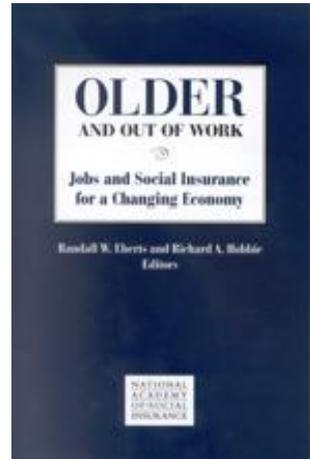

Upjohn Institute Press

Improving Health Coverage before Medicare

Paul N. Van de Water
National Academy of Social Insurance



Chapter 8 (pp. 173-182) in:

Older and Out of Work: Jobs and Social Insurance for a Changing Economy

Randall W. Eberts and Richard A. Hobbie, eds.

Kalamazoo, MI: W.E. Upjohn Institute for Employment Research, 2008

DOI: 10.17848/9781435667419.ch8

8

Improving Health Coverage before Medicare

Paul N. Van de Water
National Academy of Social Insurance

Four million people ages 55 to 64—13 percent of this age group—do not have health insurance. As a result, they face increased risk of a decline in their overall health (Baker et al. 2001). This chapter explores what can and should be done to improve the health coverage of older workers in the 10 years before they become eligible for Medicare at age 65.

WHY SHOULD WE CARE?

Why should we be concerned about improving health insurance coverage for older workers? It's not because they are more likely to be uninsured. On the contrary, it is younger workers—not older ones—who are the most likely to lack health insurance (U.S. Census Bureau 2005). Two subgroups of the near-elderly do have particularly low rates of coverage: low-income people and the unemployed. Even so, 55- to 64-year-olds do not stand out from the pack. People who have low incomes or who are out of work are much more likely to be without health insurance, whatever their age (U.S. Census Bureau 2005).

Going without health insurance, however, is a much more serious matter at older ages. Workers in the 55- to 64-year-old bracket are particularly vulnerable when uninsured because they are more likely to have health problems or chronic conditions requiring medical treatment. About one-fifth of people in this age group have only fair or poor health, and a similar proportion have a work disability (NCHS 2005;

U.S. Census Bureau 2005). Even if an older person is healthy, developing an acute or chronic condition is an ever-present possibility and a source of worry.

Because older workers are more likely to be in poor health, they also find it more difficult to obtain affordable health insurance in the individual market. Collins and her colleagues (2005) have aptly characterized the situation: older workers pay more and get less. In 2002, the average premium paid for a single policy in the individual market by people aged 55 to 64 was \$3,700, compared to \$2,770 for those aged 40 to 54 and \$1,660 for those under age 40 (Bernard 2005). Many older workers pay much more. For example, 26 percent of individually insured adults over age 50 pay more than \$6,000. And those older workers who do obtain coverage typically face higher deductibles, less comprehensive benefits, and greater out-of-pocket costs (Collins et al. 2005).

WHAT ARE THE OPTIONS?

In a paper for the National Academy of Social Insurance's 2000 conference, Nichols (2001) explored the pros and cons of various ways of expanding coverage for the near-elderly. He identified several approaches, including the following:

- Expanding the coverage of Medicare or Medicaid;
- Allowing people to buy into existing risk pools, such as Medicare, the Federal Employees Health Benefits Program, or state employees' programs;
- Providing tax credits for the purchase of public or private insurance;
- Extending the period of time for which COBRA continuation coverage is available;¹ and
- Creating new subsidy programs, risk pools, and purchasing arrangements.

Nichols's paper remains an excellent analysis of the pros and cons of these different approaches, so there is no need to review them here.

WHAT HAS HAPPENED RECENTLY?

In the six years since the publication of Nichols's chapter, most proposals to expand coverage have focused on tax credits.

In its budget for fiscal year 2001, the Clinton administration proposed to allow two groups of older workers to buy into Medicare: people aged 62 to 64 who do not have employment-based or public health insurance, and a limited number of displaced workers aged 55 to 61. The benefits would have been fully financed by premium payments, but participants would have been eligible for a tax credit equal to 25 percent of the premium. The Congressional Budget Office estimated that 1.3 million people aged 62 to 64 would participate in the buy-in by the tenth year of the program, as would 90,000 displaced workers. The Joint Committee on Taxation (JCT) estimated that the tax credit would cost \$8 billion over 10 years (CBO 2000).

In addition to the tax credit for the Medicare buy-in, the Clinton administration also proposed a 25 percent credit for taxpayers of any age who purchase COBRA continuation coverage. The JCT estimated that the credit for COBRA would cost \$13 billion over 10 years.

