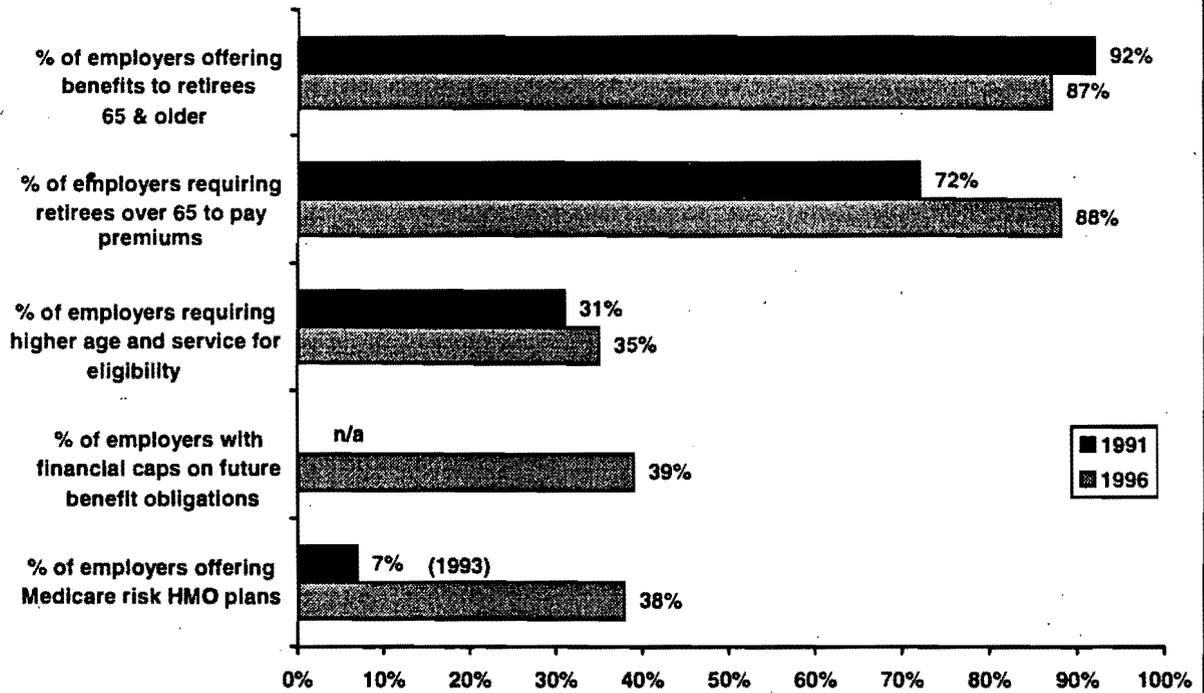
Retiree health benefits remain important to employees and retirees, even though the prevalence of such coverage has declined, eligibility has tightened, and more cost sharing is required of retirees. Potentially the biggest source of profound changes to employer-sponsored retiree health programs in the future would come from proposals to restructure the Medicare program. Depending on their specific nature, such changes could either create a safety net beneath employer-sponsored coverage for retirees or create additional incentives for employers to cut back. Policymakers focusing on potential reforms of Medicare would be well advised to take a more integrated look at the interactions between Medicare coverage and the employer-sponsored retiree health coverage on which millions of retirees still depend.

About the Hewitt Associates Database

Hewitt Associates has been tracking the salaried employee benefit provisions of major employers since 1972 through annual updates to its database of companies. The 1996 Hewitt database contains plan design information on 1,050 major employers, including 62 percent of Fortune 500 companies. Analyses of trends based on large employers (e.g., those with usually at least 1,000 employees) provides a reliable indication of the main sponsors of employer-provided coverage for retirees, because smaller firms are far less likely to provide such coverage. Ninety percent of the Hewitt database consists of companies employing 1,000 or more employees; 57 percent of the database consists of companies with 5,000 or more employees, representing roughly 25 percent of all public and private companies in the United States of that size.

⁴ *Congressional Record*, July 29, 1997, H6177.

Figure 1: Key Trends in Retiree Health Benefits Offered by a Constant Sample of Large Employers to Retirees: 1991-1996



Source: Hewitt Associates; Foster Higgins for percentage of employers offering Medicare risk HMO plans.

Medicare Buy In Penalty

Unintended
push driving
work p-Plan
or charity BUY-IN

Rand -
If cost shares &
premiums increase
to retire early
virtually disappear.

