

Medicare Buy-In File

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Not for Release

HIGHLIGHTS OF AARP MEDICARE "EARLY-BUY-IN" SURVEY
(ICR for AARP, National adult sample, age 18+ with age 50-64 oversampled.
Dec. 12-28, 1997, n=2,396. Margin of error for overall sample was +/- 2.8
percentage points and 4 percentage points for the 50-64 age group.)

Broad Approval for Concept of Medicare "Early-Buy-in" for those age 62-64 Without Other Insurance (All respondents). Overall, slightly more than three quarters of all respondents favored either "strongly" (54%) or "somewhat" (23%) allowing those age 62-64 who do not have insurance to receive Medicare benefits. Women (82%) were more in favor than were men (73%). There was widespread support for the "early-buy-in" concept across all age groups: support was highest among those age 18-49 (82%), and only slightly lower for those age 50-64 (77%). Although nearly two-thirds (63%) of respondents age 65+ favored this concept, this was the lowest favorability rating of any age group. There was also widespread support across all income and educational levels, although somewhat less among those earning \$50,000 or more a year (75%) and among college graduates (69%).

More African-Americans (89%) than whites (78%) favored the idea of a Medicare "early buy-in."

Willingness to Pay More in Taxes to Support the Idea of a Medicare "Early Buy-in" for those age 62-64 Without Other Insurance (All respondents). Those respondents who favored the idea of allowing those age 62-64 who do not have insurance receive Medicare benefits (77%) were asked whether they would favor or oppose it if that meant that their (own) taxes would go up. By the same proportions (77%) they (still) favored this idea. It should be stressed that this figure represents 60% of all respondents. Stated willingness to pay more in taxes to support this idea was almost uniformly high across age, gender, educational, and racial-ethnic lines.

Personal Experience With Loss of Health Insurance (Age 50-64 Only). More than a quarter (27%) of those 50-64 have had some direct or indirect experience with loss of health insurance as they neared retirement. This had happened to nearly one-tenth (9%) of the respondents; a fifth (19%) reported this had happened to someone they know. Such experience was pretty evenly widespread across gender, income, educational, and racial/ethnic lines.

Extent of Concern About Ability to Pay For Health Insurance (Age 50-64 Only). In the light of the above finding, it is not surprising that 7 in 10 respondents age 50-64 were either "very concerned" (47%) or "somewhat concerned" (22%) about being able to pay for health insurance upon early retirement or job loss before becoming eligible for Medicare. A high level of concern was expressed across gender, income, educational, and race-ethnicity lines, although women, the less educated, and those with lower incomes were more likely to be "very concerned."

Anticipated Sources of Insurance in Early Retirement (Age 50-64 Only). Respondents age 50-64 were asked what they would do if they were to retire or lose their job before they were eligible for Medicare and if they no longer had access to their employer's health benefits. Nearly one-half (46%) said they would purchase their own

health insurance, whereas 28% said they would be covered by their spouse's insurance, 22% stated they would be without any health insurance, and 5% did not know what they would do. There was an expected socio-economic context to these responses. Those at the highest income and educational levels were most likely to say they would purchase their own, whereas those at the lowest income level (<\$15,000 a year household income) were most likely (49%) to say they would be without any health insurance.

Perceived Willingness to Pay "Early-Buy-in" Medicare Premiums (Age 50-64 Only).

Those respondents age 50-64 who said they would purchase their own insurance (46% of all respondents in this age group) were asked whether they would purchase a policy if the cost were \$300, \$400, or \$500 a month. More than a third (38%) said they would not purchase health insurance on their own, if it cost at least \$300 a month. Most of those who would purchase insurance on their own would do even at the \$500 a month premium level (41%), compared to those who would pay as much as \$400 a month (48%), and those who would pay at least \$300 a month (62%). ~~It must be stressed that~~ when these figures are put in the context of the entire 50-64 age group, 30% would pay as much as \$300 a month, 22% would pay as much as \$400 a month, and 20% would pay as much as \$500 a month.

X Again, the socio-economic context of these responses is evident; only at the highest income level (\$50,000+) are these who said they would pay \$500 a month for their health insurance a majority (62%) of would-be purchasers.

DRAFT: Health Insurance for the People Ages 55 to 64

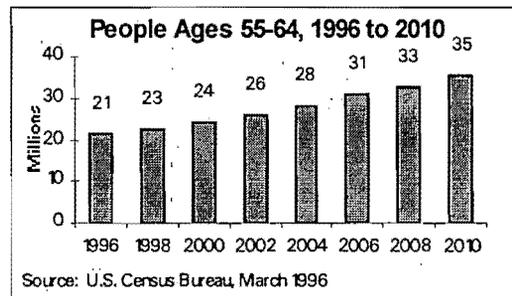
I. OVERVIEW

The number of “pre-65 year olds” — defined here as people between 55 and 65 years old — will increase dramatically in the next decade as the baby boom generation approaches retirement. Although the proportion of uninsured in this group is about equal to the national average, the number and proportion of pre-65 Americans without coverage has been increasing. Since the pre-65 year olds have more health problems, their health insurance is more expensive. This may limit their job mobility, since firms may avoid hiring older workers that risk raising their health costs. Lack of health insurance options may also prevent people from retiring early or shifting to part-time work as they approach retirement. Finally, the prevalence of retiree health insurance for people less than 65 years old has been declining in recent years. This suggests that the number of uninsured who are 55 to 64 years old will rise in the future.

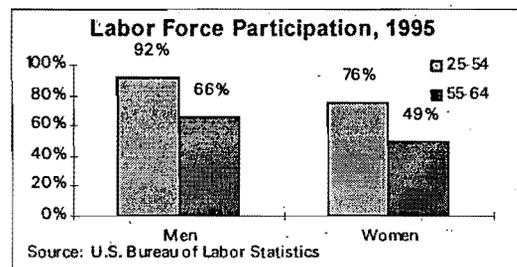
II. WHO ARE THE “PRE-65 YEAR OLDS”

The number of 55 to 64 year olds will rise rapidly in the next decade. In the United States, there are about 21 million people ages 55 to 64.