A similar but much more limited tax credit to help older displaced workers was actually enacted in 2002. The Trade Act of 2002 created the Health Coverage Tax Credit for two groups: 1) certain retirees who are 55 to 64 years old and whose pensions are paid by the Pension Benefit Guaranty Corporation (PBGC), and 2) workers who receive Trade Adjustment Assistance. The refundable credit pays 65 percent of premiums for a qualified health plan, including COBRA continuation coverage and certain state-sponsored programs (IRS 2005). Few people are eligible for the credit, however, and even fewer participate. By one estimate, 25,500 households received the credit in 2004 out of approximately 118,000 households that qualified (Dorn, Varon, and Pervez 2005). The credit also appears to have had the unintended consequence of helping bankrupt employers off-load the cost of retiree health benefits onto the taxpayer at the same time that they shift the cost of pensions to the PBGC.

The Bush administration's 2006 budget proposed a refundable credit for individually purchased health insurance, at a cost of \$64 billion over 10 years (CBO 2005). Although the maximum subsidy percentage

would nominally be 90 percent for those with incomes up to \$15,000, the credit for an adult would be limited to \$1,000. As noted earlier in the chapter, however, this amount is far below the prices actually faced by older people in the individual insurance market.

Not surprisingly, an analysis by Burman and Gruber (2005) finds that the proposed credit would increase insurance coverage primarily among the youngest and healthiest workers. Older workers would likely lose coverage on balance, as the credit for individual insurance caused employers to drop group coverage. An estimated 1.8 million people would gain coverage on net, but 3.4 million people would lose employer-sponsored insurance, and 1.3 million of those would become uninsured (Burman and Gruber 2005). As modified in the 2007 budget, the proposed credit would be available only for the purchase of a high-deductible health plan.

ADVANTAGES OF UNIVERSAL PROGRAMS

Although tax credits have been getting most of the recent attention, expanding health insurance coverage through a universal program, such as Medicare, has several advantages over means-tested approaches.

First, participation rates for means-tested programs tend to be low. Only 20 percent of eligible people receive the Health Coverage Tax Credit. Participation rates in the Medicare Savings Programs are also very low, and a National Academy of Social Insurance study panel has recently recommended ways to increase participation (Ebeler, Van de Water, and Demchak 2006).

Second, means-tested programs are much more costly and complicated to administer than universal programs. A simpler alternative is to provide benefits without regard to income or assets but to finance them through a proportional or progressive revenue source. Of course, programs should also be designed with ease of administration in mind, as seems not to have been the case for the Medicare drug benefit.

Third, means testing creates disincentives for work and saving, especially for people who are eligible for many different subsidies or credits, each with its own benefit reduction or phase-out rate. For that very reason, the UK Pensions Commission has recently recommended

moving away from reliance on means testing and toward more generous flat-rate, universal benefits. The issue will become increasingly important here in the United States as retirees come to rely more heavily on defined contribution pensions, which are counted as resources in means-tested programs such as Supplemental Security Income (SSI) and Medicaid (Parent 2006).

EXPANDING ELIGIBILITY FOR MEDICARE

In light of the advantages of universal programs, lowering the age of Medicare eligibility to 62 deserves another look. At a budgetary cost of only about 0.1–0.2 percent of payroll, this option would result in near-universal health care coverage among 62- to 64-year-olds (Johnson 2003). At the same time, it would reduce employer costs for retiree health benefits, lower both retiree and employer costs for COBRA continuation coverage, and help older workers who would otherwise have to seek nongroup insurance in the individual market.

A frequent objection to reducing the age of eligibility for Medicare is that it would entice more people to retire early on reduced Social Security benefits when we should instead be promoting longer work lives. Although this contention is doubtless correct as an empirical matter, it raises a serious ethical issue: is denying people health insurance an appropriate way of encouraging them to work longer?

When thinking about incentives, I can't keep out of my mind a phrase that the French philosopher Voltaire penned over 250 years ago. Candide, the hero of Voltaire's satirical novella of the same name, quickly recognizes that all incentives are not created equal when he is told that the British navy kills an admiral from time to time simply to encourage the others—or, as Voltaire wrote it, “pour encourager les autres.”

Reducing the age of eligibility for Medicare could well be combined with other steps that would encourage longer work lives, such as increasing the age of initial eligibility for Social Security. (In that context, Joseph White's proposal to give a break to long-service workers deserves serious consideration.)² The incentives for employers to retain or hire older workers could also be improved by restoring Medicare to its position as primary payer for workers with employer-

sponsored health insurance, as was the case before the Tax Equity and Fiscal Responsibility Act of 1982. Changes such as these would offer much better ways of ensuring that people who live longer don't regret their decision to retire early on reduced cash benefits.