PROBLEM

- As the previous presenters have described, people ages 55 to 65 face unique problems accessing health insurance.
 - **Health becomes worse:** Twice the probability of experiencing heart disease, strokes, and cancer as people ages 45 to 54.
 - **Less access to employer-based insurance** due to:
 - **Work transitions:** Proportion of workers drops from 85 to 65 percent
 - **Family transitions:** As spouses retire or go onto Medicare less access

Medicare spouses: About 20 percent of the uninsured ages 62 to 64 have a spouse (usually a husband) on Medicare
- **Individual insurance:** 2 million (10%) of 55 to 64 year olds buy individual insurance -- nearly twice the proportion of younger people (5%) according Paul's study. - EB28
- **Problems with individual insurance:**
 - Fine in some places, but people
 - **In 38 states, individual insurance policies can be denied outright.** Where 16 million ages 55 to 65, 76 percent of this population, live
 - **In 21 states, there are no assurances that pre-existing conditions are adequately covered.** Where 8 million ages 55 to 65, 36 percent, live
 - **In 34 states, there are no protections against exorbitant premiums.** Where 16 million ages 55 to 65, 75 percent of this population, live

March
Spring

Robert
Allen

In addition, the Kaiser Foundation study confirms that the individual insurance market cannot be relied upon to offer affordable insurance to all Americans. It documents insurance practices that result in denials of coverage, excessive premiums, and geographic variation, especially for older and sicker people. It reports that a 60-year old, healthy man in an average cost area could pay up to \$535 per month for coverage; if he lived in a high-cost area and had health problems, this premium could be over twice as high (250 percent of the standard premium, or over \$1,000 per month) -- or be denied coverage altogether.

POLICY

- **New choices:** Expands health insurance choices so that:
 1. **People ages 62 to 65** without access to group insurance can buy into Medicare;
 2. **Workers ages 55 and older** who lose their insurance when their firm closes or they are laid off can buy into Medicare; and *\$40*
 3. **Retirees ages 55 and older** whose employers drop their retiree health coverage after they have retired can buy into the employer's health plan through "COBRA" coverage. *133%*
 - **Paid for by premiums as well as anti-fraud and overpayment reforms.** Premium for the 62 to 65 year olds would be paid in two parts:
 - Most up front (the base premium) (\$300 / mo) and a
 - Part after they turn 65 years old (the risk portion of the premium reflecting the possibility that those who opt for this policy will have below-average health) (\$10 / mo per year of participation).
- Medicare would "loan" participants the second part of the premium until they reach 65, after which they would make a small additional payment on top of their regular Medicare Part B premium. This payment mechanism means that the legislation will impose only temporary costs on the Medicare program; these costs are paid for, dollar-for-dollar, by a series of anti-fraud and anti-overpayment initiatives.
- **Separate Trust Fund.** The buy-in takes advantage of Medicare's low administrative costs and choice of providers and plans, but its financing is totally walled off from that of current Medicare beneficiaries through a separate Trust Fund.
 - **Helps 300,000 to 400,000 Americans.** The Congressional Budget Office recently confirmed Administration estimates that hundreds of thousands of older Americans will be helped by these new choices.

WHAT THIS POLICY DOES NOT DO

- **Does not solve the problem of lack of insurance in America.** As stated earlier, the 55 to 65 year olds are not the most uninsured group in the nation.

But they are the sickest and probably the most discriminated against in the private market. This policy creates an affordable, decent health insurance choice for people who may not have any options.

- **Does not target a group for subsidies.** The President's 1999 budget does not include funds for additional subsidies for health insurance. This year, our priorities are:
 1. Ensuring that the largest expansion of health insurance for children -- CHIP -- gets aggressively and effectively implemented, including an aggressive public-private outreach campaign;
 2. Encouraging Congress to pass comprehensive tobacco legislation that will save millions of children's lives;
 3. Passing legislation that assures all Americans of basic patient protections from their health plans; and
 4. Give a vulnerable group of people access to insurance in fiscally responsible way.

And, if we had funding for subsidizes, we might not begin using them on this group. As you know, the President in previous budgets have included premium assistance for people in between jobs who are disproportionately uninsured.

- **Does not affect Medicare's solvency.** Temporary cost to the Medicare program from innovative premium "loan" is fully paid for by the President's proposal through a series of anti-fraud, abuse, and overpayment measures.