Today, they represent about 8 percent of the entire population. However, as the Baby Boom generation enters its 50s, both the number and proportion of pre-65 year olds will rise. As a result, the number of people between 55 and 64 years old is expected to increase to 30 million by 2005 and 35 million by 2010 — to 12 percent of the U.S. population, over a 50 percent increase.



Transition period for many. Americans ages 55 to 64 years old are more likely to have weaker connection to the labor force. About 12 million (57 percent) of the 21 million are active workers, compared to 83 percent of people 25 through 54 years old. Of the non-workers, about 60 percent or about 6 million are retired. In fact, about one-third of all retirees are younger than 65 years old. The remaining 3 million includes people who have never worked or are not seeking work. Some of these people, particularly men, are displaced workers (e.g., company closes down or position abolished). While 8 percent of displaced workers 25 to 54 years old leave the labor force, 25 percent of those aged 55 to 64 do.

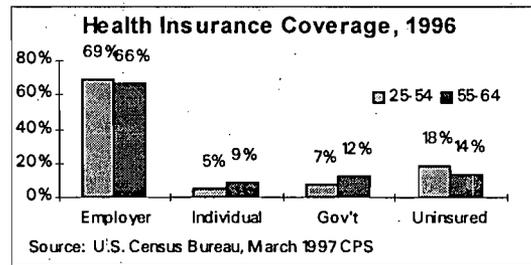


In addition to work transitions, the pre-65 year olds are more likely to experience changes in their marital status. One in five people ages 55 to 64 are widowed or divorced compared to one in eight people ages 25 to 54. Of women in this age group, 13 percent are widowed and 13 percent divorced. Since nearly half of women in this age bracket are non-workers, these events have profound effects on their economic status and likelihood of having health insurance.

Health status is worse, especially for retirees and non-workers. In addition to their changing work and marital status, the pre-65 year olds are distinct from younger groups because of their health. People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44. The probability of experiencing health problems such as heart disease, emphysema, heart attack, stroke and cancer is double that of people ages 45 to 54. Within this group, active workers are the healthiest, while early retirees and nonworkers have considerably worse health on average. This contrasts the usual image of early retirees as healthy individuals looking to extend their leisure time. Instead, poor health is a primary reason for early retirement.

III. HEALTH INSURANCE COVERAGE FOR PEOPLE AGES 55 TO 64

Most have health coverage. The proportion of 55 to 64 year olds covered by any type of health insurance (86 percent) is slightly more than the national average of 84 percent.



Different type of employer-sponsored insurance.

Like younger groups, the pre-65 year olds are mostly covered by employer-sponsored insurance (about 66 percent in 1996). However, this similarity masks the fact that about one-quarter of this coverage is for retirees and their spouses, not active employees. Also, a number of 55 to 64 year olds are covered through “COBRA” which allows those leaving firms with 20 or more employees to buy coverage through that firm for 18 months.

Nearly twice as likely to purchase individual insurance. Work transitions, which may limit access to employer-sponsored insurance, may account for the higher rate of coverage of the pre-65-year olds by individual insurance. Unlike employer-based health insurance, individual health insurance is usually less regulated and much more expensive for older and/or sicker people. For instance, the General Accounting Office found men aged 55 would have to pay two to three times more for the same policy as a 25 year old. People 55 to 64 years old who purchase individual insurance tend to have enough concerns about and problems with their health and financial resources to purchase this type of coverage.

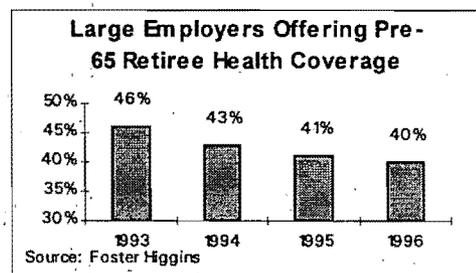
Higher rate of public coverage due to increased Medicare coverage. Medicare covers 6 percent of people 55 to 64 years old relative to 1 percent of 25 to 54 year olds. This reflects the increase in people with severe disabilities who become eligible for Part A Medicare after receiving 24 month of Social Security disability payments.

Who are the uninsured. The 3 million uninsured people ages 55 to 64 fall into three groups: workers, retirees, and non-workers. About 50 percent of the uninsured are workers: 20 percent in full-time jobs and 30 percent in part-time jobs. About 10 to 15 percent of uninsured in this age group are retired and mostly did not have access to retiree health coverage. They tend to have worked in small firms, in the manufacturing sector, lack a pension, and had low incomes while working. In addition, 15 to 20 percent are unemployed or displaced workers. Other distinctive characteristics of the uninsured include their poor health, relatively low income, and marital status. Nearly half of the uninsured ages 55 to 64 are widowed, divorced, separated or never married, foreclosing the option of getting work-based insurance through a spouse.

IV. TRENDS IN HEALTH COVERAGE FOR PEOPLE AGES 55 TO 64

Demographics assure increasing number of pre-65 uninsured. Both recent trends and demographics suggest that the number of uninsured who are 55 to 64 years old will increase. In recent years, the proportion of uninsured ages 55 to 64 has increased. After remaining stable at 12 percent from 1982 to 1992, it climbed to 14 percent in 1996. It is not clear whether this increase will continue in the future. However, even if this rate remains constant, the aging of the Baby Boom generation will shift the proportion of all Americans who are uninsured into this age group. By 2005, if the rate of uninsured remains unchanged, about 4.1 million people 55 to 64 year olds will lack insurance, a 25 percent increase over the current 3 million.

Continued lower access to retiree health coverage. A second trend affecting the coverage of people ages 55 to 64 is the recent decline in retiree health insurance. About one in five insured in this age group receives retiree health insurance. Retiree health insurance coverage expanded during the 1980s as down-sizing firms chose to encourage early retirement rather than lay off workers. However, the proportion of full-time workers in medium to large firms with access to pre-65 retiree coverage dropped from 43 percent in 1991 to 38 percent in 1995. The proportion of large employers who offer pre-65 retiree coverage fell from 46 percent in 1993 to 40 percent in 1996. For those with access to employer retiree coverage, costs have increased. The percent of employers who require their early retirees to pay premiums increased from 85 to 95 percent between 1991 and 1996. Although it is not clear that this trend will continue, it seems likely in light of the baby boom generation's approach to retirement.



