Policy Options for Filling Gaps in the Health Insurance Coverage of Older Workers and Early Retirees

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Policy Options for Filling Gaps in the Health Insurance Coverage of Older Workers and Early Retirees

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This chapter offers answers to two questions concerning the health insurance of Americans between the ages of 55 and 64: 1) who has the greatest need for health insurance policy intervention? and 2) which types of policies are likely to be most effective for these subgroups? The chapter draws upon recent literature and other chapters of this book. I present a brief analysis of a broad range of policy options, as well as some quantitative simulation exercises which highlight key features of alternative targeted coverage strategies. While care was taken to make the estimates realistic, all simulations are at best illustrative of certain principles and should not be interpreted as definitive estimates of the cost or coverage impacts of particular proposals. Finally, I use the lessons from the examples to explore a relatively new way of thinking about financing subsidies for the purchase of health insurance. This view may have particular relevance for the age 55–64 cohort as it grows in the coming decades.

WHO HAS THE GREATEST NEED FOR HEALTH INSURANCE POLICY INTERVENTION?

Recent policy discussions of coverage expansion options often focus on children or their parents, partly because members of the age 55–64 cohort are among the non-elderly most likely to have health insurance in the United States (Campbell 1999; Swartz and Stevenson 2001). Swartz and Stevenson report that only 15 percent of this group lacked health insurance in 1998, compared with 30 percent of 18-to 24-year-olds and 24 percent of 25-to 34-year-olds. Only the prime age
working population, 45–54, had a lower incidence of being uninsured (13.6 percent).

However, a compelling case can be made that the consequences of being without health insurance are potentially much more damaging to this oldest pre-Medicare cohort than to other non-elderly citizens, for two reasons. First, the financial risk of no coverage is greater.

Table 1, constructed with 1987 National Medical Expenditure Survey (NMES) data, makes the point about higher financial risk. It reports ratios of per capita spending amounts for all adults, not just workers, by age and health status category. It shows that a 55- to 64-year-old man in good health (self-reporting excellent or good) should expect to spend 2.5 times as much as a young man (21–29) in equally good health. But the age-cost gradient is steeper for men in bad health (fair or poor), at 4.2. For women, the direction is the same, but the severity of the effect is less, largely because maternity costs are associated with younger women. Interestingly, the pure health status gradient is identical across genders at 2.7. Thus, the near-elderly in bad health can expect to spend 2.7 times as much as their cohort counterparts in good health.

Table 2 shows the percentage of each age cohort, by gender, that reported fair or poor health status in the 1987 NMES. These data show that the incidence of bad health increases dramatically with age. So, while they are relatively well covered as a group, 55- to 64-year-olds are indeed more likely to be financially vulnerable to the absence of health insurance coverage than other non-elderly Americans; they can expect to spend more if uninsured for both age and declining health status reasons.

Table 1  Per-Capita Spending Ratios by Gender, Age, and Health Status

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good health(^a)</td>
<td>Bad health</td>
</tr>
<tr>
<td>Ages 55–64 / 21–29</td>
<td>2.5</td>
<td>4.2</td>
</tr>
<tr>
<td>Age 55–64, bad/good health</td>
<td>—</td>
<td>2.7</td>
</tr>
</tbody>
</table>

SOURCE: Author’s calculations using 1987 NMES data.

\(^a\) Good health = excellent or good; bad health = fair or poor
Table 2 Share of Each Age Group in Fair or Poor Health Status (%)  

<table>
<thead>
<tr>
<th>Age</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-29</td>
<td>8.8</td>
<td>12.0</td>
</tr>
<tr>
<td>30-54</td>
<td>14.8</td>
<td>18.1</td>
</tr>
<tr>
<td>55-64</td>
<td>34.1</td>
<td>35.6</td>
</tr>
</tbody>
</table>

SOURCE: Author’s tabulations using 1987 NMES.

Second, potentially greater vulnerability from having no health insurance is greater health risk. Many studies have found that the uninsured enjoy less access to care and that both their health status and mortality risk are worse than is the case for the insured (Franks, Clancy, and Gold 1993, Franks et al. 1993). None as yet (to my knowledge) have found an age-related dimension to worsened outcomes or greater health risk from being uninsured, but this is surely a testable hypothesis. If it turns out to be true, this would strengthen the case for why the 55- to 64-year-old cohort should be a policy priority. If the hypothesis is false, then the case for helping 55- to 64-year-olds is mostly financial (there would still be access differentials relative to need, since their average need is greater than younger cohorts).

