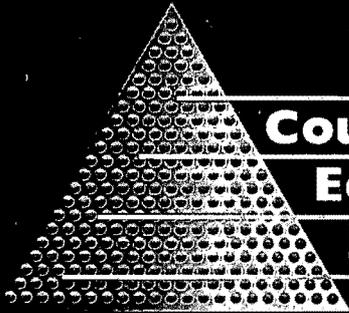


Medicare Buy-In RPL



**Council on the  
Economic Impact of  
Health System Change**

**Health Insurance for the Near Elderly**

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**May 1998**

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**DRAFT**

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## 1.0 INTRODUCTION

Americans between the ages of 54-65 constitute a segment of the population known as the near elderly, and those retired from the work force are known as early retirees. Because of factors such as disconnection from the work force, inability to qualify for group insurance, poor health status, and limited income, this segment of the population often confronts problems of inaccessibility and/or unaffordability of health insurance. As policy makers have contemplated incremental expansions of health insurance, this age group has become a focus of consideration.

The near elderly number 21.5 million and comprise about 8% of the total U.S. population.<sup>1</sup> However, with the oldest baby-boomers now 51 years old, this age cohort will expand significantly in the near future. By the year 2010 the near elderly will number 35 million and their proportion of the total population will increase by half to 12%.<sup>2</sup>

Of this age cohort of over 21 million, nearly 3 million or 14% have no health insurance.<sup>3</sup> Despite a strong economy and low health inflation, the proportion of uninsured in this group has continued to increase. Even if the current proportion of uninsured remains unchanged, the number of uninsured in this group will rise to 5 million by 2010.

Policy makers are concerned about this group for several reasons: first, they have a declining connection with the labor force and thus face <sup>①</sup> reduced access to employer sponsored health insurance (ESI); second those without access to ESI confront problems in the <sup>②</sup> individual insurance market due to their age, health status, and the resulting high cost of insurance premiums; and third, because of their diminished health status, those who are uninsured face the possibility of <sup>③</sup> large and potentially catastrophic financial costs. In part, this is a group in which many would like to purchase health insurance if they could, but the market has not provided them with accessible or affordable options.

An important factor explaining the increased number of uninsured near elderly is the decline in employer sponsored health benefits. Among active workers, the proportion of individuals under age 65 having ESI declined from 69% in 1988 to 64% in 1996.<sup>4</sup> As a result, active workers account for over half of the 3 million near elderly who are uninsured. Early retirees often depend on continued coverage of ESI to help pay for their health insurance costs into retirement. However, the decline in retiree health benefits (RHBS) has been particularly steep, falling from 44% in 1988 to 34% in 1994.<sup>5</sup> Furthermore, a declining number of firms are offering coverage to early retirees. In 1993, 46% of large firms (over 500 employees) provided early retiree health benefits, but by 1996 that had declined to 40%.<sup>6</sup>

Those who do not have access to ESI, and who are not eligible for public insurance (chiefly Medicare and Medicaid), have to purchase insurance in the individual market. Members of this age group, however, are sicker and have higher expected health costs than those in younger age groups. Therefore, their insurance premiums are higher in order to cover the expected costs. In addition, the selling and administrative costs of marketing insurance to individuals is higher than it is for groups. Chollet found that due to age rating alone, premiums charged to 60 year olds may be 2-4 times those charged to 25 year olds.<sup>7</sup> Although recent legislation, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has made individual coverage more available, it has not made it more affordable.

As a result of these factors, many of the increasing number of near elderly who do not have access to ESI, are likely to have difficulty affording insurance in the individual market. This has drawn the attention of policy makers who have made this group the next focus of efforts to incrementally expand health insurance coverage.

However, there is not general agreement that the focus on this group is warranted. The near elderly, as a whole, are neither poorer nor more lacking in health insurance coverage than other age groups. The rate of uninsurance in this group is 13.6%, among the lowest of any age group and well below the national average of nearly 18%.<sup>8</sup> Furthermore, this group constitutes

one of the wealthier age cohorts, having lower poverty rates than both the population under age 34 and over age 65.<sup>9</sup> Hence, some have argued that if efforts are to be made to expand health insurance, they should be targeted to those least able to access or afford it, particularly if such efforts involve government subsidies.

Policy interventions can follow one or a combination of potential options: expanding access to ESI and retiree health insurance; creating access to other group insurance; expanding access to government insurance; reforming the small group and individual insurance market; and utilizing safety-net providers to deliver needed services. Each of these alternatives has its own set of advantages and disadvantages, however, and all involve complex trade-offs. In this paper, we address two of the policy interventions that have been proposed.

The Clinton Administration has proposed a three-part program to confront this problem: first, certain people aged 62-65 could purchase Medicare at a “below market” premium and gradually pay back the difference after they reach age 65; second, “displaced” workers aged 55-61 could purchase Medicare at its average age-adjusted cost; and third, retired individuals whose former employers “renewed” on the provision of RHBs, could purchase health insurance through COBRA until they become Medicare eligible at age 65.

An alternative proposal has been discussed which would allow the near elderly to purchase private health insurance through an extended arm of the Federal Employees Health Benefit Program (FEHBP). Advocates of this policy contend that it is a solution based in the private market as opposed to the Clinton plan, which is likely to move people from the private market to Medicare.

In the remainder of this background paper we address these issues in greater detail. In the next section, we examine the insurance status of the near elderly. We examine barriers to insurance, and the income capacity of this age group to purchase private insurance. Disaggregating data from the 1997 Current Population Survey (CPS), we analyze the insurance,

income, and health status of individuals and the implications of efforts to expand health insurance. In Section Three, we shift our perspective to the employer and examine the trends in employer-sponsored health benefits. In Section Four, we identify policy options and summarize the Clinton and FEHBP plans and discusses advantages and disadvantages of both. In the final section, we summarize our findings and suggest topics that need further research.

## 2.0 THE INSURANCE STATUS OF NEAR ELDERLY INDIVIDUALS

We begin this section by examining the sources of health insurance for the 21.5 million near elderly compared to the overall population that is under 65:<sup>1</sup>

Table 1: Comparative Sources of Insurance for the Near Elderly and for the Population Under Age 65

	ESI	Private Individual	Public	Uninsured
21.5 Million Near Elderly	65%	10%	18%	14%
All Non-Elderly	64%	7%	16%	18%

The data in Table 1 show that overall this age cohort has a lower uninsurance rate than the national average. They also have a rate of private individual insurance considerably higher than the national average (10% vs. 7%). But the overall figures do not provide any insights about the characteristics of this group, particularly the 3 million who are uninsured. Further analysis reveals that the near elderly are a fast-growing segment of the population who are likely to confront barriers in obtaining health insurance. Among these barriers are demographics, health status, connection to the workforce, and income.

### 2.1 BARRIERS TO INSURANCE

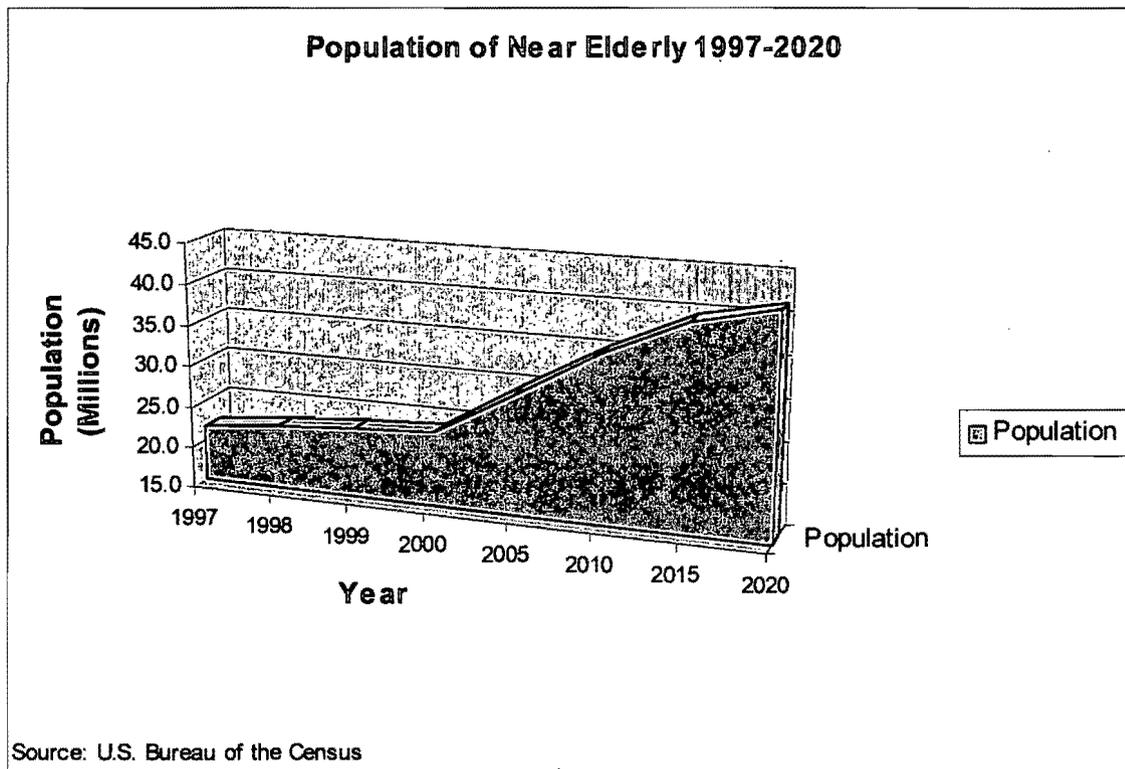
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<sup>1</sup>All data pertaining to sources of health insurance, income, and health status of individuals are from the March 1997 CPS unless otherwise cited. The sources of insurance in this and other tables exceed 100% because some people report receipt of coverage from more than one source. We use the category "private individual insurance" as a substitute for the CPS category "other private insurance." The manner in which different researchers classify these categories varies. This substitution likely overstates the purchase of private individual insurance by a small amount.

## Demographics

The near elderly number 21.5 million and comprise 8% of the total U.S. population. However, with the aging of the population, their numbers will increase sharply in the near future as indicated in Figure One.

FIGURE 1

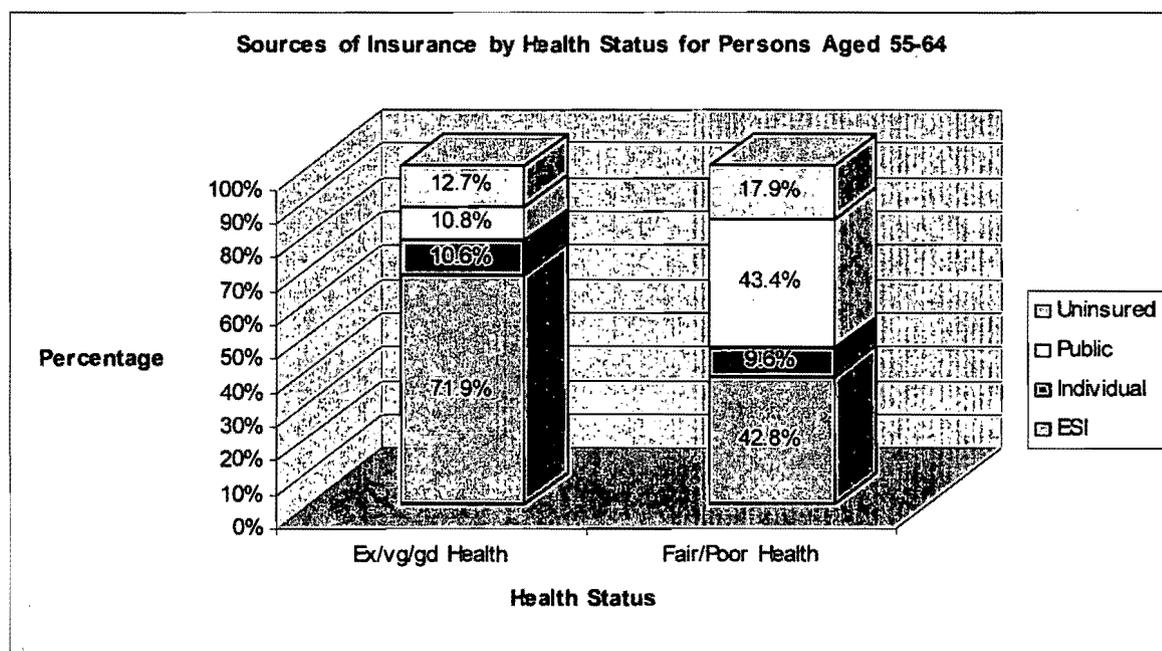


By the year 2010, the proportion of near elderly in the population will grow by 50% as this cohort will number 35 million and constitute 12% of the total U.S. population. Between now and 2020, the number of all retirees (including those over 65) will nearly double, from 55 million to almost 100 million.<sup>10</sup> This will undoubtedly exert financial pressure on both private and public sources of health insurance for this age group. As a result, health insurance for those over the age of 55, including retiree health insurance, will become increasingly important health policy and political issues.

## Health Status

This growing age cohort faces a number of obstacles in obtaining health insurance, and among the most important is health status. The near elderly have poorer health status and thus greater and costlier health needs than any other age cohort except the Medicare eligibles over age 65. And those with the poorest health have the lowest rates of insurance. Figure 2 shows the sources of insurance by health status.

