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PRIVATE HEALTH INSURANCE

Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds

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Health, Education, and
Human Services Division

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The Honorable James M. Jeffords
Chairman, Committee on Labor and
Human Resources
United States Senate

Dear Mr. Chairman:

At your request, this report examines the access of near-elderly Americans, aged 55 to 64, to health benefits through private insurance—either employer-based or individually purchased. Specifically, the report discusses the near elderly's health, employment, income, and health insurance status; ability to obtain employer-based health insurance if they retire before becoming eligible for Medicare; and use of and costs associated with purchasing coverage through the individual market or employer-based continuation insurance.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will make copies available to interested parties on request.

If you or your staff have any questions, please call me at (202) 512-7114. Major contributors to this report are listed in appendix IX.

Sincerely yours,

William J. Scanlon

William J. Scanlon
Director, Health Financing and
Systems Issues

Executive Summary

Purpose

A series of age-related transitions heighten the importance of health insurance to 55- to 64-year-old (near elderly) Americans and could place them at greater risk of losing, or paying considerably more for, coverage. Too young to qualify for Medicare, many near elderly are considering retirement or gradually moving out of the workforce. These events may be related to worsening health, job displacement, or simply the desire for more leisure time. Since health insurance for most Americans is an employment-related benefit, retirement may necessitate looking for another source of affordable coverage. However, insurance purchased directly in the individual market or temporary continuation coverage purchased through an employer are typically expensive alternatives and may not always be available. Their affordability, moreover, may be exacerbated by both declining health and the reduction in income associated with retirement. For some near elderly, an alternative to retiring without insurance is simply to continue working.

The Chairman, Senate Committee on Labor and Human Resources, requested GAO to assess the ability of Americans aged 55 to 64 to obtain health benefits through the private market—either employer-based or individually purchased. In particular, he requested an examination of the available evidence on the near elderly's

- health, employment, income, and health insurance status;
- ability to obtain employer-based health insurance if they retire before becoming eligible for Medicare; and
- use of and costs associated with purchasing coverage through the individual market or employer-based continuation insurance.

To provide the Congress with information about the near elderly and their ability to obtain health insurance, GAO analyzed the March 1997 Current Population Survey (CPS), a source widely used by researchers; reviewed the literature on employer-based health benefits for early retirees; interviewed employers, benefit consultants, insurers, and other experts knowledgeable about retiree health issues and the individual insurance market; and updated information provided in previous GAO reports.

Background

Like most Americans, over 80 percent of the near elderly have access to some type of health insurance—either comprehensive or partial. Nevertheless, continued access to health insurance is a primary concern for some 55- to 64-year-olds who retire early or who lose access to employer-based coverage. First, Medicare is not generally available until

one reaches age 65. Second, most Americans under age 65 rely on coverage provided by an employer—a link that may be severed by retirement, a voluntary reduction in hours, or job displacement. The existing alternatives to employer-based coverage for the near elderly are (1) individually purchased insurance, (2) temporary continuation coverage from a former employer, (3) public programs such as Medicare and Medicaid, and (4) becoming uninsured. Among those aged 55 to 64, Medicare or Medicaid are available only to the very poor or the disabled.

Some near elderly may encounter difficulty in obtaining comprehensive, affordable coverage through the individual market or in obtaining any health coverage at all. The high cost of individual insurance often mirrors the near elderly's greater use of medical services compared with younger age groups. Moreover, some individuals may be denied individual insurance because of preexisting health conditions. Retirees whose jobs provided health benefits that ended at retirement, however, may continue temporary coverage for up to 18 months under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Only firms with 20 or more employees who offer health insurance to active workers are required to provide COBRA continuation coverage. When available, COBRA coverage may entail substantial out-of-pocket costs, because the employer is not required to pay any portion of the premium. For eligible individuals leaving group coverage who exhaust any available COBRA or other conversion coverage, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees access to the individual market, regardless of health status and without coverage exclusions. The premiums faced by some individuals eligible for a HIPAA guaranteed access product, however, may be substantially higher than the prices charged to those in the individual market who are healthy.

Persons seeking an alternative to employer-based coverage may go through a common mental calculus in which health status and cost play a prominent role. For someone healthy, there are no access barriers to the individual market and the cost may be lower than COBRA, especially if he or she buys a policy with a higher deductible. For someone with a health condition who wants comprehensive coverage, the individual market may not be an option because of health screening by insurers—a process that can result in the denial of coverage or the exclusion of preexisiting conditions. However, COBRA, if available, has no such screening and should be more affordable than individually purchased insurance because of economies of scale and reduced administrative costs that result in lower premiums for group coverage. HIPAA's group-to-individual portability now

provides a link between COBRA and the individual market for those who are eligible, but it is too early to judge the extent to which unhealthy consumers will utilize this option.

Results in Brief

Though the near elderly access health insurance differently than other segments of the under-65 population, their overall insurance picture is no worse and is better than that of some younger age groups. These differences, however, may not portend well for the future. Since fewer employers are offering health coverage as a benefit to future retirees, the proportion of near elderly with access to affordable health insurance could decline. The resulting increase in uninsured near elderly would be exacerbated by demographic trends, since 55- to 64-year-olds represent one of the fastest growing segments of the U.S. population.

The current insurance status of the near elderly is largely due to (1) the fact that many current retirees still have access to employer-based health benefits, (2) the willingness of near-elderly Americans to devote a significant portion of their income to health insurance purchased through the individual market, and (3) the availability of public programs to disabled 55- to 64-year-olds. Today, the individual market and Medicare and Medicaid for the disabled often mitigate declining access to employer-based coverage for near-elderly Americans and may prevent a larger portion of this age group from becoming uninsured. The steady decline in the proportion of large employers who offer health benefits to early retirees, however, clouds the outlook for future retirees. In the absence of countervailing trends, it is even less likely that future 55- to 64-year-olds will be offered health insurance as a retirement benefit, and those who are will bear an increased share of the cost. Although trends in employers' required retiree cost sharing are more difficult to decipher than the decisions of firms not to offer retiree health benefits, the effects may be just as troublesome for future retirees. Thus, some additional employers have tied cost sharing to years of service; consequently, retirees who changed jobs frequently may be responsible for most of the premium.

Moreover, access and affordability problems may prevent future early retirees who lose employer-based health benefits from obtaining comprehensive private insurance. The two principal private insurance alternatives are the individual market and COBRA continuation coverage. With respect to individual insurance, the cost may put it out of reach of some 55- to 64-year-olds—an age group whose health and income are in decline. For example, the premiums for popular health insurance products

available in the individual markets of Colorado and Vermont are at least 10 percent and 8.4 percent, respectively, of the 1996 median family income for the married near elderly. In contrast, the average retiree contribution for employer subsidized family coverage is about one-half of these percentages. The near elderly who are in poorer health run the risk of paying even higher premiums, having less comprehensive coverage offered, or being denied coverage altogether. Thirteen states require insurers to sell some individual market products to all who apply, and about 20 states limit the variation among premiums that insurers may offer to individuals. GAO found that conditions such as chronic back pain and glaucoma are commonly excluded from coverage or result in higher premiums. Furthermore, significant variation exists among the states that limit premiums: A few require insurers to community-rate the coverage they sell—that is, all those covered pay the same premium—while other states allow insurers to vary premiums up to 300 percent or more.

COBRA is only available to retirees whose employers offer health benefits to active workers, and coverage is only temporary, ranging from 18 to 36 months. Information on the use of COBRA by Americans is spotty. Although 55- to 64-year-olds who become eligible for COBRA are more likely than younger age groups to enroll, the use of continuation coverage by early retirees appears to be relatively low. Since new federal protections under HIPAA—ensuring access to individual insurance for qualifying individuals who leave group coverage—hinge on exhausting COBRA, the incentives for enrolling and the length of time enrolled could change. Because employers generally do not contribute toward the premium, the cost of COBRA may be a factor in the low enrollment, even though similar coverage in the individual market may be more expensive. In 1997, the average insurance premium for employer-based coverage was about $3,800. However, there is significant variation in premiums due to firm size, benefit structure, locale, demographics, or aggressiveness in negotiating rates. For one company, total health plan premiums in 1996 for early retirees ranged from about $5,600 to almost $8,000 for family coverage. Since this firm paid the total cost of practically all of the health plans it offered to current workers, the COBRA cost would have come as a rude awakening to retirees.

Principal Findings

Changes in Employment, Health, Income, and Insurance Status Typify the Near Elderly

Currently, about 14 percent of the near elderly are uninsured—a rate comparable to that of 45- to 54-year-olds and lower than that among the entire nonelderly population. However, differences in health status, labor force attachment, and family income distinguish the near elderly from younger Americans and foreshadow some of the difficulties this age cohort could have in accessing health insurance other than that offered by an employer. The near elderly are a group in transition from the active workforce to retirement. Almost three-quarters of those between the ages of 55 and 61 were employed in 1996, and about half worked full-time. In contrast, however, less than one-half of those between the ages of 62 and 64 were employed at all during 1996, with only about one-quarter working full time. Concurrent with leaving the workforce, both the health and income of this group are beginning to decline. Compared with individuals between the ages of 45 and 54, the near elderly are more likely to experience health conditions such as diabetes, hypertension, and heart disease. Furthermore, their expenditures on health care services are estimated to be about 45 percent higher than those of the younger group, while their median family income is about 25 percent less.

The near elderly are no more likely to be uninsured than younger age groups and, in fact, their rate of uninsurance is lower than for the entire under-65 population. A key difference between the near elderly and younger age groups is their source of insurance. Sixty-five percent of 55- to 64-year-olds had employer-based insurance in 1996, compared with about 74 percent of the next younger cohort. As the near elderly transition out of the workforce, they may sever the link to employer-based health insurance. As a result, compared with younger age groups, the near elderly were the most likely to obtain health insurance through the individual market and Medicare.

Whether the near elderly obtained their health insurance through the individual market or through public sources was related to their employment, health, and income status. For example, a relatively high percentage of the near elderly with individual insurance reported that they worked (67 percent) and had excellent or good health (85 percent). In contrast, those with public sources of coverage were more likely to report that they were unemployed (87 percent) or in poor health (69 percent). And compared to those who purchased individual insurance, twice as

many with public coverage had incomes under $20,000. The link between insurance status and income is not perfect, however, since about 20 percent of the uninsured near elderly had family incomes of $50,000 or more, yet almost one-third of those with individual insurance earned less than $20,000. The cost of comprehensive coverage in the individual market suggests that those at lower incomes may be purchasing less expensive, limited-benefit products. At the same time, however, the measure of income may not include other resources available to individuals.

Future Decline Expected in Employer-Based Health Insurance for 55- to 64-Year-Olds

While an estimated 60 to 70 percent of large employers offered retiree health coverage during the 1980s, fewer than 40 percent do so today, and that number is continuing to decline despite the recent period of strong economic growth. According to surveys conducted by two benefit consulting firms, coverage offered to early retirees dropped by 8 to 9 percentage points between 1991 and 1997. Concurrently, employment has shifted away from firms more likely to offer coverage, that is, from manufacturing to service industries. The decision by some large employers not to offer retiree health benefits will primarily affect future retirees. In fact, one survey sponsored by the Labor Department suggests that only very few of those who were retired in 1994—about 2 percent—had lost coverage as a result of an employer's subsequent decision to amend the retiree health benefit plan.

The dramatic cost growth during the 1980s and early 1990s stimulated employers to become more aggressive in controlling their health care spending. Consequently, the decline in the number of large firms that offer retiree health benefits has been accompanied by efforts to control costs. Three commonly cited changes involve cost sharing, plan choice, and eligibility requirements. Although firms often made similar changes for active employees, the limited evidence available indicates that retirees are being asked to shoulder a higher portion of the health benefits premium when they leave the workforce. On average, retirees contributed $655 more for the cost of family coverage than did active workers in 1995. The retiree contribution is 4.7 percent of the 1996 median family income of 55- to 64-year-old married couples. Typically, Americans under age 65 spent about 4 percent of household income in 1994 on health care—an amount that includes not only insurance premiums or employer-required cost sharing but also out-of-pocket expenses for copayments, deductibles, and services not covered by health insurance. At the same time employers have increased retiree cost sharing, they have also tightened the eligibility requirements for participation in postemployment health benefits. Most

firms now have a minimum service and age requirement and some tie their own contribution to these minimums. For example, one employer GAO interviewed required retirees to have 35 years of service to qualify for the maximum employer contribution of 75 percent. In contrast, retirees with 19 years of service are eligible for only a 30-percent contribution. If workers change jobs frequently, especially as they become older, they may not qualify for retiree health benefits in the future.

According to surveys sponsored by the Labor Department in 1988 and 1994, higher costs for individuals could result in fewer participating in employer-based retiree health plans when such coverage is available. Between 1988 and 1994, the proportion of workers who continued coverage into retirement declined by 8 percentage points. Among those already retired, the proportion covered also declined, falling 10 percentage points over the same 6-year period. Of the approximately 5.3 million retirees who discontinued employer-based benefits in 1994, an estimated 27 percent cited the expense as a factor—up by over one-fifth from the earlier survey. For some retirees, coverage with lower cost sharing through a working or retired spouse may have influenced their decision to decline a former employer's offer of health benefits.

Age and Health Status May Limit Access of Near Elderly to Individual Coverage

In the majority of states, some individuals aged 55 to 64 may be denied coverage in the individual insurance market, may have certain conditions or body parts excluded from coverage, or may pay premiums that are significantly higher than the standard rate. Unlike employer-sponsored coverage, in which risk is spread over the entire group, premiums in the individual markets of many states reflect each individual's demographic characteristics and health status. For example, on the basis of experience, carriers anticipate that the likelihood of requiring medical care increases with age. Thus, a 60-year-old in the individual market of most states pays more than a 30-year-old for the same coverage. Likewise, carriers may also adjust premiums on the basis of a carrier's determination of the applicant's health status. This latter process is called medical underwriting.

Since health status tends to decline with age, some near elderly may face serious obstacles in their efforts to obtain needed coverage through the individual market. On the basis of the underwriting results, a carrier may deny coverage to an applicant determined to be in poorer health. Individuals with serious health conditions such as heart disease and diabetes are frequently denied coverage, as are those with such non-life-threatening conditions as chronic back pain and migraine

headaches. The most recent denial rates for carriers with whom GAO spoke ranged from zero in states where guaranteed issue is required to about 23 percent, with these carriers typically denying coverage to about 15 percent of all applicants. Carriers may also offer coverage that excludes a certain condition or part of the body. A person with asthma or glaucoma may have all costs associated with treatment of those conditions excluded from coverage.