Having established that the age 55–64 cohort deserves policy attention, who within the cohort is the most deserving? The usual and correct answers are the low income and those with low (fair or poor) health status. These two groups always fare less well in the U.S. system of voluntary insurance markets, because comprehensive health insurance is now very expensive relative to low incomes and because insurers protect themselves against adverse selection by imposing limits, restrictions, and outright refusals to insure at any price for some preexisting conditions (Chollet and Kirk 1998; GAO 1998). Among the 55–64 cohort, those living in family units with income less than 200 percent of poverty (hereafter, low-income family units) comprise half the uninsured in the cohort, and those with fair or poor status regardless of income comprise 26 percent of the uninsured in the age group. Seventeen percent of the uninsured in this cohort are both low-income and in bad health.
It is important to remember, as Swartz and Stevenson (2001) and Pollitz (2001) report, that public insurance programs play a vital role for the sickest in this age group, covering about 10 percent of all 55- to 64-year-olds but over half of those who report not working because they are ill or disabled. Given the size of the uninsured population who report fair or poor health status to survey researchers, the public programs are clearly not able to cover all those who need coverage and can’t afford to buy it on their own. Still, without Medicare and Medicaid’s disabled and medically needy programs, the coverage problem of this age group would be much worse. Also note that because Medicaid and Medicare cover the most disabled of the cohort, the risk of adverse selection from expanding voluntary coverage options for this age group is somewhat reduced.

Swartz and Stevenson report that some subgroups are particularly likely to be uninsured. The unmarried, especially women, and those who had lost a spouse to death or changing circumstance (separated and divorced) of both genders were more likely to be uninsured. Never-married women are particularly vulnerable. Women in general are more likely to rely on nongroup insurance (Swartz and Stevenson 2001), which is less stable in an underwriting environment (which prevails in most of the United States) than is group or public insurance. Thus, the most in need of policy intervention are the low-income and the less-healthy, especially women.

Predictable Future Strains

This picture is bleak enough for those who are other than healthy, married, high-income workers, but two trends make it imperative that policymakers begin to consider coverage expansion options for this population in a serious way: the size of the aging baby-boomer cohort and the decline of employer-sponsored retiree health insurance. In 1998, there were 22.9 million people between the ages of 55 and 64; by 2008, there will be 35.2 million. So whatever unique problems they have in getting and keeping health insurance coverage, these problems are going to increase in aggregate magnitude by roughly half in the coming decade.

In addition, a major pillar of coverage for 55- to 64-year-olds, employer-sponsored retirement health insurance (RHI), is eroding.
Partly due to an accounting rule change that created strong incentives to drop RHI and immediately improve a company's balance sheet and stock price, and partly due to the changing labor market in which RHI is perceived as less crucial to attract good workers in an increasingly mobile global economy, there is a clear tendency on the part of employers to reduce the generosity of postretirement health insurance offerings (GAO 1998; McArdle et al. 1999). Between 1985 and 1993, the fraction of workers with access to employer-sponsored retirement health insurance declined from about 75 percent to about 50 percent (U.S. Department of Labor 1995). Perhaps most ominously, even large firms are both dropping RHI and charging early retirees higher and higher premiums for such coverage (McArdle et al. 1999; Loprest and Zedlewski 1998). Employer surveys indicate that fewer workers are likely to have access to RHI in the future (McArdle et al. 1999).

Of course, the other side of the coin is that the absence of good early retirement health insurance options probably keeps workers in the labor force longer (Johnson, Davidoff, and Perese 2000; Karoly and Rogowski 1998; Gruber and Madrian 1995). If public policy were to make generous subsidies widely available, rates of declines in labor force participation by older workers could regain their 1970s momentum (Blau and Gilleskie 1997). Of course, some retirements are involuntary and health-related, even though the person might not be disabled enough to qualify for Medicare or Medicaid. Striking a balance here is clearly important, and thus any new subsidy proposal must be mindful of likely labor force (and payroll tax base) effects. These effects have been established qualitatively, but no consensus has been reached on the magnitude of likely responses to subsidies of varying degrees. This is an important and active area of research.1

WHICH TYPES OF POLICIES ARE LIKELY TO BE MOST EFFECTIVE FOR THE NEEDIEST SUBGROUPS, THE LOW-INCOME AND THOSE WITH HEALTH PROBLEMS?

There are two key dimensions to coverage expansion policies for the near-elderly: the subsidy mechanism and the range of market opportunities for insurance or health services on which the beneficiary
may spend the subsidy. The interactions of these dimensions is crucial in determining the ultimate effect of any policy initiative, and thus they really should be considered in tandem. To that end, I present Table 3, which should be thought of as a $4 \times 3$ matrix, each cell of which is a potential type of coverage expansion policy. This table tries to help the reader see that both dimensions are key to understanding the full set of implications about each policy alternative.

In this section, I briefly discuss some pros and cons of each approach.

**COBRA Extensions**

What I mean by mandates are laws forcing employers to make COBRA coverage available to workers for longer periods of time after they leave the firm. Under current law, if an employer offers insurance to active workers, then workers who sever employment (in firms with more than 20 workers) for any reason must be offered the option of continuing to enroll in the employer’s plan—in exchange for paying 102 percent of the total premium—for as long as 18 months (and longer under certain circumstances). COBRA provides bridge coverage to Medicare for many individuals who retire before age 65 (Loprest and Zedlewski 1998). The idea behind extending COBRA is

### Table 3 Policy Options for Filling Health Insurance Coverage Gaps for 55- to 64-Year-Olds

<table>
<thead>
<tr>
<th>Subsidy mechanism</th>
<th>Current nongroup market</th>
<th>Reformed nongroup market&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Existing risk pools&lt;sup&gt;b&lt;/sup&gt; or New Group Purchasing Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer mandates (COBRA extensions)</td>
<td>NA&lt;sup&gt;c&lt;/sup&gt;</td>
<td>NA</td>
<td>√</td>
</tr>
<tr>
<td>Existing public program expansions</td>
<td>NA</td>
<td>NA</td>
<td>√</td>
</tr>
<tr>
<td>Tax credits</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Direct subsidies</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

<sup>a</sup> Guaranteed issue, premium restrictions, etc.

