

Gaps in Health Insurance Coverage Among the Near Elderly

Statement to the Senate Finance Committee

Richard W. Johnson¹
Senior Research Associate
The Urban Institute

March 13, 2001

Thank you for the opportunity to address the committee about health insurance coverage among the near elderly, those between the ages of 55 and 64. This issue is becoming increasingly important as the first Americans born during the Baby Boom years begin to reach age 55. What distinguishes the near elderly from other groups is that they are not old enough to qualify for Medicare coverage (unless they are disabled), yet they are much more likely to experience serious health problems than younger persons. In addition, many near elderly persons have already retired, which can interfere with insurance coverage because most Americans receive their health benefits from their employers. Many of those without employer-sponsored insurance face problems obtaining coverage in the private nongroup market because of their age and health problems. Thus, health insurance coverage for the near elderly merits special attention.

I would like to make five points:

1. The near elderly are about as likely to be uninsured as younger Americans.
2. Uninsurance is concentrated among certain vulnerable groups, particularly Hispanics, blacks, and those with limited income and education.
3. Lack of insurance can be more serious for the near elderly than for younger people, because older people are more likely to have serious health problems. Families without insurance risk high out-of-pocket medical costs when serious illness strikes and may also defer necessary preventive care.
4. Even among near elderly Americans with coverage, there is cause for concern. Many receive coverage from private nongroup plans, which are generally less comprehensive and more expensive than coverage obtained from employers. Moreover, private nongroup policyholders are often subject to large increases in premiums, especially when they develop health problems.
5. Recent declines in the proportion of employers who offer retiree health insurance threaten to jeopardize coverage for future cohorts of near elderly Americans. Many retired Americans in their early sixties receive coverage from their former employers. If employers continue to scale back this benefit, or if they make it unaffordable to many participants by continuing to raise required premiums, rates of uninsurance among near elderly Americans may increase in upcoming years.

The Uninsured

About 10 percent of near elderly Americans lacked health insurance coverage in 1998, according to Urban Institute tabulations of data from the Health and Retirement Study, a nationally representative survey of Americans ages 50 and older that was conducted by the University of Michigan for the National Institute on Aging.² This figure is similar to or even somewhat lower than estimates of the rate of uninsurance for all nonelderly adults. Estimated rates of uninsurance differ across surveys, but virtually all surveys agree that the near elderly are no more likely to lack coverage than other nonelderly adults. For example, in the Urban Institute's National Survey of American Families, 13.4 percent of respondents ages 35 to 54 lacked coverage in 1997, compared with 9.5 percent of those ages 55 to 64.³ Concern about lack of coverage among near elderly Americans arises not because they are more likely to be uninsured than other age groups, but because the lack of coverage can have especially serious consequences at older ages.

As at younger ages, coverage rates vary substantially across different demographic groups of the near elderly. Figure 1 reports uninsurance rates by race, education, income, and overall health status. Lack of coverage at ages 55 to 64 is especially prevalent among Hispanics, blacks, those with incomes below 200 percent of the federal poverty level, those who did not complete high school, and those with fair or poor health. For example, 31 percent of Hispanics and 26 percent of those with limited incomes were uninsured in 1998. In addition, 15 percent of the near elderly in fair or poor health were uninsured in 1998, compared with only 8 percent of those reporting excellent or very good health.

Importance of Insurance Coverage for the Near Elderly

Health insurance is especially important for Americans in their late fifties and early sixties. Persons at this age are much more likely to experience serious health problems than younger persons. For example, individuals at ages 55 to 64 are six times as likely to have cancer than those ages 53 to 44 and five times as likely to suffer from heart disease.⁴ The prevalence of health problems at older ages translates into high health care expenses and strong demand for health insurance by the near elderly. Average health care expenditures are twice as high for those between the ages of 55 and 64 than for those 35 to 44.⁵

Numerous studies have documented the impact of health insurance status on health care access and utilization. At all ages, those without insurance are less likely to seek routine and preventive care, which can lead to a variety of preventable and potentially costly health episodes.⁶ Among the near elderly, the uninsured are about three times more likely than those with health benefits from their employers to lack a usual source of health care, meaning that the uninsured may not receive services when needed. In addition, women without insurance are only about 70 percent as likely to receive regular breast exams as those with employer-sponsored insurance.⁷ Because the incidence of many serious health problems increase with age, foregoing routine care can be especially hazardous for the near elderly.