V. RELATIONSHIP BETWEEN HEALTH COVERAGE AND WORK DECISIONS

Retiree health coverage may encourage retirement. Given the strong link between employment and health insurance, retirement decisions are likely affected by the availability and affordability of health coverage. Access to retiree health insurance may increase the likelihood of early retirement, by as much as 50 percent according to some estimates. This may be caused by large employer contributions to retiree health coverage, which essentially subsidize retirement. Similar large effects were estimated for the Health Security Act which included an employer mandate, community rating and subsidies for some early retirees; an estimated 350,000 to 600,000 people would retire early due to these policies. Lesser effects have been found for policies like COBRA that only offer small subsidies. Rather than providing a retirement incentive, such policies may remove barriers to affordable health insurance.

Other work effects. Retirement is only one of the job-related decisions affected by health insurance. The lack of insurance options causes "job lock", preventing pre-65 year olds from changing jobs for fear of losing insurance. This group may also face age discrimination in job changes since hiring them could raise premiums for some firms. Finally, the lack of affordable insurance may prevent older workers from taking "bridge jobs" to retirement: self-employment or part time work as they phase out of their careers. Thus, health insurance's role in labor force participation and productivity of the pre-65 year olds is complicated.

VI. ISSUES WITH POLICIES TO INCREASE HEALTH COVERAGE OPTIONS

Today, people approaching 65 years old have less, and probably declining, access to employer-sponsored insurance. Since this type of insurance is often the only affordable option for this group, the question is raised: are there policies that can improve insurance options? Ideas raised include extending the COBRA continuation coverage to "bridge" to Medicare eligibility and allowing a Medicare "buy in". These policies give the pre-65 year olds an option to join some "pool" which spreads their risk over many more people and lowers their average premium. Designing such policies is quite difficult, however, in light of the pre-65 year olds' poor health, existing coverage options, and policies' possible effects on work decisions.

Trade-offs between participation, adverse selection and retirement effect. The high health care costs of people ages 55 to 64 years old make the central question in any policy discussion: how much is the premium? The amount of the premium relative to other available policies determines how many and what type of people will take the option. To simplify the issue, assume that there are two options: setting the premium at an actuarially fair price and subsidizing the premium to make it more affordable.

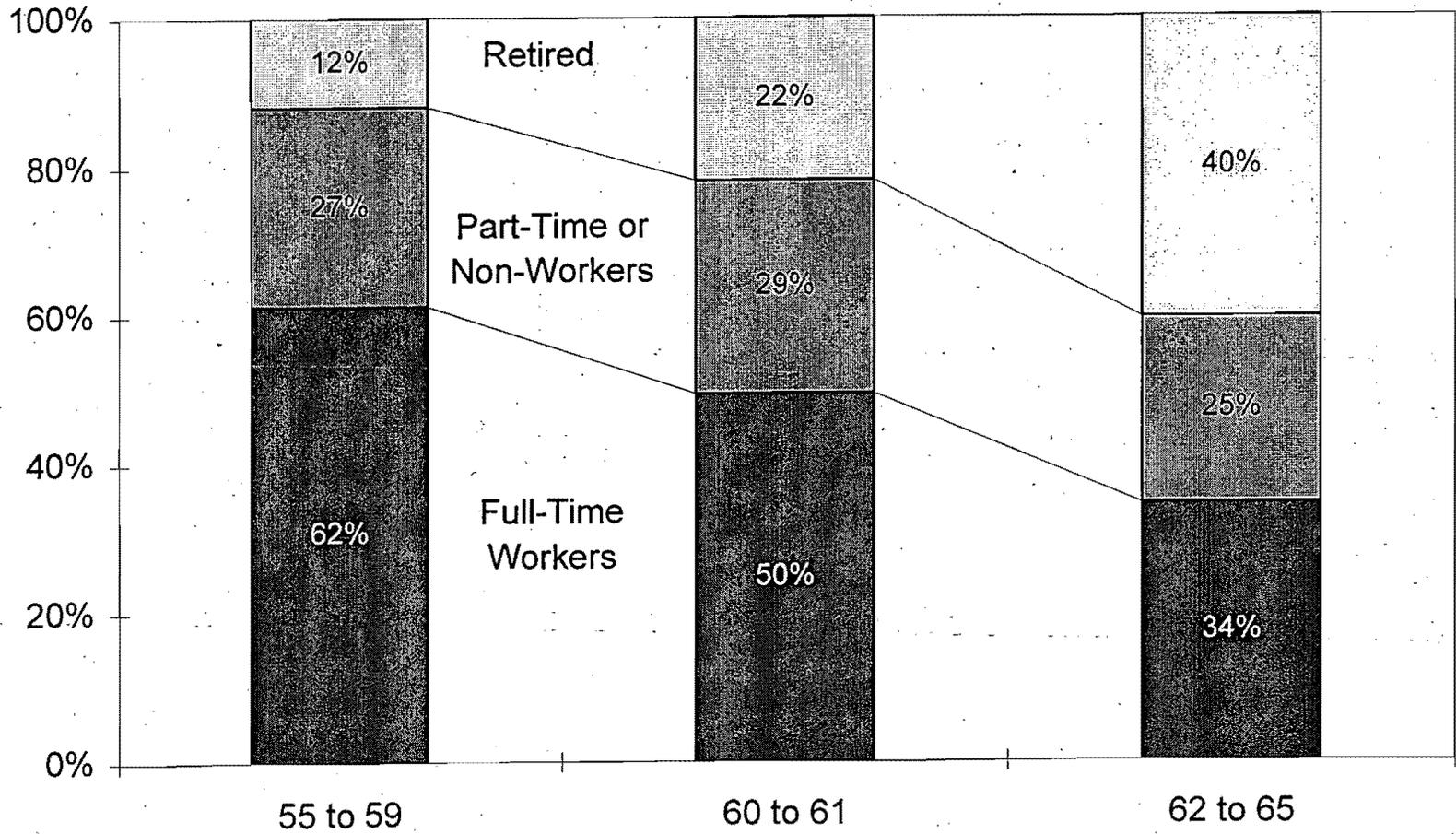
A fairly priced policy would probably cost less than an individual policy for sick people but more than an individual policy for healthy people and COBRA coverage. This means that it would attract the sicker part of the individual market and the higher income or sick uninsured who can afford and/or need this coverage. It could also provide coverage for workers either who are less healthy and would like to retire or who want to change jobs but could not previously because of job lock. It might not, however, cover many uninsured since one-quarter have incomes below 200 percent of poverty and probably could not afford an unsubsidized policy. Thus, policies without premium assistance would likely cover fewer but more needy people. This "adverse selection" could be costly to insurers and other people covered by the policy.

