

Health Coverage for the Near Elderly

Testimony

before the

Committee on Labor and Human Resources

United States Senate

Thursday, June 25, 1998

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Thank you, Mr. Chairman, for the opportunity to testify before this committee. My name is David Shactman, and I am a Senior Research Associate at the Institute for Health Policy at Brandeis University. I have been asked to respond to the recent report issued by the GAO on problems encountered by near elderly Americans in obtaining private health insurance.

I want to begin by commending Mr. Scanlon and his staff at the GAO for a well researched, thorough, and comprehensive report on this important issue. I support virtually all of the findings in this study. In my testimony today, I will highlight some of the major issues identified in the report, and then discuss their implications for policy alternatives.

Problems of the Near Elderly in Obtaining Health Insurance

I believe that the GAO was correct in concluding that near elderly Americans, those between the ages of 54 and 65, confront significant barriers in obtaining private health insurance. I also agree that those barriers are likely to increase in the future. Because of their age and expected health costs, the near elderly who cannot get insurance through employers face costly premiums in the private individual market. Typically, the individual insurance premium paid by a 60 year-old male is more than three times that of a 25 year-old for the same coverage. Hence, a family premium (in the private individual market) for a near-elderly husband and wife is apt to be in the range of \$6,000 - \$8,000 per year. At a family income of 300% above the poverty level, that would constitute 19%-25% of annual family income; or at 200% of poverty such coverage would cost 28%-38% of annual income; a burdensome amount for any American family to pay.

High premium prices in the private individual market are not likely the result of high insurance company profits -- many insurance companies would prefer to avoid this market entirely. Rather, they are the result of higher expected health costs of older people, and increased costs of marketing and selling insurance policies on an individual basis. Furthermore, prices are higher because of adverse selection - the people who are willing to pay these high premiums are people who expect their health care costs to be high.

Employer sponsored insurance (ESI) avoids these problems because premiums are estimated for the entire group rather than for each individual, and because administrative and marketing expenses for group insurance are much less expensive. Availability of employer based insurance for this age group, however, has been declining precipitously. One reason is that fewer people in this age group are working. In 1960 over 85% of near elderly males were employed. By 1995 that had fallen to 65% -- a sea-change in the work habits of the near elderly. A second reason is that provision of both ESI and retiree health benefits (RHBs) is declining. Between 1988 and 1994 the proportion of retirees having RHBs fell from 44% to 34% -- a 23% decline in just six years! The declining trends in ESI and RHBs were well documented by the GAO.

Magnifying this problem is the fact that the near elderly have the worst health status of any age group except Medicare eligibles. Furthermore, those with the poorest health have the worst coverage. Those reporting their health as fair or poor have a 41% higher rate of uninsurance than those reporting their health as excellent, very good or good, despite the fact that they have four times as much public coverage.

In summary, the picture is one in which this growing age cohort of near elderly Americans have diminishing access to employer sponsored insurance and often cannot afford private

individual insurance. And, because of their diminished health status, they face the possibility of large and potentially catastrophic financial costs. Given this situation, it is fortunate that the committee is focusing on the health insurance problems of this age group.

Work Status, Income Diversity, and the Ability to Purchase Insurance

Mr. Chairman, having examined the GAO report and my own data, there are four major points I want to emphasize that have implications for policy alternatives:

1. Most of the uninsured near elderly are current workers, not early retirees
2. The difference between the proportion of family income needed to purchase group and individual insurance is huge for people earning modest incomes
3. The insured near elderly often pay burdensome proportions of their income to purchase private individual health insurance.
4. There is considerable income diversity in this age group, even among the uninsured, so one policy is not likely to fit all.

Most of the uninsured near elderly are current workers, not early retirees

The problems of the near elderly uninsured are not concerned only with those in early retirement. Of the three million near elderly uninsured, 54% are full-time active workers. These are apt to be hard working people (often low wage earners) whose employers do not offer health benefits, and they confront the same problems as others in this age group affording private individual insurance. In total, 3/4 of the near-elderly uninsured are either working or retired from work. Hence, policies that focus on reversing the decline of private, employer sponsored health benefits to both active and retired workers could have a significant impact on this group.

The difference between the proportion of family income needed to purchase group and individual insurance is huge for people earning modest incomes

For people in this age group, the cost difference between group and individual insurance is considerable, particularly for those at modest income levels. Individual premiums vary widely, and there is no reliable way to compute an overall average. We originally made assumptions of typical individual premiums which we revised in consideration of the GAO report.¹ The following table illustrates the proportion of income needed at 200% and 300% of poverty to purchase a) ESI with cost-sharing, b) ESI with no cost-sharing, and c) private individual insurance.

Employer Sponsored and Individual Insurance: Premium cost as a % of Income (persons aged 55-64)

	Out-of-Pocket Premium	Proportion of Income at 200% of Poverty	Proportion of Income at 300% of Poverty
Employer Sponsored Insurance Single Person 22% Cost-Sharing	\$414	3%	2%
Employer Sponsored Insurance Single Person No Cost-Sharing	\$1,883	12%	8%
Private Individual Insurance Single Person	\$3,000-\$4,000	19%-25%	13%-17%
Private Individual Insurance Family of Two	\$6,000-\$8,000	28%-38%	19%-25%

¹ Our original assumptions were higher than those in the GAO report. Their footnote in Appendix V (Colorado data in 1998) are consistent with our revised estimates. There is no correct amount, as averages mean little when the variance is so high -- but these rough estimates are useful for policy analysis.

A typical near elderly individual at 200% of poverty would pay 19-25% of annual income for private individual insurance, but 12% for ESI with no employer cost sharing. Those (at 200% of poverty) fortunate enough to have ESI with typical employer cost sharing, pay only 3% of annual income for health insurance. The increased cost of individual insurance over group rates is largely because individual insurance is age rated. The cost of administration and marketing is also greater for individual insurance. As a result, group insurance, makes a large difference for the near-elderly, 40% of whom have incomes below 300% of poverty.