Coverage Options for the Near Elderly

Like other Americans, the near elderly obtain health insurance from a mix of public and private sources. However, the relatively high risk of health problems that they face limits their coverage options.

Employer-Sponsored Coverage and Retiree Health Insurance Benefits

By the time individuals reach their early sixties, many have stopped working. At ages 62 to 64, only 48 percent of men were employed in 1998, compared with 85 percent at ages 50 to 54. For women, the employment rate in 1998 dropped from 71 percent for those between the ages of 50 and 54 to 36 percent for those ages 62 to 64. Because most insurance coverage is tied to employment, retirement complicates patterns of health insurance. Some firms continue to contribute toward their workers' health benefits after retirement. These benefits, known as retiree health insurance (RHI), generally continue until age 65, when Medicare coverage begins, and sometimes supplement Medicare benefits after age 65.

However, RHI benefits are not available to most Americans. As reported in Figure 2, only 37 percent of men and 34 percent of women ages 50 to 54 in 1998 reported access to RHI from their own employers or their spouses' employers. Not surprisingly, RHI benefits were most common in high paying jobs. About 45 percent of full-time workers ages 50 to 54 earning more than \$20 per hour participated in employer-sponsored health plans that offered RHI benefits. By contrast, only 29 percent of full-time workers earning less than \$10 per hour were offered RHI benefits.

Even those offered RHI may not be able to afford it. RHI benefits are usually less generous and require more cost sharing than health benefits provided to active workers. In 1995, for example, large firms that offered health benefits paid an average of 77 percent of the premium costs for active workers, but those that offered RHI paid only 52 percent of the premium costs for retired workers.⁸ About one in ten early retirees who are offered RHI benefits turn it down because they say it is too expensive.⁹

Most retirees who lack access to RHI can continue to receive their employer-sponsored coverage for a limited time. Under COBRA regulations, employers with 20 or more employees are required to provide continuation coverage to former workers for up to 18 months (or 29 months if the worker is disabled). However, the cost to the beneficiary can be high because former workers assume full responsibility for 102 percent of the employer's group rate. These costs contribute to the low take-up rate for COBRA coverage.¹⁰ Only about 2 percent of the near elderly report COBRA coverage, according to Urban Institute estimates. Because of the limited availability of RHI coverage, the limited duration of COBRA coverage, and the relatively high costs of both types of coverage, the near elderly are significantly less likely than younger adults to have employer-sponsored coverage. According to data from the National Survey of America's Families, 73 percent of persons ages 55 to 64 received coverage from an employer in 1997, compared with 76 percent of those ages 35 to 54.¹¹

Public Sources

Near elderly persons who lack job-related health benefits have limited insurance options. Nonelderly adults can qualify for Medicare or Medicaid benefits only if they are blind or disabled. In addition, Medicaid benefits are subject to strict income and asset tests, and Medicare benefits do not begin until at least 29 months after the onset of disability.

Private Nongroup Coverage

Given these constraints, many near elderly persons without coverage from employers turn to the private nongroup market. Indeed, private nongroup coverage rates are almost twice as high at ages 55 to 64 than at ages 35 to 54.¹² However, there are a number of important drawbacks to relying upon the private nongroup market at older ages. A primary concern is the affordability of nongroup coverage. Compared to those for group policies, premiums are generally higher for private nongroup plans because risk pooling is more limited, administrative costs are higher, and employer subsidies are generally unavailable. Among a sample of individuals between the ages of 53 and 63 in 1994, annual nongroup premium costs were about \$2100, while those with employer-sponsored coverage paid out of pocket just under \$900.¹³

The affordability issue is compounded by the health problems that many retirees have when they enter the nongroup market, increasing the risk-rated premiums they face. Figure 3 reports the average monthly premiums that a sample of Americans ages 62 to 64 faced in 1998 for comprehensive nongroup coverage. Estimated premium prices were based on a survey of insurance providers conducted by the Urban Institute. Private nongroup premiums faced by individuals with two or more serious health problems were more than twice as high as those faced by individuals without any serious health problems. When previously healthy individuals become sick, their premiums can rise dramatically. Because health problems are more common among the poor than those with higher incomes, those in poverty faced substantially higher premiums on average than other individuals. Thus, the poor are doubly disadvantaged in their efforts to acquire coverage in the private market, because they lack sufficient resources to purchase health insurance and because they face particularly high prices.