A number of states as well as the federal government have undertaken a wide range of initiatives to increase access to the individual market, but obtaining coverage under these options may remain expensive, especially for less healthy individuals with high expected costs. For example, 20 states have enacted individual market insurance reforms that attempt to limit premium rate variation and the characteristics that insurers use to vary these rates, and 13 states require carriers to guarantee-issue certain products to all applicants. Even in the states that have enacted rate restrictions, however, premiums may still vary considerably. One state that restricts rates permits variation of 300 percent or more. Given the median income of the near elderly, rates in the individual market may pose an affordability problem to some. For example, the premiums for popular health insurance products available in the individual markets of Colorado and Vermont are at least 10 percent and 8.4 percent, respectively, of the 1996 median family income of married near-elderly couples. While at least 27 states have high-risk insurance pools that act as a safety net to ensure that those who need coverage can obtain it, the cost is generally 125 to 200 percent of the average or standard rate charged to healthy individuals in the individual market for a comparable plan.[1] Those who have been rejected for coverage by at least one carrier generally qualify for their state's high-risk pool. However, participation in some state pools is limited by enrollment caps.

In addition, HIPAA guarantees some people leaving group coverage access to the individual market—group-to-individual portability. Carriers must offer individual market coverage to these "HIPAA eligibles," regardless of their health status, and may not impose coverage exclusions. To be eligible for a portability product, however, an individual must have had at least 18 months of coverage under a group plan without a break of more than 63 days, and have exhausted any COBRA or other conversion coverage available. One survey estimates that 61- to 64-year-olds typically remain enrolled in COBRA for only 12 months—6 to 24 months short of the

[1]The premium in a high-risk pool, however, may still fall short of covering the expected cost of high-risk enrollees. A subsidy mechanism is commonly in place to cover these shortfalls.

maximum allowable coverage. Since HIPAA changes the incentives for electing and exhausting COBRA coverage, past evidence may not be a guide to future use. However, the premiums faced by unhealthy individuals who are eligible for a HIPAA product, like those faced by unhealthy individuals who have always relied on the individual market for coverage, may be very expensive.

COBRA Provides Temporary Access for Some Near Elderly

Federal legislation enacted in 1986 provides temporary access to employer-based health insurance under certain circumstances. Though access to such continuation coverage, which is known by the acronym COBRA, is not limited to the near elderly, it may be particularly valuable to 55- to 64-year-olds who lose access to employer-based coverage before they become eligible for Medicare. Categories of near-elderly individuals who could benefit from continuation coverage include those who (1) are laid off, (2) experience a cut-back in hours that makes them ineligible for health benefits, (3) retire, or (4) lose benefits when their spouse becomes Medicare eligible. The near elderly and others in such circumstances are eligible to elect continuation coverage if their former employer had 20 or more workers and offered health insurance.

Because the employer is not required to pay any portion of the premium, COBRA may be an expensive alternative for the near elderly—especially since the loss in employer-based coverage is probably accompanied by a decrease in earnings. The limited information available on eligibility for and use of COBRA by Americans in general and the near elderly in particular is based on past experience and may not reflect incentives to elect and exhaust continuation coverage created by the implementation of HIPAA. Moreover, the information leaves many important questions unanswered. Nonetheless, the data suggest that relatively few near elderly use COBRA. In general, however, the near elderly appear to be more likely to elect COBRA than younger age groups. Results from an analysis of a proprietary database that cannot be generalized to the whole population suggest that, on average, 61- to 64-year-olds only keep continuation coverage for a year.

Although it makes sense for the near elderly who lack an alternate source of coverage and can afford the premium to elect COBRA, there is no systematically collected evidence on the extent to which such elections affect employer costs. Employers contend that COBRA's voluntary nature and high costs due to the lack of an employer subsidy or contribution could result in the enrollment of only those individuals who expect their health care costs to exceed the premium. The costs of near elderly COBRA

enrollees in excess of the premium would in turn push up the employer's overall health care expenditures. However, the election of COBRA coverage by some near elderly as well as younger individuals may simply reflect an antipathy to living without health insurance. On the other hand, since COBRA election is associated with job turnover, the demographics of a firm or industry will also affect an employer's insurance costs. For example, a firm with an older workforce that does not offer retiree health benefits may indeed experience higher insurance costs as a result of COBRA elections.

Recommendations

This report contains no recommendations.

Comments From Reviewers

Experts on retiree health benefits and insurance markets reviewed a draft of this report. They generally agreed with the presentation of the evidence on the near elderly's access to health insurance.

Contents

Executive Summary		2
Chapter 1 Introduction		18
	Eligibility, Access, and Coverage Differ by Source of Insurance	18
	Federal Role in Ensuring Access to Private Health Insurance	21
	Objectives, Scope, and Methodology	22
Chapter 2 Demographic and Insurance Characteristics of the Near Elderly		26
	Near Elderly: Portrait of a Cohort in Transition	26
	Probability of Being Insured Rises With Age, but Sources of Insurance Differ	37
	Changing Demographic Characteristics Affect Likelihood of Being Insured and the Source of Insurance	41
	Key Characteristics of the Near Elderly, by Source of Coverage	48
Chapter 3 Future Gaps in Employer-Based Retiree Health Coverage		50
	Origin and Evolution of Retiree Health Benefits	51
	Limited Data From 1980s Suggest Significant Erosion in Coverage	52
	More Recent Surveys Paint Consistent Picture of Continued Erosion	54
	Decline in Offer of Retiree Health Benefits Accompanied by Efforts to Control Costs	61
Chapter 4 Individual Insurance: Unaffordable or Unavailable Alternative for Many Near Elderly		70
	Some Near Elderly Face a Broad Range of Choices	70
	Amount of Premiums and Health Status May Affect Access of Near Elderly	72
	State and Federal Initiatives Attempt to Expand Accessibility to This Market	78
Chapter 5 COBRA Provides Temporary Access for Some Near Elderly		85
	Terms and Conditions of COBRA Coverage	86
	Limited Evidence on Use of COBRA by the Near Elderly	88
	Proof of Adverse Selection More Intuitive Than Systematic	90

Chapter 6 Observations 96

Appendixes

Appendix I: Limited Federal Protection of Employer-Based Retiree Health Benefits 98
Appendix II: Characteristics of Public and Private Health Insurance Surveys 100
Appendix III: Demographic and Insurance Profiles of the Near Elderly and Those Aged 55 to 61 and 62 to 64 107
Appendix IV: Impact of Health Benefits on Early Retirement 109
Appendix V: Affordability of Health Insurance for the Near Elderly 111
Appendix VI: Expansions of COBRA Coverage 114
Appendix VII: State Initiatives to Increase Access to the Individual Insurance Market as of Year-End 1997 115
Appendix VIII: State Restrictions Related to Individual Market Premiums 117
Appendix IX: Major Contributors to This Report 120

Tables

Table 2.1: Number of Health Conditions per 1,000 People Among Four Age Groups 30
Table 2.2: Use of Health Care Services, by Age Group 31
Table 2.3: Average Health Care Expenditures by Age Group 31
Table 2.4: Median Family Income for the Near Elderly and Younger Age Groups, 1996 36
Table 2.5: Percentage Insured and Uninsured, by Age Group, 1996 38
Table 2.6: Percentage of Insured and Uninsured Near Elderly, Aged 55 to 61 and 62 to 64, by Source of Insurance, 1996 41
Table 2.7: Health and Insurance Status of the Near Elderly, 1996 42
Table 2.8: Type of Insurance, by Reason for Not Working, 1996 47
Table 2.9: Source of Insurance for the Near Elderly, by Income, 1996 48
Table 2.10: Demographic Profile of Vulnerable Near-Elderly Americans, by Insurance Status, 1996 49
Table 3.1: Estimates of the Percentage of Medium and Large Firms Offering Retiree Health Benefits 53
Table 3.2: Percentage of Retirees With Employer-Based Coverage 57
Table 3.3: Percentage of Firms Offering Early Retiree Health Coverage, by Type of Industry, 1993 and 1997 60
Table 3.4: Average Annual Costs for Early Retiree Coverage 61

Table 3.5: Variation in Average Annual Costs for Early Retirees, 1995 — 61
Table 3.6: Cost-Control Changes Made to Retiree Benefits in Preceding 2 Years — 63
Table 3.7: Variation in Early Retiree Contribution for Family Coverage, by Firm Size, Industry, and Region, 1995 — 65
Table 3.8: Comparison of Percentage of Covered Early Retirees and Active Workers Enrolled in Managed Care Plans — 69
Table 4.1: Examples of Variation in an Individual's Standard Monthly Premium Due to Differences in Age — 73
Table 4.2: Most Recent Declination Rates of Selected Individual Market Carriers in Seven States — 74
Table 4.3: Examples of Health Conditions for Which Carriers May Decline Coverage or That May Be Excluded From Coverage — 75
Table 4.4: Selected Carriers' Monthly Premium Price Variations Attributable to Age and Specified Health Characteristics — 76
Table 5.1: Comparison of Characteristics of Employer-Based Group Health Insurance and Individually Purchased Coverage — 92
Table 5.2: Sicker Employees Have Greater Impact on Average Health Care Costs of Smaller Employers — 92
Table II.1: Selected Characteristics of Six Surveys of the Near Elderly and Their Access to Health Insurance — 101
Table II.2: Characteristics of Employer Surveys Used in Our Analysis — 105
Table II.3: Selected Characteristics of Surveys on Health Conditions, Expenditures, and Utilization — 106
Table III.1: Key Demographic Characteristics of the Near Elderly, by Insurance Status — 107
Table III.2: Selected Characteristics of 55- to 61-Year-Olds and 62- to 64-Year-Olds — 108
Table V.1 Individual Market Premium and Early Retiree Share of Employer-Based Premium Compared With 1996 Median Income of the Near Elderly — 112

Figures

Figure 2.1: Self-Reported Health Status, by Age Group, 1996 — 28
Figure 2.2: Self-Reported Health Status of 55- to 61- and 62- to 64-Year-Olds, 1996 — 29
Figure 2.3: Percentage of Near Elderly Who Did Not Work, by Primary Reason Reported, 1996 — 33

Figure 2.4: Employment Status of 55- to 61- and 62- to 64-Year-Olds—Percentage Working Full Time, Working Part Time, and Not Employed, 1996 34
Figure 2.5: Percentage of 55- to 61- and 62- to 64-Year-Olds Who Reported Not Working, by Reason, 1996 35
Figure 2.6: Health and Employment Status of the Near Elderly, 1996 36
Figure 2.7: Distribution of Total Family Income for 55- to 64-Year-Olds, 1996 37
Figure 2.8: Percentage of Insured and Uninsured Individuals, by Source of Insurance and Age Group, 1996 40
Figure 2.9: Insurance Status of the Near Elderly, by Employment Status, 1996 44
Figure 2.10: Percentage With Insurance Through Their Employer, by Industry Sector, 1996 46
Figure 3.1: Percentage of Medium and Large Employers Offering Retiree Health Coverage, 1991-97 55

Abbreviations

AHCPR	Agency for Health Care Policy and Research
BLS	Bureau of Labor Statistics
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
CPS	Current Population Survey
DOD	Department of Defense
EBRI	Employee Benefit Research Institute
ERISA	Employee Retirement Income Security Act of 1974
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
HRS	Health and Retirement Survey
MEPS	Medical Expenditure Panel Survey
MSA	medical savings account
NAMCS	National Ambulatory Medical Care Survey
NCHS	National Center for Health Statistics
NHAMCS	National Hospital Ambulatory Medical Care Survey
NHDS	National Hospital Discharge Survey
NHIS	National Health Interview Survey
NMES	National Medical Expenditure Survey
POS	point of service
PPO	preferred provider organization
PSU	primary sampling unit
SIPP	Survey of Income and Program Participation
SPD	Summary Plan Description
WBGH	Washington Business Group on Health

Introduction

Increasingly, public attention has focused on the health insurance status of Americans between the ages of 55 and 64. Although federal legislation establishes the normal retirement age for full pension benefits at 65, many individuals leave the labor force 5 to 10 years earlier.[2] Labor force participation rates among 55- to 64-year-old men have declined since at least the 1960s.[3] For those who retire before becoming eligible for Medicare, the availability of health benefits is of particular concern. Coverage for most Americans is tied to employment—the very link that is severed by retirement or loosened by a person's gradual detachment from the labor force. Since 55- to 64-year-olds are more likely to use medical services, insurance they purchase directly in the individual market may be expensive and harder to pay for, considering the decline in income as a result of retirement. Because fewer employers offer retiree health coverage as a benefit and individually purchased insurance, when available, may be prohibitively expensive, the proportion of this age group that is uninsured may rise.[4]

Eligibility, Access, and Coverage Differ by Source of Insurance

Although most of the near elderly receive coverage as a benefit through their employer, some purchase health insurance on their own. The former is commonly referred to as employer-based group coverage and the latter as individual coverage. Complementing these two types of private health insurance are public programs, including Medicaid for the poor and Medicare for the elderly and disabled.[5] Fundamental differences

[2]The Employee Retirement Income Security Act of 1974 (ERISA) requires private pension plans to set the normal retirement age (retirement with full pension benefits) at no later than age 65.

[3]In an April 1997 Issue Brief, the Employee Benefit Research Institute (EBRI) reported that 65.5 percent of men aged 55 to 64 participated in the labor force in 1995 compared with 84.6 percent in 1965. In contrast, participation rates for women of the same age cohort have been rising steadily. The decline in labor force participation among men has been attributed to (1) Social Security coverage, (2) early retirement benefits provided by private pension plans, (3) buyouts offered by employers seeking to pare down their workforces, and (4) desire for more leisure that is now affordable because of increased financial security.

[4]Over the past decade, proposals have been introduced in the Congress to provide the near elderly with access to the Federal Employees Health Benefits Program, to Medicare, or to expanded COBRA coverage. Such proposals continue to be debated.

[5]Private health insurance, including coverage through an employer-sponsored group plan or the individual market, represents about one-third of all U.S. health expenditures—or nearly 5 cents of every dollar spent in the United States—and provides health coverage for 7 of every 10 Americans. Public health insurance, including Medicaid and Medicare, represents about another third of total U.S. health spending. The remaining 36 percent of health spending is not financed through health insurance but represents out-of-pocket spending by consumers for copayments, deductibles, and medical services not covered by insurance. For more information on major trends in the private health insurance market during the 1980s and 1990s, see Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures (GAO/HEHS-97-122, July 24, 1997).

distinguish employer-sponsored group coverage from the individual insurance market and public insurance programs.