On the other hand, if a policy includes subsidies to lower premium costs, it would likely attract healthier and a larger number of participants since the premium would be lower than what is offered to most in the individual market. While more of these participants would be uninsured, a number could be individuals who previously had private insurance but for whom this option is less expensive ("crowd out"). This could also have a larger effect on worker's job decisions, potentially accelerating the decline of retiree health coverage and increasing early retirement. This could make the cost of subsidies extremely high, most likely outweighing the benefits from adding healthier people to the pool and reducing adverse selection.

V. CONCLUSION

Policy options probably are needed to assist people ages 55 to 64 afford health insurance. Despite the high coverage rate of 55 to 64 year olds, the type and stability of that coverage is questionable. And, the need for affordable insurance will grow as the proportion of Americans in this age group swells.

1. Older People Are Less Likely to Work



Similarly, the proportion of uninsured who are retired increases from 12% for people ages 55 to 59 to 43% for people 62 to 65

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 than 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 can be quite expensive for a healthy person. [Based on preliminary study by Alpha Center for Kaiser Family Foundation; please call for permission to cite]

United States General Accounting Office

GAO

Report to the Chairman, Committee on
Labor and Human Resources, U.S.
Senate

November 1996

PRIVATE HEALTH INSURANCE

Millions Relying on Individual Market Face Cost and Coverage Trade-Offs



G A O
75 years
1921 - 1996

GAO/HEHS-97-8

Executive Summary

urpose

While most Americans obtain their health insurance coverage through employer-sponsored group plans or government programs like Medicare and Medicaid, a significant minority purchase health insurance individually for themselves and their families. These participants in the individual health insurance market primarily rely on their own resources to obtain information on insurance options and to finance their health coverage.

Integrating the individual market into legislative proposals for reforming health insurance has been a thorny issue at both the state and federal levels. In part, this has stemmed from the paucity of information on the nature of this market and the characteristics of its participants. Accordingly, the Chairman of the Senate Committee on Labor and Human Resources asked GAO to report on

- the size of the individual market, recent trends in it, and the demographic characteristics of its participants;
- the market structure, including how individuals access the market, the prices, other characteristics of health plans offered, and the number of individual carriers offering plans; and
- the insurance reforms and other measures states have taken to increase individuals' access to health insurance.

Background

Participants in the individual market include self-employed people; people whose employers do not offer health insurance coverage; people not in the labor force; early retirees who no longer have employment-based coverage and are not yet eligible for Medicare; and people who lose their jobs and have exhausted or are ineligible for continuation of coverage. There is considerable controversy regarding simple questions such as how many people purchase individual insurance. Considerable variation in how the market operates and is regulated at the state level further complicates the picture.

To fill this information void, GAO analyzed data from the Bureau of the Census and other sources, and interviewed representatives of insurance carriers and state regulators in seven states. These states—Arizona, Colorado, Illinois, New Jersey, New York, North Dakota, and Vermont—were selected on the basis of variations in such characteristics as their overall population and the extent of individual insurance market reforms passed by the state. In some of these states, GAO interviewed relevant industry and consumer representatives as well. GAO also obtained

information on those states that passed individual insurance reforms from 1990 through 1995 and those states that undertook other measures to increase individuals' access to health insurance.

Results in Brief

The family farmer, the recent college graduate, the early retiree, and the worker for a firm that chooses not to offer health insurance coverage are among those who are not generally covered in a voluntary, employment-based insurance market. About 10.5 million Americans under 65 years of age (4.5 percent of the nonelderly population) relied on private individual health insurance as their only source of health coverage during 1994. Individual insurance is most common in the Mountain and Plains states, with at least 10 percent of the nonelderly in Iowa, Nebraska, North Dakota, and South Dakota having individual insurance. Also, individual insurance is more prevalent among particular segments of the labor force, with nearly 20 percent of the self-employed and 17 percent of farm workers being covered by individual insurance. When compared with those enrolled in employer-sponsored group coverage, individual health insurance enrollees are, on average, older and have lower income; however, they are similar in their self-reported health status, with three-quarters reporting their health condition as being very good or excellent.

The manner in which individuals access the individual insurance market and the wide range of available products differentiate this type of coverage from employer-sponsored coverage. Unlike the latter, which is generally obtained, administered, and largely financed by the employer, individuals must identify and evaluate multiple health insurance products and then obtain and finance the coverage on their own. Recognizing the importance of offering affordable options to individuals with different economic resources and health needs, carriers offer a wide range of health plans with a variety of cost-sharing options. Individuals in the states GAO visited could select products from no fewer than 7 to over 100 carriers, with deductibles ranging from \$250 to \$10,000 or more. Typically, higher deductibles translate to lower premiums but at increased financial risk to the consumer.

In the majority of states, which permit medical underwriting, individuals may be excluded from the private insurance market, may only be able to obtain limited benefit coverage, or may pay premiums that are significantly higher than the standard rate for similar coverage. Unlike employer-sponsored coverage for which risk is spread over the entire

group, carriers in these states determine premium price and eligibility on the basis of the risk indicated by each individual's demographic characteristics and health status. Carriers GAO visited declined coverage to up to 33 percent of applicants because they had conditions such as acquired immunodeficiency syndrome (AIDS) and heart disease. Moreover, if they do not decline coverage, carriers may permanently exclude from coverage certain conditions or body parts, or charge significantly higher premiums to those expected to incur large health care costs. For example, GAO found that conditions such as chronic back pain and anemia are commonly excluded from coverage or result in higher premiums.

At least 43 states have sought to increase the health coverage options available to otherwise uninsurable individuals, although these options may cost considerably more than the standard rate. Twenty-five states have created high-risk insurance programs, while many states have passed individual market insurance reforms. In eight states and the District of Columbia, all individuals may be guaranteed coverage through a carrier that acts as insurer of last resort. In at least seven states, no safety net exists to provide unhealthy individuals access to health insurance. At the federal level, the recently passed Health Insurance Portability and Accountability Act of 1996 also contains provisions intended to enhance access to the individual insurance market.