Related to the high price of private nongroup coverage is the problem of limited benefits. Many private nongroup plans do not provide comprehensive benefits to policyholders. Because of the high cost of comprehensive coverage, many who purchase nongroup policies opt for plans that offer only limited coverage, with high deductibles, high cost-sharing requirements, and limited benefits. Moreover, insurers are often reluctant to offer low-deductible comprehensive coverage because these policies generally attract persons with health problems who use many services. This adverse selection problem drives up premiums and discourages all but the most heavy users of health services from purchasing coverage, causing the market for these policies to break down. Many insurers also exclude coverage for pre-existing health conditions. Urban Institute estimates indicate that about 12 percent of Americans ages 55 to 64 with private nongroup coverage have restrictions on their policies because of pre-existing conditions. Consequently, many near elderly persons with nongroup coverage may be underinsured, leaving them vulnerable to high out-of-pocket costs if they become seriously ill.

Even when near elderly Americans are able to afford the high cost of private nongroup coverage, they may be denied coverage by insurers. According to a recent study of the nongroup health insurance market in ten states, insurers often deny coverage for such health problems as rheumatoid arthritis, chronic headaches, kidney stones, angina, heart disease, and stroke.¹⁴

A number of laws and regulations at both the federal and state levels have been enacted recently to address problems with the private nongroup market, but it is not yet clear how effective these initiatives will be in improving access to nongroup coverage for near elderly Americans. With the passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, federal law now requires insurers to offer policies to retirees who have exhausted COBRA coverage. However, there are no restrictions on the premiums they can charge, so this legislation does not address concerns about the affordability of nongroup coverage. Some states now limit the variation in the price that private insurers can charge across different age or health groups, which could lower premium costs for the near elderly, but these restrictions are not present in every state. Moreover, restrictions on premium variation without other market reforms could raise health insurance premiums for everyone in the private nongroup market.

Types of Coverage Received by Near Elderly Americans in 1998

Figure 4 reports the distribution of health insurance coverage in 1998 for men and women between the ages of 55 and 64, based on estimates from the Health and Retirement Study. Overall, for men and women combined, about 41 percent of near elderly Americans were covered by their own current employers. Another 13 percent received coverage from former employers, and 16 percent received coverage through their spouses' employers. In all, 73 percent of the near elderly had workplace coverage. About 8 percent purchased private nongroup coverage and 9 percent received public benefits through the Medicare or Medicaid programs. Just over 10 percent of the near elderly were uninsured in 1998.

There are important differences in coverage between men and women in their fifties and early sixties. As reported in Figure 4, women are much less likely than men to receive coverage through their own employment, either as active workers or as retirees. Conversely, they are much more likely than men to receive coverage from their spouses' employers. As a result, divorcees and widows stand to lose their insurance coverage. Women are also more likely than men to purchase private nongroup coverage and are more likely to be uninsured (11.4 percent vs. 9.1 percent).

Rates of uninsurance increase slightly as individuals move from their early fifties to their early sixties. As reported in Figure 5, rates of uninsurance in 1998 rose from 9 percent among those between the ages of 50 and 54 to 10.3 percent among those between the ages of 62 and 64. However, differences in the type of coverage individuals received were more dramatic than differences in uninsurance rates. The likelihood that individuals receive health benefits from current employers steadily falls during this critical decade of life, while the likelihood of receiving coverage from former employers, private nongroup plans, and the public sector steadily rises. For example, at ages 50 to 54, some 74 percent of Americans reported coverage

from current employers. The comparable figure is only 36 percent for ages 62 to 64. Coverage rates from former employers were 30 percent at ages 62 to 64 – far higher than the 6 percent rate for Americans at ages 50 to 54. Even so, coverage from current employers drops off so precipitously for older groups that overall employer-sponsored coverage was 14 percentage points lower at ages 62 to 64 than at ages 50 to 54 (66 percent vs. 80 percent). What does offset the shortfall in employer-sponsored coverage at older ages are sharp increases in private nongroup coverage and public coverage, both of which were twice as prevalent at ages 62 to 64 than at ages 50 to 54. Almost all of this rise in public coverage comes from an increase in disability-related Medicare coverage.