Employer-Based. Eligibility for group health coverage through an employer typically depends on holding or having held a full-time job or working a sufficient number of hours to meet a minimum eligibility requirement. Increasingly, however, firms are imposing age and length of service eligibility requirements for retiree health benefits. Premiums in the group market are often considerably lower than those in the individual market because they are based on the experience of the entire group, and the larger the group, the smaller the impact of high-cost individuals on the overall premium. Also, individuals with employer-based coverage do not face the task of accessing the insurance market or identifying and comparing a multitude of products on their own. Rather, the employer arranges access and greatly simplifies the task of identifying and comparing products.[6] Employers who offer health coverage generally provide a comprehensive benefit package with an associated deductible and copayment. Normally, annual out-of-pocket costs are capped, and health services beyond that point are reimbursed at 100 percent. Finally, selecting cost-sharing options and paying for the products is often eased by employer contributions and payroll deductions.[7]

Individual Market. Instances when Americans may turn to the individual market for health insurance include employment in part-time or temporary jobs, periods of unemployment between jobs, and retirement prior to Medicare eligibility. Unlike employer-based health benefits, however, eligibility and premiums in the individual markets of many states are determined on the basis of the risk associated with each applicant's demographic characteristics and health status. As a result, coverage in the individual market for those aged 55 to 64 and for individuals whose health is declining may be unavailable or considerably more expensive. Since consumers must absorb the entire cost of coverage themselves, carriers have recognized the importance of offering affordable options to people

[6]KPMG Peat Marwick reported that among employers of all sizes, those with at least 5,000 employees are more likely to offer multiple health plans to their employees. Furthermore, while 74 percent of the largest employers offered three or more health plans, only 25 percent of midsize employers (200 to 999 workers) and 51 percent of large employers (1,000 to 4,999) did so. In fact, the report noted that almost 50 percent of midsize employers offer just one health plan to their employees. See KPMG Peat Marwick, Health Benefits in 1997 (New York, N.Y.: KPMG Peat Marwick, June 1997).

[7]Health benefits are a means for employers to attract and retain workers with the necessary skills. They represent a business cost—part of the firm's compensation package for workers. Economists tend to view employer contributions toward the cost of health insurance as forgone wages that otherwise could have been paid to workers. However, the employer contribution is frequently referred to as a subsidy and may be viewed as such by some employees.

with different economic resources and health needs, and offer a wide range of health plans with a variety of covered benefits and cost-sharing options. The cost-sharing arrangement selected is a key determinant of the price of an individual insurance product—the higher the potential out-of-pocket expenses, the lower the premium, and the greater the financial risk to the consumer. Finally, because carriers in many states can exclude preexisting health conditions from coverage, the benefits purchased may not be comprehensive. Recent federal legislation, discussed below, prevents preexisting condition exclusions for eligible individuals leaving group coverage.

Public Insurance Programs. Significant differences also exist in eligibility for and coverage available through public programs such as Medicaid and Medicare. Medicaid, financed jointly by the federal government and the states, is the dominant public program for financing health coverage for low-income Americans—families, primarily women and children, and the aged, blind, and disabled. Medicare is a national insurance program established in 1965 for elderly Americans aged 65 or older. For Americans under age 65, only those with end-stage renal disease or those who have been determined disabled under the Social Security Act qualify for Medicare.[8] Disabled individuals must fulfill a 2-year waiting period before they are eligible for Medicare; however, in most states, the low-income disabled who receive Supplemental Security Income automatically qualify for Medicaid.

Medicare benefits contain more gaps than those offered through Medicaid or a large employer. For example, standard (fee-for-service) Medicare has separate benefits for hospitalization (part A) and physician/outpatient (part B) services. Those eligible for Medicare are automatically enrolled in part A but must pay a premium to elect part B coverage. Part A has a relatively high deductible for each hospitalization and requires copayments for stays longer than 60 days.[9] Part B has a separate deductible, requires 20 percent coinsurance for physicians' bills, and does not cover prescription drugs. Unlike most employer-based insurance,

[8]Under the Social Security Act, individuals are determined to be disabled when they are unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last 12 months or longer.

[9]Coverage for care in hospitals is measured in benefit periods. A benefit period begins the day an individual is admitted to a hospital and ends when he or she has been out of the hospital for 60 consecutive days, including the day of discharge. In 1998, the deductible for each benefit period is $764. The copayment is $191 per day for more than 60 but fewer than 91 days of hospitalization; it rises to $382 per day from the 91st through the 150th day. Beyond 150 days, Medicare pays nothing, leaving the beneficiary responsible for all costs.

neither part A nor part B has a limit on out-of-pocket costs. To cover some of the gaps in Medicare coverage, beneficiaries often purchase Medigap insurance; alternatively, if available, they may enroll in a Medicare managed care plan, which generally offers a richer benefit package than fee-for-service Medicare, often with no premium.[10] Finally, some beneficiaries have access to employer-based retiree health benefits, which supplement their Medicare coverage. Medicaid, like most employer-sponsored coverage, offers a comprehensive benefit package, but the depth of coverage varies substantially among states. Federal guidelines require coverage of a broad range of services, including inpatient and outpatient hospital care, physician services, laboratory services, and nursing home and home health care. Most of those enrolled in the program incur no out-of-pocket expenses.[11]

Federal Role in Ensuring Access to Private Health Insurance

Although the decision to offer health benefits to workers or retirees is essentially voluntary, several federal laws have influenced their provision by employers. For example, since 1954, the tax code has encouraged employment-based health coverage by making employer health benefit payments tax deductible and by excluding employer-provided benefits from employees' taxable income. Also, ERISA, which was enacted in 1974, allows employers to offer uniform national health benefits by preempting states from directly regulating employer benefit plans. ERISA, however, does impose some federal requirements on employer-based plans, including requirements to provide employees with a plan description within 90 days of enrollment and implement a process for appealing claim denials. Because of the federal preemption of state regulation, the rights of active and retired employees under ERISA are largely determined in the courts. Appendix I contains a description of the role of ERISA in safeguarding access to coverage provided voluntarily by an employer.

In addition, federal law guarantees that individuals leaving employer-sponsored group health plans have access to continued coverage, and ultimately to a product in the individual market. First, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which amended ERISA, requires group health plans covering 20 or more workers to offer 18 to 36 months of continued health coverage to former employees and their dependents in certain circumstances, such as when an employee

[10]For certain low-income Medicare beneficiaries, Medicaid may pay the part B premiums, deductibles, and coinsurance.

[11]States may impose nominal deductibles, coinsurance, or copayments on some recipients for certain services. However, pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy health maintenance organization (HMO) enrollees are excluded from this cost sharing.

is terminated or laid off, or quits or retires. Although COBRA is not specifically targeted at the near elderly, it clearly provides this age cohort with the opportunity to continue health coverage as they transition from the active workforce to retirement. The mandate to offer continuation coverage, however, does not oblige employers to share in the premium.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) further guarantees access to individual market coverage to individuals leaving group health plans. Group-to-individual portability is available to eligible individuals who, among other criteria, have exhausted their available COBRA or other conversion coverage,[12] regardless of their health status and without the imposition of coverage exclusions for preexisting conditions. HIPAA, however, does not provide similar guarantees of coverage for others in the individual market.

Objectives, Scope, and Methodology

The Chairman, Senate Committee on Labor and Human Resources, asked us to assess the ability of Americans aged 55 to 64 to obtain health benefits through the employer-sponsored or individual insurance markets. He specifically asked for information on the near elderly's (1) health, employment, income, and health insurance status; (2) ability to obtain employer-based coverage if they retire before becoming eligible for Medicare; and (3) use of and costs associated with purchasing coverage through the individual market or COBRA continuation insurance.

To determine the demographic and health insurance status of the near elderly, we analyzed the March 1997 Current Population Survey (CPS). Appendix II discusses some of the strengths and limitations of the CPS and other surveys that we considered. As part of our analysis of the CPS, we separately examined two subgroups of the near elderly—those aged 55 to 61, who are more likely to be in the labor force, and those aged 62 to 64, who have a greater chance of being retired. Since the March CPS asks respondents about their employment, retirement, health, income, marital, and social security status, we were able to make observations about the relationship of these variables to the health insurance status of the near elderly. To supplement CPS data on the health status of this age cohort, we also obtained more objective data on their health conditions, health care use, and health care expenditures from the Agency for Health Care Policy and Research and the National Center for Health Statistics.

[12]Some state laws extend continuation requirements similar to COBRA to groups with fewer than 20 employees, and several states require carriers to offer individuals a product comparable to their group coverage on a guaranteed-issue basis.

To determine trends in employer-based health insurance coverage for those who retire before reaching Medicare eligibility, we conducted a literature review on employer-based health benefits for early retirees. The focus of that review included information on (1) factors contributing to the decline in employer-based benefits, (2) terminations of retiree coverage, (3) changes in the terms and conditions under which coverage is made available to both current and future retirees, and (4) retirement and the influence of health benefits. We culled data on more recent trends in retiree coverage from periodic surveys sponsored by private benefit consultants and by the federal government. In general, we only reported trend data from nationally representative surveys.

Information on continuation coverage is not available from the March 1997 CPS. Consequently, in order to examine the extent of the near elderly's utilization of COBRA coverage, we relied on analyses of two special CPS supplements sponsored by the Pension and Welfare Benefits Administration of the Department of Labor—one conducted in 1988 and a second in 1994. We supplemented these analyses with data drawn from (1) the administrative records maintained by a COBRA third-party administrator and (2) an annual survey that attempts to measure adverse risk selection as a result of COBRA.

To determine the access of the near elderly to the individual insurance market, we updated information collected in our 1996 report[13] on the cost and coverage trade-offs faced by Americans who rely on this market for coverage. In particular, we contacted officials from a number of state insurance departments and insurance carriers to obtain information about carrier underwriting practices, current premium prices for the most popular products, and recent state and federal legislation that affect individuals' access to this market. Because certain aspects of individual insurance markets can vary significantly among states, our 1996 study relied on case studies of such markets in a number of states.[14] Although the findings from these states, including the premium prices of individual

[13]Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996). See also Alpha Center, Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States, Report to the Kaiser Family Foundation (Washington, D.C.: Alpha Center, Mar. 1998).

[14]We selected these states judgmentally on the basis of variations in their populations, urban/rural compositions, and the extent of individual insurance market reforms implemented. In each state, we interviewed and obtained data from representatives of the state insurance department and at least one of the largest individual market carriers. From insurance department representatives, we obtained information concerning the regulation and, where applicable, reform of the individual insurance market and the number and market share of individual market carriers in the state. From carriers, we obtained information concerning products offered, including their benefit structure, cost-sharing alternatives, eligibility, and prices.

products, cannot be generalized to the nation as a whole, we believe they are reasonably representative of the range of individual insurance market dynamics across the country. Also updated were 1995 data for each state concerning individual market insurance reforms, high-risk pools, and insurers of last resort.

The following chapters of this report focus on how the near elderly obtain health insurance and the obstacles they face in doing so. Understanding a few key distinctions among the various types of surveys used will facilitate the understanding of the data presented in this report. First, surveys can have different units of analysis. Certain surveys are based on interviews with a sample of individuals, some of whom are near elderly; others are the product of information collected from a sample of employers or establishments.[15] Because of these different units of analysis, it is often difficult to make comparisons across the two types of surveys. Second, although various surveys collect information relevant to understanding the insurance status of the near elderly, 55- to 64-year-olds are not usually their primary focus. As a result, a particular sample may not be sufficiently large to precisely answer questions about a certain subset of the near elderly. Conversely, the survey (or an analysis by others) may have defined the near-elderly group differently, making it difficult to report on an issue with respect to 55- to 64-year-olds.

Changes in survey methodology over time often preclude or complicate the identification of insurance trends among the near elderly. This is particularly true about employer survey data from the 1980s but also affects some surveys conducted in the 1990s. Though the changes may have improved the reliability and relevance of the data, they are often not comparable with earlier results from the same survey. Finally, some of the data sets are proprietary, and not all of the information collected is publicly available. The sample sizes, and thus the precision of the estimates derived, vary. Throughout this report, we alert the reader to the source of the survey data being reported, any limitations in that data, and any caveats that must accompany the survey findings because of the size of the sample.

A number of experts on retiree health benefits and insurance markets commented on a draft of this report. They generally agreed with our presentation of the evidence on the near elderly's access to health insurance. We incorporated their comments as appropriate. Our review

[15]An establishment is not necessarily a unique business. Thus, different branches of the same firm might be included in a sample of establishments.

was conducted between August 1997 and January 1998 in accordance with generally accepted government auditing standards.

Demographic and Insurance Characteristics of the Near Elderly

Because near-elderly Americans between the ages of 55 and 64 are different from younger age groups in terms of health, work, and income status, their access to and sources of health insurance also differ. This chapter uses the March 1997 CPS to depict the demographic and insurance characteristics of the near elderly and two subgroups—those aged 55 to 61 and 62 to 64.[16]

Compared with younger age groups, the near elderly exhibit declining workforce attachment, health, and income. As the near elderly retire or cut back on their hours of work, they run the risk of severing their link to employer-based health insurance. Nonetheless, the percentage of uninsured in this age group is relatively low because of their increased reliance on health insurance through the individual market, Medicaid, and Medicare. Health, income, and employment status appear to influence how the near elderly obtain coverage. In general, those with individual insurance appear to have more in common with recipients of employer-based coverage than with the near elderly who had other sources of health benefits such as Medicaid or Medicare. Specifically, a smaller percentage of those with employer and individual coverage had low incomes, were minorities, were not working, or were in poor health. Key differences between those with individual and employer-based coverage, however, are that a larger percentage of the former were women, unmarried, unemployed, and with low incomes. There is also a similarity between the 55- to 64-year-olds who had public insurance and those who were uninsured. As compared with those with other sources of coverage, a higher percentage of both groups had low incomes, were minorities, were not working, or were in poor health. Again, however, there were important differences between these two groups. Specifically, compared with those with public insurance, the uninsured were more likely to work, be married, have better health, and have higher incomes.

Near Elderly: Portrait of a Cohort in Transition

Differences in health, labor force attachment, and family income distinguish the near elderly from younger Americans, underscoring the importance of access to affordable health insurance for this age group. The near elderly comprise about 21 million Americans. One of the fastest growing age cohorts, this group is projected to increase to 35 million over the next 12 years and to nearly double between today and the year 2020—jumping from 8 to 13 percent of the U.S. population. The near elderly might best be characterized as a group in transition. Neither young nor old, 55- to 64-year-olds have reached a turning point in their lives.

[16]App. II contains more details on the methodology we used in our CPS analyses.

Many are beginning to focus on withdrawal from the labor force and eventual retirement. For some, this disengagement is motivated by chronic conditions or slowly worsening health, conditions that may be work-related. Those near elderly with children see them growing up and leaving home. Finally, family incomes are beginning to decrease as more individuals adjust to living on a pension.