Another objection to lowering the age of eligibility for Medicare is that it would reduce the incentive for employers to provide retiree health benefits. But since retiree health benefits seem to be disappearing anyway, this argument has lost much of its force. Moreover, the new prescription drug benefit has filled one of the major gaps in Medicare—and one of the major reasons that retirees needed supplemental coverage.

In fact, it is equally plausible to argue that employers would be more likely to retain retiree health benefits for those who need them most—namely, workers who have retired early from extremely arduous or stressful jobs—if they were relieved of the pressure to provide benefits to those over age 62. Reducing the age of eligibility for Medicare would be consistent with other recent changes designed to reduce the cost of retiree health insurance to employers, such as the Health Coverage Tax Credit and the subsidies to sponsors of qualified retiree prescription drug plans.

Another way of expanding Medicare would be to eliminate the two-year Medicare waiting period required for those who become entitled to receive Social Security Disability Insurance. Since 40 percent of new benefit awards to disabled workers are made to people aged 55 or over, this change would help a significant number of the most needy and vulnerable older workers.

VALUES MATTER

The American public believes that good health care should be available to everybody, not just to those who can afford it. In one recent poll, 84 percent of Americans said that health care should be provided equally to everyone, just like public education (NewsHour with Jim Lehrer and Kaiser Family Foundation 2000). Most faith groups—including denominations from Roman Catholic to Southern Baptist—agree that health care should not be rationed solely on the basis of eco-

nomics (U.S. Conference of Catholic Bishops 1993; Southern Baptist Convention 1994). If our society acted on this belief, it would influence our answers to a wide variety of health policy questions.

For example, how can we encourage efficient utilization of health care services? Many observers suggest that consumers should face financial incentives to limit their use of care. But copayments and deductibles—especially *high* deductibles—place a much greater burden on people with lower incomes. Is that fair?

What about access to care? Medicaid gives its low-income beneficiaries a limited choice of providers and often makes them face long waits for appointments. Private plans provide financial incentives to use generic drugs rather than brand names. Some analysts propose going a step further: they suggest that insurance plans offer differential access to technology. One tier of benefits would provide access to current medical technology; another (and cheaper) tier would provide access only to technology that is 10 or 20 years old. Would that be morally acceptable?

What about paying for quality? Paying for quality is all the rage, and it sounds sensible. But if high-quality providers are paid more, will consumers be charged more to use them? If so, as Vladeck (2003) has said, people would “have the ‘choice’ of how much more they are prepared to pay to reduce the likelihood that they will be maimed or killed during the course of [a] hospitalization.” Would it be equitable to allow or even encourage differences in the quality of care based on an individual’s purchasing power? Furthermore, how do all of these issues relate to efforts to eliminate racial and ethnic differences in health access and outcomes, as promised in the federal government’s *Healthy People 2010* initiative (HHS 2000)?

Most important, in light of the strong public consensus for expanding health coverage, we need to focus on finding solutions, not pointing fingers. Reischauer (1998) wrote the following about President Clinton’s proposed Medicare buy-in: “While the . . . initiative raises complex issues, it responds to a significant problem. Rather than trashing the plan, as the opposition has done, policymakers should work to mitigate undesirable secondary effects that inevitably accompany efforts to expand access to affordable care.” That message still rings true today.

Notes

1. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides certain former employees and their dependents access to temporary continuation of health insurance coverage at group rates.
2. White's remarks came at the 2006 NASI Conference. See Chapter 9 of this volume, pp. 183–204.

References

- Baker, David W., Joseph J. Sudano, Jeffrey M. Albert, Elaine A. Borawski, and Avi Dor. 2001. "Lack of Health Insurance and Decline in Overall Health in Late Middle Age." *New England Journal of Medicine* 345(15): 1106–1112.
- Bernard, Didem M. 2005. *Premiums in the Individual Health Insurance Market for Policyholders under Age 65, 1996 and 2002*. Medical Expenditure Panel Survey Statistical Brief No. 72. Rockville, MD: Agency for Healthcare Research and Quality.
- Burman, Leonard E., and Jonathan Gruber. 2005. *Tax Credits for Health Insurance*. Urban-Brookings Tax Policy Center: Tax Policy Issues and Options No. 11. Washington, DC: Urban Institute.
- Collins, Sara R., Cathy Schoen, Michelle M. Doty, Alyssa L. Holmgren, and Sabrina K. How. 2005. *Paying More for Less: Older Adults in the Individual Insurance Market. Findings from the Commonwealth Fund Survey of Older Adults*. Issue Brief, Task Force on the Future of Health Insurance. New York: Commonwealth Fund.
- Congressional Budget Office (CBO). 2000. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001*. Washington, DC: Congressional Budget Office.
- . 2005. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2006*. Washington, DC: Congressional Budget Office
- Dorn, Stan, Janet Varon, and Fouad Pervez. 2005. *Limited Take-Up of Health Coverage Tax Credits: A Challenge to Future Tax Credit Design*. Issue Brief. New York: Commonwealth Fund.
- Ebeler, Jack C., Paul N. Van de Water, and Cyanne Demchak, eds. 2006. *Improving the Medicare Savings Programs*. Report of the Study Panel on Medicare/Medicaid Dual Eligibles. Washington, DC: National Academy of Social Insurance.
- Internal Revenue Service (IRS). 2005. *HCTC: Individuals—Are You Eligible for the HCTC?* Washington, DC: Internal Revenue Service, U.S. Department of

