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Senate Special Committee on Aging

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Expanding Health Insurance Coverage for the Near-Elderly

Good Morning. My name is John Sheils. I am a Senior Vice President with the Lewin Group specializing in analyses of proposals to expand health insurance coverage and reform the American health care system. I have been asked to discuss the likely impacts of health reform proposals on coverage and costs for people age 55 to 64, often referred to as the "near-elderly." The Lewin Group does not advocate for or against any legislation. I include at the end of my testimony supporting data for my remarks.

The population age 55 to 64 is highly diverse in terms of income, sources of health insurance and health status. Many in this group have well paying jobs and over 53 percent have employer-sponsored health insurance (ESI). Another 3.2 million are covered as early retirees under an employer health plan ***(Figure 1)***.[1] However, about 5.1 million people in this age group (16 percent) are uninsured and another 1.6 million (5.1 percent) are purchasing coverage on their own in the individual insurance market. This population is highly vulnerable to the onset of illness and its financial impacts.

The near-elderly are more likely to become ill or develop chronic health conditions than any other age group, except for those aged 65 and older. We estimate that nation-wide spending for personal health services (excluding long-term care) in 2008 will be about $9,440 per person age 55 to 64, compared with an average of about $3,710 for all others under the age of 55 ***(Figure 2)***.[2] While much of this cost will be covered by public and private insurance, about one in five people age 55 to 64 will have premium and out-of-pocket spending in excess of 15 percent of family income ***(Figure 3)***.[3] Premium and out-of-pocket spending for the near-elderly will average $5,060 per family in 2008.[4]

The uninsured in this group tend to be in poorer health and have lower incomes than their privately insured counterparts. About 19 percent of the uninsured age 55 to 64 have incomes below the Federal Poverty Level (FPL) (i.e., $10,400 for an individual and $21,200 for a family of 4), compared with 9.1 percent for all of those in this age group ***(Figure 4)***. About 22.4 percent of the uninsured age 55 to 64 report themselves to be in fair to poor health status compared to only about 11.7 percent among people with employer health coverage ***(Figure 5)***. There is also evidence that many of these

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1 Lewin Group Estimates using the pooled March Current Population Survey (CPS) data for 2005 through 2007.

2 Estimates include total spending for health services and supplies for primary and acute health care services and products such as prescription drugs. These figures exclude long-term care, insurance and program administration, public health, research and construction.

3 Includes out-of-pocket spending for health services (excluding long-term care), including deductibles, co-payments, and payments for non-covered services. Also includes family premium payments for public and private insurance, including the employee contribution for ESI coverage.

4 This is the average amount for families headed by someone age 55 to 64.

individuals delay receiving needed health care until they turn age 65 and qualify for Medicare.[5]

Private health insurance premiums can be very high for these people. We have estimated that the premium for a typical employer benefits package for someone age 55 to 64 would be about $744 per month (i.e., $8,928 per year), compared with an overall average of about $357 for all workers ***(Figure 6)***.[6] A family premium for a policy holder age 55 to 64 would be $1,363 per month, which equals about $16,356 per year.

People can purchase coverage from a former employer offering ESI for up to 18 months by paying a premium equal to 102 percent of the average cost for all workers in the firm (i.e., COBRA coverage). This can be a relatively good deal for the near-elderly because their premium is based upon the employer's pooled risk for all of their employees, regardless of age. However, these premiums are un-subsidized by the employer and can still be beyond the reach of many of those who are eligible.

The rising cost of health care has fueled a steady erosion of employer coverage affecting people in all age groups. The percentage of firms offering employer health benefits declined from 69 percent in 2000 to 60 percent in 2007.[7] The percentage of large firms offering retiree benefits also declined from 37 percent in 2000 to 33 percent in 2007. This is slowly increasing the number of people with individually purchased non-group insurance as their only coverage option.

Coverage in the individual market for people in this age group can be very expensive and difficult to find due to the practice of medical underwriting. Medical underwriting is a process whereby insurers deny coverage and/or increase premiums for people with a chronic illness. All but three states permit plans to deny coverage on the basis of health status, and all but two states permit health plans to increase premiums for people with health problems. Although many states limit the variation in premiums with health status, chronically ill people will typically pay much more for coverage than others.

It is important to recognize that for those who are healthy, medical underwriting can mean lower premiums due to the exclusion of higher-cost individuals from the carrier's risk pool. In many states with medical underwriting, the average premium for non-group coverage can be up to 20 percent lower than for employer coverage, due to the exclusion of the chronically ill from private non-group coverage.