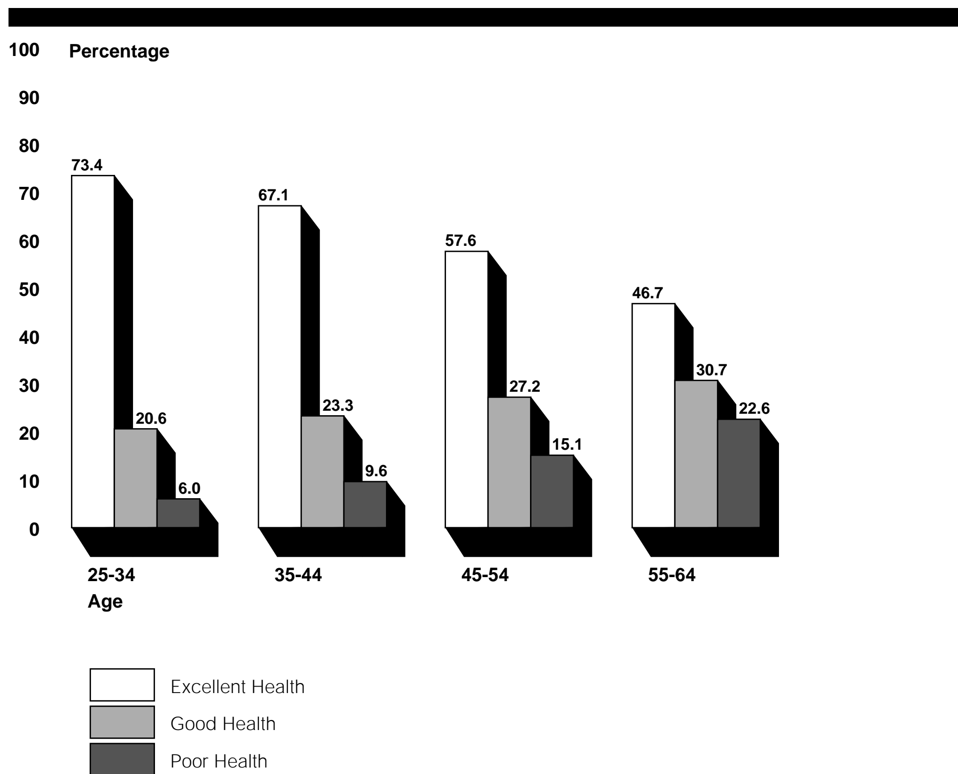
Near Elderly Report Declining Health as They Age

Self-reported health status suggests a pattern of declining health as individuals grow older. Such subjective findings are corroborated by more objective data from the National Center for Health Statistics (NCHS) and Agency for Health Care Policy and Research (AHCPR). Compared with younger age groups, individuals aged 55 to 64 (1) have the highest prevalence of many serious health conditions, (2) are the most frequent users of health care services, and (3) incur higher health care expenditures.

In response to a health question on the CPS, the near elderly gave the lowest personal assessments of any group (see fig. 2.1).[17] For example, while almost three-quarters of 25- to 34-year-olds rated their health status as excellent, less than one-half of the near elderly reported their health this positively. Conversely, about one quarter of 55- to 64-year-olds assessed their health as poor compared with only 6 percent of those under age 35.

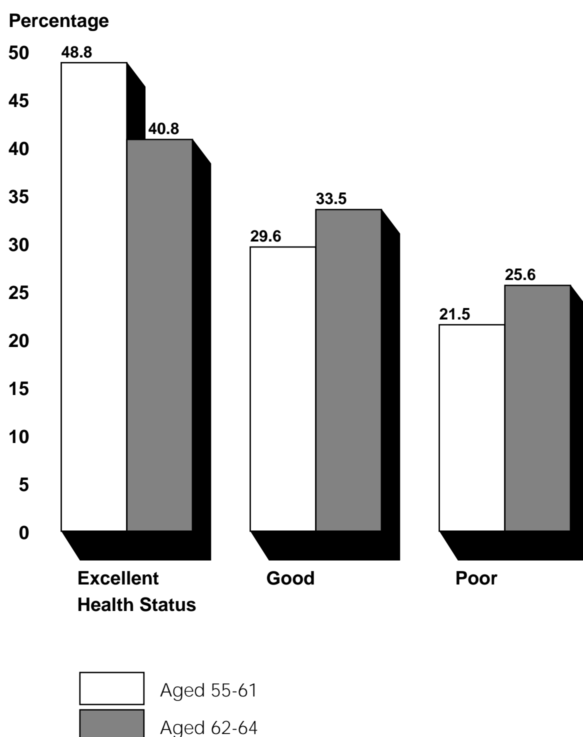
[17]The CPS question asked respondents to rate their health status as excellent, very good, good, fair, or poor. To simplify our presentation of these data, we have collapsed these responses into three categories. Specifically, our excellent category includes both the excellent and very good responses, and our poor category includes both the fair and poor responses.

Figure 2.1: Self-Reported Health Status, by Age Group, 1996



Even among the near elderly, self-reported health status worsens with age. As shown in figure 2.2, nearly one-half of 55- to 61-year-olds rated their health status as excellent compared with 41 percent of 62- to 64-year-olds. Conversely, more individuals over age 61 reported that their health was poor.

Figure 2.2: Self-Reported Health Status of 55- to 61- and 62- to 64-Year-Olds, 1996



These self-reported health assessments from the CPS are corroborated by more objective data on the health status of the near elderly. Tables 2.1, 2.2, and 2.3 present NCHS and AHCPR data comparing the health status and expenditures of 55- to 64-year-olds with the experience of younger Americans. As demonstrated by table 2.1, the incidence of conditions such as diabetes, glaucoma, heart disease, and hypertension is more prevalent among the near elderly than among younger age cohorts. In addition, the near elderly are the most frequent users of many health care services. Their hospital discharge rates and days of hospital care were 51 percent and 66 percent higher, respectively, than those of 45- to 54-year-olds (see table 2.2). Similarly, the near elderly visited physicians at a rate that was nearly 20 percent higher than that of any younger age group. Finally, the near elderly have the highest annual health care expenditures of any group under age 65—estimated to be about $5,000 per person in

1998—45 percent higher than for individuals 45 to 54 years of age, and more than 120 percent higher than for those aged 35 to 44 (see table 2.3).[18]

Table 2.1: Number of Health Conditions Per 1,000 People Among Four Age Groups

	Age group			
Condition	**25 - 34**	**35 - 44**	**45 - 54**	**55 - 64**
Arthritis	41.19	79.85	174.48	294.75
Cataract	3.42	3.21	5.85	33.73
Cerebrovascular disease	1.98	3.30	11.62	27.73
Diabetes	9.35	20.17	46.74	86.09
Gallbladder disease	6.34	3.04	5.49	11.17
Glaucoma	1.95	5.30	7.63	17.70
Ischemic heart disease	2.71	7.90	29.23	72.30
Heart rhythm disorders	21.75	30.43	38.82	53.25
Other heart disease	3.62	7.88	19.35	36.47
Hernia	7.40	17.06	25.27	39.80
Hypertension	40.42	82.45	176.21	285.88
Ulcer	19.45	22.79	17.26	36.01
Varicose veins	19.82	31.00	42.07	62.57

Source: Data derived from the NCHS 1994 National Health Interview Survey.

[18]The Agency for Health Care Policy and Research "aged" 1987 data to represent 1998 dollars.

Table 2.2: Use of Health Care Services, by Age Group

	Age group			
	25 - 34	35 - 44	45 - 54	55 - 64
Hospital discharges[a]				
Rate per 1,000 people per year	107.2	82.8	102.6	154.6
Days of care[a]				
Rate per 1,000 people per year	412.8	425.8	571.6	948.7
Average length of stay (days)	3.8	5.1	5.6	6.1
Physician visits[b]				
Rate per 1,000 people per year	2,140	2,274	2,973	3,545
Outpatient department visits[c]				
Rate per 1,000 people per year	227	218	264	305
Emergency department visits[c]				
Rate per 1,000 people per year	378	297	255	263

[a]Data reproduced from "National Hospital Discharge Survey: Annual Summary, 1994," Vital and Health Statistics, Series 13, No. 128 (Hyattsville, Md.: NCHS, May 1997).

[b]Data derived from "1996 National Ambulatory Medical Care Survey," Advance Data (Hyattsville, Md.: NCHS, Dec. 17, 1997).

[c]Data derived from "1996 National Hospital Ambulatory Medical Care Survey," Advance Data (Hyattsville, Md.: NCHS, Dec. 17, 1997).

Table 2.3: Average Health Care Expenditures by Age Group

	Age group			
Expenditures	**25 - 34**	**35 - 44**	**45 - 54**	**55 - 64**
Emergency room	$78.60	$55.81	$48.46	$80.17
Hospital room and board	732.34	644.61	1,151.05	2,187.09
Inpatient physician services	196.02	208.81	386.32	463.17
Outpatient hospital services	68.51	67.62	124.28	73.13
Physician office services	555.23	573.60	881.42	1,074.00
Prescription drugs	109.46	181.72	340.54	513.62
All medical services	**$2,110.55**	**$2,233.91**	**$3,454.93**	**$5,023.58**

Note: Expenditures are based on the 1987 National Medical Expenditure Survey and were aged by AHCPR to represent 1998 dollars.

Near Elderly Are in Transition From the Active Workforce to Retirement

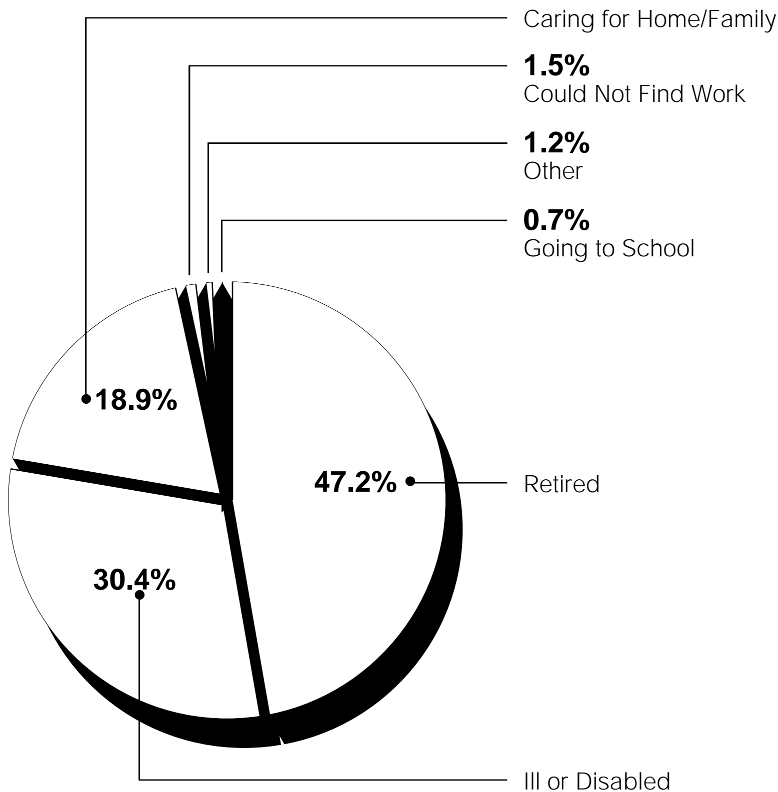
Although a majority of the near elderly reported that they worked for some period of time in 1996, this age cohort is moving from full-time employment into retirement, a change that may result in the loss of employer-based health coverage. The transition is apparent in data on the work status of the near elderly and is even starker when comparing the experience of 55- to 61-year-olds with those 62 and older.

About two-thirds of the near elderly were employed for some period of time in 1996 compared with about 85 percent of those between the ages of 25 and 54. Almost 43 percent were employed full time for the entire year. The remainder either worked full time for part of the year (9 percent) or part time (13 percent). And the majority of part-timers worked fewer than 20 hours per week. Of those who were employed in 1996, about 18 percent were self-employed, with the remainder working in either the private sector or government.

The remaining one-third of the near elderly were out of the labor force entirely. As shown in figure 2.3, almost 80 percent of nonworkers reported retirement, illness, or disability as the main reasons for not working. Another one-fifth did not work in order to care for their homes and families. Few of the nonworking near elderly were displaced from a job or looking for work. Only about 117,000 (1.5 percent) reported "inability to find a job" as the main reason for not working. This estimate is corroborated by a related question to which about 155,000 (2 percent) nonworkers said that they had been laid off or were looking for work during that time period.[19] The near elderly did not differ from other age groups in the extent to which they were displaced from work.

[19]Because of the small number of cases, the actual size of this group could vary by as much as 30 percent. Because of the imprecision of these estimates, we report no additional information on the characteristics of these individuals.

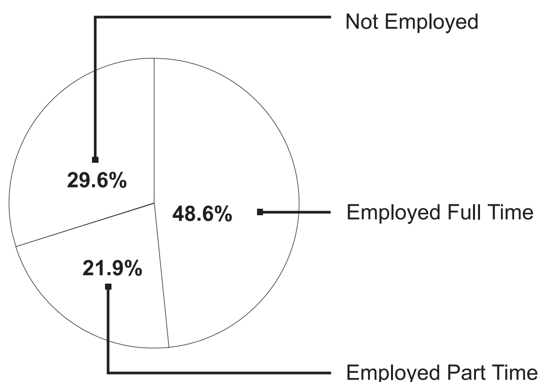
Figure 2.3: Percentage of Near Elderly Who Did Not Work, by Primary Reason Reported, 1996



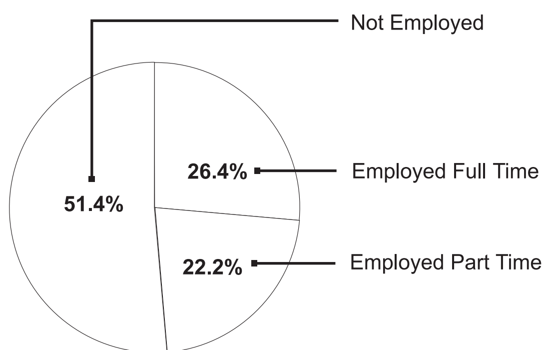
While the fact that fewer than one-half of the near elderly worked full time for the whole year suggests a transition to retirement, the progression is even more evident when comparing the employment status of the 55- to 61-year-old members of this group with those 62 and older. Figure 2.4 demonstrates that by age 62 an even smaller percentage worked full time and over one-half were not employed at all.