WHAT THIS POLICY DOES

- **In a fiscally constrained environment, gives some vulnerable people new choices.**
 - May not be many, but for those people this protection, which they fully pay for, is invaluable.
- **May improve choices in the private market as individual insurers compete for these people.**

I failed
we failed

Look at whole
unusual problem

- Next year PEBB
= choice.

- Get label, in
our p-208

- PMA Benefits

- Competitive

Summary

Subsidized

- Federal Tax credits (credit)

→ Private sector savings / delivery

Cost:

• Retiree Prgs

• Subsidization

Congressional Budget Office (CBO) Analysis of the President's Medicare Buy-In Proposal

As part of their analysis of the President's Budget, CBO analyzed the Medicare buy in proposal. Their analysis confirms the Administration's Actuaries' estimates that this policy does not hurt the Medicare Trust Fund. Specifically:

- **Less than a day's worth of Medicare spending:** The net cost of the Medicare buy-in, according to CBO, is \$300 million over 5 years — half of what Medicare spends in a single day and only 0.003 percent of Medicare spending over 5 years. The Administration will work with Congress to close this small gap.
- **More participants:** Participation is estimated to be over 33 percent higher than what the Administration estimated — 410,000.
- **Lower cost:** The post-65 premium that people ages 62 to 65 would pay is only \$10 per month per year — \$6 per month and \$72 less per year than Administration estimates.¹

Medicare Buy-In, 1999-2003 (\$ in Billions, Fiscal Years)

| | | |
|----------------------------------|--------------|--------------------------------|
| Spending (5 years) | | |
| 62 to 65 Year Olds | 8.9 | |
| Displaced Workers | 0.5 | |
| Total | 9.3 * | |
| Premium revenue (5 years) | | |
| 62 to 65 Year Olds | -7.3 | |
| Post-65 | -0.2 ** | |
| Displaced Workers | -0.3 | |
| Total | -7.8 | |
| Net Costs | 1.5 | (Administration: 1.5) |
| Anti-Fraud Savings | | |
| Premium offset | -1.4 | |
| | +0.3 | (Administration: -2.4) |
| NET MEDICARE | +0.3* | (Administration: -0.8)* |

* Numbers may not sum to total due to rounding

** These premiums increase after the first 5 years as participants turn age 65

Participation when fully phased in: 410,000 (Administration: 300,000)

Premiums in 1999:

| | | |
|--------------------|-------------------------|-------------------------|
| 62 to 65 Year Olds | \$310 per month | (Administration: \$305) |
| Post-65 | \$10 per month per year | (Administration: \$16) |
| Displaced Workers | \$400 per month | (Administration: \$400) |

1. Although the base premium is slightly higher, overall premiums are much lower since the post-65 premium, which is \$6 less per month, would be paid every year until age 85.

INDIVIDUAL HEALTH INSURANCE AND OLDER AMERICANS

- **Older Americans are more likely to buy individual health insurance.**
 - About 9 percent of the 55 to 65 are covered by individual insurance -- nearly twice the proportion of younger people (5 percent). (CPS)
 - The proportion is even higher for people ages 62 to 64: about 12 percent. (CPS)
- **Individual health insurance can be costly.** Individual insurance is typically more expensive than group (employer-based) health insurance because the risk of enrolling a sick person is not spread across all employees and administrative costs are higher.
 - In 1994, nearly four times the proportion of people buying individual insurance paid premiums higher than \$500 relative to people covered by employer plans. (NHIS)
- **Few states regulate the individual insurance premiums.** Only 18 states place restrictions on how much insurers may charge, and in most states, insurers may:
 - Deny coverage altogether to people with certain types of pre-existing conditions
 - 33 percent of applicants to individual insurers were declined coverage because of a health condition, according to one GAO study.
 - Deny coverage of a particular health condition
 - In Florida, where only about half of people ages 62 to 65 are covered by employer plans, commercial individual policy insurers may both look back at person's health history indefinitely and exclude coverage of conditions like arthritis or severe emphysema. [Based on preliminary study by Alpha Center for Kaiser Family Foundation; please call for permission to cite]
 - Medically "underwrite" or base premiums on a person's health status. This practice is widespread in the individual insurance market.
 - One commercial Blue Cross plan, for example, marks up their standard rates by 20 percent for mild health problems (e.g., ulcer, gall bladder disease) and 50 percent for mid-level health problems (e.g., moderate emphysema). Since the standard rates are already age rated, this coverage is can be quite expensive. [Based on preliminary study by Alpha Center for Kaiser Family Foundation; please call for permission to cite]