Changes in the composition of coverage as individuals approach the Medicare eligibility age have important implications for the health security of the near elderly. Private nongroup coverage is generally less comprehensive and more expensive than employer-sponsored coverage. In addition, individuals who develop serious health problems can experience large premium hikes. Similarly, individuals pay more for retiree health insurance than for employer-sponsored insurance received while working. Recent declines in the proportion of employers offering retiree health insurance may also jeopardize coverage for future cohorts of near elderly Americans.

Outlook for Coverage of the Near Elderly in the Future

Insurance coverage for the near elderly may deteriorate in the near future, primarily because of recent declines in RHI coverage. The availability of RHI benefits has been declining steadily over the past decade. Recent declines in the availability of RHI may further erode employer-sponsored coverage for the near elderly in upcoming years. Between 1991 and 1998, for example, the prevalence of retiree health benefits sponsored by large employers fell from 80 percent to 67 percent.¹⁵ When these workers retire in upcoming years, fewer of them will be able to rely upon employer-sponsored coverage than the current generation of near elderly retirees.

At the same time, employers have been shifting more of the costs of RHI plans on to participants. Among full-time workers in medium and large firms that offered RHI coverage, the percentage who would be required to make contributions upon retirement to offset at least part of the cost of their plans increased from 35 percent in 1985 to 91 percent in 1995.¹⁶ When these workers retire, the high level of contributions required by their former employers might force many of them to decline RHI coverage. Other cost-cutting measures that firms have increasingly implemented in recent years include the tightening of eligibility requirements, the introduction of caps on the future obligations that employers could face for their RHI plans, and the substitution of indemnity plans with managed care plans. The cutbacks are generally attributed to rising health care costs and new accounting rules, introduced in 1993, requiring employers for the first time to recognize the present value of expected future retiree health care costs as liabilities on their balance sheets.

Another threat to RHI coverage for future retirees is that employers are generally not legally bound to honor their past promises about retiree health benefits. Unlike employer-

sponsored pension plans, retiree health benefit plans do not vest. As a result, employers can amend or terminate retiree health benefits at will, as long as they indicate that the terms of the plan are subject to change. Even though employers may offer retiree health benefits when individuals are working or when they retire, there is no guarantee that those benefits will continue throughout the individuals' lifetimes or even until they become eligible for Medicare coverage.

One possible response to the decline in RHI benefits is that workers could delay retirement until they reach the Medicare eligibility age. By remaining at work instead of withdrawing from the labor force, they could retain their employer-sponsored health benefits. In fact, a number of studies have shown that workers are substantially less likely to retire if their employer-sponsored coverage does not continue until they reach age 65 than if their employers provide RHI benefits.¹⁷ Encouraging healthy workers to remain in the labor force has some obvious public policy advantages. But, for those who are forced to retire early because of health problems, the lack of RHI benefits can have serious consequences, especially if they do not qualify for disability-related Medicare benefits. Even for those who do qualify for Medicare, the 29-month waiting period for benefits can be burdensome.

Implications for Reform

In many respects, policy issues concerning uninsurance among the near elderly are similar to those concerning uninsurance among younger adults. The overall percentage of near elderly Americans without health insurance is no higher than the percentage of younger adults lacking coverage, and across all nonelderly ages uninsurance is concentrated among certain disadvantaged groups. Thus, just as for younger persons, for many persons ages 55 to 64 the lack of health insurance results from their limited incomes. For other near elderly persons, the lack of adequate insurance coverage is related to their age and to health problems. Some lose health benefits when they retire, and comprehensive health insurance coverage is difficult to purchase in the nongroup market at older ages.

The expansion of tax credits for the purchase of individual health insurance plans has often been discussed as a possible way to reduce uninsurance rates. Although my task here is not to discuss the advantages or disadvantages of this approach, it is important to note that the problems that the near elderly confront in the private nongroup market suggest that tax credits will have only limited effects on coverage rates at older ages. Reducing the after-tax premium cost to individuals will not resolve the problems of adverse selection, denials of coverage, and pre-existing condition exclusions that confront many near elderly Americans in the private nongroup market.