<sup>b</sup> Purchasing co-ops, FEHBP, Medicaid, Medicare, state high-risk or HIPAA pools.

<sup>c</sup> NA = not applicable.
to permit access to the group market longer, maybe 36 months or until the age of Medicare eligibility is reached (this is sometimes offered as a complement to proposals to raise the age of Medicare eligibility to 67). The virtue of extending COBRA is that access to a shared-risk pool (the employer group) would be enhanced at low (nominally zero) cost to the federal government.

The downsides to COBRA extensions are 1) it does nothing for nonworkers save dependents of recent retirees; 2) while lower than most nongroup premiums, 102 percent of the employer premium is still more than many early retirees can afford to pay; and most seriously, 3) it constitutes an implicit tax on existing workers and firms, since wages will (on average) be lowered to pay for the higher premiums required to cover the cost of retirees. There would also be a second-order reduction in federal tax revenues, since wages are taxed and employer-provided health insurance premium payments are not. Thus, COBRA extensions are not “free” and, on the whole, do not seem to be a particularly effective way of extending coverage to those in this cohort who need it most. Recall, many of those most in need for early retiree health insurance worked for firms that did not offer employer-sponsored insurance to active workers. Having access to COBRA is fairly highly correlated with income in the first place (Loprest and Zedlewski 1998).

Public Program Expansions

An administratively straightforward way to expand coverage for those most in need would be to change eligibility for Medicaid or Medicare or both. These programs already serve the very sick and disabled (see Pollitz [2001] for a brief overview of each), and Medicaid also covers many low-income individuals, though typically much younger than this cohort. This approach, like the COBRA extension, would permit coverage expansion to avoid the complexities and inefficiencies of the private nongroup insurance market. These complexities can be severe, as we discuss presently.

The downsides to public program expansion are partly technical but mostly political. The technical problem is in “slightly” increasing the range of conditions or functional diagnoses that are considered “disabled” enough to merit inclusion in either Medicare or Medicaid.
There is concern and some evidence that medical judgments are inconsistent and elastic, leading to an "endogenous" assignment of disability that could expand public program rolls well beyond the intent of the law and agreed upon medical need (Kubik 1996).

The larger objections to public program eligibility expansions are political. The obvious point is the considerable resistance in the Congress to expanding any entitlement program, especially our entitlement insurance programs. In addition, if Medicaid—the joint state and federal program—is the preferred vehicle (and in general it has been the program expanded to accept broader definitions of disability in recent years), then truly effective expansion requires states to share the new federal goals, for they will be asked to spend their own money on this. The variance in state coverage and enrollment of different types of Medicaid eligibles suggests that this "goal sharing" should not be taken for granted.

Tax Credits

In contrast to public program eligibility expansion, there is currently something of a groundswell of bipartisan political support for tax credits that could be used for the purchase of health insurance. Briefly put, many are attracted to the principle of tax credits, even if there is no agreement yet on key details. This movement seems to be propelled by a confluence of forces in support of one or more of the following: 1) tax equity (why subsidize employer premiums but not the self-employed or nonworkers?); 2) individual choice (partly philosophical and partly a more subtle form of the current backlash against managed care, led by those who have a strong stake in the fee-for-service system and blame employers for foisting managed care on workers); 3) target efficiency (which tax credits can be designed to be); and 4) tax cuts (as tax credits can be described for political purposes). Two recent papers have analyzed tax credits of various forms (Gruber and Levitt 2000; Pauly and Herring 1999b) for the general non-elderly population. The major downside of tax credits is that they must be administered within the income tax system. This makes it difficult to reach those who have no federal tax liability and do not file tax returns (approximately 45 percent of the uninsured in all age brackets [Gruber
and Levitt 2000]). The tax system is a cumbersome avenue for any eligible person of a means-tested program. (The opposition of Treasury professionals to administering subsidies through the tax system is legendary inside the Beltway). Thus, using the tax system to administer a subsidy is likely to result in lower enrollment than would subsidies of equal size that could be obtained with less applicant and administrative burden. Second (and related), for tax credits to work well for the target low-income population, they must be both refundable (for those with zero or low tax liabilities) and available when premiums must be paid, i.e., up front, not in April of the following year. The low-income population cannot finance health insurance with an interest-free loan, otherwise they wouldn’t need a subsidy in the first place. Refundability and prepayment raise serious year-end reconciliation complexities and potential reductions in target efficiency. Finally, as Pauly and Herring show and others have long stated (Blumberg 1999), tax credits must be fairly large to do any good at all for the low-income population. This is not a critique of tax credits per se, but rather a statement that they may work better for lower middle-income people than for the truly low-income population.