FIGURE 2



Those who are in fair or poor health have much lower rates of ESI than their healthier counterparts. A considerably larger portion are uninsured (despite the fact that their health needs are greater), and they are much more dependent on public insurance. For many in this age group, their poorer health status and age can make private individual insurance costly and unaffordable. This is exacerbated by the fact that many in the most vulnerable categories have limited income.

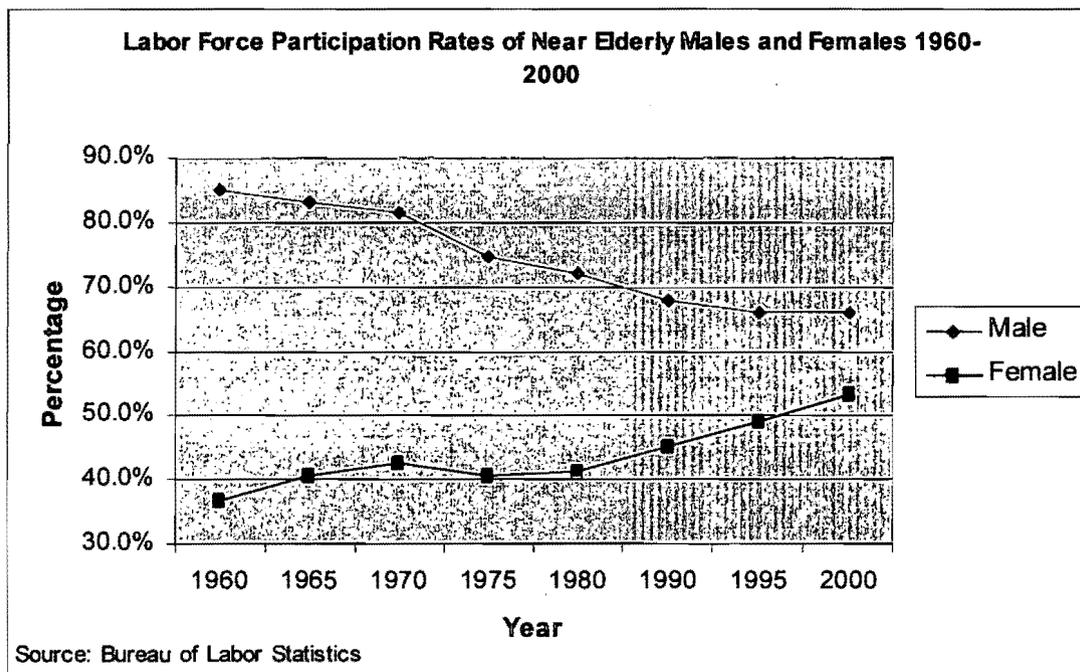
### *Income*

Overall, the near elderly do not have lower incomes relative to other age groups. In fact, their income exceeds those in age groups under 35 and over 64. However, those that lack health insurance have lower incomes than those who are insured. Of the nearly 3 million uninsured near elderly, over half have family incomes below 200% of the poverty level, and they have an uninsured rate of 28%. Many of these people must buy health insurance in the individual market, where the cost of premiums can represent a large portion of annual family income. As a result, the cost of such policies can be a financial burden to some and prohibitive to others. Consequently, the relative importance of group coverage, particularly ESI, is increased.

### *Connection to the Workforce*

Despite the importance of ESI to members of this age group, they have diminishing ties to employment. As seen in Figure # 3 on the following page, 85.2% of near elderly males were still working in 1960, but by 1995 that had fallen sharply to 65.5%. Although the labor participation rate of women increased during this period, many in this age cohort are not actively working.

FIGURE 3



Despite the fact that diminishing ties to the labor force are a barrier to group insurance, we see from Table 2 that over 50% of this age group are still individuals who are currently employed.

Table 2: The Near Elderly Uninsured by Major Activity

Work Status	Employed	Retired	Ill or Disabled	Non-Worker
3 million uninsured	53.5%	20.2%	9.5%	16.8%

Although many policy discussions tend to focus on retiree health benefits when considering the near elderly, it is clear that an important part of the problem is among those who are still working.

## 2.2 POTENTIAL TO PURCHASE INSURANCE

Although the poorest of the near elderly have the highest rates of uninsurance, a surprisingly significant proportion find it possible to purchase insurance if it is available. We examine this further by looking at the cost of insurance premiums as a proportion of income, and

the propensity of this age group, within different income levels, to purchase individual insurance. In Table 3, we present estimates of the percentage of income needed to purchase ESI and individual health insurance at family incomes of 200% and 300% above the poverty level.

Table 3: Employer Sponsored Insurance: Premium Cost as a Proportion of Income (persons aged 55-64)<sup>11</sup>

	Average Premium	Net Premium After Cost-Share	% Income at 200% Poverty (47.9% of near elderly earn $\geq$ 200%) \$32,100 family of 4 \$15,780 single	% Income at 300% Poverty (32.2% of near elderly earn $\geq$ 300%) \$48,150 family of 4 \$23,670 single
Family Coverage No Cost Sharing	\$5,071*	\$5,071	16%	11%
Single Person No Cost Sharing	\$1,883	\$1,883	12%	8%
Family Coverage 33% Cost Sharing	\$5,071	\$1,673	5%	3%
Single Person 22% Cost Sharing	\$1,883	\$414	3%	2%
Private Individual Insurance: Premium Cost as a Proportion of Income (persons aged 55-64)				
	Premium	% Income at 200% Poverty \$21,220 family of 2 \$15,780 single	% Income at 300% Poverty \$31,830 family of 2 \$23,670 single	
Coverage for Two People	\$9,000	42%	28%	
Coverage for Single Person	\$4,500	29%	19%	

\* We match the national average premium for family coverage with poverty levels for families of four. Many near elderly may need insurance for only two. Some may pay the above family premium, but others may have access to family policies rated for two people or be able to purchase two single ESI policies. In the latter case, two single ESI policies would cost \$3,766 and constitute 18% of family income at 200% poverty and 12% at 300% poverty with no cost sharing. If families of two had to pay the full average national family premium of \$5,071, it would cost 24% of income at 200% poverty and 16% at 300% poverty with no cost sharing.

There is no national database for private individual insurance. Our estimate of the "average" premium is simply an assumption based on our study of the literature. Because of large variations in premiums, any estimates of the average cost of individual insurance should be interpreted with caution. Individual rates vary according to the age, health status, and life style habits of each individual, as opposed to ESI which is based on the risk experience of the entire group. Individual rates also vary by state and location, and are strongly impacted by state insurance laws. In a recent study of the individual market, Deborah Chollet points out that rates for a 60 year old male in an intermediate cost market varied from \$1,788 to \$6,420, while, in a high cost market, standard rates could be 50% higher.<sup>12</sup> Furthermore, premiums in the individual market can be rated-up an additional 50-100% for such common conditions as obesity and hypertension.<sup>13</sup> In almost all states, the near elderly would be rated by age and health status in addition to other factors. Chollet found that age-based rates for a 60 year old are typically three times those for a twenty-five year old.<sup>14</sup> Hence, the variation among premiums is large and the concept of average premium less meaningful, but we find these estimates useful for considering the national impact of different policies.

Among people with family incomes at 200% and 300% of poverty, it makes a great deal of difference whether insurance is employer based with cost sharing, employer based without cost sharing, or whether it is purchased in the individual market. At both 200% and 300% of poverty, premiums in the individual market cost more than twice the proportion of income as those purchased through employers; and ESI without employer cost sharing costs more than three times the proportion of income as ESI with typical cost sharing. An individual at 200% poverty would pay only 3% of annual income for ESI with cost sharing, 12% for ESI without cost sharing, and 29% for private individual insurance.

With the above as rough estimates of the cost of coverage as a proportion of income, we next look at the actual purchases of individual insurance by this age group at different levels of income. When ESI is not available, the near elderly more readily seek insurance in the individual insurance market whereas those in younger age groups tend to remain uninsured. The rate of

individual insurance coverage is 10.4% among all of the near elderly, compared to 4.9% for those aged 35-44 and 5.9% for those aged 45-54. One way of gauging the propensity of this age group to purchase insurance is to calculate the proportion of people purchasing individual insurance who do not have insurance from other sources. We use the formula:

$$P=I / ( I +U)$$

Where P is the proportion of people who purchase individual insurance, I is the number of people who purchase individual insurance and U is the number of uninsured. Table 4 shows these calculations at different levels of family income.

Table 4: % of Persons With No Other Source of Insurance  
Who Purchase Individual Insurance by Income Status

Income Level	% Purchasing Individual Insurance
< 100% Poverty	25.7%
100%-149%	31.8%
150%-199%	42.0%
200%-249%	48.5%
250-299%	44.7%
>300%	53.3%
Total 55-64 Pop.	42.8%

At family incomes above 200% of poverty, close to half of the people without other sources of insurance purchase in the individual market. In fact, a surprising 25.7% of near elderly whose family incomes are below the poverty level purchase individual insurance even though it could represent half of their annual income. One might speculate that some of this group may have other assets or some other means of support which may help them pay such burdensome

amounts. They also have high expected health costs. Less than 1/4 of this group describe their health status as excellent or very good.

Considering the implications of both of the two previous charts, it is evident that among those earning over 200% of poverty, many are willing to purchase in the individual market. At the same time, however, the cost of individual insurance is such a high proportion of income, that many others are likely deterred. Hence, public policies making health insurance more accessible or less expensive could be attractive for many in this age group, even if cost sharing or subsidies are not provided. Among those who earn less than 200% of poverty, some purchase individual insurance at burdensome rates, and policies making less expensive group or public insurance available would relieve some of that burden. However, most earning under 200% of poverty would not be helped by such programs unless considerable subsidies were provided.

### **2.3 INSURANCE STATUS BY MAJOR ACTIVITY, INCOME, AND HEALTH STATUS**

In this section we examine both the near elderly who are working, and also the non-workers who comprise the other half of the uninsured, and who have different characteristics which affect their access to health insurance. Using tabulations from the 1997 March CPS, provided by the Employee Benefit Research Institute (EBRI), we present a series of charts and figures showing the sources of health insurance by major activity (employed, retired, ill or disabled, and non-workers). Then, within each major activity, we examine the sources of insurance by income status and by health status. The complete tables are in the Appendix, and are the basis for the remaining portion of this section.

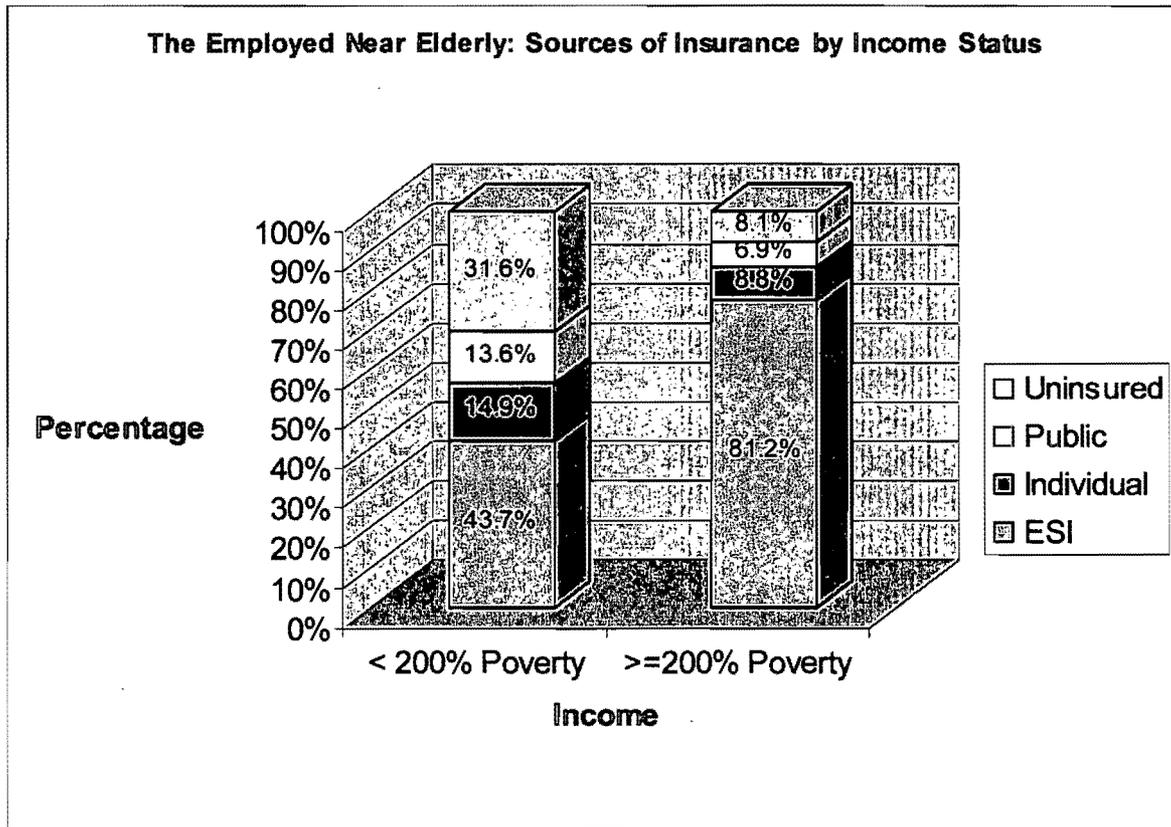
#### **2.3.1 The Employed**

Of the 21.5 million near elderly, 13.9 million or 65% are employed. Among those employed, 86% have private insurance (76% ESI, 10% individual). Only 11% are uninsured, a

rate well below the national average of 18%. However, those 11% represent almost 1.6 million individuals or 54% of the uninsured near elderly. In other words, over half of the near elderly uninsured are full-time workers.