A Medicare buy-in plan, in which persons below the age of full eligibility would be allowed to purchase Medicare coverage, has also been proposed as a way to help uninsured near elderly Americans obtain coverage. By offering Medicare benefits, the buy-in approach does not rely on the fragile nongroup market. A forthcoming study by the Kaiser Family Foundation indicates that a *cost-neutral* buy-in plan would not substantially increase coverage rates.¹⁸ Because many of the uninsured have limited incomes, few persons without private coverage

could afford the high premiums that the program would have to charge to cover its costs. However, a buy-in program could substantially improve coverage rates for the near elderly if it subsidized premium costs for low-income individuals. Under one set of income-related premiums, a Medicare buy-in plan could cut uninsurance rates for the near elderly almost in half.

Endnotes

¹ This statement reflects the views of the author and does not necessarily represent the views of the Urban Institute, its sponsors, or its Board of Trustees.

² The estimates of uninsurance reported here are substantially lower than those derived from the Current Population Survey (CPS), which are frequently cited, but they are consistent with estimates from other sources, including the National Survey of American Families. CPS estimates may be higher because it asks about coverage during the previous calendar year, whereas the Health and Retirement Study measures insurance coverage at the time of the survey. In addition, the CPS asks a series of questions about insurance coverage and then assumes that any person not designated as being covered through any type of insurance is uninsured. The Health and Retirement Study adds a question that verifies whether respondents who appear not to have coverage are, in fact, uninsured.

³ Brennan, Niall. 2000. "Health Insurance Coverage of the Near Elderly." *New Federalism National Survey of American Families Series B*, No. B-21. Washington, D.C.: The Urban Institute.

⁴ The incidence of cancer at ages 55 to 64 is 1,052 per 100,000, compared with only 172 per 100,000 at ages 35 to 44. (Source: Ries LAG, Wingo PA, Miller DS, Howe HL, Weir HK, Rosenberg HM, Vernon SW, Cronin K, Edwards BK. 2000. "The Annual Report to the Nation on the Status of Cancer, 1973-1997, With a Special Section on Colorectal Cancer." *Cancer* 88(10): 2398-424.) The prevalence of heart disease increases from 31 per 1,000 among men under age 45 to 134 per 1,000 among men between the ages of 45 and 64. (Source: National Center for Health Statistics. 1999. *Current Estimates from the National Health Interview Survey 1999*. Vital and Health Statistics Series 10, No. 200. Public Health Service. Hyattsville, MD: U.S. Government Printing Office.)

⁵ General Accounting Office. 1998. "Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year Olds." GAO/HEHS-98-133. Washington, D.C.: General Accounting Office.

⁶ Weissman, Joel S., and Arnold M. Epstein. 1994. *Falling Through the Safety Net: Insurance Status and Access to Care*. Baltimore, MD: Johns Hopkins University Press.

⁷ Brennan, *op. cit.*

⁸ Foster Higgins. 1996. *National Survey of Employer Sponsored Health Plans, 1995*. New York: A. Foster Higgins & Co., Inc.

⁹ Loprest, Pamela. 1998 "Retiree Health Benefits: Availability from Employers and Participation by Employees." *The Gerontologist* 38(6): 684-694.

¹⁰ Flynn, Patrice. 1994. "COBRA Qualifying Events and Elections, 1987-1991." *Inquiry* 31: 215-220.

¹¹ Brennan, *op. cit.*

¹² Brennan, *op. cit.*

¹³ Johnson, Richard W., and Stephen Crystal. 2000. "Uninsured Status and Out-of-Pocket Costs at Midlife." *Health Services Research* 35 (5, Part I): 911-932.

¹⁴ Chollet, Deborah J., and Adele M. Kirk. 1998. "Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States." Henry J. Kaiser Family Foundation Report No. 1376. Menlo Park, CA: Henry J. Kaiser Family Foundation.