There are few good options available to people in this age group who have a chronic health condition. For example, about 32 states have established "high risk" pools to

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5 Jody Schimmel, "Pent-up Demand and the Discovery of New Health Conditions after Medicare Enrollment," University of Michigan; and Li-Wu Chen, et al. "Pent-up Demand: Health Care use of the Uninsured Near-Elderly.

6 We assumed the Blue Cross / Blue Shield Standard Option PPO plan offered through the Federal Workers Health Benefits Program (FEHBP). We estimate that this plan is at the 60th percentile among plans in terms of actuarial value.

7 "Employer Health Benefits: Annual Survey 2007," the Kaiser Family Foundation and the Health Research and Education Trust (HRET).

provide coverage to people who have been denied coverage due to their health status. Under these plans, people are typically required to pay a premium equal to about 150 percent of "standard risk", which is an estimate of what costs would be for an average individual of their age.[8] High risk pool costs generally exceed the amount of premium received, which are typically financed with an assessment on insurers operating in the state.

However, the premiums charged in high risk pools still can be prohibitive. For example, in the Iowa high-risk pool, the premium for a plan with a $1,000 deductible ranges between $569 per month ($6,828 per year) at age 55 and $870 per month ($10,440 per year) at age 64.[9] Even with a $10,000 deductible, the premium is still about $417 per month for someone age 64.

People who can establish that they are substantially disabled may be eligible for coverage through Medicare or Medicaid. Qualified disabled people generally can obtain coverage under Medicare, but only after a two-year waiting period. The disabled are also eligible for Medicaid if they have low incomes, typically less than 74 percent of the FPL, but only after nearly exhausting their assets. In fact, in all but about 6 states, non-disabled adults under age 65 who do not have custodial responsibilities for children are not eligible for Medicaid regardless of how little income they have.

A range of proposals have emerged in recent years that would help expand coverage for the near-elderly. One relatively modest proposal would be to allow people age 62 through 64 to buy-in to Medicare by paying the Medicare premiums up to a maximum of 10 percent of the applicant's family income. Based upon a prior study, we estimate that such a program would cover about 914,000 people age 62 to 64, of whom about 285,000 would be newly insured people. The program would cost the federal government about $3.0 billion per year. [10]

Another approach would be to expand eligibility under Medicaid for those aged 55 to 64 living below the FPL regardless of disability status. We have estimated that this would cover about 1.1 million of the uninsured in this age group at a cost of about $16.7 billion per year.[11] However, these analyses have shown that any program to achieve a broad expansion in coverage for the near-elderly must deal with the sharply higher cost of coverage for this group for those at both low- and moderate-income levels.

We have studied several Congressional bills that would provide a fixed dollar tax-credit for individually purchased non-group insurance of between $1,500 and $3,000 for individuals with incomes as high as 300 percent of the FPL. While these bills would

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8 Premiums in high risk pools range between 150 percent and 200 percent of standard risk costs.

9 Premium data for the Iowa Comprehensive Health Association.

10 Updated estimates from: John Sheils, "The Potential Impact of the President's Medicare Buy-in Proposal on the number of Uninsured Persons and Medicare Program Costs," (report to the Commonwealth Fund), The Lewin Group, September 22, 2000.

11 About 2.6 million people between the ages of 55 and 64 would be eligible of which about 1.7 million would enroll. Enrollees would include about 1.1 million uninsured people and about 600,000 people who would drop private coverage to enroll in Medicaid. Estimates assume no premium requirement for enrollees.

greatly improve access for millions of Americans, the tax credit would be far too small to assure the affordability of coverage for people age 55 to 64. Even a tax credit of $3,000 would fall far short of what is needed to pay a high risk pool premium of $10,000 per year for someone with a modest income. Conversely, the flat credit would cover most of the premium charged to younger and healthier adults. Thus, it will be important for the credit to reflect variations in the actual cost of coverage.

An alternative to varying the tax credit with the premium amount would be to couple the tax credit with a requirement for all insurers to guarantee the issue of coverage at a "community rate" for all applicants. This means that insurers must accept all applicants and are required to charge the same premium to all regardless of age, gender or health status (variation is typically permitted for family type and geography). This would substantially lower the premium for the near-elderly resulting in increased coverage for this group, but would simultaneously increase premiums for the young, causing some to drop coverage.

Any program requiring all people to have insurance coverage will need a comprehensive plan for assuring the affordability of coverage to assure that all individuals can reasonably comply with the mandate. This is likely to require a combination of insurance market reforms and premium subsidies for families with incomes as high as 400 percent of the FPL.