**Direct Subsidies**

Direct subsidies (a new program, not an extension of Medicare or Medicaid) could be designed to have the technical advantages of tax credits (target efficiency, horizontal equity) without the administrative disadvantages of using the tax system for a means-tested subsidy program. This is not to say that the administrative difficulties of setting up a new subsidy program are trivial. But the motivating idea of a “new and different” subsidy program would be to provide direct purchasing power (and, perhaps, health plan purchasing expertise; more on this later in the discussion of market opportunities) without the regulations and complex vendor-relations histories of Medicare and Medicaid.

One downside of a new direct subsidy program is shared with tax credits, and that is that the subsidies must be large to engender much new coverage. The resulting public price tag contributes to direct subsidies’ major political problem, the absence of a widely shared new political vision for a new expansive health insurance entitlement.
Using the Current Nongroup Market

The nongroup health insurance market is functional in all 50 states and works better than its reputation in some health policy circles, at least according to a new book by Mark Pauly and Brad Herring (1999a). They make one overarching and controversial empirical claim: risks are pooled to nearly equal (and imperfect) degrees by large-group, small-group, and nongroup insurers. They conclude that there is no systematic empirical evidence of aggressive risk rating by nongroup insurers.

Even if one accepts Pauly and Herring’s new empirical claims (and I suspect they will remain controversial for at least a while yet), their fundamental deduction is that the primary differences between insurance markets stem from their inherently different administrative loading costs. Group insurance can exploit economies of scale and thus costs less than nongroup insurance can. Thus, high administrative costs are a major downside of the current nongroup market.

Other reports about the actual workings of the nongroup market are not so sanguine on the relative absence of aggressive risk rating (Chollet and Kirk 1998; GAO 1997; Hall 2000). Also, recall that risk rating, as well as age rating (which is ubiquitous and quite reasonable given the expenditure facts presented in Table 1), means that people in our cohort will pay higher equilibrium premiums under the current nongroup market’s relative laissez faire regulation, even if they can on average find policies to buy as Pauly’s empirical results suggest. So, paying more for a given set of benefits plus paying a higher administrative load is the reality for 55- to 64-year-olds in the unreformed nongroup market.

Reforming the Nongroup Market

Almost all discussions of the actual behavior of nongroup insurers (Hall 1999; Chollet and Kirk 1998), as opposed to the empirical results of Pauly and Herring, invariably lead to calls for some kind of reforms (Swartz and Garnick 2000; Chollet and Kirk 2000; Hall 2000). The basic idea is that guaranteed issue and restrictions on premium variances would guarantee access at affordable prices for most people trying to purchase coverage in the nongroup market. A reformed
nongroup market could indeed look a great deal friendlier to the garden variety 55- to 64-year-old than it does in most states today (Pollitz 2001; BCBSA 1999).

However, reforms that increase access for older and sicker would-be purchasers raise average premiums and are quite likely to raise by a substantial amount the premiums of most of those who were purchasing in the prereform environment (Nichols 2000). Empirical evidence on the effect of nongroup reforms is scant if not rare, but the studies that have been done uniformly find that nongroup reforms do indeed reduce net insurance coverage overall (Marsteller et al. 1998; Zucker-man and Rajan 1999; Sloan and Conover 1998). Thus, while reforms would undoubtedly help some (perhaps especially those 55–64 with the greatest health needs), these reforms would also likely cause others to pay more and might cause them to go without coverage altogether.

Perhaps those who would obtain or would retain coverage in a reformed nongroup insurance environment have worse health status than those who voluntarily drop coverage because of premium increases. This is an important area of future research which is not well known at the moment. There are also case studies of how reforms have been implemented with relatively little obvious downsides (Swartz and Garnick 2000; Hall 2000; Nichols 2000). But these successful implementation strategies require a degree of political will (e.g., requiring group insurers to offer products in the nongroup market) that is not present in most states and does not appear to be present in Congress either.

**Buying into Existing Risk Pools**

If an unreformed nongroup market is unpalatable to most observers and a reformed nongroup market is fraught with tradeoffs for the unsubsidized to bear, then allowing 55- to 64-year-olds to take their tax credit or direct subsidy into a group setting to purchase health insurance makes a tremendous amount of sense. Large pools exist and could be expanded at much lower administrative costs than either type of nongroup market could offer. Furthermore, they provide natural and existing risk-pooling mechanisms. Among the more attractive options are statewide purchasing cooperatives for employees of small businesses (CHIP in California), the Federal Employees Health Benefit
Plan (FEHBP), or state employee plans (e.g., CALPERS in California). In addition, administrative and marketing efficiencies would result if new subsidies of whatever form were allowed to be used to buy into Medicare or Medicaid. Finally, state high-risk pools or the mechanisms created by states to comply with HIPAA "federal eligibles" could also be opened up to the new beneficiaries at relatively low administrative costs.

The downside of using existing pools is that existing members might not be willing to be rated collectively with the new enrollees, especially if they turned out to be higher than average risks, even controlling for age. Conversely, the new enrollees might not like being charged actuarially fair premiums with high-risk pool members, if that were the mechanism of choice. But once the decision is made to rate the populations separately, some of the administrative efficiencies of group purchase would be lost.