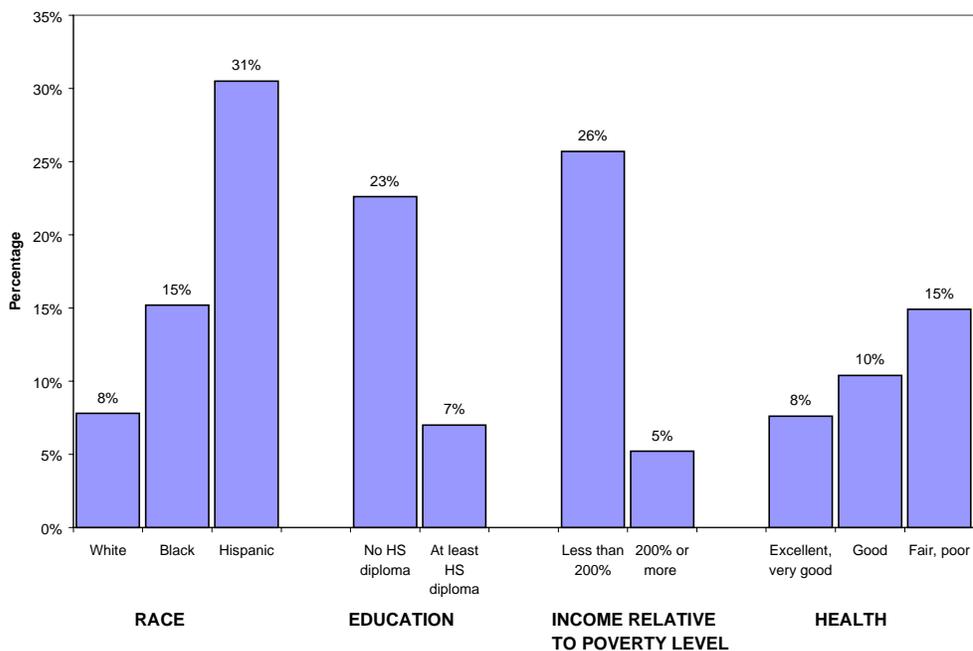
¹⁵ McArdle, Frank, Steve Coppock, Dale Yamamoto, and Andrew Zebrak. 1999. "Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits." Menlo Park, CA: Henry J. Kaiser Family Foundation.

¹⁶ Bureau of Labor Statistics. 1998. *Employee Benefits in Medium and Large Private Establishments, 1995*. Washington, D.C.: U.S. Government Printing Office; Karoly, Lynn A., and Jeannette A. Rogowski. 1998b. "Retiree Health Benefits and Retirement Behavior: Implications for Health Policy." In *Health Benefits and the Workforce*, vol. 2 (43-71). Washington, D.C.: U.S. Department of Labor.

¹⁷ Johnson, Richard W., Amy J. Davidoff, and Kevin Perese. 2000. "Health Insurance Costs and Early Retirement Decisions." Washington, D.C.: The Urban Institute.

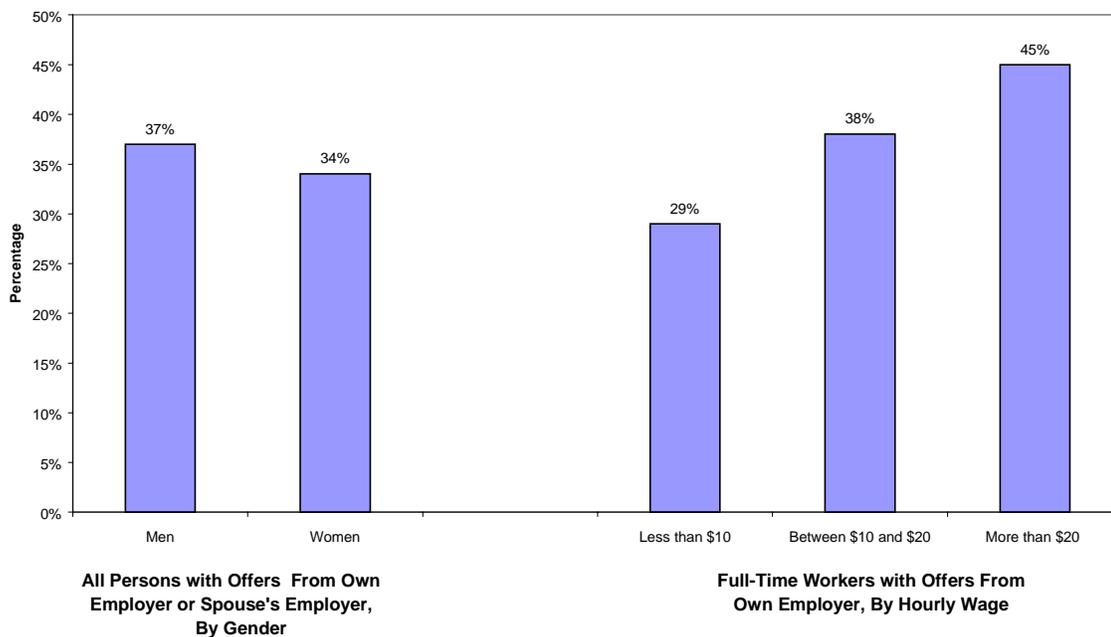
¹⁸ Johnson, Richard W., Marilyn Moon, and Amy J. Davidoff. Forthcoming. "A Medicare Buy In for the Near Elderly: Design Issues and Potential Effects on Coverage." Washington, D.C.: Henry J. Kaiser Family Foundation.