Although it is far too early to assess all of the effects of the act, it does include provisions that explicitly deal with both the individual and employer-sponsored insurance markets. Provisions directly affecting the individual market include portability and guaranteed renewal. The success of further efforts to improve access, affordability, and quality of health insurance for all Americans will depend largely on continued growth in the understanding of both of these health insurance markets.

Principal Findings

Individual Insurance Is an Important Source of Coverage for Many Americans

Individual health insurance covers a significant minority of the U.S. population. For 10.5 million Americans under 65 years of age—4.5 percent of the nonelderly population—individually purchased health insurance was their only source of health coverage in 1994, according to GAO's analysis of the 1995 Current Population Survey. Another 8.6 million nonelderly people (3.7 percent) were covered by individual plans and we

10.5 = NA ONLY
8.6 = NA + OTHER

also covered by an employment-based plan or one provided through a government program either concurrently or at different periods during the year. Because of the often transient nature of this market, some of these people may have held individual insurance temporarily and then had another source of coverage during the remainder of the year, whereas others may have held both types of health coverage simultaneously. Because many of these other sources of coverage may be narrower supplemental policies rather than comprehensive health plans, GAO focused its data analysis on the 10.5 million people who exclusively held individual insurance in 1994. Dental? MM?

The individual market insures a substantial share of the population in some states, particularly in the Mountain and Plains states. In North Dakota, nearly 14 percent of the population relies on the individual market as its only source of health coverage. In Iowa, Montana, Nebraska, and South Dakota, the proportions of the population participating in the individual market are all twice the national average. Also, most adults who purchase individual insurance are employed and often work in particular industries. For example, about 17 percent of farm workers and 7 percent of construction workers rely on this market for coverage. In contrast, less than 2 percent of workers in the durable goods manufacturing and public administration sectors purchase individual plans.

Those with individual health insurance tend to be older than those with employment-based coverage but are similar in their self-reported health status. People between 60 and 64 years of age are nearly three times as likely to have individual insurance as those 20 to 29 years old. Also, a disproportionate share of early retirees and people who have been widowed participate in the individual market—9.8 percent and 9.2 percent, respectively. Only 6 percent of those with individual insurance reported their health condition as fair or poor, while three-fourths indicated that their health was at least very good—the same proportion as those with employment-based coverage. People with disabilities are less likely to purchase individual coverage, reflecting greater reliance on government-sponsored health insurance programs and possibly also their higher costs for private coverage and medical underwriting and preexisting condition limitations.

**Multiple Points of Access
and Product Choices
Distinguish the Individual
From the
Employer-Sponsored
Insurance Market**

The many ways in which consumers access the individual insurance market and the wide range of products available to them stand in stark contrast to the limited options in the employer-sponsored group insurance market. Employees are typically offered one plan or a choice among a few different health plans and cost-sharing options. Plans are typically selected and administered by an employee benefits manager and are largely financed by the employer.

In contrast, individuals must identify and compare health insurance products and then obtain and finance the products chosen on their own. An individual may access the market in a variety of ways, such as by contacting an insurance agent or a carrier directly in response to advertising or name recognition, obtaining conversion coverage, or joining a business organization or other group that pools the purchasing power of a number of individuals. For example, trade associations and chambers of commerce may permit self-employed individuals to participate in their small-employer pools. Other arrangements make use of individuals' common affiliation to provide access to coverage. For example, the largest individual market carrier in North Dakota sells about 76 percent of its individual coverage through a pooled "bank depositors" plan.

Individuals typically may choose from products offered by multiple carriers. In states GAO visited, individuals could choose from plans offered by at least 7 carriers in Vermont to well over 100 carriers in Arizona, Colorado, and Illinois. Blue Cross and Blue Shield plans played a prominent role in the individual markets of most of the states GAO visited. And finally, the extent of managed care in this market lags behind that of other insurance market segments, although growth has accelerated recently.

Recognizing that affordability is a paramount concern in this market and that individuals have different health needs and economic resources, carriers offer a variety of products with a wide range of cost-sharing options. Healthy consumers who do not expect to need medical care are more likely to demand products with the lowest possible monthly premiums. These products will typically have comparatively high copayments or deductibles. Other individuals may only be able to afford coverage with high cost-sharing options, regardless of their health. If they can afford to do so, consumers who anticipate needing medical care may be willing to pay higher premiums to protect themselves from large out-of-pocket costs. Products offered in the states GAO visited typically included a wide range of cost-sharing alternatives. Most commonly

selected by consumers were deductibles ranging from \$250 to \$2,500, although deductibles of \$5,000, \$10,000, and higher were also available.

Some Consumers Are Denied Individual Coverage Because of Their Health Status

In the majority of states, which permit medical underwriting, individuals may be denied coverage in the private insurance market, have available to them only limited benefit coverage, or pay considerably more than the standard rate for coverage, depending on their demographic characteristics and health status. Unlike employer-sponsored coverage for which risk is spread over the entire group, carriers in these states may assign rates to each individual on the basis of the risk indicated by characteristics such as age, gender, location, and smoking status. These rates may then be adjusted on the basis of a carrier's determination of the applicant's health status.

A carrier may deny coverage to an applicant determined to be of substandard health. The declination rates for carriers GAO visited range from zero in states where guaranteed issue is required to about 33 percent, with carriers typically denying coverage to about 18 percent of all applicants. Individuals with serious health conditions such as AIDS and heart disease are virtually always denied coverage, as those with such non-life-threatening conditions as chronic back pain and attention deficit disorder may be. At least two carriers GAO visited almost always decline any applicant who smokes.

Carriers may also offer coverage that excludes a certain condition or part of the body, or offer coverage only at a higher, nonstandard rate. Almost all the indemnity insurers GAO visited add riders to policies to exclude certain conditions either temporarily or permanently. A person with a knee injury or glaucoma may have all costs associated with treatment of those conditions excluded from coverage. More chronic conditions such as asthma may also be excluded. Some carriers GAO visited will accept applicants with some health conditions but will charge a higher premium to cover the higher expected costs. For example, one Illinois carrier charges a 100-percent surcharge over the standard premium rates to about 2 percent of its individual enrollees determined to be of substandard health.