Allowing the newly subsidized 55- to 64-year-olds to buy into public programs would not raise cost issues, because these programs are and would remain free to currently qualified beneficiaries. However, if the new enrollees got substantially different benefit packages—for example, if they got prescription drug coverage through a Medicare + Choice HMO—there might be stronger equity-based opposition raised by current beneficiaries. Further, deciding what price to charge the "buying" enrollees is no simple matter for a public program, for here the relative risk-rating heterogeneity and controversies seep back into the calculation.

Organizing New Risk Pools and Purchasing Authorities

Alternatively, with a new federal health insurance subsidy program targeted directly at 55- to 64-year-olds, the government could set up a whole new purchasing agency, modeled after the best private or public health plan purchasing agencies, that would organize enrollment and health plan options for the new beneficiaries. This entity could write RFPs and negotiate with health plans and insurers, while coordinating enrollment, beneficiary plan choice, and financial transactions to maximize administrative efficiencies for all. Eligibility standards would have to be established and enforced, but these functions have to be performed somewhere by someone. Creating a whole new purchasing
agent would have the major virtue of allowing the new program to establish its own relations with beneficiaries, vendors, and insurers without the legacies and resentments each might bring from the Medicaid or Medicare programs. It may also be the only quick way to get creative about risk adjusting and competitive bidding, both of which may be particularly helpful for insuring the 55–64 population, as we shall discuss later after presenting some simulation results.

The downside of a new agency is that it would surely cost more to run at the outset than the marginal cost of adding these functions to existing Medicare or Medicaid programs. Plus, it would be vulnerable to the charge of government proliferation, since a new federal entity would be born. These disadvantages would have to be weighed against the potential long-run advantages of freedom from existing programs' rules. The ultimate judgment may hinge upon how much like a private sector “sponsor,”—e.g., the Buyer’s Health Care Action Group in Minnesota or the Pacific Business Group on Health in San Francisco—Congress would want this new purchasing agent to be. The more freedom to contract and aggressive use of government bargaining power on behalf of beneficiary choices and welfare are valued, the more likely the optimal choice would be a new entity. However, if the public organization of subsidized beneficiaries’ purchase of participating health plans is intended to be as passive as most Medicare and Medicaid health plan purchasing has been to date, i.e., if policymakers think of the program as a provider support device as much as a beneficiary subsidy mechanism, then creating a new entity is not likely to be worth the political and administrative trouble.

A FEW SPECIFIC POLICY SIMULATIONS

In this section, I present some simulation results of the policy options that seem promising and efficient enough to be feasible in our current political environment of parsimony towards coverage expansions (i.e., they are on a financial scale commensurate with Vice President Gore’s proposal to cover parents of Medicaid and CHIP children and Governor Bush’s modest tax credit proposal). Table 4 presents some contextual facts and basic assumptions.
First, recall that there are approximately 23 million people between 55 and 64 today. About 3.4 million are uninsured, while another 2 million purchase coverage in the nongroup market, and thus their hold on health insurance is more tenuous than those insured through work (past or present) or in public programs. About 6 million people in this cohort have incomes below 200 percent of poverty, and 5.4 million report fair or poor health status. Finally, 2.6 million are estimated to have both low income and bad health status.

The key assumption in all policy analyses of coverage expansions is the premium that must be paid for the desired insurance product, for this parameter simultaneously determines both total program cost and enrollment (conditional on the income distribution) in the likely event that some (maybe all) will be made eligible for a partial subsidy. Without exaggeration, one can state that the reliability, representativeness, and quality of publicly available premium data for the nongroup market range from fair to poor. I consulted studies of the nongroup market (GAO 1998; Chollett and Kirk 1998; Chollett 2000; Kirk 2000; Swartz and Garnick 2000; Hall 2000; Pauly and Herring 1999a), high-risk pools (Communicating for Agriculture 1999), analyses of Medicare buy-in proposals (Loprest and Moon 1999; CBO 1998), and both NMES and MEPS data (the latter supplied by John Eisenberg). The premium assumptions in Table 4 represent a judgmental average of all

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### Table 4 Some Basic Facts and Assumptions

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<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Total 55–64 population (millions)</td>
<td>22.9</td>
</tr>
<tr>
<td>Uninsured</td>
<td>3.4</td>
</tr>
<tr>
<td>Nongroup</td>
<td>2.0</td>
</tr>
<tr>
<td>Low income</td>
<td>6.1</td>
</tr>
<tr>
<td>Fair/poor health</td>
<td>5.4</td>
</tr>
<tr>
<td>Low income and bad health</td>
<td>2.6</td>
</tr>
<tr>
<td>Est. standard premium ($)</td>
<td>2,500</td>
</tr>
<tr>
<td>Est. high-risk premium ($)</td>
<td>6,750</td>
</tr>
<tr>
<td>Est. community rate ($)</td>
<td>3,900</td>
</tr>
</tbody>
</table>

**SOURCE:** 1999 CPS and author's calculations in 1998 dollars.
the above sources, where each source estimate or fact was adjusted to account for the particular nature of the underlying pool.