Figure 1
Percentage Uninsured, Ages 55 to 64, by Demographic Characteristic, 1998



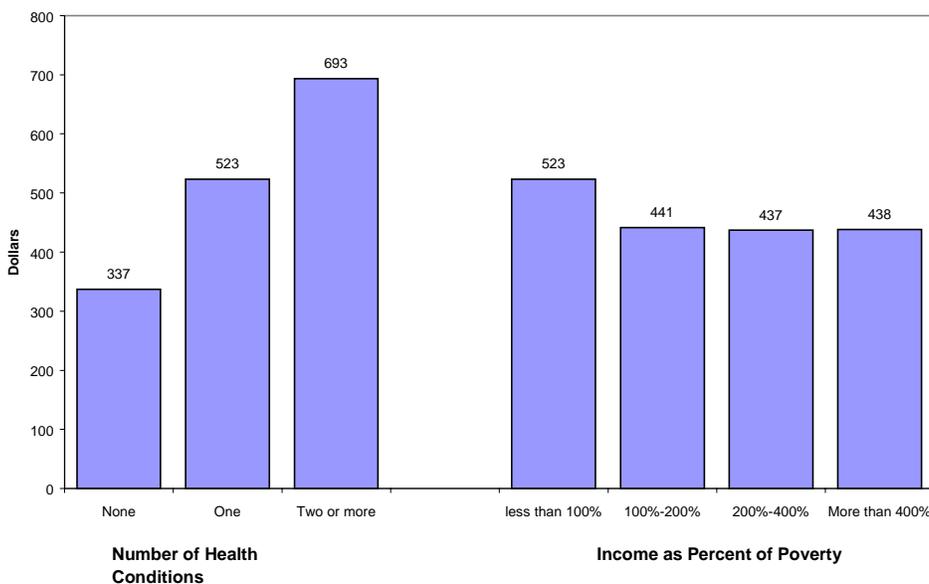
Source: Urban Institute tabulations from the Health and Retirement Study, 2001

Figure 2
Percentage of Persons Ages 50 to 54 With Access to RHI Benefits, 1998



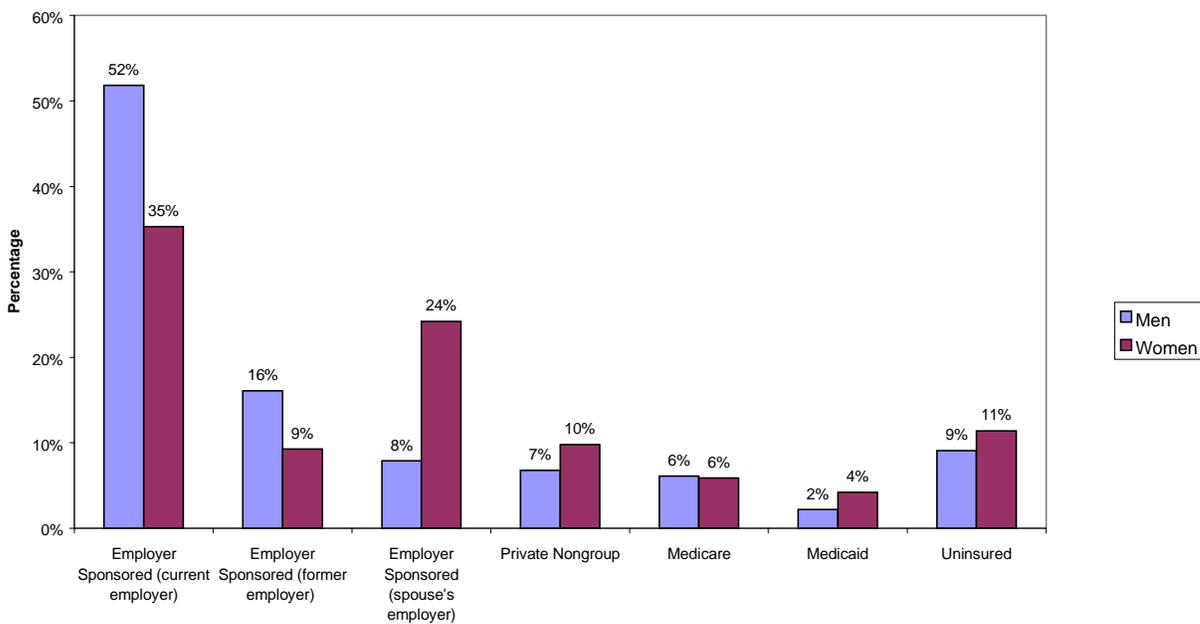
Source: Urban Institute tabulations from the 1998 Health and Retirement Study, 2001