Figure 2.4: Employment Status of 55- to 61- and 62- to 64-Year-Olds—Percentage Working Full Time, Working Part Time, and Not Employed, 1996

Aged 55-61



Aged 62-64

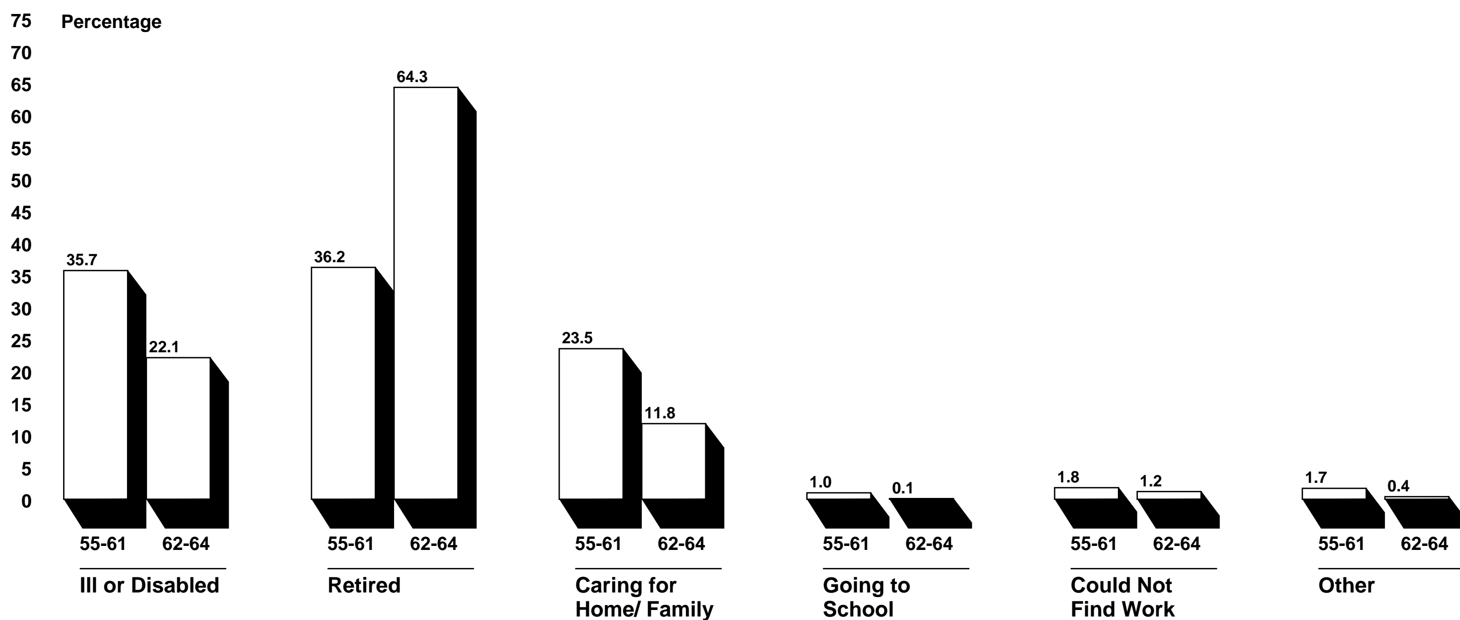


Another indicator of detachment from the workforce for 62- to 64-year-olds is the proportion who elect Social Security benefits before they reach the normal retirement age of 65. In 1996, about one-half of this age group who were eligible elected to receive Social Security benefits early with a reduced annuity and only about one-third of those individuals worked at all in 1996.

As shown in figure 2.5, the relationship between age and retirement is also reflected in the reasons individuals reported for not working. Almost two-thirds of those 62 and older were retired compared with about one-third of the younger near elderly.[20] However, fewer of the former indicated they did not work because of illness or disability or because they were taking care of home and family.

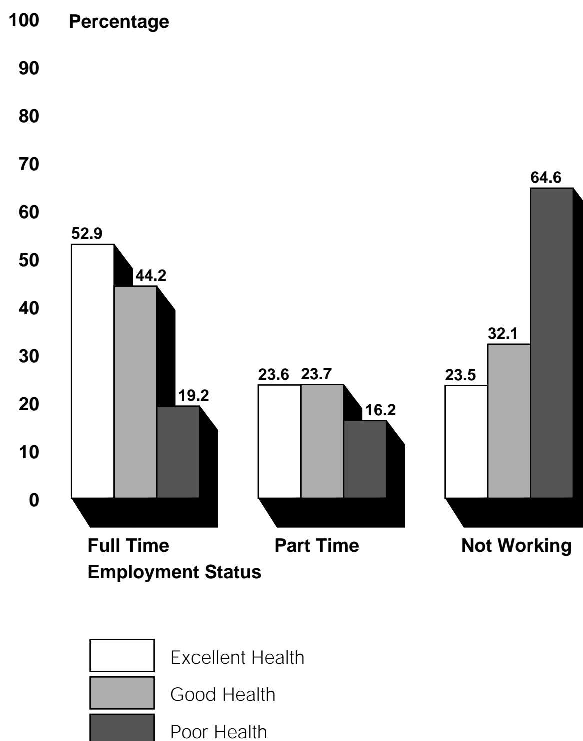
[20]The trend toward earlier retirement is also demonstrated by examining labor force participation rates over time. For example, while about 84.6 percent of males aged 55 to 64 participated in the labor force in 1965, only about 65.5 percent worked in 1995.

Figure 2.5: Percentage of 55- to 61- and 62- to 64-Year-Olds Who Reported Not Working, by Reason, 1996



The transition into retirement as the near elderly grow progressively older could, in part, be influenced by their worsening health status. As noted earlier, health status declines with age and self-reported health status is slightly worse for the older members of this age group. When the overall group's employment status is examined in the context of its health status, we find that a much smaller percentage of those in poor health worked during 1996 compared with those who reported having better health (see fig. 2.6).

Figure 2.6: Health and Employment Status of the Near Elderly, 1996



Income Begins to Decline After Age 55 as Likelihood of Being Retired Increases

In 1996, the median family income for people between the ages of 55 and 64 was about $40,000.[21] A comparison of their income with that of other age groups, however, suggests that income peaks before age 55 and then declines. As shown in table 2.4, the median family income rose from a low of about $36,000 for people aged 25 to 34 to a high of $52,000 for 45- to 54-year-olds. In contrast, the median family income dropped for the near elderly.

Table 2.4: Median Family Income for the Near Elderly and Younger Age Groups, 1996

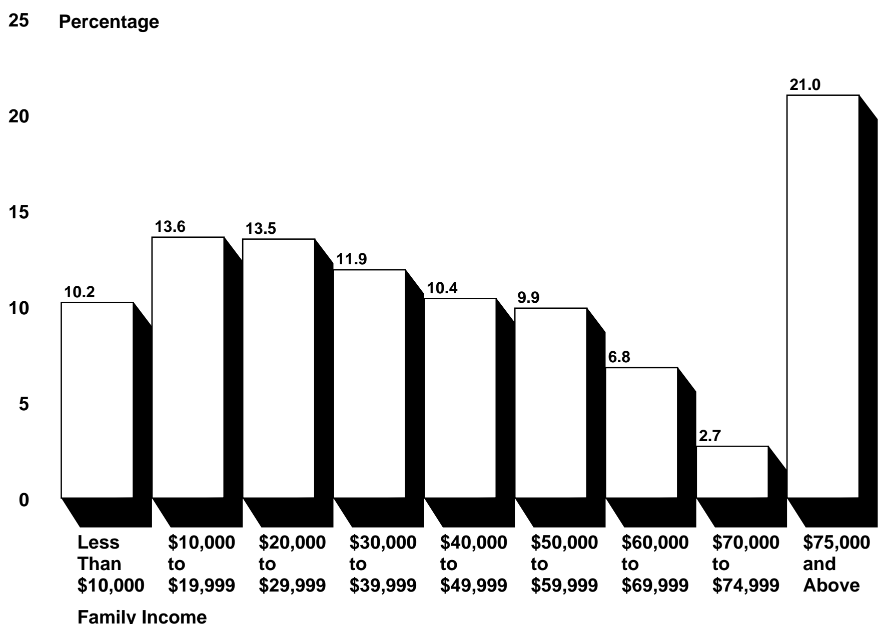
Age group	Total family income (median)
25 - 34	$35,922
35 - 44	$45,810
45 - 54	$52,000
55 - 64	$40,444

[21]For the CPS, total family income represents pre-tax earnings. Although the inclusion of assets such as homes, investments, and savings would provide a more comprehensive measure of financial resources, such data are not available through the CPS.

Although the median family income of 55- to 64-year-olds was about $40,000, almost 20 percent of this age group lived close to or below the poverty level.[22] About 18 percent of these individuals had incomes less than 150 percent of the poverty level in 1996, and about 10 percent had a total family income below the poverty level.

Figure 2.7 shows the distribution of family income for the near elderly. About one-quarter had a family income of less than $20,000 and almost 40 percent earned less than $30,000. However, over 20 percent of the near elderly had a total family income of $75,000 or more.

Figure 2.7: Distribution of Total Family Income for 55- to 64-Year-Olds, 1996



Probability of Being Insured Rises With Age, but Sources of Insurance Differ

In addition to changes in health, work, and income status, the interval between ages 55 and 64 is also a transitional period in terms of health insurance. Eligibility for Medicare is up to 10 years away, and employer-based coverage may well end with retirement. Consequently, access to individually purchased coverage and to public programs for the poor and disabled becomes increasingly important with age. For some

[22]Poverty level refers to the federal poverty guidelines, which are used to establish eligibility for certain federal assistance programs. The guidelines are updated annually to reflect changes in the cost of living, and vary according to family size. In 1996, the poverty level for a near-elderly married couple was about $10,500.

near elderly, however, the lack of an affordable alternative results in their being uninsured.

Given that aging is associated with a higher utilization of health care services, it is not surprising that the near elderly are among the most likely age group to have insurance and the least likely to be uninsured. According to our analysis of the March 1997 CPS, about 18.5 million near-elderly Americans had health insurance at some time during 1996 and the remaining 3 million were uninsured.[23] As shown in table 2.5, the near elderly and those aged 45 to 54 were the most likely groups to be insured.[24]

Table 2.5: Percentage Insured and Uninsured, by Age Group, 1996

	Age group				Total population under age 65
	25-34	35-44	45-54	55-64	
Insured	77.7	83.7	86.3	**86.2**	82.4
Uninsured	22.3	16.3	13.7	**13.8**	17.6
Total (number in millions)	**100 (40.3)**	**100 (44.0)**	**100 (33.0)**	**100 (21.5)**	**100 (235)**

While as likely to have insurance as those aged 45 to 54, the near elderly access their coverage differently (see fig. 2.8). Through age 54, each successive age group was more likely to have employer-based coverage and less likely to be uninsured.[25] This pattern was broken by the near elderly, however, as employer-based coverage was lower than for most other age groups. In part, this reflects their disengagement from the labor force and the lower probability of firms offering retiree coverage. On the other hand, the likelihood of the near elderly being uninsured was no

[23]Since 1993, the percentage of uninsured near elderly has remained fairly stable, at 13.4 percent in 1993, 13.9 percent in 1994, and 13.3 percent in 1995. A recent report based on a household survey called the Community Tracking Study suggests that the number of uninsured near elderly in 1996-97 was lower than our estimate. The response rate for the survey was 65 percent and included 33,000 families. See Peter J. Cunningham, "Next Steps in Incremental Health Insurance Expansions: Who Is Most Deserving?" Issue Brief, No. 12 (Washington, D.C.: Center for Studying Health System Change, Apr. 1998).

[24]Ninety-nine percent of those aged 65 or older were insured in 1996. For most of these individuals, Medicare was the primary source of coverage, but two-thirds also purchased individual insurance, commonly known as Medigap, and about one-third had supplementary insurance though a former employer.

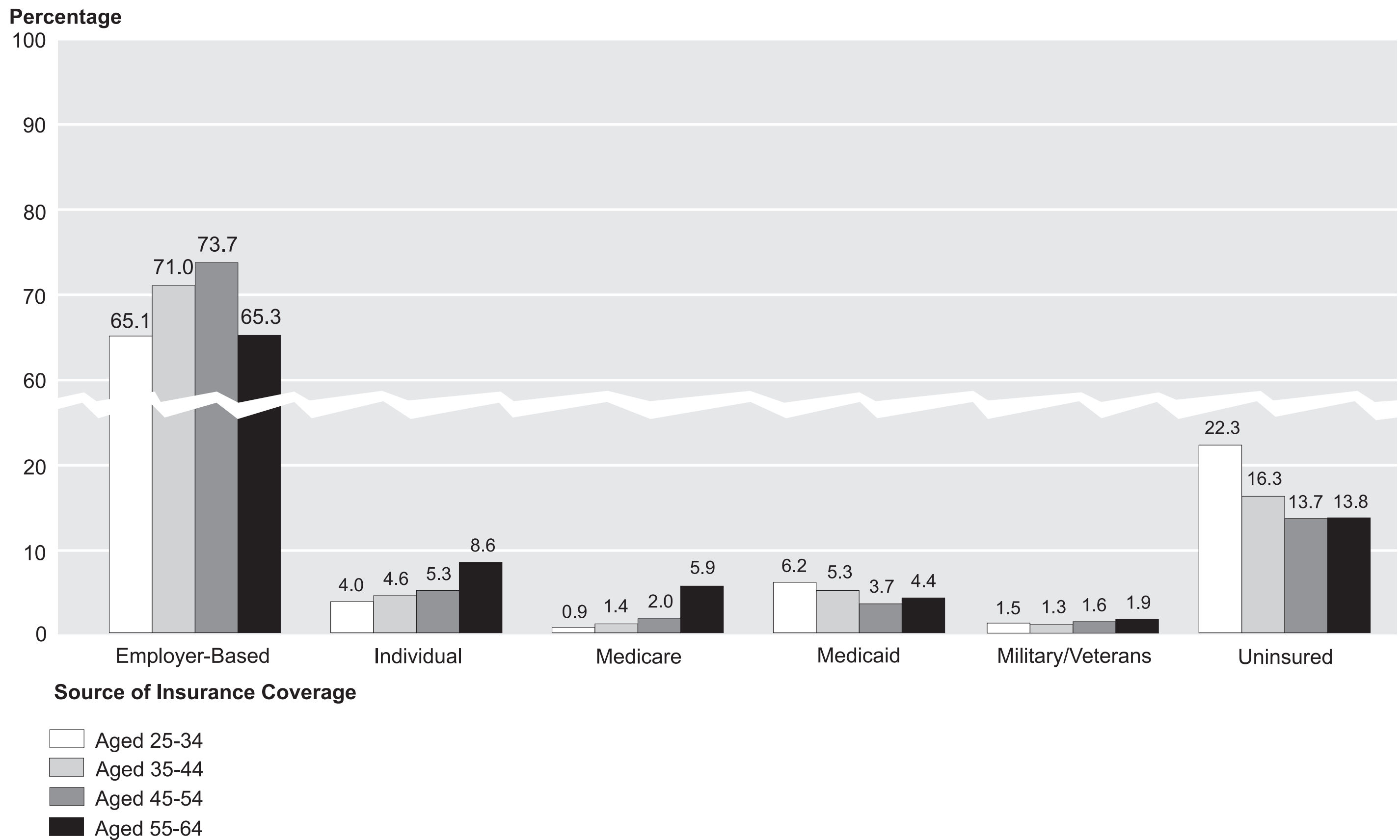
[25]The CPS asks respondents if they had health insurance through an employer or union but does not distinguish coverage from these two sources. In our presentation of this information, we refer to insurance through either of these sources as employer-based. The CPS also does not identify whether an individual has only temporary employer-based coverage under COBRA.

different than that of 45- to 54-year-olds. Individual insurance[26] and public programs such as Medicare compensated for the drop in employer-based coverage for the near elderly.[27]

[26]The CPS question does not distinguish between comprehensive and more limited policies that are available in the individual market. In addition, some policies may exclude a preexisting condition from coverage. Limited-benefit products include hospital indemnity, medical-expense, and specified-disease plans. Hospital and medical-expense plans offer a limited, usually flat reimbursement for hospital and medical/surgical expenses, respectively. Specified-disease plans provide coverage only for a particular disease. An individual with a family history of cancer might purchase a cancer-only policy. Limited-benefit products may represent a significant share of the individual market in some states. For additional information, see Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996).