For example, high-risk pool premiums must be adjusted for the fact that they are set below the actuarial value, but claims and administrative costs are published along with premium receipts, so this is fairly simple. What is not published is the degree to which adverse selection into high-risk pools is likely worse than would result from the kinds of subsidy programs for the persons aged 55–64 who are uninsured (and thus not in a state high-risk pool) today. CBO and others made analogous adjustments from the published estimates of nongroup premiums when predicting who would take a Medicare buy-in option. In addition, MEPS data were provided for workers only, and they are healthier than nonworkers in every age cohort. The NMES per capita spending data are in the public domain, and the data based on them that I presented in Tables 1 and 2 are for all 55- to 64-year-olds. They include nonworkers, obviously, but have the disadvantage of also including publicly insured individuals who are unlikely to switch into the new subsidy program and are most likely to be the sickest of all. Plus, the NMES data are from 1987, and while they can be “aged” using HCFA’s national health account growth rates, the delivery system is quite different today, so the age- and health status gradients may have changed (though I suspect not much).2

I welcome suggestions for better ways to estimate premiums for these kinds of policies, but I believe these estimates are at least “in the town the ballpark is in,” to invoke Bob Reischauer’s famous description of health reform estimates, and that will suffice for discussion purposes at least. The important fact to note about them is the gap between the high-risk premium ($6,750) and the standard premium ($2,500). The former are computed for those with fair or poor health status, and the latter for those in excellent or good health. The community rate ($3,900) represents the weighted average of each type of person if all nonpublicly insured 55- to 64-year-olds were to become insured through the hypothetical new subsidy program and the ratio of (fair + poor) ÷ total is the same as in 1987.

Table 5 summarizes and compares the three subsidy policy initiatives I explore in some detail. My objective is to maximize coverage of the target population at minimum cost, so in each case, I assume a direct subsidy (to maximize participation and target efficiency) and that
Table 5 Subsidy Options Simulated

<table>
<thead>
<tr>
<th>Subsidy Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income-based subsidy for 55-64 year olds</td>
<td>100% for those below poverty</td>
</tr>
<tr>
<td></td>
<td>Sliding scale between 100-200%</td>
</tr>
<tr>
<td></td>
<td>Not available for those in public, with ESI/RHI</td>
</tr>
<tr>
<td></td>
<td>Group purchase mechanism</td>
</tr>
<tr>
<td>Health status-based subsidy for 55-64 year olds</td>
<td>100% for those with fair or poor health</td>
</tr>
<tr>
<td></td>
<td>Not available for those in public, with ESI/RHI</td>
</tr>
<tr>
<td></td>
<td>Group purchase mechanism</td>
</tr>
<tr>
<td>Income and health status-based subsidy for 55-64 year olds</td>
<td>100% for low income with bad health</td>
</tr>
<tr>
<td></td>
<td>Not available for those in public, with ESI/RHI</td>
</tr>
<tr>
<td></td>
<td>Group purchase mechanism</td>
</tr>
</tbody>
</table>

beneficiaries will be allowed to select plans through some kind of group purchasing mechanism, the exact nature of which is not specified. To be conservative, I assume this group purchasing agent is less efficient than either Medicare or large employers, and I therefore assign an administrative load on expected health care costs (which includes eligibility determination costs plus the agency's and the insurer's administrative costs) of 20 percent. Other institutional assumptions are that beneficiaries will be guaranteed issue (i.e., no one can be denied coverage because of health status) and that the newly subsidized population will be rated separately from participants in current markets. In each case, I assume the subsidy is targeted and available only to those who are not currently enrolled in a public program and do not have access to ESI/RHI, but I presume that 90 percent of current participants in the nongroup market who are made eligible will participate in the program, and that 10 percent of those with ESI/RHI will drift over into the program either by choice or because their employers will induce or force them to.

The first policy is targeted to low-income 55- to 64-year-olds. It would provide 100 percent of the cost of a plan (presumed to cost the
community rate of $3,900 in the income-related case) for all persons 55–64 who have incomes at or below poverty and who are not eligible for Medicare or Medicaid and without access to ESI or RHI. Starting at incomes just above 100 percent of poverty, subsidies (and participation) decline along a sliding scale to 0 at 200 percent of poverty.

The second policy is targeted at those who have the greatest health needs. It would grant a 100 percent subsidy to all persons with fair or poor health, regardless of income. The price of coverage for each of these persons is presumed to be $6,750. Eligibility for this kind of policy could be determined or certified by physicians, in a process similar to the individual functional assessment test now given to potentially "disabled" Medicaid enrollees. Alternatively, and preferably from my point of view, one can imagine using a kind of underwriting process, similar to that used by nongroup insurers all the time, but in cooperation with the purchasing authority so it can be standardized across plans. Postenrollment encounter data could be required of participating health plans to assess the accuracy of \textit{ex ante} assessments, and this would work best if a competitive bidding process was also implemented to set the price the government pays for this population.