Figure 3
Average Mean Monthly Premiums for Private Nongroup Coverage, Ages 62 to 64, 1998



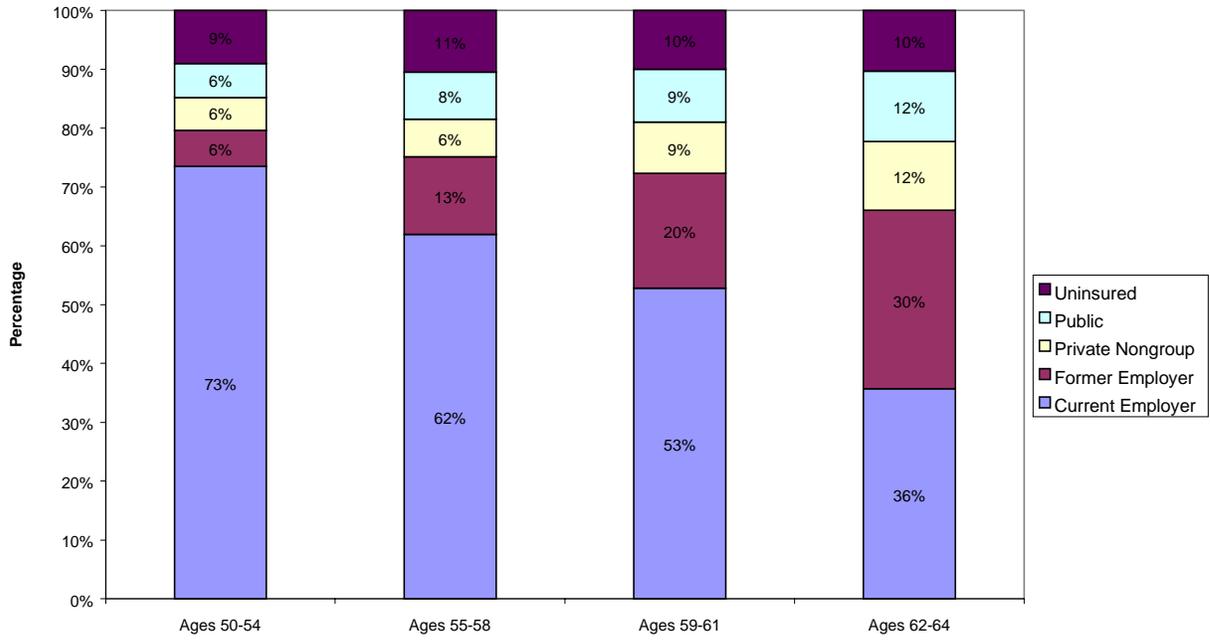
Source: Urban Institute tabulations from the 1998 Health and Retirement Study and survey of private insurers, 2001

Figure 4
Health Insurance Coverage at Ages 55 to 64, 1998



Source: Urban Institute tabulations from the 1998 Health and Retirement Study, 2001

Figure 5
Health Insurance Coverage by Age, 1998



Source: Urban Institute tabulations from the 1998 Health and Retirement Study, 2001