DESCRIPTION OF THE HEALTH POLICIES FOR PEOPLE AGES 55 TO 65

MEDICARE BUY-IN

Who Is Eligible

- **People ages 62 to 65.** People are eligible if they:
 - Do not have access to employer sponsored or public insurance
 - Have exhausted their COBRA continuation coverage
 - Will qualify for Medicare when they turn age 65
- **Displaced workers ages 55 and older.** Displaced workers ages 55 to 61 and their spouse (regardless of age) are eligible if the workers:
 - Lost their job due to employer closing or downsizing or their position being eliminated (defined as being eligible for unemployment insurance) after 1/6/98.
 - Had health insurance on their previous job for at least one year (certified through the process created under the HIPAA to guarantee continuation coverage)
 - Have exhausted their COBRA continuation coverage
 - Will qualify for Medicare when they turn age 65

How Do They Enroll

- **People ages 62 to 65 years** would apply at Social Security Offices. They would bring proof of their age and eligibility for Social Security and Medicare when they turn 65.
- **Dislocated workers** would apply at HCFA regional offices (or Social Security Offices). They would bring with them proof of unemployment insurance eligibility and certification that they had insurance on their previous job for at least one year.
- **Time-limited enrollment option:** People eligible would have to enroll within a specified time period after the qualifying event. Once they disenroll, they cannot re-enroll unless they have a new, qualifying event.

How Much Do They Pay

- **People ages 62 to 65 years.** Participants would pay two premiums:
 - **Base premium:** The base premium would be paid monthly between enrollment and when the participant turns age 65. It is based on the average health costs for people in this age group. For 1999, it would be around \$300 per month (geographically adjusted). HCFA would bill participants for this premium (or Social Security would deduct this amount from the Social Security checks).
 - **Risk premium:** The risk premium is the part of the premium associated with the extra costs of participants. It would be paid monthly beginning at age 65 and depends on the number of years that the participant bought into Medicare. At the most, it will be around \$10 to 20 per month for each year of participation. Social Security would deduct this amount from Social Security checks. Participants would pay this premium until they turn age 85. They also have the option to pay off the full risk premium amount when turning age 65 rather than pay monthly.
- **Displaced workers.** Participants would pay one premium, the base premium plus an add-on for the extra risk of the group. This amount is about \$400 (geographically adjusted). Participants would pay this on a monthly basis. HCFA would bill participants for this premium.

How Long Are Participants Eligible

- **People ages 62 to 65 years** may disenroll at any time, but must pay the risk premium as though they were enrolled for the full year. For example, a person who disenrolls after 18 months would pay a risk premium upon turning age 65 based on two full years of participation. Disenrollees also have the option to pay off their risk premium all at once rather than paying monthly upon turning age 65. People in this group cannot re-enroll.
- **Displaced workers ages 55 and older** and their spouses may continue to buy into Medicare until they turn 62, when they become eligible for the more general buy-in, or until they gain access to employer-based insurance. They cannot re-enroll unless they are re-employed and displaced again.

Are Participants "Medicare Beneficiaries"

- **Benefits and most protections** are, for paying participants, the same as those of Medicare beneficiaries. Participants will have the choice of fee-for-service or managed care. Payments from participants and for participants will be run through the Medicare Trust Funds. However, Part B premiums will not be based on these Part B expenditures.
- **No Medicaid assistance** will be offered to participants for either the base premium or the risk premium.

COBRA OPTION FOR CERTAIN RETIREES

Who Is Eligible

- **Retirees and their dependents who:**
 - Were covered by an employer-sponsored retiree health plan
 - Had that coverage terminated after they retired after 1/6/98 [check].

How Do They Enroll

- **Through their former employer**, in the same way as current COBRA eligibles

How Much Do They Pay

- **125% of the group rate** for active employees.

How Long Are Participants Eligible

- **Retirees:** Until they turn 65 years old
- **Dependents:** For 18 months after their retiree turns 65 or dies

[The EEOC has tried to provide ADA protection to these individuals by issuing guidance advising that an employer who takes adverse action against an individual on the basis of genetic information relating to illness, disease, or other disorders regards that individual as having a disability within the meaning of the ADA. The guidance, however, is limited in scope and legal effect. It does not have the same legally binding effect on a court as a statute or regulation.]

HOW MANY AMERICANS WOULD BE AFFECTED BY LEGISLATION?