In essence, this option is for the government to become an organized purchaser for those between 55 and 64 and in poor health.\textsuperscript{3} In principle, there is no reason that moral hazard on the part of insurers should be debilitating for this scheme, and competitive bidding (and concomitant data reporting requirements just like private sector organized purchasers use) may be all that is necessary to minimize this risk and monitor the effectiveness of competition. If insurers can define health states that we agree deserve this kind of subsidy, then we can write an RFP for covering people who possess them and competitive bidding should be able to elicit a fair price for the government to pay. "Fair + poor" self-reported health status is merely a simplified way I can approximate a concept like "bad health" using nationally representative survey data. Using all of those currently reporting fair and poor health in the analysis of this option probably represents an upper bound of the numbers of people that AHRQ and private insurers would declare to be possessors of the appropriately targeted health states, i.e., those that lie between current definitions of disabled and the health status level underlying the concept of "standard" risk in the insurance industry. Competitive bidding is a powerful tool for eliciting cost-
based prices of services that has typically been absent when Medicaid and Medicare disability determination were being made. At a minimum, it seems worth provoking a conversation about how this might be implemented, if people do agree that helping those with low health status is a primary goal for coverage expansion policy, especially for the 55–64 population which has a far greater percentage of members with fair + poor health status than the nonelderly age cohorts (remember Table 2).

The third policy explored is a combination income–health status subsidy. The idea is to provide 100 percent for all the low-income persons who also have fair or poor health status. Again, the subsidy would not be available to those who have public coverage or access to ESI/RHI.

Table 6 reports the bottom line results of these policy simulations. No subsidy approach dominates in all dimensions, so that a case can be made for and against each of the subsidy targets. They were of course designed to illustrate certain prototypical features of each subsidy type.

The income-only subsidy covers the most people and is relatively target-efficient. The health-status-only subsidy costs more, but covers the vast majority of those with a compelling and unmet health-status-related demand for health insurance. The income + health status subsidy is cheaper and more efficient than the health-status-only subsidy alone, for it covers 55 percent of the fair + poor people at 65 percent of the cost of the health-status-only subsidy scheme. This is because the fair + poor are more numerous in the lower income ranges.

### Table 6 Simulated Results of Policy Options

<table>
<thead>
<tr>
<th>Basis for subsidy</th>
<th>Income</th>
<th>Health</th>
<th>Income and health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly covered (millions)</td>
<td>1.2</td>
<td>0.77</td>
<td>0.5</td>
</tr>
<tr>
<td>% of uninsured newly covered</td>
<td>34</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>% of uninsured in fair/poor health covered</td>
<td>44</td>
<td>85</td>
<td>55</td>
</tr>
<tr>
<td>Total cost ($, billions)</td>
<td>6.6</td>
<td>7.1</td>
<td>4.3</td>
</tr>
<tr>
<td>Cost per newly insured ($)</td>
<td>5,674</td>
<td>9,280</td>
<td>8,644</td>
</tr>
</tbody>
</table>

SOURCE: Author's calculations using CPS, NMES, MEPS, and other data.
The relative efficiency of income + health status-based subsidies for this population is appealing to the economist in me, but it does leave out those in poor health at higher incomes. One might infer that those who remain uninsured do so voluntarily, since their families have means, but two facts about the current nongroup market in most states give pause to reaching this conclusion. First, in most states, insurers are allowed to refuse to sell in the nongroup market except to the relatively small number of HIPAA eligibles. Pauly and Herring report that if the underwriting process leads a nongroup insurer to think that a person's health merits a premium of 3 times standard, they most often refuse to sell at all. Recall that the NMES data support the existence of a 2.7 health status multiple within the 55–64 age cohort. If nongroup insurers measure applicants' health risks relative to the population standard, as seems likely, then many of those with fair or poor health status who are uninsured despite having higher incomes may very well have had trouble finding a willing seller. Second, even if they could find a willing seller at actuarially fair prices, the $6,750 price I estimated is more than 10 percent of income until income exceeds 8 times poverty (for single individuals). And of course, some insurers may offer a price far above the actuarially fair one in order to discourage purchases by individuals who are feared to be quite sick.

This price/income fact made me think about an addition to the income + health-based subsidy, an addition that relates to a choice between subsidies and separate group purchase mechanisms on the one hand versus subsidies and a reformed nongroup market on the other.

Suppose that instead of creating a new group purchasing entity, we gave the newly eligible subsidies and sent them off into a reformed nongroup market to purchase would they could. This approach would likely include some kind of community rating (CR) requirement, at least within age cohorts. Let $h =$ the high-risk premium and $c =$ the community rate. The idea is that the unsubsidized, those with incomes above 200 percent of poverty, say, could buy a policy at $c$. In that sense, you could say they were "community rate-protected," in that they would never pay more than $c$.

Because I am wary of trying to accomplish wholesale reform of the nongroup market in today's political climate, I recommended creating the separate group purchase mechanism and the types of subsidies I have described. But we could easily create a subsidy just for the
amount above the community rate, $h - c$, for those who have incomes between 200 percent of poverty and 800 percent of poverty. That way, those with fair or poor health and incomes above 200 percent would pay $c$, the exact community rate they would have paid if we had reformed the nongroup market, but we could avoid the collateral damage to those whose premiums would have been increased. Presumably, most if not all of those in fair or poor health with reasonable incomes would gladly pay $c$ to get guaranteed issue health insurance.

Table 7 reports the results of this type of subsidy. The first column is the same as column 3 from Table 6, the income + health status subsidy. The "CR Protection alone" column reports what this $h - c$ subsidy does for those with incomes between 200 and 800 percent of poverty, and the final column combines it with the income + health status subsidy we've already analyzed. There we see that the total cost is still modest, the target efficiency on those with fair or poor health is very good, and the overall target efficiency in cost per newly insured person is improved from that obtained with the income + health status subsidy without CR protection.