Figure 4 compares the sources of insurance between those active workers whose family incomes are above and below 200% of poverty. Of those active workers with family incomes over 200% of poverty, the proportion who have ESI is much higher and the proportion who are uninsured much lower.

FIGURE 4



Not surprisingly, those with access to ESI are the individuals with higher paying jobs, and many of the uninsured are persons often referred to as “the working poor.” Although ESI is the most important source of insurance to workers in this age group, it has declined considerably

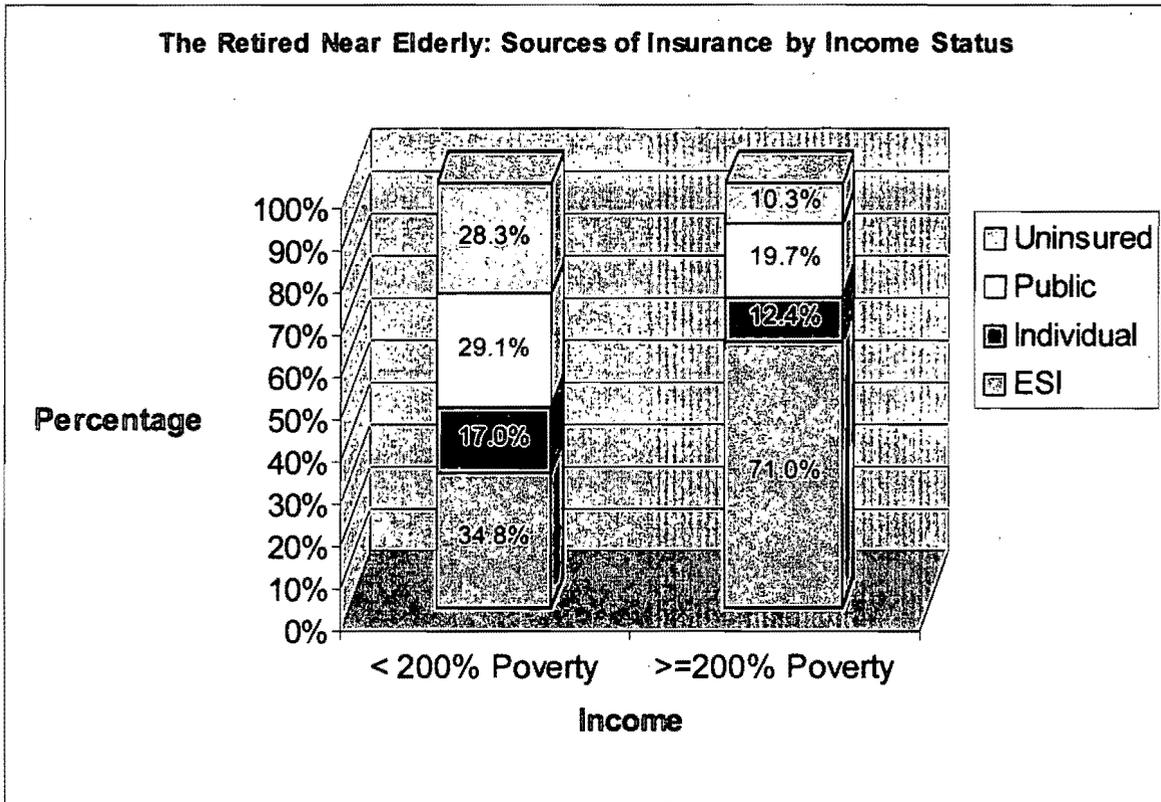
since the 1980s. Any comprehensive solution for this age group must target the provision of employer-sponsored benefits and the working uninsured.

What separates the working uninsured from retirees and other non-workers is that many have the income capacity to purchase health insurance. Close to one million active workers who are uninsured have family incomes above 200% of poverty. As we saw in the last section, despite the high cost of private individual insurance, almost half of this income group who do not have insurance from any other source purchase individual insurance. If insurance was available at group rates, it would not only be likely to attract more of the working uninsured, but would also reduce the considerable burden many persons in this group now pay to purchase insurance in the private individual market.

### **2.3.2 The Retired**

Of the 21.5 million near elderly, 3.6 million or 17% are retired. Of those retirees, slightly over 600,000 are uninsured, which is one fifth of the total number of near elderly uninsured. Compared to the working near elderly that we just examined, the retired have less ESI, higher rates of individual insurance, much higher rates of public coverage, and a significantly higher rate of uninsurance. Figure Five compares the sources of insurance between those retired workers whose family incomes are above and below 200% of poverty.

FIGURE 5



Those with family incomes under 200% of poverty have half the rate of ESI coverage, and almost three times the rate of uninsurance of those earning over 200% of poverty. A complete table of sources of insurance by income for the retired near elderly can be found in the Appendix.

Of those retirees with incomes above 200% of poverty, 10% are uninsured and would likely be the ones to benefit most from policies that increase access or affordability of insurance. Unlike the working uninsured, however, they constitute only 8% of the total near elderly uninsured. This is partly because retirees are a self-selected group, often choosing to retire only if they have health insurance.

Many of the near elderly, however, do not retire by choice but are forced to leave work because of poor health, regardless of their income status. In a survey of 55-61 year olds who left the work force, nearly twice as many (34%) cited health as the reason as opposed to retirement

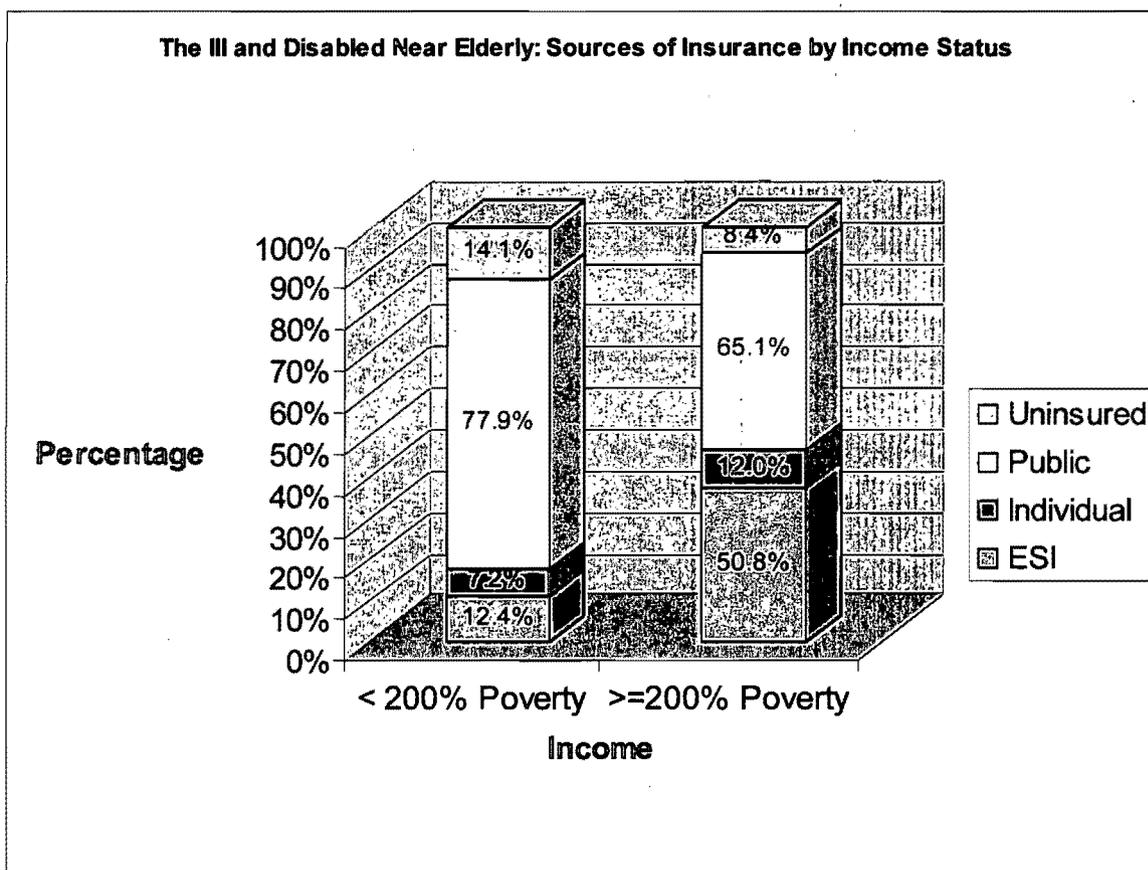
(18%).<sup>15</sup> Indeed, those describing their health as fair or poor are 1/3 more likely to be uninsured than those describing their health as excellent, very good, or good. The difference would be more pronounced except for the fact that those in fair or poor health have twice the rate of public insurance than those in excellent, very good, and good health.

Clearly, the uninsured retirees in this group are sicker and in greater need of insurance than those who are employed. One can surmise that more of this group would like to purchase health insurance, but have limited income capacity and face high prices because of insurance underwriting. Evidence of their propensity to purchase insurance can be seen in their high rate of individual coverage. Of those with family incomes below 200% of poverty 17% have individual coverage. This is nearly 2 ½ times the national rate. These are individuals who could greatly benefit from retiree health benefits (RHBs). However, the provision of RHBs by employers has been declining even more rapidly than the overall provision of ESI. Making insurance available at a group rate might entice the small proportion earning over 200% of poverty and those with the worst health status. However, in order to make a significant impact on this entire cohort that represents 20% of the uninsured problem, a government subsidy would most likely be needed.

### **2.3.3 The Ill and Disabled**

Of the 21.5 million near elderly, 2.3 million or 11% are ill or disabled. Three fourths of this group have public insurance, so the rate of uninsured in this group is only 12%. The number of uninsured who are ill or disabled represents 9.5% of the total near elderly uninsured. Figure 6 compares the sources of insurance of the ill and disabled whose family incomes are above and below 200% of poverty.

FIGURE 6



Of those ill or disabled who have family incomes in excess of 200% of poverty, only 8.4% are uninsured. Conversely, of those with family incomes less than 200% of poverty, 14.1% are uninsured. Over 3/4 of the uninsured in this group have family incomes below 200% of poverty, and many would not be able to purchase insurance without a considerable subsidy. The remaining 1/4 who have family incomes in excess of 200% poverty represent only 2% of the total near elderly uninsured.

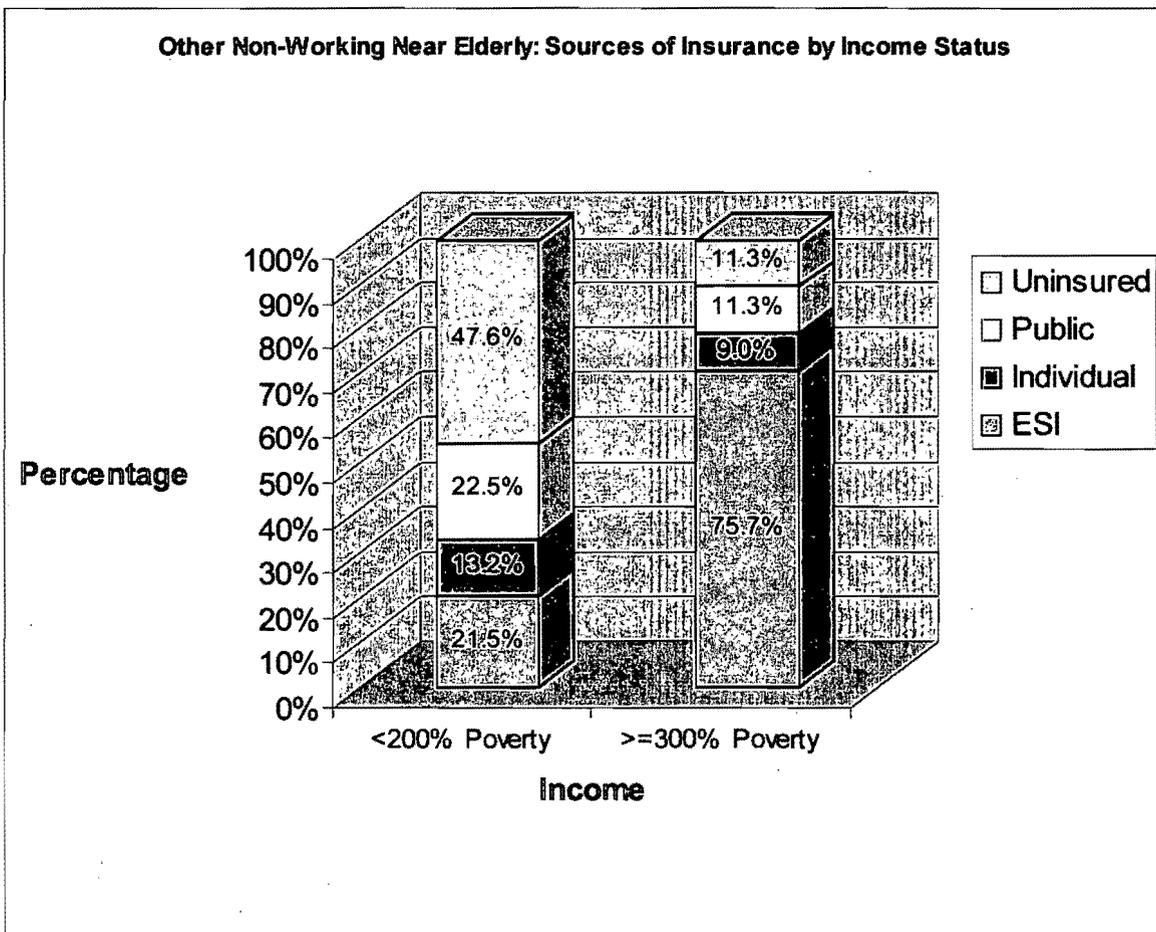
#### 2.3.4 Other Non-Workers

The category we call “other non-workers” is comprised mostly of those not working because of home or family reasons (85%), and a residual made up of unemployed, displaced

workers, students, and those not seeking employment (15%). Of the 21.5 million near elderly, 1.7 million or 8% fall into this group. Not surprisingly, this group has the largest rate of uninsurance at over 29%. The nearly 500,000 uninsured in this group constitute almost 14% of the total uninsured near elderly.