Legislation would protect all Americans from workplace discrimination based on genetic information. It would also protect future generations of American from discrimination based on the genetic information of their parents or grandparents.

DO MANY EMPLOYERS CURRENTLY REQUIRE GENETIC TESTING OF THEIR EMPLOYEES OR POTENTIAL EMPLOYEES? IF NOT, IS LEGISLATION REALLY NEEDED?

A 1989 survey of large businesses, private utilities, and labor unions found that 5 percent of the 330 organizations responding conducted genetic screening or monitoring of its workers. Another 1989 survey of 400 firms, conducted by Northwestern National Life Insurance, found that 15 percent of the companies planned, by the year 2000, to check the genetic status of prospective employees and their dependents before making employment offers.

There are also studies that show that Americans are being discriminated against based on their genetic information, including in the work force. While most employers are not inappropriately using this information, Americans should be assured that they will not be discriminated against on the basis of genetic information.

Moreover, the Human Genome Project is making rapid progress in their understanding of genetics. The use of genetic testing is only going to become increasingly common. The economic incentive to discriminate based on genetic information is likely to increase as genetic research advances and the costs of genetic testing decrease.

Federal legislation is essential to ensure that advances in genetic information can be fully utilized to promote health and safety and that individuals are protected against abuses like workplace discrimination.

Key Differences Between Medicare Early Access Proposal and the President's Proposal

BUY-IN

Rules for dropping out and reentry for people ages 62-65:

Budget: One-time opportunity for enrollment; no re-entry if you drop out
People must disenroll when gaining access to Federal or group health insurance

Bill: Can re-enter if you re-qualify
People may continue to participate if they gain access to Federal or group health insurance

Geographic adjustment:

Budget: Says that both the base and deferred premium are geographically adjusted
No limits on geographic adjustment

Bill: Only the base premium is geographically adjusted
The Secretary "shall limit the maximum premium under this paragraph in a premium area to assure participation in all areas in the United States".

Trust Funds:

Budget: No separate trust fund; part of Medicare Part A and B Trust Funds

Bill: Separate "Medicare Early Access Trust Fund", funded by premium payments and transfers from Medicare Trust Funds in the amount of the CBO estimated savings at the time of enactment of the new fraud and overpayment savings (and for years after the 10-year budget estimates, the amount of savings trended for aggregate expenditure growth).

COBRA

Qualifying Event:

Budget: Termination of retiree health coverage

Bill: Termination of "substantial reduction", defined as a decrease in the actuarial value of benefits of half or an increase in the premiums so that they exceed 125 percent of the active workers' premium

Dependent Coverage:

Budget: Like COBRA, 36 months after qualified retiree dies or turns 65

Bill: 36 months after qualified retiree dies or turns 65 or longer of the employer contract was longer

Buying into Medicare at 60

Americans ages 60 to 65 are one of the hardest to insure populations. They often lose their health care coverage to layoffs from downsizing, health-related issues or by choice and often do not have sufficient health care. One proposal would allow 60-65 year olds to buy into the Medicare program, helping provide much needed coverage for this group. Do you do you strongly support, somewhat support, somewhat oppose, or strongly oppose allowing uninsured 60-65 year olds to buy into Medicare?

- ✓ 85% support (57% strongly +28% somewhat)
- 10% oppose (5% strongly +5% somewhat)

23% say that this will attract the sickest most costly individuals from this age group, raising the costs of Medicare at a time when we are trying to devise ways to reduce the costs of this program. 75% say that although these people are the most needy, allowing them to buy into Medicare is better than letting them to go without health care or forcing them into the Medicaid system.

Long Term Care/Chronic Prescription Coverage

Currently Medicare does not cover long term care for chronically ill seniors. Would you do you strongly support, somewhat support, somewhat oppose, or strongly requiring Medicare managed care plans to cover long term care/ chronic prescription drugs?

Long Term Care

- ✓ 84% support (53% strongly +31% somewhat)
- 13% oppose (8% strongly +5% somewhat)

Chronic Prescription Drugs

- ✓ 82% support (52% strongly +30% somewhat)
- 11% oppose (7% strongly +4% somewhat)

64% say that coverage of long term care and prescription drugs for chronically ill seniors are necessary because of the skyrocketing costs of medicine and care. They argue that these benefits would only be required for the more expensive Medicare managed care plans and not the fee-for-service plans.

26% say that this will be an unfair burden on managed care plans and that it will attract the sicker beneficiaries to enter managed care.