[27]Although the normal Medicare eligibility age is 65, individuals under age 65 who are receiving Social Security cash benefits on the basis of disability are eligible after a 24-month waiting period. Also, most individuals who need a kidney transplant or dialysis may also be covered, regardless of age.

Figure 2.8: Percentage of Insured and Uninsured Individuals, by Source of Insurance and Age Group, 1996



Note: The March CPS asked whether individuals were covered by the Department of Defense (DOD) through its direct care system or the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), or the Department of Veterans Affairs. However, responses to this question do not distinguish among the three. The military health care system is composed of hospitals and clinics of the Army, Navy, and Air Force, called the direct care system; and CHAMPUS. Active duty military members receive all medical services through the direct care system. For active duty family members and retirees and their family members under age 65, CHAMPUS, an insurance-like program administered by the DOD, pays for a portion of the care they receive from private sector health care providers when military facility care is not available or too distant. DOD administers the CHAMPUS benefit under the new TRICARE program, which offers eligible beneficiaries HMO, preferred provider organization, and fee-for-service options. The Department of Veterans Affairs provides medical services to all veterans, subject to the availability of resources. Priority is given to veterans with service-connected disabilities, low incomes, or special health care needs.

The decreased reliance on employer-based health insurance for the near elderly is most pronounced among the oldest members of the group. As shown in table 2.6, the percentage of 62- to 64-year-olds with such coverage was almost 8 points lower than for the younger members of the near elderly. The further decline in employer-based coverage should be accompanied by changes in the number of uninsured and those obtaining coverage through the individual market and Medicare. All three categories did in fact show an increase among 62- to 64-year-olds; these differences, however, were only statistically significant for Medicare.[28]

Table 2.6: Percentage of Insured and Uninsured Near Elderly, Aged 55 to 61 and 62 to 64, by Source of Insurance, 1996

Source of insurance	Aged 55 - 61	Aged 62 - 64
Employer	67.4	59.6
Individual	8.0	10.1
Medicare	4.9	8.5
Medicaid	4.6	4.0
Military/veterans	1.9	2.1
Uninsured	13.2	15.5
Total	**100.0**	**100.0**

Note: Percentages may not add to 100 because of rounding.

Changing Demographic Characteristics Affect Likelihood of Being Insured and the Source of Insurance

As noted earlier, the health, employment, and income of individuals change as they grow older. Our analysis of the March 1997 CPS indicates that these changes affect the insurance status of the near elderly. Overwhelmingly, those who have better health, are employed, or have higher incomes are more likely to be insured and to have coverage through an employer. Conversely, those in poor health, who are not working, and who have low incomes have a greater probability of being uninsured or relying on Medicare or Medicaid. Although the data also suggest that certain characteristics are linked to the likelihood of having individual insurance—having better health, working part time, and having low income—the results were not statistically significant.

Health and Insurance Status

Among the near elderly, a better self-reported health status translated into a greater likelihood of being insured and of obtaining this coverage through an employer. In contrast, those who rated their health as poor

[28]For purposes of our analysis, we considered a difference to be statistically significant when the odds were no greater than 5 in 100 that the difference could have occurred by chance.

were more likely to be uninsured or to obtain coverage through a public program.

As shown in table 2.7, only 43 percent of those with poor health had employer-based coverage, while about 76 percent of those with excellent health and 66 percent of those with good health were covered through an employer. And individuals in poorer health were at least 10 times more likely to be covered through Medicare or Medicaid, compared with those in the best of health. Poor health status, however, does not guarantee access to insurance, as reflected in the fact that about 18 percent of the nearly elderly who reported their health status as poor were uninsured.

Table 2.7: Health and Insurance Status of the Near Elderly, 1996

Numbers in percent

	Health status		
Type of insurance	**Excellent**	**Good**	**Poor**
Employer	75.7	66.1	42.8
Individual	9.1	9.9	5.8
Medicare	1.2	4.0	17.9
Medicaid	1.3	2.5	13.4
Military/veterans	1.8	2.0	2.1
Uninsured	10.8	15.5	17.9
Total	**100.0**	**100.0**	**100.0**

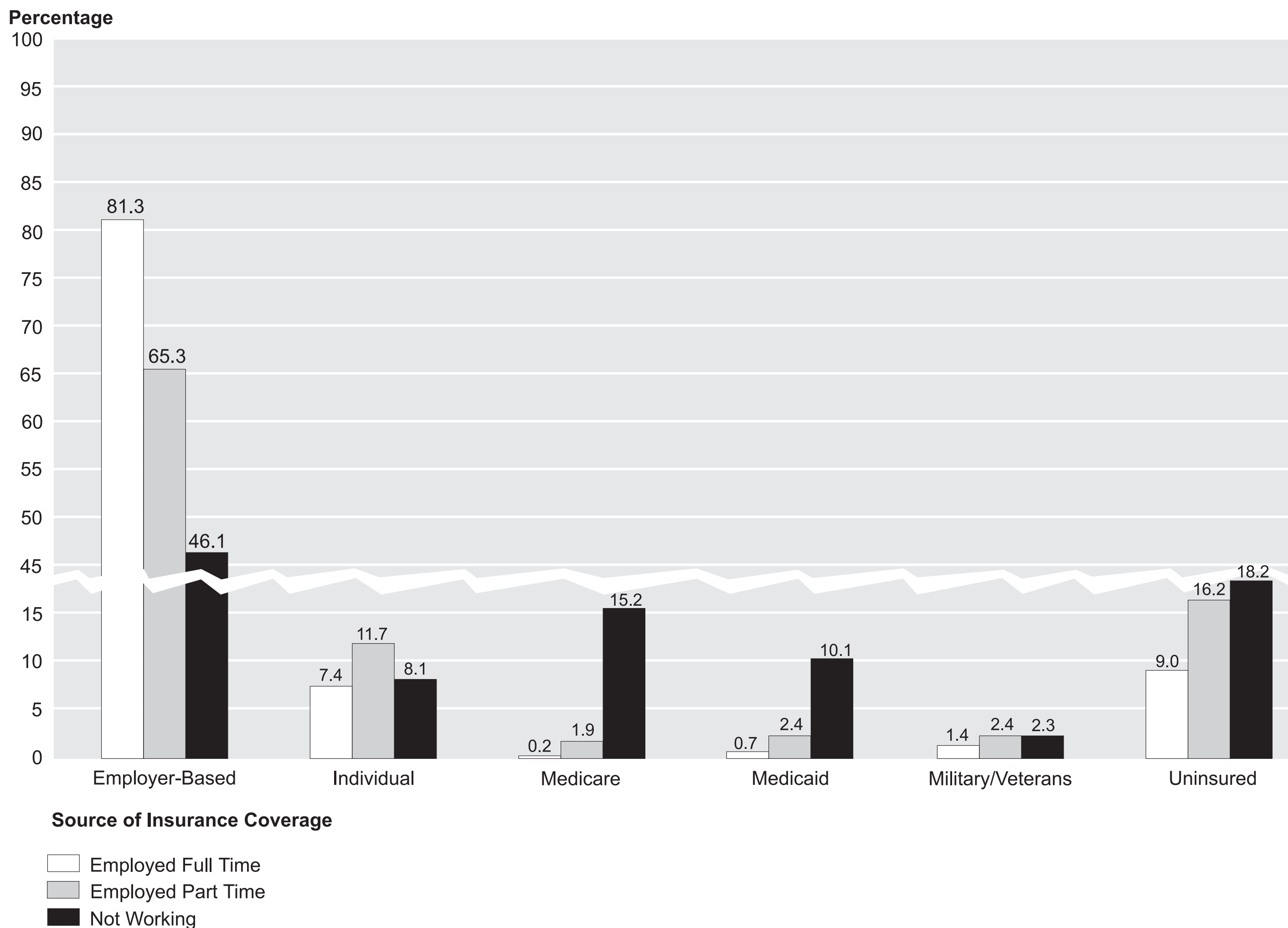
Note: Percentages may not add to 100 because of rounding.

Employment and Insurance Status

Among the near elderly, there is a link between insurance status and three work-related variables: (1) number of hours worked, (2) nature of the employment, and (3) type of industry. First, the near elderly typically had insurance, but those who worked full time were more likely to be insured. More than 90 percent of the near elderly who worked full time had some kind of health insurance, compared with 82 percent of those who did not work at all. Moreover, the number of hours worked affected the source of coverage—that is, whether the insurance was obtained through an employer, the individual market, or public sources (see fig. 2.9). For example, 81 percent of the near elderly who worked full time in 1996 had employer-based coverage, compared with only 65 percent who worked part time and only 46 percent of those who did not work. These differences are even more dramatic when we distinguish employer-based coverage through the individual's employer from that obtained through a

spouse. Specifically, about 73 percent of full-time workers had coverage through their employer, compared with 46 percent of part-time workers and 25 percent of those who did not work. In addition, those aged 55 to 64 who worked part time were more likely to purchase individual insurance than were those who worked full time. This pattern may be explained by the possibility that those who worked full time were more likely to have employer-based health insurance at retirement. As was the case with health status, there is a relationship between not working and reliance on public sources of coverage. Thus, those who were not employed in 1996 were at least 10 times more likely to have Medicare or Medicaid than the near elderly who were employed full time.

Figure 2.9: Insurance Status of the Near Elderly, by Employment Status, 1996



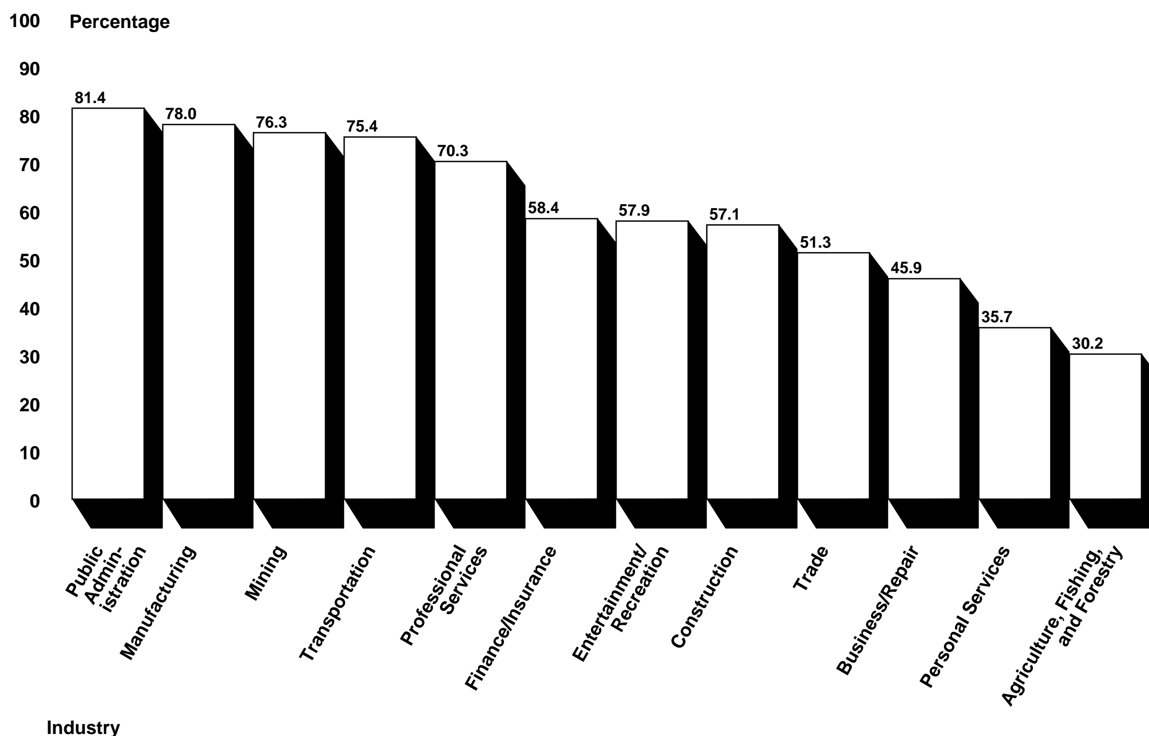
Second, the insurance status of 55- to 64-year-olds varied by the nature of their employment, that is, whom they worked for. Thus, individuals who worked for an employer as opposed to being self-employed were more likely to have employer-based health insurance through that employer, while the latter were more likely to have individually purchased insurance. Eighty-three percent of those who worked for a public employer in 1996 had coverage through their employer as did 67 percent of those who

worked for a private employer. In contrast, 42 percent of the incorporated self-employed and 27 percent of the unincorporated self-employed had this source of coverage.[29] However, only 4 percent of individuals who worked for a public employer and 6 percent who worked for a private employer had individually purchased insurance compared with more than 20 percent of the self-employed.

Finally, health insurance was more common in certain industries. As shown in figure 2.10, the near elderly employed in public administration, manufacturing, mining, transportation, and professional services were the most likely to have health insurance through their employer, while those who performed personal services or worked in agriculture, fishing, and forestry were the least likely to have coverage through this source. As noted in chapter 3, an increasing share of the labor force is working in the service sector, while a decreasing share is working in manufacturing and transportation; hence, the number of retirees without insurance through an employer could be higher in the future.