Because this group is a mixture of people from different work orientations, it is harder to categorize. Figure 7 compares the sources of insurance between those active workers whose family incomes are above 300% of poverty to those below 200% (we use different poverty levels because of availability of data).

FIGURE 7



It is significant that 42% of this group have family incomes of over 300% of poverty. Many of these are likely to be non-working family members in which the head of household is employed and has access to ESI. Of those over 300% of poverty 75.7% have ESI and 11.3% are uninsured. In stark contrast, of those with family incomes less than 200% of poverty, 21.5% have ESI and 47.6% are uninsured. Those uninsured earning over 300% of poverty represent 2.7% of the total near elderly uninsured. Although this is a small portion of the total, this group might be expected to purchase health insurance if it was more accessible or less expensive.

As one would expect, the balance of this group have very low incomes. Over 65% of the uninsured have family incomes of less than 200% of poverty and about 80% have family incomes below 300% of poverty. Some in this group would likely purchase individual insurance at a heavy financial burden because of their diminished health status. Among those reporting their health as fair or poor, nearly 40% are uninsured, twice the uninsurance rate of those in this cohort who report their health as excellent or very good. But even with a high propensity to purchase insurance, most would likely need government subsidies.

### **2.3.5 Conclusions**

We draw a number of conclusions from the disaggregation of insurance information discussed above:

1. Significant barriers exist that prevent many of the near elderly from purchasing health insurance even though they may have a high propensity to do so. Among these barriers are poor health status, limited income, and disconnection from the labor force. In addition, demographics and declining employer sponsored insurance benefits could result in much larger numbers of affected individuals in the future.

2. The risk and potential cost from being uninsured is greatest among the near elderly because their health status is worse than any other age group except Medicare eligibles who are guaranteed public insurance.
3. At income levels of 200% and 300% of poverty, the difference in the proportion of income necessary to purchase different kinds of insurance is substantial. Even without employer cost sharing, the proportion of family income to purchase ESI is less than half that of individual insurance.
4. The near elderly are risk averse, and surprising numbers purchase individual insurance at costs which represent high proportions of income. Even at 200% of poverty, nearly half of those with no other source of insurance purchase in the individual market.
5. By far, the most significant subset of the uninsured are those who are working. They represent 54% of the total uninsured near elderly and have both the capacity and propensity to buy insurance if it is accessible and reasonably affordable. Policies to increase access to ESI could be highly successful among this group. Lacking that, however, access to other affordable insurance through either the private or public sector could be effective.
6. Of the retirees who are uninsured, many have limited incomes and many have diminished health status. Poor health status is likely to be a major reason for retirement among those retiring without access to health benefits. The uninsured in this group with family incomes above 200% of poverty comprise about 8% of the total near elderly uninsured. Hence, access to affordable private or public insurance would help a small but significant number from this group. Among those with family incomes under 200% of poverty, some would purchase individual insurance at a burdensome level of income, but many retirees would need a subsidy from the government to avoid being uninsured.

7. Most of the ill or disabled have public insurance. The uninsured in this group with family incomes over 200% of poverty is only about 3% of the total near elderly uninsured. Although there is a high propensity among this group to purchase insurance, only a small number would likely benefit from access to more affordable private or public insurance. Part of this group would purchase individual insurance at premium rates that would represent large proportions of their incomes, but most would need a significant subsidy or an expansion in the eligibility for public disability benefits.
8. Among the other uninsured, there is a small but significant subset (2.7% of the total near elderly) with family incomes above 300% of poverty. These individuals could benefit from access to less expensive insurance from either the private or public sector. Most of this group, however, would need significant subsidies to purchase insurance.
9. In total, nearly half of the near elderly uninsured have incomes above 200% of poverty and many of them would likely benefit from access to group insurance or a buy-in to public insurance. Among the half earning under 200% of poverty, some purchase individual insurance at a burdensome cost and would benefit considerably from less expensive options. Most, however, would need considerable subsidies .
10. Increased employer-sponsored benefits would have a large impact on the near elderly. Active and retired workers constitute 74% of the near elderly uninsured. Incentives for expanded provision of ESI and RHBs, even without cost sharing, could have a significant impact.
11. The near elderly are more risk averse and purchase greater amounts of individual insurance than other age groups. More affordable individual and small group insurance could provide benefits similar to those that result from improved access to group and public insurance as recommended above.

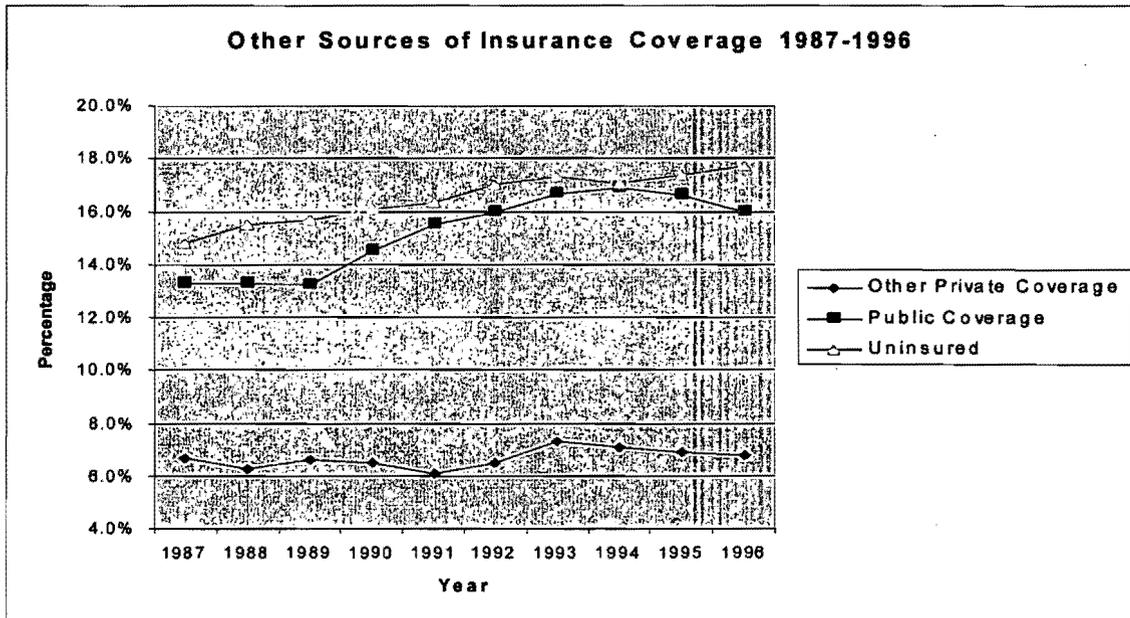
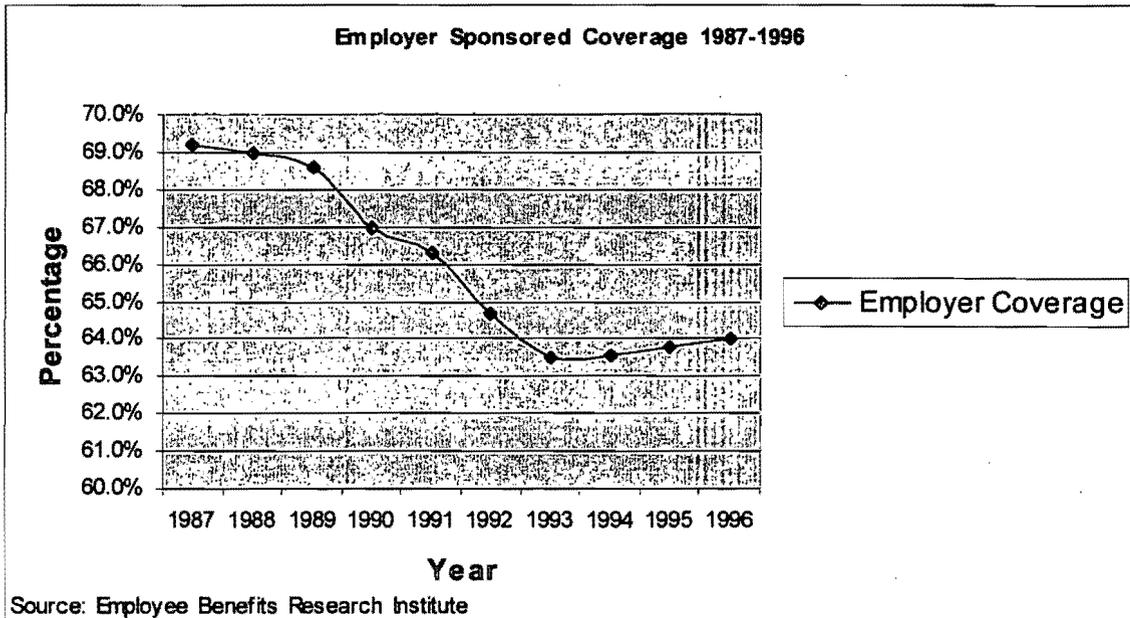
### **3.0 THE PROVISION OF HEALTH INSURANCE BY EMPLOYERS**

Employer-sponsored health insurance is of critical importance to the insurance status of the near elderly. Of the almost 3 million near elderly uninsured, 2.2 million or 74% are either working or retired from work. Of those 2.2 million, 55% have incomes in excess of 200% of the poverty level and 38% over 300% of the poverty level. Therefore, a substantial portion of the near elderly uninsured are workers or retired workers who are likely to have the capacity to purchase health insurance if it is accessible and affordable. However, as we saw in the previous section, at relatively low levels of income the difference between the affordability of ESI and individual insurance is considerable. Furthermore, ESI has been declining for virtually all age groups and in all regions of the country. We will examine ESI for the near elderly in two categories: active and retired workers.

#### **3.1 Active Workers**

The decline in ESI among active workers, has been studied frequently in the literature. In this paper, we briefly summarize recent findings and update data on ESI to include the 1997 CPS. Figures Eight and Nine on the following page shows the trend in employer-sponsored and other sources of insurance from 1988-1996.

FIGURES 8,9



During this period ESI as a proportion of the non-elderly population declined from 69% to 64%. Private individual coverage increased slightly and public insurance, particularly through expansions of Medicaid, increased from 13.2% to 16%. As a result, the number of uninsured rose from 32 to 41 million or from 15.5% to 17.7% of the non-elderly population.

Many have analyzed the factors behind the recent trends in ESI and we will very briefly review the consensus of the literature. It is helpful to think of two time periods: 1986-1993, and 1994-1996. It was in the period from 1986-1993 when ESI declined sharply. The most important reason for the reduction was the decline in affordability. Health insurance premiums were rising sharply and real incomes were relatively stagnant. Most of the decline was from fewer firms offering insurance, although the take-up rate by employees was also a factor. Many other forces contributed to the decline including industry shifts, changes in skill requirements within industries, international competitiveness, increases in part-time and temporary labor, declining bargaining strength of unions, and crowding out by the expansion of Medicaid eligibility.

During the 1994-1996 period, the rate of ESI stabilized, rising less than ½ of one per cent over the three year period. Again, the major reason was affordability, this time caused by the moderation in health premium inflation. Real incomes in this period were slow to recover, and several analysts have concluded that the failure of ESI to recover toward former levels was more a factor of the take-up rate by employees than the offer rate by employers.<sup>16</sup> This was partly caused by the fact that employers, on average, required greater cost sharing of health premiums from their workers. Additional factors during this period were the one-time switch to managed care, the fight for market share between managed care companies, the timing of the insurance cycle, and strong economic growth coupled with low unemployment.