Over the past 15 months, I have had the privilege to collaborate with Senator Wyden and his staff in designing the "Healthy Americans Act" (HAA). The proposal would achieve near universal health coverage under private insurance for all Americans, including those now on Medicaid, except for those already covered through Medicare or the military. Participants would chose from a selection of competing private plans offered through newly created regional purchasing organizations called "Health Help Agencies" (HHAs). All Americans would have coverage at least as comprehensive as the coverage now provided to members of Congress and federal workers.

The bill assures the affordability of coverage through a combination of insurance market reforms and premium subsidies. Under the HAA, all Americans are required to have health insurance. Insurers are required to sell insurance on a guaranteed issue basis with community rated premiums. The program would fully subsidize the premium for those living below 100 percent of the FPL, with the premium phasing-in for people living between 100 percent and 400 percent of the FPL.

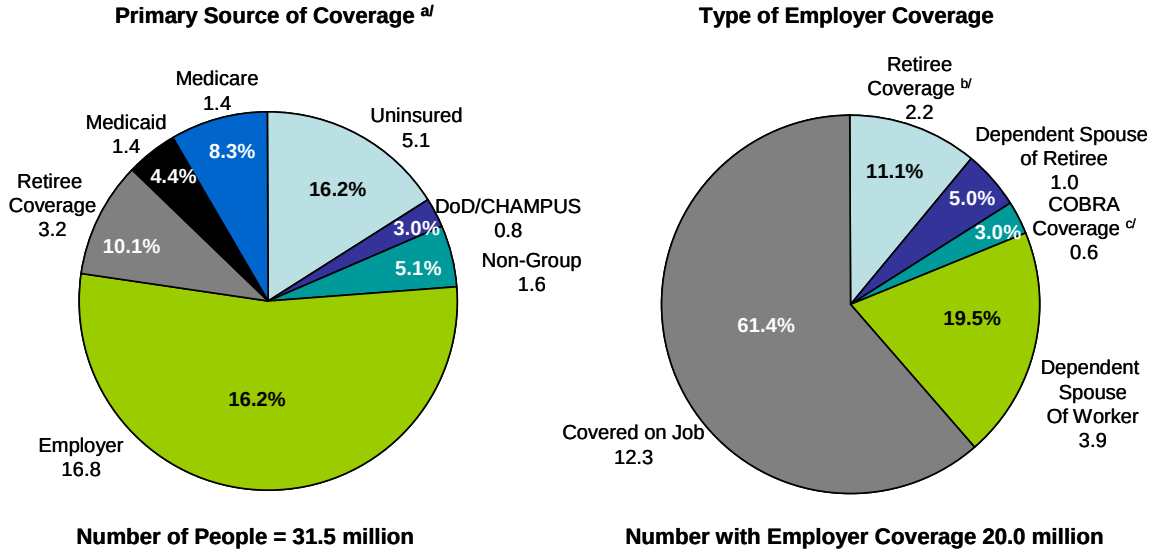
This combination of market reforms and premium subsidies is designed to assure the affordability of coverage across all age and income groups regardless of health status. People who do not have enough income to pay taxes are assumed to be eligible for the program with full subsidies, thus eliminating the need to apply separately for assistance as under the current Medicaid program. This approach is designed to simplify administration and assure high levels of enrollment in the program.

The act also seeks to change incentives for both consumers and providers to slow the rate of growth in health spending. Employers would be required to "cash-out" their

health plans by terminating their existing health coverage and paying the amount saved to their workers in the form of increased wages. People would then pay the full amount of the premium, less premium subsidies. The current tax exemption for employer provided health benefits is also eliminated to strengthen incentives for families to seek lower cost coverage. However, a new "health premium" tax deduction is created so that these wage increases do not increase federal personal income tax payments. To maintain incentives to control costs, the deduction is fixed and cannot be increased by purchasing more costly coverage.

Whatever approach is taken to expand health insurance coverage, it must be based upon a careful assessment of the affordability of coverage for all Americans and the near-elderly in particular. To be viable in the long-term, any program also must be accompanied with changes in patient and physician incentives that will help slow the rate of growth in health spending.

Figure 1
People Age 55-64 by Primary Source of Insurance: Average Monthly (millions)



a/ We assumed that Medicare is the primary source of coverage for persons reporting Medicare coverage. For others, DoD/TRICARE and employer coverage were assumed to be the primary source of coverage when reported. Medicaid was assumed to be the primary source of coverage if people reported Medicaid as their only sourse of coverage. Non-group coverage was assumed to be primary if this is the only source reported.

b/ People reporting that they have employer-based coverage in their own name are assumed to have retiree coverage if they reported that they are "retired" or if they are receiving a pension and are working less than 35 hours per week.

c/ Based on Lewin Group analysis of the pooled Survey of Income and Program Participation (SIPP) data.