State and Federal Initiatives Attempt to Expand Accessibility

At least 43 states have attempted to increase the health coverage options available to otherwise uninsurable individuals, although these options may be available only at a considerably higher price. Currently, about 25 states

have high-risk insurance pools that ensure individuals who need coverage can obtain it, although this coverage generally costs 50 percent more than the standard rate and may not always be available. Individuals who have been rejected for coverage by at least one carrier generally qualify for a high-risk pool.

Eighteen of the 25 states that passed some type of individual insurance reform between 1990 and 1995 attempt to limit the range over which premium rates may vary or the characteristics used to determine the rates. While New Jersey, New York, and Vermont require carriers to provide coverage to any individual who applies and to use community rating with limited qualification to determine premium rates, most other states still allow carriers to deny coverage to unhealthy individuals and permit premium rate variations of up to 300 percent or more. In eight states and the District of Columbia, the local Blue Cross and Blue Shield plan offers at least one product to individuals on an open enrollment basis as the insurer of last resort. Absent rating restrictions, however, carriers are not necessarily limited in the premium prices they charge for these plans. In at least 10 states, some individuals may have no access to insurance coverage.

At the federal level, the recently passed Health Insurance Portability and Accountability Act of 1996 will affect the individual health insurance market. The act guarantees access to the individual market to consumers with qualifying previous group coverage and guarantees the renewal of individual coverage. For self-employed individuals, the act authorizes the use of federally tax-deductible medical savings accounts and increases the deductibility of health insurance.

Recommendations

This report contains no recommendations.

Agency Comments

State insurance regulators GAO visited and the National Association of Insurance Commissioners reviewed a draft of this report and provided technical suggestions. GAO incorporated their changes where appropriate.

DRAFT

Cases of "Broken Promises" for Retirees

Boisvert et al v. American Service Bureau Inc. (1996)

This suit was brought by early retirees of defendant American Service Bureau (ASB) in federal district court in northern Illinois. In 1989 ASB was purchased by another company resulting in the relocation of most of the company offices from Illinois to Massachusetts. Most company staff were not asked to relocate and their employment was terminated. Plaintiffs, eight early retirees who were members of ASB's management team, were offered by ASB in 1991 and 1992 to participate in ASB's Early Retiree Program. The Program allowed employees between age 55 and 65 to retire early if they had accumulated 10 or more years of service with ASB. Under the terms of the Program each plaintiff received oral and written representations that they would be able to retire and continue to receive employee welfare benefits (group medical, dental and life benefits) on the same terms as active ASB employees until age 65, as long as the policy remained in force, unless they failed to pay premiums, accepted employment with a direct competitor of ASB or went to work for another employer where similar group insurance was available. When each plaintiff retired they executed a Release where they agreed to release ASB of any discrimination claims and not to accept employment with a competitor in exchange for certain severance payments. In November 1994 ASB notified the plaintiffs that the Early Retiree program would be terminated effective January 1995.

In the lawsuit the plaintiffs made several allegations including the argument that by signing the Release ASB was contractually obliged to provide these benefits until they were 65, and that they relied on this to their detriment. The court ruled against the plaintiffs saying that ASB did not condition the receipt of early retiree benefits on plaintiffs' signing the Release. ASB only contracted in the Release to provide the plaintiffs with severance payment. The court also found that the summary plan description, letters to plaintiffs describing the early retirement program and the terms of the contract between ASB and the insurance company from whom ASB purchased the benefit clearly state that coverage would terminate when the group policy terminated.

Center et al v. First International Life Insurance (1997)

In this case a group of retirees (some of them early retirees) brought suit against their former employer who they alleged promised them lifetime health care benefits. The Plaintiff's employer, First International, was going through corporate restructuring in the early 1990s and eliminated several positions including those held by plaintiffs. The plaintiffs retired relying on the oral and written promises of their employer that their health benefits would continue. When First International was bought out by Standard Management Company all benefit programs were terminated. Plaintiffs then sued. The Court held against the plaintiff's on most of their claims, holding that the oral and written statements relied on by plaintiffs were contrary to the unambiguous language of the plan that stated that benefits could be terminated at any time.

Pirelli Armstrong case

This lawsuit was brought by an early retiree against his former employer, the Pirelli Armstrong Tire Company. After retiring early and with medical insurance through Pirelli, Pirelli announced that it was terminating all health benefit for retirees due to rising health care costs. The plaintiff has filed suit alleging that Pirelli promised him lifetime health benefits. This case is pending. An earlier case brought by a local union against Pirelli for the same claim resulted in a federal court decision in favor of the plaintiff. The court held that the employer had no right to terminate the benefits.

Frahm v. Equitable Life Assurance Society of the United States (1997)

In 1997, six retired employees of the Equitable Life Assurance Society (Equitable) sued Equitable for breaching its promises to provide fixed cost lifetime post-retirement health benefits. Equitable, an insurance company that does business nationally, had employed the retirees at different agencies. Many of the retirees claimed that they had based their decision to retire early in part on Equitable's employees' assurances that their benefits during retirement would be "locked in" or "frozen" at the level they had been during employment.

At the time they retired in 1991, Equitable's health insurance was provided through an indemnity plan and deductible levels were fixed. In 1992, Equitable announced that it would be implementing a cost-saving managed care program called CHOICE for retired employees' health insurance coverage, as it had already done for current employees. Continued coverage under the CHOICE plan for the retirees involved greater cost-sharing. At the time the retirees brought their suit, they estimated that the additional cost of continuing coverage under the CHOICE plan ranged from \$2,000 to \$12,000 per individual, or a total of \$25,100 to \$29,100 in increased health costs for all the retirees who brought suit.

The Federal District Court for the Northern District of Illinois ruled against the retirees, finding they had no right to the fixed benefits they claimed because the plan documents had always clearly stated Equitable's right to amend the plan or its terms at any time.