The future trend of ESI is uncertain, but many feel that it is likely to fall as the underlying causes of health care inflation re-emerge. The long-term drivers of health inflation are thought to be technology and demographics, and many analysts think these forces will cause health inflation to resume its long-term historical trend. In addition, much of the savings derived from the one-time switch from indemnity plans to managed care may have been realized. Another reason we have not seen a rise in health insurance premiums is because insurance companies have endured several years of low profit margins. This trend cannot continue over the long-term, however, and we are likely to see a return to the insurance cycle and higher health insurance premiums. Some contend that the failure of ESI to increase meaningfully during this period of prolonged prosperity

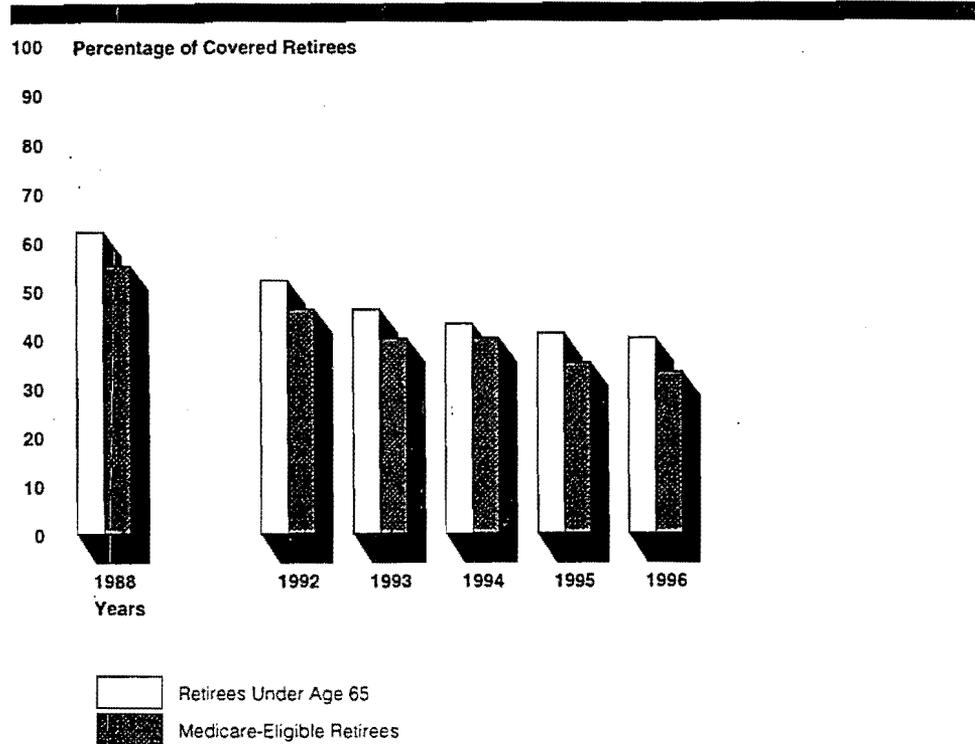
and low inflation augurs for future reductions when the economy eventually turns down or the rise in health premiums resumes. This could have a reverberating effect on the near elderly. Not only will employers provide less insurance to their current employees, but those who do not provide benefits to active workers are also unlikely to provide coverage for retirees.

Yet the provision of ESI can be a key factor in decreasing the number of near elderly uninsured. As we have seen, incentives to increase ESI, even if they do not include cost sharing, could have a significant impact. An effective alternative may be to allow workers to buy into other kinds of group insurance plans like the FEHBP. The potential problem with such alternatives is that they must be structured to minimize adverse selection and to avoid incentives for employers to discontinue providing their own health benefits.

### 3.2 Retired Workers

ESI for retired workers, or retiree health benefits (RHBs) declined at an even faster rate than ESI for current workers. Table 10 shows that the number of large firms (over 500 employees) offering RHBs declined steadily from 1988 to 1996.<sup>17</sup>

Figure 1: Percentage of Large Employers Offering Retiree Medical Coverage, 1988 and 1992-96



Note: Data from 1988 and 1992 are not strictly comparable with data collected after 1992.

The proportion of *all* retirees having RHBs declined from 44% in 1988 to 34% in 1994.<sup>18</sup> This represents a decline of 23% in just a six year period. Among private sector workers coverage fell from 37% to 27% during the same period.<sup>19</sup> Focusing only on *early* retirees, the rate of decline from 1993-1996 was similar, but coverage was slightly higher at 40% for all retirees and 30% for those in the private sector.<sup>20</sup>

Employer benefits for early retirees are considerably more expensive than for those over age 65 because Medicare becomes the primary payer for the 65+ group, and the employer's policy constitutes "Medigap" or "wrap-around" type coverage. Hence, in 1996 the average cost of health benefits for early retirees was \$5,210, compared with \$1,874 for retirees age 65 and over. Nevertheless, only 33% of large employers offered RHBs to retirees over age 64 compared to 40% offered to early retirees.<sup>21</sup> Despite the cost, employers apparently view early retiree health benefits as an effective tool to encourage retirement of older, less productive workers, as well as an attractive benefit to employees in their productive years. Nevertheless, the supply of RHBs to all workers has declined considerably in recent years.

There are numerous reasons for the magnitude of this decline. The most important is the decline in ESI for active workers as we previously discussed. Changes in demographics are also an important factor. When employers first offered retiree benefits, there were few retirees in proportion to active workers and the cost compared to total payroll was small. The ability to "wrap around" Medicare also enabled firms to offer a valuable benefit at a small cost. However, with an aging workforce, there are fewer workers supporting more retirees. That, together with increased medical capabilities and higher costs have made RHBs substantially more expensive.

Union status and firm size are also significant factors in the provision of RHBs. The proportion of retirees in 1994 with RHBs who had union contracts was 41% versus 19% for those in firms without union contracts. The proportion of retirees in 1994 who had RHBs in firms of more than 1000 employees was 46% versus 22% for those in firms with less than 100 employees. Several other important factors help explain the recent decline.

### 3.2.1 Financial Accounting Standards Board (FASB) Rule # 106

Apart from forces in the market, a regulatory change adopted in 1990 and effective 12/15/92 had a significant influence on the current decline. Financial Accounting Statement #106 (FAS106) adopted by the Financial Accounting Standards Board (FASB) in 1990 required companies to recognize on their balance sheets the present value of the cost of providing all future retiree health benefits. In the past, employers simply deducted the cost of providing benefits as they occurred. The obligation to recognize all future costs as liabilities had a substantial adverse affect on the balance sheet of many companies, particularly those in mature industries with unionized work forces. It also made employers aware of the magnitude of benefits that would come due in the future. Partially as a result, the proportion of large firms offering early retiree benefits declined sharply since 1990 as we saw in the previous figure.

At least in the past several years, however, that decline has largely not been the result of large firms dropping benefits. Hewitt Associates<sup>22</sup> conducted a survey of large firms (over 1,000 employees), and used both a constant sample of companies (counting only those firms that reported in both 1991 and 1996); and a complete sample (counting all reporting firms whether or not they reported in both years). The constant sample showed virtually no decline, but the complete sample showed declines similar in magnitude to those reported by others. One could conclude that the difference is primarily new firms not offering benefits and, to a lesser extent, old firms which offered benefits, merging or going out of business.

FAS 106 does not require employers to pre-fund benefits, so the regulation does not affect cash flow. Interestingly, some employers might favor pre-funding if they could claim a tax deduction as they are allowed to do with pensions. This would provide an incentive for employers to maintain their provision of RHBs and also make future retirement obligations more secure for employees. However, it would result in short-term losses of federal tax revenues and, hence, has not been seriously discussed. Policy makers could consider changes in this area as an alternative means of reducing the number of near elderly uninsured.

### **3.2.2 Termination of Retiree Health Benefits**

Another factor in the decline of retiree health coverage is employers' termination of RHBs. Although it has not been widespread, termination of RHBs has been a controversial issue legally, politically, and within labor-management negotiations. Almost all companies who promise their employees RHBs also reserve the right to alter or terminate them at any time. There have been numerous legal cases arising out of employer's termination of benefits. Federal courts have generally ruled that employers have the right to terminate benefits provided they explicitly reserve the right to do so, and provided the written contractual language is clear and unambiguous. Policy makers have considered regulation in this area, but the provision of ESI and RHBs are voluntary, and the consequence of regulatory action could be to further reduce the provision of employer health benefits.

A stark example of what can happen when workers lose RHBs occurred in 1966 when the Pabst Brewing Company terminated the health benefits of 750 retirees. All but a few were receiving retiree health benefits completely paid for by the company. When they had to turn to the individual market in Wisconsin, the cost for a family policy was \$8,187.<sup>23</sup>

### **3.2.3 Increased Cost Sharing and Declining Take-Up Rates**

Instead of terminating benefits, many employers have sought to reduce their retiree obligations in other ways. The most prevalent change has been to increase employee cost sharing. The proportion of employers who paid the full cost of RHBs fell from 42% to 37% between 1988 and 1994.<sup>24</sup> In addition to a higher proportion of firms demanding employee contributions, those firms that required cost sharing have demanded increases in the proportion paid by workers. Between 1988 and 1994 the average employee share, inflation adjusted, increased 23% for family coverage and 9% for single coverage.<sup>25</sup> Employers have also tightened eligibility requirements, designated maximum spending limits, and transferred workers from indemnity to managed care plans.

Shifting more of the cost of benefits to retirees has caused more retirees to decline benefits when offered. When surveyed in 1994 about why they did not take up RHBs when offered, 27% of respondents answered "too expensive" as the reason versus 21% in 1988.<sup>26</sup> Furthermore, between 1988 and 1994, the proportion of those who had coverage going into retirement declined by four percentage points; but the proportion of those retirees reporting current coverage fell by 10 percentage points.<sup>27</sup> Therefore, although there has been a sharp decline in RHBs offered, the declining take up rate has also been an important factor.

#### **3.2.4 The Consolidated Omnibus Reconciliation Act of 1985 (COBRA)**

Some retired workers access health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This law requires employers who have more than 20 employees to continue to provide access to ESI to former workers for a period of 18 months after they terminate their employment (unless fired for cause). Employees are required to pay 102% of the group premium to continue the same coverage they were receiving. There is no cost sharing obligation for employers.

There is evidence that some workers who do not have RHBs, retire at 63 ½ years of age and use COBRA as a bridge until they become Medicare eligible. At various times, policy makers have considered COBRA expansions as a means of reducing the number of uninsured, particularly in the case of the near elderly. A small part of the Clinton early retiree plan, which we review in the next section, expands COBRA eligibility.

Employers have found COBRA to be an expensive mandate. Even though there is no cost sharing, the employees who choose to pay for COBRA coverage are, on the average, older and sicker than those who decline. Hence, the costs of claims for the average COBRA employee in 1996 was \$5,591 compared to \$3,332 for other employees<sup>28</sup>. Since COBRA employees pay only 102% of the average cost, employers who self-insure incur most of the cost differential. In addition, employers find that the cost to administer COBRA is substantial.

Proposals to extend COBRA to the near elderly need to be considered carefully. Shifting more cost to employers may encourage them to drop the voluntary coverage they provide, or to pass the cost on to employees through tighter eligibility requirements or increased cost sharing. Pooling COBRA recipients with other insured raises the group premium cost and could potentially reduce the proportion of insured among younger workers; but creating a separate pool could make rates much more expensive for the older age groups and lead to adverse selection and spiraling rates. Requiring COBRA recipients to pay somewhat higher premiums (i.e., 125%-150% of group rates) is a middle ground but could also increase adverse selection so that only the sickest individuals who could not get less expensive coverage elsewhere would select the plan. Offering a high-deductible option may be a potential means of minimizing selection. Higher rates (and/or reduced benefits) coupled with government subsidies could make COBRA more cost-neutral to employers and affordable for individuals. Such subsidies would have to make COBRA more expensive than group rates (to minimize substitution) but less expensive than other alternatives (to minimize selection). However, government subsidies might be administratively complex and expensive. Clearly, there are no easy policy options for COBRA expansions.

In summary, the trend of RHBs for the near elderly is clearly down, decreasing more rapidly than ESI as a whole. Among small firms, the provision of RHBs has always been low and is likely to remain so. In the case of larger employers, policy interventions to stem or reverse the trend could have a significant impact on the total uninsured near elderly. This would be true even without employer cost sharing. Policy makers could consider several strategies to encourage the provision of ESI and RHBs. We identify these and other policy options in the following section.

## **4.0 POLICY OPTIONS AND PROPOSED SOLUTIONS**

### **4.1 POLICY OPTIONS**

There are basically five strategies or combinations thereof that policy makers can pursue in confronting the health insurance problems of the near elderly:

1. Expand Access to Employer Sponsored Insurance
2. Create Access to Group Insurance Pools
3. Expand Eligibility for Government Insurance
4. Reform the Individual and Small Group Insurance Market
5. Depend on Safety Net Providers to Deliver Needed Health Services

#### ***Expand Access to Employer Sponsored Insurance***

Policy makers could attempt to expand access to ESI. Since so many of the near elderly uninsured are either workers or past workers, expanding employer's provision of ESI and/or RHBs would likely be effective. This could potentially be accomplished by ameliorating the effect of FAS106 by providing additional tax incentives to employers to offer insurance with or without cost sharing, by COBRA expansion, or by employer mandates. There would be a delicate balance to consider between shifting further obligations to employers and the risk of employers terminating the voluntary benefits they provide.

#### ***Create Access to Group Insurance Pools***

Forming new purchasing groups outside of employers, or letting workers buy into existing purchasing groups (sponsored by private or public organizations) would constitute additional options. Allowing the near elderly to buy into the FEHBP plan is an option that we discuss further in Section 5.3. Premium rates in separate pools for the near elderly would be

significantly higher than those in employment based pools because the expected health costs of this age group are higher. Nevertheless, pooling would reduce administrative and sales costs, and eliminate access problems due to cautious medical underwriting. Any pool created outside of employment would have to be carefully structured so that it would not encourage employers to drop coverage they presently provide.

### ***Expand Eligibility for Government Insurance***

Policy makers could also provide affordable insurance through government programs. One option for expanding eligibility for government insurance is the Clinton plan, allowing people under certain conditions to buy into Medicare. We review this in Section 5.2. A second option would be to expand eligibility for Medicaid. In the early 1990s we expanded eligibility to children under 18 who came from low income families. More recently the State Children's Health Insurance Program (SCHIP) was passed as part of the Balanced Budget Act of 1997. A third option is to expand eligibility for disability benefits. That was done in a de facto fashion in the 1980s through expansion of SSI payments. With all of these options, policy makers must consider the potential effect of "crowding out" or substituting public for private insurance. In addition, budget considerations must be taken into account.