- the Treasury. <http://www.irs.gov/individuals/article/0,,id=109945,00.html> (accessed November 1, 2006).
- Johnson, Richard W. 2003. *When Should Medicare Coverage Begin?* Health and Income Security for an Aging Workforce Brief No. 6. Washington, DC: National Academy of Social Insurance.
- National Center for Health Statistics (NCHS). 2005. *Health, United States, 2005: With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.
- NewsHour with Jim Lehrer and the Henry J. Kaiser Family Foundation. 2000. Joint survey about the uninsured in America. Arlington, VA: NewsHour with Jim Lehrer; Menlo Park, CA: Kaiser Family Foundation.
- Nichols, Len M. 2001. "Policy Options for Filling Gaps in the Health Insurance Coverage of Older Workers and Early Retirees." In *Ensuring Health and Income Security for an Aging Work Force*, Peter P. Budetti, Richard V. Burkhauser, Janice M. Gregory, and H. Allan Hunt, eds. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research, pp. 451–475.
- Parent, Rene. 2006. *Defined Contribution Pension Plans and the Supplemental Security Income Program*. Policy Brief No. 2006-01. Washington, DC: Social Security Administration.
- Reischauer, Robert D. 1998. "Medicare for the Almost-Old." *Washington Post*, January 12, A:17.
- Southern Baptist Convention. 1994. *Resolution on Health Care Reform*. Nashville, TN: Southern Baptist Convention. <http://www.sbc.net/resolutions/amResolution.asp?ID=594> (accessed November 1, 2006).
- U.S. Census Bureau. 2005. *Current Population Survey (CPS) Table Creator*. For the Annual Social and Economic Supplement. Washington, DC: U.S. Census Bureau. http://www.census.gov/hhes/www/cpstc/cps_table_creator.html (accessed November 1, 2006).
- U.S. Conference of Catholic Bishops. 1993. *A Framework for Comprehensive Health Care Reform*. Washington, DC: USCCB Publishing.
- U.S. Department of Health and Human Services (HHS). 2000. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: Health and Human Services.
- Vladeck, Bruce C. 2003. "If Paying for Quality Is Such a Bad Idea, Why Is Everyone For It?" *Washington and Lee Law Review* 60(4): 1345–1372.

Older and Out of Work

Jobs and Social Insurance for a Changing Economy

Randall W. Eberts
Richard A. Hobbie
Editors

2008

W.E. Upjohn Institute for Employment Research
Kalamazoo, Michigan

© 2008
National Academy of Social Insurance
1776 Massachusetts Ave. N.W.
Washington, D.C. 20036

Older and Out of Work: Jobs and Social Insurance for a Changing Economy

may be ordered from

W.E. Upjohn Institute for Employment Research
300 S. Westnedge Avenue
Kalamazoo, Michigan 49007-4686

Library of Congress Cataloging-in-Publication Data

Older and out of work : jobs and social insurance for a changing economy / Randall W. Eberts, Richard A. Hobbie, editors.

p. cm.

Includes bibliographical references and index.

ISBN-13: 978-0-88099-329-6 (pbk. : alk. paper)

ISBN-10: 0-88099-329-4 (pbk. : alk. paper)

ISBN-13: 978-0-88099-330-2 (hardcover : alk. paper)

ISBN-10: 0-88099-330-8 (hardcover : alk. paper)

1. Older people—Employment—United States. 2. Age and employment—United States. I. Eberts, Randall W. II. Hobbie, Richard.

HD6280.O533 2008

331.3'980973—dc22

2008027941

The facts presented in this study and the observations and viewpoints expressed are the sole responsibility of the authors. They do not necessarily represent positions of the W.E. Upjohn Institute for Employment Research or the National Academy of Social Insurance.

Cover design by Alcorn Publication Design.

Index prepared by Diane Worden.

Printed in the United States of America.

Printed on recycled paper.