Pabst Brewing Company, Inc. v. Corrao (1997)

Pabst Brewing Company had promised to provide health insurance coverage to its retired employees as part of the collectively bargained agreement. The retirees understood this contractual provision to mean that benefits would be provided for their lifetime and would continue for their dependents six months after their death. However, in 1996 Pabst announced that it would discontinue the health benefits of the approximately 800 retirees. The retirees filed an action in federal district court to enjoin Pabst from terminating their benefits, arguing that Pabst's repeated assurances of continued coverage in other contexts should be considered as evidence of the company's intent to be bound by its promises. The Federal District Court for the Eastern District of Wisconsin ruled against the employees, finding that the terms of the collective bargaining agreement did not require Pabst to continue to offer coverage after the agreement had expired.

GAO

Report to the Honorable
Jerry Kleczka, House of Representatives

BROKEN PROMISES

July 1997

RETIREE HEALTH INSURANCE

Erosion in Employer-Based Health Benefits for Early Retirees

X-RAY AT RDS
USSS



**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 surveys 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 age 55 and older, the Labor Department reported that the number of individuals who continued to receive employer-based health benefits in 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.

Background

Although some Americans purchase health insurance individually for themselves or their dependents, most receive coverage as a benefit through their employer. The former is commonly referred to as individual coverage and the latter as employer-based group coverage. Complementing these two types of private insurance¹ are public programs including Medicaid for the poor and Medicare for the elderly and disabled. With the exception of the long-term disabled, Medicare is only available to individuals aged 65 and older. The lack of affordable health insurance for older Americans—either employer based or purchased individually—was a key factor leading to the establishment of Medicare in 1965.³

The availability of employer-based health benefits is of particular concern to older Americans approaching or at retirement age—individuals who consume a higher level of medical services and whose health care costs are commensurately more expensive. For those under age 65 and not yet eligible for Medicare, the decision to retire may turn on the continuation of health benefits by an employer. For those 65 or older living on a fixed income, employer-based benefits may help fill coverage gaps in Medicare such as deductibles and copayments or the lack of a prescription drug benefit. (See app. II for a description of Medicare benefits and how they differ from employer-based coverage.) In 1994, about 75 percent of retirees were over age 65 and thus employer-based coverage supplemented Medicare benefits; the remaining 25 percent were ineligible for Medicare

¹A significant portion of employer-based private insurance is provided by the public sector. The federal government covers civilian workers through its Federal Employees Health Benefit Program, while the Department of Defense operates a health care system for military personnel. Similarly, state and local governments also provide employee health benefits. About 17 percent of workers aged 18 to 64 have coverage provided through a public sector employer.

²Other public sources of health services include the Indian Health Service, the Department of Veterans Affairs, and public clinics and hospitals.

³Insurance coverage as part of a retirement benefit was the exception, not the rule, and private insurance companies had shown a reluctance to offer coverage to older persons even when these individuals could afford it. See Marilyn Moon, *Medicare Now and in the Future* (Washington, D.C.: Urban Institute Press, 1993), p. 25.

January 6, 1998

TO: Stuart Altman
Laura Tyson
Bruce Vladeck
Tony Watson (via David Abernathy)

FROM: Chris Jennings and Gene Sperling

RE: BACKGROUND ON THE PRE-65 YEAR OLD POLICIES

Per our conversation yesterday, here is the background information on the policies. The only paper that is public is the two-page fact sheet. The rest are included for your information only.

As you'll see, there is not an extraordinary amount of policy details in the attached documents; it includes mostly background facts. This is honestly because we expected to have a few more weeks to iron out these details before announcing the policy. However, our experience has been that this might be positive because Congress has its own ideas -- and often good ideas -- on how some of these specifics should be shaped.

Please call us or Jeanne Lambrew (202/456-5377) for any further information or clarification. And, as we said yesterday, welcome aboard.

Insurance Status 55-59 Year Olds

CPS Data

INDIVIDUAL

1997 CPS

Age	ESI, Own	ESI, Not Own	Medicare	Medicaid	VA	Other	Not Insured	Total
55-59	6,092,000	1,883,000	485,000	527,000	192,000	905,000	1,495,000	11,579,000
60-61	1,966,000	630,000	279,000	189,000	102,000	352,000	577,000	4,095,000
62-64	2,644,000	817,000	496,000	232,000	123,000	588,000	902,000	5,802,000
Total	10,702,000	3,330,000	1,260,000	948,000	417,000	1,845,000	2,974,000	21,476,000

Age	ESI, Own	ESI, Not Own	Medicare	Medicaid	VA	Other	Not Insured	Total
55-59	53%	16%	4%	5%	2%	8%	13%	100%
60-61	48%	15%	7%	5%	2%	9%	14%	100%
62-64	46%	14%	9%	4%	2%	10%	16%	100%
Total	50%	16%	6%	4%	2%	9%	14%	100%

1996 CPS

Age	ESI, Own	ESI, Not Own	Medicare	Medicaid	VA	Other	Not Insured	Total
55-59	6,072,000	1,875,000	449,000	470,000	186,000	760,000	1,488,000	11,300,000
60-61	2,031,000	649,000	248,000	163,000	109,000	360,000	499,000	4,059,000
62-64	2,678,000	795,000	500,000	213,000	199,000	514,000	827,000	5,726,000
Total	10,781,000	3,319,000	1,197,000	846,000	494,000	1,634,000	2,814,000	21,085,000

Age	ESI, Own	ESI, Not Own	Medicare	Medicaid	VA	Other	Not Insured	Total
55-59	54%	17%	4%	4%	2%	7%	13%	100%
60-61	50%	16%	6%	4%	3%	9%	12%	100%
62-64	47%	14%	9%	4%	3%	9%	14%	100%
Total	51%	16%	6%	4%	2%	8%	13%	100%

CPS INSURANCE = No Clear Trends

55-59 Year Olds

Ins. Status	1990	1991	1992	1993	1994	1995	1996	1997
ESI, Own	48%	48%	48%	48%	50%	54%	54%	53%
ESI, Not Own	19%	20%	20%	20%	18%	17%	17%	16%
Medicare	4%	3%	4%	4%	4%	4%	4%	4%
Medicaid	3%	4%	4%	4%	4%	4%	4%	5%
VA	3%	3%	3%	2%	2%	2%	2%	2%
Other	10%	9%	10%	9%	10%	7%	7%	8%
Not Insured	12%	13%	12%	13%	13%	13%	13%	13%
Total	100%	100%	100%	100%	100%	100%	100%	100%