Finally, Table 8 compares the required net increase in average federal income tax rates necessary to finance the income + health status + CR protection subsidy (0.108 percent, that is, one-tenth of 1 percentage point) with the average premium increase in the nongroup market for 55- to 64-year-olds if the same number of subsidized purchasers entered the nongroup market with guaranteed issue and community rat-

### Table 7 Simulated Results of Community-Rating Protection

<table>
<thead>
<tr>
<th>Basis for subsidy</th>
<th>Income + health</th>
<th>CR protection alone</th>
<th>Income + health + CR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly covered (millions)</td>
<td>0.5</td>
<td>0.25</td>
<td>0.75</td>
</tr>
<tr>
<td>% of uninsured newly covered</td>
<td>15</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>% of uninsured in fair/poor health covered</td>
<td>55</td>
<td>28</td>
<td>83</td>
</tr>
<tr>
<td>Total cost ($, billions)</td>
<td>4.3</td>
<td>1.2</td>
<td>5.5</td>
</tr>
<tr>
<td>Cost per newly insured ($)</td>
<td>8,644</td>
<td>4,972</td>
<td>7,333</td>
</tr>
</tbody>
</table>

SOURCE: Author's calculations using CPS, NMES, MEPS, and other data.
Table 8 Alternative “Tax” Rates from Subsidizing Low-Income + High-Risk Protection (%)

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in average federal income tax rate required to finance Income + Health + CR</td>
<td>0.108</td>
</tr>
<tr>
<td>Increase in average premium from putting same number of high risk into nongroup market with CR</td>
<td>23.9</td>
</tr>
<tr>
<td>Share of nongroup market that would be high risk under reform</td>
<td>45.2</td>
</tr>
</tbody>
</table>

This large premium increase results because the fraction of nongroup purchasers who would be in fair or poor health in that cohort would basically double to 45.2 percent. I have no doubt the tiny income tax increase would cause much less disruption than this large premium increase, except perhaps in certain ideological circles which oppose all publicly financed coverage expansions.

CONCLUSIONS

The need for health insurance policy options for the 55–64 group is compelling now and is going to intensify as the baby boomers expand that cohort in the next decade. The financial risk of going without coverage is high for members of this cohort, the health risks could be substantial (we do not know a great deal about this at the present time), and a traditional pillar of pre-Medicare coverage, employer-sponsored retiree coverage, is expected to continue to decline in prevalence.

Reasonably inexpensive and targeted subsidy programs can be devised and implemented that would go a long way toward covering the neediest near-elderly, those with low incomes and low health status. The subsidy and purchasing entity that achieves the best overall outcome, in my view, has the virtue of highlighting the fact that subsidies most efficiently eradicate need when they reflect both income and health status dimensions of people’s lives.

Researching and writing this paper has forced me to reflect on many dimensions of coverage expansion options. I would like to conclude by offering the following normative principles for health insur-
ance subsidy policy that seem particularly applicable to the 55- to 64-year-old cohort and maybe others as well.

- No poor person should pay for health insurance. (Corollary: No person who makes more than 10 times poverty should tell a person in poverty what that poor person can afford to pay.)
- No person with poor health should pay more than the actuarially fair community rate unless their income is high.
- The people of the United States can afford to offer substantial relief to 55- to 64-year-olds with low incomes who are also in bad health, and indeed to most of those in poor health regardless of income.
- We can offer this relief with very modest income tax rate increases. This is a much less costly financing mechanism—in terms of social disruption—than forcing nongroup insurers to charge community rated premiums to all purchasers.

Notes

I am grateful to Kathy Swartz, Rich Johnson, Karen Pollitz, Alan Monheit, Marilyn Moon, Bo Garrett, Linda Blumberg, and Frank Sammartino for many helpful conversations and to Joseph Llobrera for timely research assistance. I remain solely responsible for all errors or omissions. The views expressed herein are mine alone and not those of the Urban Institute, its Trustees, or its sponsors. My address is 2100 M Street, NW, Washington, DC, 20037; (202)261-5697; lnichols@ui.urban.org.

1. See Johnson, Davidoff, and Perese (2000) for a summary of recent and ongoing work.
2. Berk and Monheit (1992) show that the distribution of health expenditures has been remarkably stable since 1929, so that the skewness (10 percent of the population accounting for 70 percent of the spending) that was present in the 1987 data is very likely to still be present.
3. The hypothetical new program needs a name. For this cohort, all concepts are “near-something” (-Medicare, -work, -elderly, etc.). “Near” makes me think of something off in the distance, somehow better than what we have now. This all suggests Avalon, the mythical Arthurian island, shrouded in mist, where the Lady of Lake lives, where Arthur was taken after he was slain, and from whence Camelot will return, if it ever does. It could be the Avalon Purchasing Authority (APA), with apologies to the American Psychological Association.
4. In each case I assumed that a 100 percent subsidy would engender an 85 percent participation rate from the currently uninsured who were targeted, 90 percent
from current nongroup purchasers who would be eligible, and 10 percent of current ESI and RHI holders who are ineligible but expected to drift. I also assumed that participation would decline linearly as the subsidy falls to zero.

References