Source: The Lewin Group analysis of the pooled March Current Population Survey (CPS) for 2005 through 2007corrected for under-reporting of Medicaid coverage.

Figure 2
Average Total Spending for Personal Health Care by Age in 2008 [a/]

	Average Spending
Under Age 19	**$2,154**
19-24	$2,526
25-34	$3,778
35-44	$4,953
45-54	$6,067
All under age 55	**$3,710**
55-64	$9,441
All under age 65	**$4,480**
Age 65+	$13,019
All People	**$5,499**

a/ Includes spending for all health services except long-term care including the amounts paid by public and private payers and the amounts paid out-of-pocket for care. Excludes long term care, insurance administration, public health, research and construction.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 3
Premium and Out-of-Pocket Health Spending for Families Headed by Someone Age 55 to 64: 2008

Average Spending	All Age 55-64	Insured	Uninsured [a/]
Average Spending per Family	$5,060	$5,926	$3,747
Families by Health Spending as a Percent of Income			
Less than 5%	44.8%	43.8%	49.7%
5.0% - 7.5%	13.6%	13.5%	13.7%
7.5% - 10.0%	9.6%	10.0%	7.5%
10.0% - 15.0%	11.8%	12.3%	9.5%
15% or more	20.3%	20.4%	19.7%
Total	**100%**	**100%**	**100%**

a/ Includes all families headed by someone age 55 to 64 with one or more family member that is uninsured.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 4
Distribution of People Age 55 – 64 by Family Income

	All Age 55-64	Uninsured 55-64
Total Family Income		
Less than $10,000	7.0%	14.3%
$10,000 - $19,000	8.8%	16.7%
$20,000 - $29,999	9.8%	17.0%
$30,000 - $39,999	9.9%	13.2%
$40,000 - $49,999	9.1%	8.1%
$50,000 - $74,999	19.3%	13.4%
$75,000 - $99,999	12.7%	7.5%
$100,000 or more	23.5%	9.8%
All Families	100.0%	100.0%
Income as a Percentage of the Federal Poverty Level (FPL)		
Below FPL	9.3%	19.0%
100% - 150% of FPL	6.1%	11.8%
150% - 200% of FPL	6.9%	12.1%
200% - 300% of FPL	13.6%	19.8%
300% - 400% of FPL	13.1%	12.0%
400% – 500% of FPL	11.3%	7.3%
500% or more of FPL	39.9%	17.9%
All Families	100.0%	100.0%

Source: Lewin Group analysis of the pooled March Current Population Survey (CPS) for 2005 – 2007.

Figure 5
Distribution of People Age 55 – 64 by Self-Reported Health Status and Primary Source of Coverage

Self-Reported Health Status	All People	Medicare	Medicaid	Employer Coverage	CHAMPUS	Non-Group Insurance	Uninsured
Excellent	18.6%	3.1%	6.1%	22.2%	12.9%	23.7%	15.0%
Very Good	30.4%	8.7%	12.1%	35.3%	24.0%	32.6%	27.8%
Good	30.5%	22.0%	25.9%	30.8%	28.8%	30.3%	34.9%
Fair	13.5%	33.8%	31.0%	9.0%	22.0%	10.2%	16.0%
Poor	7.0%	32.4%	24.9%	2.7%	12.3%	3.2%	6.4%
Total	100%	100%	100%	100%	100%	100%	100%
Number of People (millions)	31.5	2.6	1.4	20.0	0.8	1.6	5.1

Source: Lewin Group analysis of the pooled March Current Population Survey (CPS) for 2005 – 2007.

Figure 6
Estimated Monthly Premiums for the Federal Workers BC/BS Standard Option Health Plan for a Typical Population by Age and Gender of the Policy Holder [a/]

	Single	Family
Under 25 Males	$161.47	$583.32
25 - 34 Males	$197.38	$850.34
35 - 44 Males	$261.01	$1,015.23
45 - 54 Males	$438.18	$1,141.72
55 - 64 Males	$744.59	$1,363.86
Under 25 Females	$288.53	$621.39
25 - 34 Females	$363.14	$877.25
35 -44 Females	$422.48	$972.39
45 - 54 Females	$556.95	$1,149.37
55 - 64 Females	$801.36	$1,411.24
Average Across all Policy Holders	$357.47	$892.34
Per Member Per Month (PMPM) [b/]		$326.85

a/ Estimates are for the privately insured population. We assumed the Blue Cross / Blue Shield Standard Option PPO plan offered through the Federal Workers Health Benefits Program (FEHBP).
b/ Average across all covered people including policy holders and dependents.
Source: Lewin Group estimates using actuarial analyses prepared by NovaRest Consulting.