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60-61 Year Olds

Ins. Status	1990	1991	1992	1993	1994	1995	1996	1997
ESI, Own	46%	46%	46%	48%	48%	49%	50%	48%
ESI, Not Own	19%	18%	18%	16%	16%	17%	16%	15%
Medicare	6%	5%	5%	5%	5%	5%	6%	7%
Medicaid	3%	3%	4%	4%	4%	4%	4%	5%
VA	4%	4%	3%	2%	2%	3%	3%	2%
Other	12%	11%	12%	10%	10%	9%	9%	9%
Not Insured	10%	13%	12%	14%	14%	13%	12%	14%
Total	100%	100%	100%	100%	100%	100%	100%	100%

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62-64 Year Olds

Ins. Status	1990	1991	1992	1993	1994	1995	1996	1997
ESI, Own	43%	42%	43%	41%	42%	44%	47%	46%
ESI, Not Own	17%	17%	15%	17%	15%	15%	14%	14%
Medicare	7%	8%	8%	9%	8%	8%	9%	9%
Medicaid	4%	3%	3%	3%	3%	4%	4%	4%
VA	4%	3%	3%	3%	4%	4%	3%	2%
Other	14%	15%	14%	14%	13%	11%	9%	10%
Not Insured	12%	12%	13%	13%	14%	15%	14%	16%
Total	100%	100%	100%	100%	100%	100%	100%	100%

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For 33 years, Medicare has been more than a program -- it has been the way we honor our duty to our parents, and build the future for our children. When Medicare was first passed into law, President Johnson said "it proved that the vitality of our democracy can shape the oldest of our values to the needs and obligations" of changing times. Once again, we are faced with changing times -- a new economy, changing the way we live and work ... new technologies and medical breakthroughs, holding out hope for longer, healthier lives ... and a new century, brimming with promise. The values remain the same -- but these new times demand that we find new ways of creating opportunity for all Americans.

America today has a new economic strategy designed to expand opportunity and strengthen our families in changing times -- a strategy rooted in fiscal responsibility, expanded trade, and unprecedented investments in our people. Yesterday, I announced that the budget that I will submit to Congress in three weeks will be a balanced budget for 1999. It will be the first balanced budget in 30 years. And it is within this balanced budget that we will expand access to health care for millions of Americans.

Last summer, with the balanced budget agreement I signed with Congress, we took action to extend the life of the Medicare Trust Fund until at least 2010, and we appointed a Medicare Commission to make sure that Medicare can meet the needs of baby boomers.

We are taking action to root out fraud and abuse in the Medicare system, assigning more prosecutors, shutting down fly by night home health care providers, and taking steps to put an end to overpayments for prescription drugs. Since I took office, our crackdown on Medicare fraud has saved over \$20 billion in health care claims -- tax payer money that would have been wasted, but has gone instead to provide quality health care for some of our most vulnerable citizens.

I will continue to do everything I can to ensure that the Medicare system that served our parents so well will be there for our children.

And that means bringing Medicare into the 21st Century in a fiscally responsible way that recognizes the changing needs of our people in a new era. We know that the new economy, as it creates extraordinary opportunity, can also create new uncertainty, for some families more than others. The threat of losing health care coverage is one of the greatest fears that American families face -- and far too many people between the ages of 55 and 65 don't have health insurance. Some lose their health care coverage when their spouse becomes eligible for Medicare and loses his or her health insurance at work. Some lose their coverage when they lose their jobs because of downsizing or lay-offs.

Others lose their insurance when their employers unexpectedly drop their retirement health care plans. Still others hold on to their health insurance, but at a rate so high that it threatens their financial security.

These people have spent their lifetimes working hard, supporting their families, and contributing to society. And just at the time they most need health care, they are falling through the cracks of our health care system, subject to higher premiums, or even denial of coverage. Today, I am proposing a plan that recognizes these new conditions, and takes action to expand access to health care to hundreds of thousands of Americans.

First, for the very first time, people between the ages of 62 and 65 will be able to buy into the Medicare program at a fair premium that for many is far more affordable than private insurance -- but firmly based in the actual costs of insuring people in this age group.

This is an entirely new way of adapting a program that has worked in the past to the needs of the future. It is a fiscally responsible plan that places no new burdens on Medicare. It is financed by principally by premiums and by the money we save from cracking down on Medicare fraud and abuse. This plan will provide access to health care for hundreds of thousands of Americans. And I believe it is the right thing to do.

Second, statistics show that older Americans who lose their jobs are much less likely to find new employment -- and far too often, when they lose their jobs, they lose their health insurance. Under this proposal, people between the ages of 55 and 65 who have been laid off or displaced will also be able to buy into Medicare early, protecting them against the debilitating cost of unforeseen illness.

Third, we know that in recent years, some employers have walked away from their commitments to provide retirement health benefits to long-time, loyal employees. Under our proposal, retirees who lose their health coverage, between the ages of 55 and 65, will be allowed to buy into their former employers' health plans until they qualify for Medicare.

Taken together, these steps will help take American health care into the 21st Century -- providing more American families with the health care they need to thrive, maintaining the fiscal responsibility that is giving more Americans the chance to live out their dreams, and shaping our most enduring values to meet the needs of changing times.

Thank you and God bless you.

**PRESIDENT WILLIAM J. CLINTON
REMARKS FOR MEDICARE EVENT
THE ROOSEVELT ROOM
January 6, 1998**

Acknowledgments: VP Gore, Sec. Shalala, Sec. Herman, Members TK

As Ruth Cain just made so clear, for many Americans, access to quality health care can mean the difference between a healthy, productive life and the burdens of illness, worry, and financial strain. Today, we are taking action to provide some of our most vulnerable older Americans with important new health care options that give them the security they deserve. ~~lets them buy into~~ ~~one of our nation's greatest achievements: Medicare.~~

For 33 years, Medicare has been more than a program -- it has been the way we honor our duty to our parents, and build the future for our children. When Medicare was first passed into law, President Johnson said "it proved that the vitality of our democracy can shape the oldest of our values to the needs and obligations" of changing times. Once again, we are faced with changing times -- a new economy, changing the way we live and work ... new technologies and medical breakthroughs, holding out hope for longer, healthier lives ... and a new century, brimming with promise. The values remain the same -- but these new times demand that we find new ways of creating opportunity for all Americans.

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