### ***Reform the Individual and Small Group Insurance Market***

Policy makers have exerted a great deal of effort to reform individual and small group insurance markets. The states have been particularly active in regulating and restructuring these markets. Such policies as community rating, guaranteed issue, rating bands, purchasing groups, and free care pools are among an array of strategies being attempted by different states. The federal government has also had an impact of the individual market through HIPAA. Despite these attempts, however, the individual and small group market remains expensive and burdensome for a large proportion of the uninsured. Two recent studies by Chollet and Kirk<sup>29</sup> and by Gabel, Hunt, and Kim<sup>30</sup> have analyzed the market for individual insurance. Both were

pessimistic about the potential to make this market significantly more affordable for many of the uninsured. Either tax incentives or government subsidies will likely be needed to accomplish substantial gains in this area.

### *Depend on Safety-Net Providers*

In the past, we have largely depended on safety-net providers to deliver care to many of the 41 million uninsured including the 3 million near elderly uninsured. Studies show, however, that the uninsured get poorer access to health services and have worse health outcomes than do the insured with the same health status.<sup>31</sup> It is also of concern that safety net providers may not be well suited for many of the near elderly. Many of these providers are often difficult to visit, being located in inner cities and poor neighborhoods, and they tend to focus on outpatient services and younger families. Unless other solutions are provided, however, we will continue to substitute safety-net providers for those who cannot pay for health services through private or public insurance.

## **4.2 THE CLINTON PLAN**

The Clinton Administration's plan consists of a three-part program to partially alleviate the health insurance problems of the near elderly and is summarized as follows:<sup>2</sup>

1. Individuals aged 62 through 65 who do not have either ESI or Medicaid can buy into the Medicare program at, and only at, the time they become eligible under these requirements. They can buy in at an estimated premium of \$316 per month. Their actuarial cost will exceed this amount but they will pay back the difference by paying an extra premium when they become Medicare eligible. That extra premium is estimated to be slightly over \$10 per month for each year of pre-65

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<sup>2</sup>All projections for the Clinton plan are from the Congressional Budget Office unless explicitly noted otherwise

benefits and must be paid from age 65 to age 85. For example, someone who participated in the program for all three years (age 62 through 65) would have to pay \$31 extra per month when they become 65.

2. Individuals and their spouses aged 55-61 can buy into Medicare for \$400 per month if they satisfy all of the following conditions:
  - a. Lost insurance because of a job loss
  - b. Had some kind of ESI (including COBRA) for 12 months previous to job loss.
  - c. Eligible for unemployment compensation
  - d. Exhausted COBRA benefits
  
3. Individuals and their spouses over age 55 whose employer promised RHBs and then reneged on that promise would be able to continue health insurance through COBRA until they reach the age of 65.

It is important to put the goals of this program into perspective. This is a limited and targeted program which attempts to alleviate the problems of a sub-group of the near elderly. The program is only intended to enroll some 300,000 people or 400,000 by the year 2003. It is not intended as a measurable step toward reducing the number of uninsured nationally. Less than 1% of the uninsured will be impacted by these policies. However, the program does provide a solution for people who have legitimate problems accessing and affording health insurance.

The CBO has published an analysis of the Clinton plan and we briefly summarize their findings. Part 1 of the program easily affects the most people. Close to one million of the near elderly uninsured and about 600,000 near elderly who purchase individual insurance would qualify

for the buy-in. Of the one million uninsured, it is estimated that about 90,000 would participate.<sup>3</sup> Of the 600,000 holding private individual insurance, about 210,000 would switch to the Medicare buy-in which they could purchase at much less burdensome rates. CBO estimates that a total of 320,000 would participate in 1999 and that would increase to 390,000 in 2003. The total cost to the government for the five-year period 1999-2003 would be \$1.9 billion.

Part 2 of the program has fairly stringent eligibility requirements as outlined above. CBO estimates that only 18,000 full year equivalents will participate by the year 2003. Even people who fulfill all the requirements are apt not to select this program with its \$4,800 annual premium per individual unless they have health problems that would make alternative private individual coverage more expensive. Many of the ones who do select this program, however, likely have no other accessible or affordable option in the private market. Because this program will be selected by unhealthy people, there is an estimated cost to the government is \$130 million over the period 1999-2003.

Part 3 of the program will likely affect a very small number of people. It is likely to lower the incentive of employers to renege on RHBs, since they will have to provide coverage anyway through COBRA. It could cause some employers to decide not to offer RHBs in the first place, but the effect, if any, seems likely to be very small. Since employers provide coverage under this portion of the program, there is no cost to the government.

Using CBO estimates of premium cost, we calculate the cost as a proportion of income for parts 1 and 2 of this plan for people at 200% and 300% of poverty.

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<sup>3</sup> Additionally it is estimated that about 18,000 individuals who would retire earlier and a small number of individuals whose employers dropped retiree coverage as a result of this option would buy into the plan.

Clinton Administration Medicare Buy-In: Premium Cost as a Proportion of Income

	Premium	% Income 200% Poverty	% Income 300% Poverty	% Income 400% Poverty
Part I: 62-65 Year Old Family Coverage	\$7,584	36%	24%	18%
Part I: 62-65 Year Old Single Coverage	\$3,792	24%	16%	12%
Part II: 55-61 Year Old Family Coverage	\$9,600	45%	30%	23%
Part II: 55-61 Year Old Single Coverage	\$4,800	30%	20%	15%

Note: For family incomes at 200% poverty or above, 44% of near elderly families and 50% of singles exceed this level

For family incomes at 300% poverty or above, 29% of near elderly families and 34% of singles exceed this level

For family incomes at 400% poverty or above, 18% of near elderly families and 23% of singles exceed this level

If one makes a “ballpark” assumption that most people at relatively low incomes would have problems spending much more than about 10-20% of their incomes on health insurance, then most of the people who can afford to participate in this buy-in will be in the upper quarter of wage earners. However, we have seen evidence that the near elderly are quite risk averse regarding health costs. Some will take advantage of this option even though it represents a higher proportion of their annual income. Still others, who are paying burdensome premiums in the individual market, will be able to alleviate some of that burden by switching to this program. In addition, this program would be an option for an unknown number of individuals in poor health who are willing to spend large proportions of their incomes on insurance, but are refused coverage or rated-up beyond their means because of pre-existing conditions. In total, although the numbers are small, this coverage can provide an otherwise absent solution for many of these individuals.

### *Advantages of the Clinton Administration's Proposal*

1. The program focuses on a small number of people who have a legitimate problem accessing and/or affording health insurance in the private market.
2. For the most part, this program helps people who are financially willing to pay for themselves. As a result, the cost to the government is relatively small.
3. For the most part, this proposal does not burden employers or private insurers with additional costs or mandates.
4. This program makes health insurance more affordable to those with private individual policies who are otherwise expending a large portion of their income on health insurance.
5. Part 1 makes the age for partial eligibility for Medicare consistent with partial eligibility for Social Security.
6. If the age for Medicare eligibility is raised, this program might be essential in providing a bridge to that new age level; a burden that would otherwise fall heavily on both employers and individuals.

### *Disadvantages of the Clinton Administration's Proposal*

1. The program does not target the most needy in terms of income. Instead it directs resources to help those in this group who are generally in the upper quartile of income.
2. The program is targeted so that 2/3 of the people who participate already have health insurance through the private individual market.

3. Rather than providing a private market solution, it provides a government solution (with the exception of part 3). In addition, 2/3 of those who choose to participate are moved from the private to the public insurance sector.
4. The program targets approximately half of the uninsured near elderly and does not address most people in the 55-61 age range.
5. The proposal expands the Medicare program during a time when it faces long-term solvency problems and when its future structure is being debated in a separate forum. This could become a particular concern if the full future payback in Part One becomes politically difficult to demand from Medicare beneficiaries.

#### 4.3 THE FEHBP PLAN

One policy alternative that has been discussed to help the near elderly is to let them buy into the FEHBP.<sup>32</sup> This would, in essence, be a private sector solution and would be more politically acceptable to those who wish to avoid enlarging the role of government. Furthermore, it would not impact the Medicare program during a period of debate about Medicare's future.

Structuring an effective FEHBP buy-in, however, may not be an easy task. Because of their higher expected health costs, if the near elderly are pooled with FEHBP members they will cause premiums for existing policy holders to rise. This cross-subsidization would initially make premiums more affordable for the near elderly, but could cause healthier people to move to less expensive plans and, hence, create spiraling premiums. It is also likely to cause political backlash among federal workers.

Conversely, if the near elderly are pooled separately, the actuarial fair premium is likely to be quite expensive. Although reduced costs of administration and marketing could yield savings

over individual insurance rates, the premium costs of this group would still exceed that of employment groups which are not age rated. Given the experience of this age group and their risk aversion to high medical costs, some would undoubtedly buy into such an option. Among many of those with family incomes of less than 200% of poverty, however, a subsidy from the government would likely be needed. Combining a separate FEHBP pool with a limited government subsidy for lower income persons could provide an attractive option. Such a subsidy would have to be administratively efficient and not cause substitution of ESI. Further research could provide details of how such a program could be structured.

## 5.0 CONCLUSION: POLICY ISSUES AND QUESTIONS FOR FUTURE RESEARCH

The near elderly confront a number of barriers in obtaining health insurance. Relative to other age groups, they have a high propensity to purchase insurance but often are faced with costly premiums in the private individual insurance market because of their expected health costs.

About half of the near elderly are workers, and another quarter are retired from work. Hence, access to group insurance through current or former employers would benefit most of this group. However, the supply of both ESI and RHBs by employers has declined, and employers have shifted more of the cost of these benefits to workers, causing a decrease in demand.

Reduced access to ESI makes a big difference to people earning relatively low levels of income. At family income levels of 200% and 300% of poverty, the proportion of income necessary to purchase individual insurance is more than twice that for ESI, even without employer cost sharing.

Approximately half of the near elderly have family incomes over 200% of poverty. Statistics show that among those at that income level who have no other sources of health insurance, almost half purchase individual insurance. If less expensive insurance were available, either from the private or public market, it would benefit these people in two ways: first, more people would be able to afford health premiums; and second, those paying expensive individual rates would obtain some financial relief.

Among the half of the near elderly who have family incomes below 200% of poverty, some (particularly those with diminished health status) purchase insurance even at burdensome proportions of their annual income. Less expensive insurance options would relieve some of that financial burden. Most of this lower income group, however, would not be helped by mere availability of group insurance unless they were given considerable subsidies. Hence, programs

such as the Clinton Plan or the FEHBP buy-in could help many in the upper income half of this group, but would address few in the lower income half.

There appear to be a number of areas in which further research could point the way toward potential policy interventions. On the employer side, little has been published about ameliorating the impact of FAS 106, either by a change in accounting rules or by a more favorable tax treatment for employers who pre-fund benefits. New ideas about increasing tax incentives to employers to provide ESI, even without cost sharing, have not been discussed.

Proposals to permit groups to buy into either private or public insurance are just beginning to be discussed. The Clinton plan presents one alternative focused mostly on those aged 62-64. Many details need to be studied for an FEHBP type of plan. That option, combined with a subsidy, could produce a broadly effective policy if it could be structured properly.

In recent years, incremental expansion of public insurance has been the policy most frequently used to reduce the number of uninsured. The ability to structure such policies while minimizing the effects of crowding out private coverage presents an ongoing challenge to policy makers and researchers.

A great deal of effort has been expended to improve the individual and small group insurance market. Recently, research has been pessimistic about the potential of this market to help many of the uninsured. A review of the consequences of HIPAA, and how it might be altered to achieve better outcomes, could be fruitful.

Finally, the safety net providers have always played the role of "provider of last resort." The uninsured have depended on them, even though these providers may not be well matched to the needs of the near elderly population. The future of these providers in a competitive health industry that reduces cross subsidization is unknown. How the safety net will work for a burgeoning elder population is a question we will have to confront in the future.