[29]Someone who is self-employed may purchase group health insurance for him- or herself and any employees of the firm.

Figure 2.10: Percentage With Insurance Through Their Employer, by Industry Sector, 1996



Reasons the Near Elderly Did Not Work and Insurance Status

As reported earlier, almost 97 percent of the near elderly who did not work in 1996 reported retirement, illness or disability, or caring for their home or family as their main reason for being out of the labor force (see fig. 2.3). Additionally, a small number (about 117,000 individuals) in this age group indicated that they were unemployed in 1996 because they were unable to find work.[30] Just as the insurance status of the near elderly varied according to their relative attachment to the workforce or to the type of work performed, whether or not a person had insurance as well as the type of insurance they held also varied by the reasons given for not working (see table 2.8).

[30]As mentioned previously, the actual size of this group could vary by as much as 30 percent.

Table 2.8 : Type of Insurance, by Reason for Not Working, 1996

Numbers in percent

Type of insurance	Retired	Caring for home/family	Ill/disabled	Could not find work
Employer	58.1	51.8	25.3	29.5
Individual	11.2	7.9	2.5	9.3
Medicare	9.6	3.0	32.8	0.0
Medicaid	2.2	6.6	25.1	7.8
Military/veterans	2.2	2.7	2.1	0.0
Uninsured	16.7	27.9	12.2	53.4
Total	**100.0**	**100.0**	**100.0**	**100.0**

Note: Percentages may not add to 100 because of rounding.

First, whether or not an individual had insurance differed depending on the reason given for not working. For example, about 83 percent of the retired and 88 percent of the ill or disabled had some kind of health insurance, compared with 72 percent of those who were caring for a home or family and only 47 percent of those who could not find work.

Second, the source of coverage held by the near elderly differed depending on the reason they did not work. While both the retired and the ill or disabled were the most likely to have health insurance, the former were more than twice as likely to have employer-based insurance as the latter. Conversely, the ill or disabled were more than three times as likely to be covered by Medicare and 10 times more likely to be covered by Medicaid than those who were retired. As shown in table 2.8, those who were caring for a home or family essentially mirrored the retired group with respect to source of insurance. Most of the former individuals, however, obtained coverage through a spouse. Among these four groups, the percentage of uninsured was highest for those reporting an inability to find work, but because of their small representation in the overall sample, we could not make further observations.

Income and Insurance Status

As mentioned earlier, income is lower for individuals 55 to 64 years of age than for younger groups. Whether or not the near elderly had insurance, as well as their source of insurance, however, differed by income level. Compared with the near elderly with high incomes, those with low incomes were more likely to be uninsured or to rely on Medicaid or Medicare. As shown in table 2.9, the percentage of 55- to 64-year-olds without insurance fell from a high of about 33 percent for those with

incomes less than $10,000 to about 6 percent for those with incomes of $75,000 or more. Similarly, the proportion covered by Medicaid and Medicare dropped significantly when incomes exceeded $20,000.

The near elderly with low incomes were also the least likely to have employer-based coverage. As shown in table 2.9, those with incomes less than $10,000 had the lowest level of employer-based coverage, while such coverage increased significantly up to the $30,000 income level and then gradually rose as income exceeded this amount.

Despite their limited resources, the near elderly with low incomes purchased individual insurance at about the same rate as did those with higher incomes.[31] Although table 2.9 suggests that the low-income near elderly were more likely to purchase individual insurance than those with higher incomes, these differences were not statistically significant.

Table 2.9: Source of Insurance for the Near Elderly, by Income, 1996

Numbers in percent

Total family income	Less than $10,000	$10,000 to $19,999	$20,000 to $29,999	$30,000 to $39,999	$40,000 to $49,999	$50,000 to $59,999	$60,000 to $69,999	$70,000 to $74,999	$75,000 and above
Employer	15.6	41.2	62.7	71.5	74.5	78.7	78.7	84.6	85.7
Individual	10.3	11.1	11.8	7.5	10.3	6.9	6.5	4.3	5.9
Medicare	16.5	14.3	5.1	4.6	1.9	3.2	3.2	2.1	1.0
Medicaid	22.2	8.7	3.6	1.3	0.7	1.4	0.4	0.5	0.3
Military/ veterans	2.7	2.0	3.0	2.2	2.0	1.1	2.0	1.0	1.2
Uninsured	32.6	22.8	13.8	12.9	10.6	8.7	9.1	7.5	5.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Note: Percentages may not add to 100 because of rounding.

Key Characteristics of the Near Elderly, by Source of Coverage

Focusing discretely on the individual demographic characteristics of the near elderly as they relate to insurance status provides a fragmented portrait of those who have a particular type of insurance or who are uninsured. Table 2.10 profiles 55- to 64-year-olds by source of insurance—highlighting the extent to which the most vulnerable have coverage through employer-based, individual, or public insurance or go without insurance altogether. Appendix III has a more detailed profile of

[31] The cost of comprehensive coverage in the individual market suggests that those at lower incomes may be purchasing less expensive, limited-benefit products.

the near elderly by source of coverage as well as demographic and insurance profiles of those 55 to 61 and 62 to 64 years of age.

In general, the near elderly with employer-based insurance are similar to those with individual coverage. Only a small percentage had low incomes, were minorities, were not working, or were in poor health. Key differences between these groups, however, relate to their gender, marital status, work status, and income. Specifically, as compared with those with employer-based insurance, a larger percentage of those with individual insurance were women, unmarried, and unemployed and had low incomes.

Likewise, there is a similarity between 55- to 64-year-olds who had public insurance and those who were uninsured. A relatively higher percentage of both groups had low incomes, were minorities, were not working, or were in poor health. Again, however, there were important differences between these groups. Compared with those with public insurance, the uninsured were more likely to work, have better health, and have higher incomes, but were less likely to be married. Focusing on the most vulnerable, however, obscures the extent to which 55- to 64-year-olds with higher incomes are uninsured. Thus, over 20 percent of the uninsured had incomes of $50,000 or more.[32]

Table 2.10: Demographic Profile of Vulnerable Near-Elderly Americans, by Insurance Status, 1996

	Percentage with each characteristic			
Characteristic	Employer-based	Individual	Public	Uninsured
Family income under $20,000[a]	10.9	29.8	68.8	46.3
Female	49.7	58.7	56.8	57.5
Minority	16.3	13.0	38.8	38.0
Not working	25.0	33.4	87.1	46.5
Poor health	14.8	15.4	68.9	29.2
Unmarried	21.3	34.2	60.8	38.0

[a]Median family income in 1996 for the near elderly was $50,700 for those with employer-based coverage, $30,920 for those with individual coverage, $12,813 for those with public insurance, and $21,750 for the uninsured.

[32]We compared the self-reported health status of the uninsured near elderly who had incomes of $50,000 or more with both insured individuals within the same income range and with uninsured near elderly with lower incomes. Compared with the insured near elderly with incomes of $50,000 or more, about 7 percent more of the uninsured near elderly in this income range reported poor health; however, this difference is not statistically significant. The uninsured near elderly in this income range were less likely to have poor health than were uninsured individuals with incomes below $30,000.

Future Gaps in Employer-Based Retiree Health Coverage

Employers have been the main source of health insurance for Americans since World War II. During the 1950s, large employers began to incorporate health coverage for retirees into their benefit packages. The trend toward more widely available and more generous retiree health benefits began to change in the 1980s. Today, many policymakers are concerned about the future viability of employer-based retiree health coverage and the implications for older Americans who are not yet eligible for Medicare. Evidence from several different sources paints a picture of eroding retiree health benefits. Because each of these sources alone gives an incomplete picture, this chapter uses both employer and retiree surveys to describe the current situation and future outlook for employer-based retiree health benefits.

The number of medium and large employers offering health insurance to retirees appears to have dropped precipitously from levels reported in the 1980s.[33] Moreover, during the 1990s, it has continued to drift slowly downward. Coincidentally, the decline in employers offering retiree coverage has been exacerbated by a shift in employment away from firms more likely to offer coverage toward those less likely to do so, that is, from manufacturing to service industries.[34] When retiree health benefits are offered by a large employer, retiree participation has also declined—a development attributed to the trend toward greater cost sharing. However, this decline has been offset, in part, by an increase in labor force participation among women. Thus, retirees who decline coverage from a former employer may have access to less expensive insurance through a working or retired spouse. Although the decision by larger employers not to offer retiree health benefits has affected some current retirees, it will have a greater effect on those who will retire in the future. This finding appears to be supported by the fact that the decline in the availability of employer-based coverage has not resulted in as large an increase in early retirees without private health insurance.

Though employer surveys demonstrate that fewer firms are offering retiree health coverage, they provide limited evidence as to how changes in the terms under which such benefits are proffered affect their affordability for both current and future retirees. The sketchy evidence

[33] There is no uniform convention for characterizing firm size. The two surveys we generally report on collect data from firms with 200 or more and 500 or more employees.

[34] There has been a debate about whether employment has also shifted away from larger to smaller firms. In 1996, EBRI reported 1987 and 1992 Census data showing that compared to the proportion of workers in smaller firms, the proportion in firms with 500 or more employees declined by 1.8 percentage points. See "The Changing World of Work and Employee Benefits," Issue Brief, No. 172 (EBRI, Apr. 1996).

available does suggest that retirees are being asked to contribute a larger share of the premium than active employees. If past trends are a reliable indicator, increased cost sharing may suppress the demand for retiree health benefits even though some firms continue to make them available. The erosion in retiree health coverage has persisted, despite a turnaround in two trends that had contributed to the decline—the abatement in health care inflation and the reemergence of a strong, internationally competitive economy. This persistent erosion raises a fundamental question about the future protection available to retired individuals through employer-based health insurance.

Origin and Evolution of Retiree Health Benefits

Employer-based health benefits for active employees had became a standard benefit by the early 1950s. According to Rappaport and Malone, however, retiree health coverage evolved more as an afterthought to pension benefits—a way to ease the transition from employment to retirement.[35] Health insurance was generally considered a goodwill gesture and an inexpensive addition to the total retirement package. Eligibility was usually based on pension plan eligibility, regardless of the retiree's age or years of service. And many employers paid the full premium for retiree health coverage because of its reasonable cost at the time and the difficulty of collecting premiums from retirees.

Medicare, created in 1965, spurred the general expansion of retiree health coverage by making it much less expensive for employers to offer to help meet retiree health care needs.[36] Most employers that provided retiree health coverage did so on a lifetime basis. The trend, especially for firms with labor unions, was to continuously improve retiree health benefits. With relatively few retirees, comparatively small health benefit costs, and a philosophy that American manufacturing would continue to dominate world markets, employers rarely even measured or voiced concern about the cost of retiree medical benefits.[37]

This situation began to change during the 1980s. A coincidence of factors and trends gave rise to attempts by some employers to modify or even

[35]Anna M. Rappaport and Carol H. Malone, "Adequacy of Employer-Sponsored Retiree Health Benefit Programs," in Providing Health Care Benefits in Retirement, eds. Mazo, Rappaport, and Schieber (Philadelphia, Pa.: Pension Research Council, the Wharton School of the University of Pennsylvania, 1994).

[36]Judy Mazo, "Introduction to Retiree Health Benefits," in Providing Health Care Benefits in Retirement.

[37]G. Lawrence Atkins, "The Employer Role in Financing Health Care for Retirees," in Providing Health Care Benefits in Retirement.

eliminate retiree health benefits, including (1) sharply rising medical costs, (2) heightened foreign competition, (3) corporate takeovers, (4) the declining bargaining power of labor, and (5) a change in accounting standards. This last factor is often cited as a major contributor to the decline in employer-based retiree health coverage.[38] In 1993, after over a decade of discussion, large employers were required to report annually on the liability represented by the promise to provide retiree health benefits to current and future retirees.[39] The new accounting standard, commonly referred to as FAS 106, does not require that employers set aside funds to pay for these future costs and thus it does not affect their cash flow.[40] There was concern, however, that these liabilities would affect companies' stock prices. Since employers typically cover retiree health costs as they are incurred, this liability is largely unfunded. The estimated liability in 1988 of between $221 billion and $332 billion was staggering and is widely viewed as having served as a wake-up call to employers about the magnitude of their future obligations. In responding to benefit consultant surveys, many companies cited the fact that FAS 106 results in reductions in reported income and shareholder equity as a reason for reassessing the nature of their commitment to retiree health benefits.[41]

Limited Data From 1980s Suggest Significant Erosion in Coverage

The picture of the extent to which large employers offered retiree health benefits during the 1980s is murky at best. Much of the available evidence is from surveys conducted by major benefit consultants using current or potential clients as their sample. Since these clients (larger employers) are more likely to offer retiree health coverage, the estimates derived from such a nonrandom sample are likely to reflect an upward bias. Table 3.1

[38]A study that examined why firms reduced retiree health benefits found strong support for viewing the new accounting standard, referred to as FAS 106, as an important, but not sole, contributor. Firms who cut retiree health benefits were financially weaker than firms who did not cut benefits, and they had higher retiree health care costs at the time benefits were reduced. See H. Fred Mittelstaedt and others, "SFAS No. 106 and Benefit Reductions in Employer-Sponsored Retiree Health Care Plans," The Accounting Review, Vol. 70, No. 4 (Oct. 1995).

[39]Initially, the new requirements only affected publicly traded corporations with 500 or more employees. Beginning in 1995, FAS 106 requirements became applicable to smaller firms. The requirement does not apply to firms whose employees receive health benefits through a Taft-Hartley plan. Such plans are union-organized and provide health coverage under collectively bargained agreements. A similar requirement known as GASB-26 became effective for state and local governments in June 1996.

[40]ERISA not only requires employers to fund their pension plans but gives employees vested rights upon meeting certain service requirements—such as being employed a minimum of 5 years. Health benefits, on the other hand, were excluded from such funding and vesting requirements. Retiree health benefits are funded on a pay-as-you-go basis and are not portable. For additional information on the impact of FAS 106, see Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (GAO/HRD-93-125, July 9, 1993).

[41]Many financial experts are concerned because these long-term liabilities erode equity positions and will become current obligations in future years.

compares estimates from five such surveys conducted between 1983 and 1988.[42] The results from two surveys—the Washington Business Group on Health (WBGH) and Hewitt—appear to be outliers. The WBGH estimates are based on a very small sample size (131 firms). The Hewitt results are higher than other 1980s estimates and similar to results Hewitt reported in 1997. Thus, Hewitt's finding that 92 percent of large firms offered early retiree coverage in 1996 suggests that little change has occurred among large employers since 1985.[43]

Table 3.1: Estimates of the Percentage of Medium and Large Firms Offering Retiree Health Benefits

Estimated percentage	Date	Sample	Source
67[a]	1983-85	Medium and large firms	J. Dopkeen[b]
74[a]	1985	886 large employers	Mercer-Meidinger, Inc.
98[c]	1985	131 large private employers	WBGH
91[c]	1985	762 medium and large employers	Hewitt
62[c]	1988	Over 1,600 firms of all sizes	Foster Higgins

[a]These estimates include both early retirees and those who are over age 65.