The insured near elderly often pay burdensome proportions of their income to purchase individual health insurance.

At family incomes of 200% of poverty, close to half of the near elderly *who have no other source of insurance*, purchase health insurance in the private individual market. This is the case even though the cost of individual insurance at that income level is estimated to be 28-38% of annual income for a family of two.² Hence, many in this age group are paying burdensome amounts of income to purchase insurance, and policies that give them access to less expensive insurance could alleviate some of that financial burden.

There is Considerable Income Diversity -- One Policy Will Not Fit All

One might assume that policies to assist the near elderly uninsured must target low income people. However, as the table indicates below, there is much income diversity in this age group, even among the uninsured.

² These proportions of income would be for a comprehensive policy. The GAO report points out that these large proportions suggest that lower income people may be purchasing limited benefit products which are less expensive. In addition, self-reported income may not include other financial resources available to these people.

Income Distribution of the Uninsured Near Elderly	
Income Level	Per Cent
Below Poverty Level	24.7%
100%-200% of Poverty	27.3%
200%-300% of Poverty	26.6%
400% of Poverty or Above	21.3%
Total (all income levels)	99.9%

Almost half of the uninsured near elderly have family incomes over 200% of the poverty level, and incomes are divided almost evenly across the four poverty levels as shown above. Given this degree of income diversity, one policy is not apt to effectively target all of this age group.

Conclusions and Policy Implications

It is true that the highest rates of uninsurance occur within those groups of the near elderly having low incomes and/or poor health status. However, we know that even the near elderly uninsured are not primarily poor or unhealthy and that income is widely distributed among this group. Furthermore, those of this age group who have no other sources of insurance have shown a propensity to spend substantial portions of their income to purchase health insurance. Given these findings, a potential buy-in to group insurance (public or private), even without subsidies, could appeal to a significant portion of this age group. This is particularly true because the difference between the cost of group and individual insurance relative to income is substantial for people earning low and moderate incomes.

It is important to keep in mind, however, that such non-subsidized programs will mainly help those in the higher part of the earnings distribution. For those at lower incomes, less expensive premiums could relieve the financial burden that some of these individuals pay to buy private individual insurance, but most in the lower income range would need a program with substantial subsidies to enable them to purchase health insurance.

There are two ways in which policies to increase access to group insurance would benefit this population: first, more of this age group who are currently uninsured would be able to afford health insurance premiums; and second, those now paying burdensome proportions of their income to purchase private individual insurance could obtain some financial relief.

A variety of options are available to policy makers to increase the accessibility of group insurance. One option, proposed by the Clinton administration, is to let some members of this group buy into Medicare. The Clinton plan, with its low initial premium and deferred payback, is carefully structured to avoid adverse selection and should be effective for the population it targets. The population targeted is mostly 62-64 year-olds, who represent about 1/3 of the uninsured in this age group.

A second set of policy options is to allow the near elderly an opportunity to buy into group insurance outside of employment (sponsored by either public or private organizations). One proposal recommends a buy-in to the Federal Employees Health Benefit Plan (FEHBP). A buy-in to the existing FEHBP pool would, in effect, subsidize this age group and provide attractive premiums, but would raise the premiums of current FEHBP members. If a separate FEHBP pool was created, premium rates would be significantly higher than ESI rates. This could produce savings in administration and marketing, but could also attract mostly sicker individuals

causing rates to spiral. These options would primarily target people in the upper portion of the income strata, and help only a few at the lower end. If a public subsidy could be combined with a separate FEHBP pool, a much broader audience of the near elderly could be targeted. Such a plan, however, has not been discussed in detail.

A third set of options is to increase the incentive of employers to provide insurance (with or without cost-sharing) to their active and retired workers. Since 3/4 of the uninsured near elderly are actively working or retired from work, these options would target a substantial portion of this group. Policy makers could consider tax policies to ameliorate the impact of FAS-106,³ such as tax deductible pre-funding of retiree benefits. Other potential options to expand ESI include tax incentives to employers, expansions of COBRA, or employer mandates. Such options have to balance the cost to employers with the prospect that employers could terminate their voluntary provision of these benefits.

There are other policy alternatives in addition to group insurance. Expanding eligibility to government programs such as Medicare and Medicaid are options that have been used most frequently in the past to expand health insurance coverage. These options, of course, have budgetary implications and also could cause crowding-out of private insurance. Reforms of the individual and small group insurance market provide another set of options. However, there have been many attempts to improve this market, and it has remained expensive and unaffordable to

³ FAS-106, an accounting rule adopted by the Financial Accounting Standards Board, requires employers to recognize on their balance sheet the present value of all future retirement health obligations. In 1992, it was largely the adoption of this rule that caused the stockholder's equity in General Motors to fall from \$27.3 billion to \$6.2 billion in one year! The fact that corporations can eliminate that magnitude of liability by simply discontinuing benefits, bodes ill for the future of RHBs.

many. Recent studies have been pessimistic about the prospect for substantial improvements.

Our findings show that a considerable part of this population could benefit from the opportunity to purchase group insurance. Although the Clinton plan is limited in scope, it has been well structured and should help the population that it targets. Other more comprehensive plans, or possible private sector buy-ins should also be considered, but no detailed proposals have emerged at the time of this writing. Any comprehensive solution for this age group would have to include government subsidies, since a buy-in will not help most of those at the lower end of the income spectrum.

Thank you, Mr. Chairman, and members of the committee for allowing me to testify before you today on this important public policy issue. I hope my comments will be of some assistance in your deliberations.