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- 10.U.S. Bureau of the Census supra #1
- 11.The cost of ESI premiums are based on a KPMG national survey of firms with over 200 employees purchasing coverage for HMOs. Indemnity policies would cost approximately 6% more for families and 10% more for single coverage. Estimates of cost sharing are based on the Foster Higgins National Survey of Employer Sponsored Health Plans. The cost of individual insurance is much harder to estimate because there is wide variance among states and among individually rated premiums. As a result, these averages mean less for individuals, but are useful for estimating proportions of income nationally. We simply make a "ballpark" assumption based upon our study of the market.
- 12.Deborah J. Chollet and Adele M. Kirk supra #7
- 13.IBID
- 14.IBID

- 15.U.S. Department of Labor supra #5
- 16.Peter J. Cunningham, "Next Steps in Incremental Health Insurance Expansions: Who is More Deserving?" Center for Studying Health System Change. April 1998
- 17.This table is reproduced from the U.S. G.A.O. HEHS-97-150
- 18.U.S. Department of Labor supra #5
- 19.IBID
- 20.IBID
- 21.Employee Benefit Research Institute supra #4
- 22.Hewitt Associates, "Retiree Health Trends and Implications of Possible Medicare Reforms," Kaiser Medicare Policy Project September 1997
- 23.U.S. G.A.O. HEHS-97-150
- 24.U.S. Department of Labor supra #5
- 25.IBID
- 26.IBID
- 27.IBID
- 28.Paul Fronstin, "Health Insurance Portability: COBRA Expansions and Job Mortality," EBRI Issue Brief Number 194 February 1998
- 29.Deborah J. Chollet and Adele M. Kirk supra #7
- 30.Gabel et al., "The Financial Burden of Self-Paid Health Insurance on the Poor and Near-Poor," The Commonwealth Fund, April 1998.
- 31.Diane Rowland Judith Feder, and Patricia s. Keenan, Stuart H. Altman et al ed. "The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?" 1998
- 32.See David B. Kendall, "President Clinton's Medicare Buy-in Right Goal, Wrong Program," Policy Briefing, Progressive Policy Institute February, 1998

**APPENDIX**

**All persons aged 55-64 with Selected Sources of Insurance By Income Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Total 55-64 Pop.	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
<100% Poverty	2,220,112	613,855	359,950	299,139	60,811	253,905	984,661	388,233	713,151	735,086
100%-149%	1,662,533	736,059	511,212	398,703	112,509	224,847	573,733	305,482	326,815	481,198
150%-199%	1,636,822	1,023,437	783,175	611,072	172,104	240,262	442,380	276,246	146,860	331,779
200%-249%	1,652,596	1,225,836	959,665	735,367	224,298	266,171	323,415	194,198	72,079	282,611
250%-299%	1,570,235	1,270,654	1,120,525	839,136	281,388	150,129	252,197	128,009	61,513	185,548
>300%	12,724,177	11,379,785	10,288,085	7,685,225	2,602,860	1,091,700	1,331,417	529,832	256,175	957,537

**All persons aged 55-64 with Selected Sources of Insurance By Income Status  
Percentage within category of Income Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Total 55-64 Pop.	100.0%	75.7%	65.3%	49.2%	16.1%	10.4%	18.2%	8.5%	7.3%	13.9%
<100% Poverty	100.0%	27.6%	16.2%	13.5%	2.7%	11.4%	44.4%	17.5%	32.1%	33.1%
100%-149%	100.0%	44.3%	30.7%	24.0%	6.8%	13.5%	34.5%	18.4%	19.7%	28.9%
150%-199%	100.0%	62.5%	47.8%	37.3%	10.5%	14.7%	27.0%	16.9%	9.0%	20.3%
200%-249%	100.0%	74.2%	58.1%	44.5%	13.6%	16.1%	19.6%	11.8%	4.4%	17.1%
250%-299%	100.0%	80.9%	71.4%	53.4%	17.9%	9.6%	16.1%	8.2%	3.9%	11.8%
>300%	100.0%	89.4%	80.9%	60.4%	20.5%	8.6%	10.5%	4.2%	2.0%	7.5%

**All persons aged 55-64 with Selected Sources of Insurance By Income Status  
% Within Category of Health Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Total 55-64 Pop.	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<100% Poverty	10.3%	3.8%	2.6%	2.8%	1.8%	11.4%	25.2%	21.3%	45.2%	24.7%
100%-149%	7.7%	4.5%	3.6%	3.8%	3.3%	10.1%	14.7%	16.8%	20.7%	16.2%
150%-199%	7.6%	6.3%	5.6%	5.8%	5.0%	10.8%	11.3%	15.2%	9.3%	11.2%
200%-249%	7.7%	7.5%	6.8%	7.0%	6.5%	12.0%	8.3%	10.7%	4.6%	9.5%
250%-299%	7.3%	7.8%	8.0%	7.9%	8.1%	6.7%	6.5%	7.0%	3.9%	6.2%
>300%	59.3%	70.0%	73.4%	72.7%	75.4%	49.0%	34.1%	29.1%	16.2%	32.2%

**All persons aged 55-64 with Selected Sources of Insurance By Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Total Pop. 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
Excellent	4,230,059	3,639,627	3,216,253	2,468,291	747,962	423,374	351,066	68,889	100,339	460,109
Very good	5,784,378	4,946,258	4,367,310	3,369,121	998,189	578,948	542,796	140,959	149,660	621,690
Good	6,591,545	5,115,747	4,357,166	3,316,901	1,040,264	758,581	902,807	407,783	280,126	1,022,431
Fair	3,014,139	1,815,543	1,515,006	1,059,316	455,690	300,537	977,076	542,204	435,845	588,188
Poor	1,846,352	732,451	566,877	355,012	211,865	165,574	1,134,060	662,164	610,623	281,340

**All persons aged 55-64 with Selected Sources of Insurance By Health Status  
Percentage within category of Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Total Pop. 55-64	100.0%	75.7%	65.3%	49.2%	16.1%	10.4%	18.2%	8.5%	7.3%	13.9%
Excellent	100.0%	86.0%	76.0%	58.4%	17.7%	10.0%	8.3%	1.6%	2.4%	10.9%
Very good	100.0%	85.5%	75.5%	58.2%	17.3%	10.0%	9.4%	2.4%	2.6%	10.7%
Good	100.0%	77.6%	66.1%	50.3%	15.8%	11.5%	13.7%	6.2%	4.2%	15.5%
Fair	100.0%	60.2%	50.3%	35.1%	15.1%	10.0%	32.4%	18.0%	14.5%	19.5%
Poor	100.0%	39.7%	30.7%	19.2%	11.5%	9.0%	61.4%	35.9%	33.1%	15.2%

**All persons aged 55-64 with Selected Sources of Insurance By Health Status  
Percentage within category of Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Total Pop. 55-64	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Excellent	19.7%	22.4%	22.9%	23.4%	21.7%	19.0%	9.0%	3.8%	6.4%	15.5%
Very good	26.9%	30.4%	31.1%	31.9%	28.9%	26.0%	13.9%	7.7%	9.5%	20.9%
Good	30.7%	31.5%	31.1%	31.4%	30.1%	34.1%	23.1%	22.4%	17.8%	34.4%
Fair	14.0%	11.2%	10.8%	10.0%	13.2%	13.5%	25.0%	29.8%	27.6%	19.8%
Poor	8.6%	4.5%	4.0%	3.4%	6.1%	7.4%	29.0%	36.3%	38.7%	9.5%

**All Active Workers Aged 55-64 with Selected Sources of Insurance by Income Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Active 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
<100% Poverty	484,665	214,898	143,598	132,349	11,249	71,300	82,164	16,682	62,213	199,082
100%-149%	632,296	349,405	263,677	230,257	33,420	85,728	90,212	24,203	63,625	215,345
150%-199%	858,077	592,498	455,400	407,173	48,227	137,098	95,552	32,066	35,966	209,238
200%-249%	1,002,149	794,503	634,687	551,355	83,332	159,816	77,090	22,859	19,207	181,102
250%-299%	983,057	820,474	717,404	622,189	95,214	103,070	96,810	23,892	25,005	117,282
>300%	9,893,358	9,073,295	8,294,560	6,763,199	1,531,362	778,735	646,047	66,214	136,183	669,457

**All Active Workers Aged 55-64 with Selected Sources of Insurance by Income Status**

**Percentage within category of Income Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Active Working	100.0%	85.5%	75.9%	62.8%	13.0%	9.6%	7.9%	1.3%	2.5%	11.5%
<100% Poverty	100.0%	44.3%	29.6%	27.3%	2.3%	14.7%	17.0%	3.4%	12.8%	41.1%
100%-149%	100.0%	55.3%	41.7%	36.4%	5.3%	13.6%	14.3%	3.8%	10.1%	34.1%
150%-199%	100.0%	69.0%	53.1%	47.5%	5.6%	16.0%	11.1%	3.7%	4.2%	24.4%
200%-249%	100.0%	79.3%	63.3%	55.0%	8.3%	15.9%	7.7%	2.3%	1.9%	18.1%
250%-299%	100.0%	83.5%	73.0%	63.3%	9.7%	10.5%	9.8%	2.4%	2.5%	11.9%
>300%	100.0%	91.7%	83.8%	68.4%	15.5%	7.9%	6.5%	0.7%	1.4%	6.8%

**All Active Workers Aged 55-64 with Selected Sources of Insurance by Income Status**

**% Within Category of Health Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Active Working	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<100% Poverty	3.5%	1.8%	1.4%	1.5%	0.6%	5.3%	7.6%	9.0%	18.2%	12.5%
100%-149%	4.6%	2.9%	2.5%	2.6%	1.9%	6.4%	8.3%	13.0%	18.6%	13.5%
150%-199%	6.2%	5.0%	4.3%	4.7%	2.7%	10.3%	8.8%	17.2%	10.5%	13.1%
200%-249%	7.2%	6.7%	6.0%	6.3%	4.6%	12.0%	7.1%	12.3%	5.6%	11.4%
250%-299%	7.1%	6.9%	6.8%	7.1%	5.3%	7.7%	8.9%	12.9%	7.3%	7.4%
>300%	71.4%	76.6%	78.9%	77.7%	84.9%	58.3%	59.4%	35.6%	39.8%	42.1%

**All Active Workers Aged 55-64 with Selected Sources of Insurance by Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Active Workers	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
Excellent	3,294,399	2,939,702	2,670,209	2,197,930	472,280	269,493	190,186	6,381	58,499	301,395
Very good	4,360,945	3,840,649	3,433,292	2,846,432	586,860	407,357	293,577	24,353	81,294	417,339
Good	4,476,077	3,780,865	3,306,276	2,765,396	540,881	474,588	361,234	78,329	99,008	563,986
Fair	1,362,769	1,049,555	901,706	746,540	155,166	147,849	165,679	41,596	64,730	234,059
Poor	359,413	234,303	197,843	150,225	47,618	36,460	77,200	35,257	38,669	74,728

**All Active Workers aged 55-64 with Selected Sources of Insurance By Health Status  
Percentage within category of Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Active Workers	100.0%	85.5%	75.9%	62.8%	13.0%	9.6%	7.9%	1.3%	2.5%	11.5%
Excellent	100.0%	89.2%	81.1%	66.7%	14.3%	8.2%	5.8%	0.2%	1.8%	9.1%
Very good	100.0%	88.1%	78.7%	65.3%	13.5%	9.3%	6.7%	0.6%	1.9%	9.6%
Good	100.0%	84.5%	73.9%	61.8%	12.1%	10.6%	8.1%	1.7%	2.2%	12.6%
Fair	100.0%	77.0%	66.2%	54.8%	11.4%	10.8%	12.2%	3.1%	4.7%	17.2%
Poor	100.0%	65.2%	55.0%	41.8%	13.2%	10.1%	21.5%	9.8%	10.8%	20.8%

**All Active Workers aged 55-64 with Selected Sources of Insurance By Health Status  
Percentage within category of Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Active Workers	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Excellent	23.8%	24.8%	25.4%	25.2%	26.2%	20.2%	17.5%	3.4%	17.1%	18.9%
Very good	31.5%	32.4%	32.7%	32.7%	32.6%	30.5%	27.0%	13.1%	23.8%	26.2%
Good	32.3%	31.9%	31.5%	31.8%	30.0%	35.5%	33.2%	42.1%	28.9%	35.4%
Fair	9.8%	8.9%	8.6%	8.6%	8.6%	11.1%	15.2%	22.4%	18.9%	14.7%
Poor	2.6%	2.0%	1.9%	1.7%	2.6%	2.7%	7.1%	19.0%	11.3%	4.7%

**All Retired Persons Aged 55-64 with Selected Sources of Insurance by Income Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All 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
<100% Poverty	523,200	207,268	119,057	105,260	13,798	88,210	170,273	110,177	65,156	179,686
100%-149%	411,868	209,922	139,504	99,682	39,822	70,419	100,303	63,830	25,547	130,386
150%-199%	346,442	246,435	186,880	132,094	54,786	59,554	102,150	78,119	12,638	52,125
200%-249%	348,926	273,901	206,270	137,679	68,591	67,631	91,910	62,337	6,825	42,886
250%-299%	349,467	286,759	254,032	165,306	88,726	32,727	74,431	42,935	16,440	33,163
>300%	1,615,873	1,368,738	1,182,787	717,854	464,933	185,951	289,990	174,501	20,513	162,973

**All Retired Persons Aged 55-64 with Selected Sources of Insurance by Income Status  
Percentage within category of Income Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Retired	100.0%	72.1%	58.1%	37.8%	20.3%	14.0%	23.1%	14.8%	4.1%	16.7%
<100% Poverty	100.0%	39.6%	22.8%	20.1%	2.6%	16.9%	32.5%	21.1%	12.5%	34.3%
100%-149%	100.0%	51.0%	33.9%	24.2%	9.7%	17.1%	24.4%	15.5%	6.2%	31.7%
150%-199%	100.0%	71.1%	53.9%	38.1%	15.8%	17.2%	29.5%	22.5%	3.6%	15.0%
200%-249%	100.0%	78.5%	59.1%	39.5%	19.7%	19.4%	26.3%	17.9%	2.0%	12.3%
250%-299%	100.0%	82.1%	72.7%	47.3%	25.4%	9.4%	21.3%	12.3%	4.7%	9.5%
>300%	100.0%	84.7%	73.2%	44.4%	28.8%	11.5%	17.9%	10.8%	1.3%	10.1%

**All Retired Persons Aged 55-64 with Selected Sources of Insurance by Income Status  
% Within Category of Health Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Retired	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<100% Poverty	14.6%	8.0%	5.7%	7.8%	1.9%	17.5%	20.5%	20.7%	44.3%	29.9%
100%-149%	11.5%	8.1%	6.7%	7.3%	5.5%	14.0%	12.1%	12.0%	17.4%	21.7%
150%-199%	9.6%	9.5%	8.9%	9.7%	7.5%	11.8%	12.3%	14.7%	8.6%	8.7%
200%-249%	9.7%	10.6%	9.9%	10.1%	9.4%	13.4%	11.1%	11.7%	4.6%	7.1%
250%-299%	9.7%	11.1%	12.2%	12.2%	12.1%	6.5%	9.0%	8.1%	11.2%	5.5%
>300%	44.9%	52.8%	56.6%	52.9%	63.6%	36.9%	35.0%	32.8%	13.9%	27.1%

**All Retired Persons Aged 55-64 with Selected Sources of Insurance by Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All 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
Excellent	637,494	501,671	387,615	244,611	143,005	114,055	104,183	47,670	16,350	96,313
Very good	905,491	755,325	638,320	448,176	190,143	117,005	135,143	83,597	17,676	108,618
Good	1,225,846	879,781	699,082	453,071	246,011	180,699	247,218	165,937	38,365	225,771
Fair	600,874	346,001	282,385	174,163	108,223	63,616	216,196	141,897	39,265	138,442
Poor	226,069	110,246	81,128	37,854	43,274	29,118	126,319	92,799	35,464	32,075

**All Retired Persons aged 55-64 with Selected Sources of Insurance By Health Status  
Percentage within category of Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Retired	100.0%	72.1%	58.1%	37.8%	20.3%	14.0%	23.1%	14.8%	4.1%	16.7%
Excellent	100.0%	78.7%	60.8%	38.4%	22.4%	17.9%	16.3%	7.5%	2.6%	15.1%
Very good	100.0%	83.4%	70.5%	49.5%	21.0%	12.9%	14.9%	9.2%	2.0%	12.0%
Good	100.0%	71.8%	57.0%	37.0%	20.1%	14.7%	20.2%	13.5%	3.1%	18.4%
Fair	100.0%	57.6%	47.0%	29.0%	18.0%	10.6%	36.0%	23.6%	6.5%	23.0%
Poor	100.0%	48.8%	35.9%	16.7%	19.1%	12.9%	55.9%	41.0%	15.7%	14.2%

**All Retired Persons aged 55-64 with Selected Sources of Insurance By Health Status  
Percentage within category of Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Retired	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Excellent	17.7%	19.3%	18.6%	18.0%	19.6%	22.6%	12.6%	9.0%	11.1%	16.0%
Very good	25.2%	29.1%	30.6%	33.0%	26.0%	23.2%	16.3%	15.7%	12.0%	18.1%
Good	34.1%	33.9%	33.5%	33.4%	33.7%	35.8%	29.8%	31.2%	26.1%	37.6%
Fair	16.7%	13.3%	13.5%	12.8%	14.8%	12.6%	26.1%	26.7%	26.7%	23.0%
Poor	6.3%	4.3%	3.9%	2.8%	5.9%	5.8%	15.2%	17.4%	24.1%	5.3%

**All Ill or Disabled Persons Aged 55-64 with Selected Sources of Insurance by Income Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All 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
<100% Poverty	791,941	88,542	45,094	34,380	10,713	43,448	616,158	237,356	499,681	137,254
100%-149%	444,613	102,645	55,356	39,330	16,026	47,289	348,897	215,124	214,606	54,880
150%-199%	299,794	109,671	89,514	56,252	33,262	20,157	231,380	162,324	87,662	24,150
200%-249%	163,655	79,863	54,347	29,823	24,524	25,516	124,463	96,903	40,607	13,746
250%-299%	122,284	83,293	77,247	35,435	41,812	6,046	68,935	57,756	18,289	8,033
>300%	492,608	325,746	263,673	119,779	143,894	62,072	313,712	270,548	83,117	43,678

**All Ill or Disabled Persons Aged 55-64 with Selected Sources of Insurance by Income Status  
Percentage within category of Income Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Ill or Disabled	100.0%	34.1%	25.3%	13.6%	11.7%	8.8%	73.6%	44.9%	40.8%	12.2%
<100% Poverty	100.0%	11.2%	5.7%	4.3%	1.4%	5.5%	77.8%	30.0%	63.1%	17.3%
100%-149%	100.0%	23.1%	12.5%	8.8%	3.6%	10.6%	78.5%	48.4%	48.3%	12.3%
150%-199%	100.0%	36.6%	29.9%	18.8%	11.1%	6.7%	77.2%	54.1%	29.2%	8.1%
200%-249%	100.0%	48.8%	33.2%	18.2%	15.0%	15.6%	76.1%	59.2%	24.8%	8.4%
250%-299%	100.0%	68.1%	63.2%	29.0%	34.2%	4.9%	56.4%	47.2%	15.0%	6.6%
>300%	100.0%	66.1%	53.5%	24.3%	29.2%	12.6%	63.7%	54.9%	16.9%	8.9%

**All Ill or Disabled Persons Aged 55-64 with Selected Sources of Insurance by Income Status  
% Within Category of Health Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Ill or Disabled	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<100% Poverty	34.2%	11.2%	7.7%	10.9%	4.0%	21.2%	36.2%	22.8%	52.9%	48.7%
100%-149%	19.2%	13.0%	9.5%	12.5%	5.9%	23.1%	20.5%	20.7%	22.7%	19.5%
150%-199%	13.0%	13.9%	15.3%	17.9%	12.3%	9.9%	13.6%	15.6%	9.3%	8.6%
200%-249%	7.1%	10.1%	9.3%	9.5%	9.1%	12.5%	7.3%	9.3%	4.3%	4.9%
250%-299%	5.3%	10.5%	13.2%	11.2%	15.5%	3.0%	4.0%	5.6%	1.9%	2.9%
>300%	21.3%	41.2%	45.1%	38.0%	53.2%	30.3%	18.4%	26.0%	8.8%	15.5%

**All Ill or Disabled Persons Aged 55-64 with Selected Sources of Insurance by Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All 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
Excellent	27,907	6,174	4,290	2,010	2,281	1,884	23,281	9,950	15,589	1,603
Very good	79,137	32,354	21,270	11,809	9,461	11,084	59,772	28,092	34,169	4,990
Good	316,942	132,990	92,093	44,607	47,486	40,897	209,001	137,980	98,385	42,501
Fair	732,622	265,658	211,675	107,624	104,051	53,983	516,654	330,998	283,218	97,733
Poor	1,158,287	352,583	255,902	148,950	106,952	96,681	894,838	532,991	512,602	134,912

**All Ill or Disabled Persons aged 55-64 with Selected Sources of Insurance By Health Status**

**Percentage within category of Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Ill or Disabled	100.0%	34.1%	25.3%	13.6%	11.7%	8.8%	73.6%	44.9%	40.8%	12.2%
Excellent	100.0%	22.1%	15.4%	7.2%	8.2%	6.8%	83.4%	35.7%	55.9%	5.7%
Very good	100.0%	40.9%	26.9%	14.9%	12.0%	14.0%	75.5%	35.5%	43.2%	6.3%
Good	100.0%	42.0%	29.1%	14.1%	15.0%	12.9%	65.9%	43.5%	31.0%	13.4%
Fair	100.0%	36.3%	28.9%	14.7%	14.2%	7.4%	70.5%	45.2%	38.7%	13.3%
Poor	100.0%	30.4%	22.1%	12.9%	9.2%	8.3%	77.3%	46.0%	44.3%	11.6%

**All Ill or Disabled Persons aged 55-64 with Selected Sources of Insurance By Health Status**

**Percentage within category of Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
All Ill or Disabled	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Excellent	1.2%	0.8%	0.7%	0.6%	0.8%	0.9%	1.4%	1.0%	1.7%	0.6%
Very good	3.4%	4.1%	3.6%	3.7%	3.5%	5.4%	3.5%	2.7%	3.6%	1.8%
Good	13.7%	16.8%	15.7%	14.2%	17.6%	20.0%	12.3%	13.3%	10.4%	15.1%
Fair	31.6%	33.6%	36.2%	34.2%	38.5%	26.4%	30.3%	31.8%	30.0%	34.7%
Poor	50.0%	44.6%	43.7%	47.3%	39.6%	47.3%	52.5%	51.2%	54.3%	47.9%

**All Other Non-Workers**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Other Non-Wkrs	1,702,202	1,021,770	839,525	189,244	650,279	182,246	287,325	64,172	143,312	499,293
<100% Poverty	420,306	103,148	52,201	27,150	#VALUE!	50,947	116,065	24,018	86,100	219,062
100%-149%	173,757	74,087	52,676	29,434	23,242	21,412	34,321	#VALUE!	23,037	80,587
150%-199%	132,509	74,834	51,380	15,552	#VALUE!	23,452	13,299	#VALUE!	10,594	46,266
200%-249%	137,867	77,568	64,361	16,509	47,851	13,208	29,952	12,098	#VALUE!	44,877
250%-299%	115,426	80,127	71,841	16,206	55,636	#VALUE!	12,022	#VALUE!	#VALUE!	#VALUE!
>300%	722,337	612,006	547,064	84,393	462,671	64,942	81,667	#VALUE!	#VALUE!	81,430

**All Other Non-Workers**

**Percentage within category of Income Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Other Non-Wkrs	100.0%	60.0%	49.3%	11.1%	38.2%	10.7%	16.9%	3.8%	8.4%	29.3%
<100% Poverty	100.0%	24.5%	12.4%	6.5%	#VALUE!	12.1%	27.6%	5.7%	20.5%	52.1%
100%-149%	100.0%	42.6%	30.3%	16.9%	13.4%	12.3%	19.8%	#VALUE!	13.3%	46.4%
150%-199%	100.0%	56.5%	38.8%	11.7%	#VALUE!	17.7%	10.0%	#VALUE!	8.0%	34.9%
200%-249%	100.0%	56.3%	46.7%	12.0%	34.7%	9.6%	21.7%	8.8%	#VALUE!	32.6%
250%-299%	100.0%	69.4%	62.2%	14.0%	48.2%	#VALUE!	10.4%	#VALUE!	#VALUE!	#VALUE!
>300%	100.0%	84.7%	75.7%	11.7%	64.1%	9.0%	11.3%	#VALUE!	#VALUE!	11.3%

**All Other Non-Workers**

**% Within Category of Health Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Other Non-Wkrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<100% Poverty	24.7%	10.1%	6.2%	14.3%	#VALUE!	28.0%	40.4%	37.4%	60.1%	43.9%
100%-149%	10.2%	7.3%	6.3%	15.6%	3.6%	11.7%	11.9%	#VALUE!	16.1%	16.1%
150%-199%	7.8%	7.3%	6.1%	8.2%	#VALUE!	12.9%	4.6%	#VALUE!	7.4%	9.3%
200%-249%	8.1%	7.6%	7.7%	8.7%	7.4%	7.2%	10.4%	18.9%	#VALUE!	9.0%
250%-299%	6.8%	7.8%	8.6%	8.6%	8.6%	#VALUE!	4.2%	#VALUE!	#VALUE!	#VALUE!
>300%	42.4%	59.9%	65.2%	44.6%	71.1%	35.6%	28.4%	#VALUE!	#VALUE!	16.3%

**All Other Non-Workers Aged 55-64 with Selected Sources of Insurance by Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Other Non-Wkrs	1,702,202	1,021,770	839,525	189,244	650,279	182,246	287,325	64,172	143,312	499,293
Excellent	270,260	192,080	154,138	23,741	130,396	37,942	33,416	#VALUE!	#VALUE!	60,797
Very good	438,805	317,930	274,428	62,704	211,725	43,502	54,305	#VALUE!	16,522	90,743
Good	572,681	322,111	259,714	53,827	205,887	62,397	85,354	25,536	44,369	190,173
Fair	317,875	154,329	119,240	30,989	88,251	35,090	78,547	27,712	#VALUE!	117,954
Poor	102,583	35,319	32,004	#VALUE!	14,021	3,315	35,703	#VALUE!	23,888	39,625

**All Other Non-Workers Aged 55-64 with Selected Sources of Insurance by Health Status**

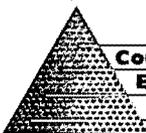
**Percentage within category of Health Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Other Non-Wkrs	100.0%	60.0%	49.3%	11.1%	38.2%	10.7%	16.9%	3.8%	8.4%	29.3%
Excellent	100.0%	71.1%	57.0%	8.8%	48.2%	14.0%	12.4%	#VALUE!	#VALUE!	22.5%
Very good	100.0%	72.5%	62.5%	14.3%	48.3%	9.9%	12.4%	#VALUE!	3.8%	20.7%
Good	100.0%	56.2%	45.4%	9.4%	36.0%	10.9%	14.9%	4.5%	7.7%	33.2%
Fair	100.0%	48.6%	37.5%	9.7%	27.8%	11.0%	24.7%	8.7%	#VALUE!	37.1%
Poor	100.0%	34.4%	31.2%	#VALUE!	13.7%	3.2%	34.8%	#VALUE!	23.3%	38.6%

**All Other Non-Workers Aged 55-64 with Selected Sources of Insurance by Health Status**

**Percentage within category of Insurance Status**

	Total	Total Private	Total ESI	Direct ESI	Indirect ESI	Other Private	Total Public	Medicare	Medicaid	Uninsured
Other Non-Wkrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Excellent	15.9%	18.8%	18.4%	12.5%	20.1%	20.8%	11.6%	#VALUE!	#VALUE!	12.2%
Very good	25.8%	31.1%	32.7%	33.1%	32.6%	23.9%	18.9%	#VALUE!	11.5%	18.2%
Good	33.6%	31.5%	30.9%	28.4%	31.7%	34.2%	29.7%	39.8%	31.0%	38.1%
Fair	18.7%	15.1%	14.2%	16.4%	13.6%	19.3%	27.3%	43.2%	#VALUE!	23.6%
Poor	6.0%	3.5%	3.8%	#VALUE!	2.2%	1.8%	12.4%	#VALUE!	16.7%	7.9%



**Council on the  
Economic Impact of  
Health System Change**

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