[b]J. Dopkeen, "Pew Memorial Trust Fund Synthesis: Post Retirement Health Benefits," Health Services Research, 21:6 (Feb. 1987). Dopkeen bases his estimates on surveys conducted by 12 major benefit consulting firms from 1983 to 1985.

[c]These estimates are for early retirees only. Comparable percentages for older retirees are as follows: WBGH—95 percent, Hewitt—86 percent, and Foster Higgins—55 percent.

A 1984 Department of Labor survey also sheds some light on the prevalence of employer-based retiree health benefits. At firms with 100 or more employees, 60 percent of workers had their coverage continued when they retired early. These results are in line with the range of estimates shown in table 3.1.

[42]A number of these surveys were cited in Wm. M. Mercer-Meidinger-Hansen, Inc., for the American Association of Retired Persons, Financing Postretirement Medical Benefits: Assuring Economic Security for Retirees, Select Committee on Aging, U.S. House of Representatives, Committee Publication No. 100-617 (Washington, D.C.: May 1987), p. 30.

[43]Hewitt Associates, Retiree Health Trends and Implications of Possible Medicare Reforms (Washington, D.C.: The Henry J. Kaiser Family Foundation, Sept. 1997). Hewitt prefers to characterize its conclusions as based on a database rather than a survey. This proprietary database of large employers consists primarily of Hewitt clients. The report points out that there was little change among a constant sample from this database between 1991 and 1996. For its constant sample, the percentage of employers offering retiree health benefits was higher than for the overall database, which includes newer companies not offering retiree coverage.

More Recent Surveys Paint Consistent Picture of Continued Erosion

While the limited data available suggest that upward of 60 to 70 percent of large employers offered retiree health insurance in the 1980s, far fewer than half do so today, and that number is continuing to decline despite the recent period of strong economic growth. That evidence, from more rigorous employer surveys conducted in the past several years, is corroborated by surveys sponsored by the Labor Department.

Fewer Employers Offer Coverage

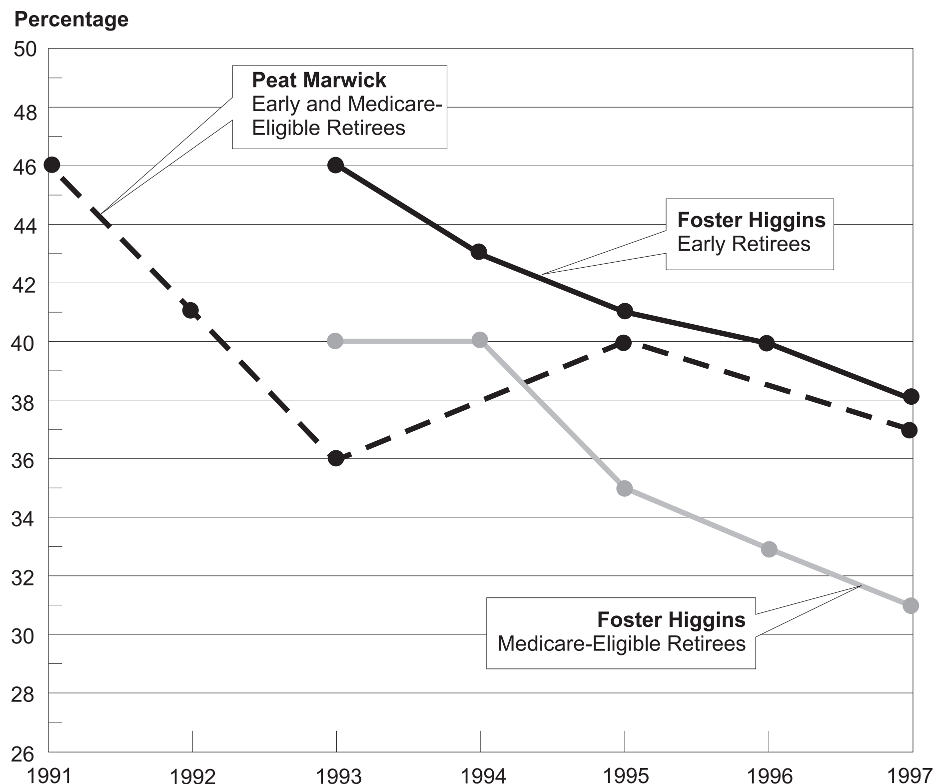
Results from periodic surveys conducted by two benefit consulting firms, Mercer/Foster Higgins[44] and KPMG Peat Marwick, are consistent and indicate a further decline in the availability of retiree coverage from medium and large employers between 1991 and 1997.[45] Both surveys are based on a random sample whose results can be generalized to a larger population of employers rather than on a database of clients such as that used by Hewitt and others.[46] See appendix II for more information on the characteristics of the Foster Higgins and Peat Marwick surveys. As shown in figure 3.1, Foster Higgins indicated an overall decline of 8 percentage points in coverage offered to early retirees, while Peat Marwick reported a drop of 9 percentage points for all retirees during roughly the same period. Unlike Foster Higgins, Peat Marwick did not report separately on early and Medicare-eligible retirees.

[44]In 1997, Foster Higgins and William Mercer, another large benefit consulting firm, merged. Because this report uses surveys from years before and after the merger, we refer to “Foster Higgins” surveys.

[45]The Foster Higgins survey includes employers with 10 or more workers but generally limits its analysis of retiree health coverage to firms with 500 or more employees. Peat Marwick collects and reports data on firms with 200 or more employees.

[46]While the surveys were based on relatively large samples of employers, the extent to which they are generalizable is uncertain. First, the response rates varied from year to year: for example, 78 percent in 1993 to only 50 percent in 1997 for Foster Higgins. Peat Marwick had similar response rates for these 2 years. Second, neither survey reported information on the precision of its estimates. As a result, we do not know how closely each sample reproduced the results that would have been obtained had the entire population been surveyed.

Figure 3.1: Percentage of Medium and Large Employers Offering Retiree Health Coverage, 1991-97



Note: The Foster Higgins survey was not based on a random sample prior to 1993, and consequently the results are not comparable with data collected in subsequent years. Peat Marwick's 1994 and 1996 reports did not include data on retiree coverage. Although Foster Higgins only reported on the extent to which employers with 500 or more workers provide retiree coverage, its sample included firms with as few as 10 employees. In 1996, only 8 percent of all firms with 10 or more workers offered health insurance to early retirees. As shown, the 1996 offer rate was 40 percent for firms with 500 or more workers.

The trends outlined in figure 3.1 raise a question about assessments by some experts that retiree health offerings have stabilized or that the decline has been limited. Although the erosion is slow, its cumulative impact is significant.

Data From CPS Supplements Corroborates Decline

In addition to employer surveys, interviews with retirees provide another, albeit indirect, source of data on employer-based health coverage for the near elderly. A 1995 report by the Pension and Welfare Benefits

Administration of the Department of Labor shows the extent to which retirees were covered by employer-based health insurance at various points in time—before retirement, just after retirement, and at some subsequent date.[47] The report compares data collected on retiree health coverage from special supplements to the August 1988 and September 1994 CPSs. The resulting data provide only a limited picture of employer trends because they (1) are based on interviews with retired workers and (2) do not always clearly distinguish between the availability of coverage and a worker's decision not to participate in employer-based retiree coverage. If a worker did not "continue" such coverage, the individual was asked the reasons for discontinuation. Since questions about reasons for discontinuing coverage were expanded in the 1994 survey, it is difficult to make a precise comparison across the periods.

The Labor Department's analysis of the CPS data revealed a significant erosion between 1988 and 1994 in the number of individuals who retained employer-based health coverage upon retirement. As shown in table 3.2, 42 percent of retirees aged 55 and older continued such coverage into retirement in 1994, a decline of 8 percentage points since 1988. Among the numerous reasons cited in the 1994 survey for discontinuing coverage were (1) "eligibility period expired," (2) "retirees not covered," and (3) "became ineligible after employer amended plan." Combining these three factors, about 34 percent of early retirees in 1994 were not eligible to enroll in an employer's plan after retirement.[48] Although it is not possible to provide a precise estimate of how much of the decline is due to lower offer rates by employers, it seems reasonable to attribute at least some portion of the decline to this factor.[49]

[47]U.S. Department of Labor, Pension and Welfare Benefits Administration, Retirement Benefits of American Workers: New Findings From the September 1994 Current Population Survey (Washington, D.C.: Department of Labor, Sept. 1995), p. 25.

[48]However, 11 percent of respondents said that the reason they discontinued coverage was "other," that is, not specified in the options available in the questionnaire.

[49]A recent Urban Institute report imputes 1988 and 1994 offer rates by tabulating specific reasons given for discontinuing coverage that imply access to employer-based retiree health benefits. The study concludes that the number of workers aged 55 to 64 who were offered retiree coverage fell from 67 percent in 1988 to 53 percent in 1994. See Pamela Loprest, Retiree Health Benefits: Availability From Employers and Participation by Employees (Washington, D.C.: Urban Institute, Oct. 1997).

Table 3.2: Percentage of Retirees With Employer-Based Coverage

	All retirees (aged 55 and older)	
	1988	1994
Active employees with coverage at time of retirement	69	65
Workers who continued coverage into retirement	50	42
Retirees currently covered by employer's plan	44	34
Retirees who believed their employer-based coverage could be continued for life	32	30

Source: Department of Labor, Pension and Welfare Benefits Administration.

The data also showed that the percentage of individuals with employer-based coverage continued to decrease throughout retirement. Only 34 percent still retained coverage several years after retirement. The decline in participation during retirement has several explanations. First, some individuals elect COBRA at retirement because no retiree coverage is offered. Such coverage, however, is only temporary—generally 18 months for a worker leaving a job. Second, as figure 3.1 shows, firms are less likely to offer coverage to individuals who are Medicare-eligible than to early retirees. Thus, some retirees may have lost employer-based coverage when they reached age 65. Third, some individuals qualify for Medicare before age 65 because of a disability. Fourth, some retirees have access to health insurance through a spouse's employer. Fifth, some employers may have unexpectedly stopped offering coverage to retirees after an individual retired. Finally, evidence suggesting reduced participation by retirees as a result of employer-required cost sharing will be discussed later in this chapter.

Based on our analysis of CPS data, the percentage of early retirees with private health insurance (both employer-based and individually purchased) fell 7 percentage points from 76 percent to 69 percent between 1989 and 1995.[50] The decrease in the proportion of early retirees with private health insurance does not appear to correspond to the magnitude of the decline in the availability of retiree coverage documented in employer surveys and in the 1988 and 1994 CPS supplements. Among the possible reasons for the mismatch between availability and coverage trends are that (1) the decision to retire is often predicated on the availability of health benefits; (2) coverage may be available through other sources, such as a working or retired spouse; (3) employers' decisions not to offer retiree health benefits are frequently directed at future rather than

[50]See GAO/HEHS-97-122.

current retirees; and (4) individuals may have postponed their retirement plans to avoid becoming uninsured or because of the high costs of purchasing individual insurance or COBRA continuation coverage. Appendix IV discusses the available research on the relationship between the availability of health insurance and the decision to retire early.

Termination of Coverage Not Limited to Future Retirees

The cancellation of benefits for current retirees, often emotionally charged, has captured the attention of the executive branch, the Congress, and the press.[51] The information available on these terminations, primarily in the form of newspaper articles and information on lawsuits brought by affected retirees, is often anecdotal rather than systematic.[52] The perception that more than just a few employers are terminating coverage for current retirees may be fueled by frequent articles discussing cuts to and changes in retiree coverage. For example, a lengthy lawsuit, tracked by the press since 1989, involves a challenge to General Motors' cut in health benefits for salaried retirees—that is, an attempt to introduce cost-sharing requirements for what had heretofore been a benefit provided at little or no cost. GM, however, was not attempting to terminate coverage for these retirees—a subtlety that is sometimes lost in the concern over the general erosion of retiree health coverage. In fact, employer surveys indicate that firms are more likely to terminate benefits for future as opposed to current retirees. Fear of litigation as well as ethical and public relations concerns are cited as explanations for why employers have chosen to concentrate their cost-cutting efforts on future retirees.

Despite the future focus of many employers' actions, survey data suggest that current retirees are also being affected by the decline in offer rates. The Foster Higgins data in figure 3.1 reflect the decline in offer rates among employers who make coverage available to "most retirees," excluding firms who have only terminated health benefits for future retirees or hires, or both. Thus, the 8-percentage-point decline in the number of employers offering early retiree coverage suggests that some

[51]In 1996, the Secretary of Labor expressed concern over the hardships imposed on individuals by the unexpected termination of employer-based retiree health benefits and instructed Labor's solicitor's office to file *amicus curiae* briefs in support of retiree litigation. Similarly, Representative Kleczka introduced legislation in 1997 after employers in Wisconsin unexpectedly terminated retiree health insurance for some of his constituents. The legislation would have made such retirees eligible to purchase COBRA coverage through their former employers until age 65.

[52]Using lawsuits to identify terminations is complicated by the fact that such litigation may take years to resolve and that unfavorable decisions can be appealed and overturned. The Labor Department's solicitor's office files *amicus curiae* briefs in some cases brought by retirees but does not track the frequency of such lawsuits.

portion of the erosion has affected current retirees as well.[53] According to the 1994 CPS supplement, 2 percent of retirees—about 40,000 individuals—became ineligible for continued retiree coverage after their employers amended their plans.[54]

Characteristics of Firms Offering Retiree Coverage

Aggregate data on the erosion in retiree health coverage obscure significant differences among firms of varying sizes and types of industry. As noted earlier, the larger the firm, the more likely it is to offer health benefits to both active and retired workers. However, the decline in offer rates to retirees, as reflected in figure 3.1, is not restricted to firms at the lower end of the size spectrum reported on. Foster Higgins reports that employers with 5,000, 10,000, and even 20,000 or more employees have also shown a decline. Surprisingly, the decline for the largest of firms has been uninterrupted; employers with 500 or 1,000 workers, on the other hand, have shown more variability, and, according to Foster Higgins, an increase in the offer rate.

According to Foster Higgins, jumbo firms employing at least 20,000 workers are more than twice as likely as smaller firms to offer early retiree health insurance. Thus, 69 percent of jumbo firms offered early retiree coverage in 1997 compared with 31 percent of firms with between 500 and 999 employees. However, just 4 years earlier, 84 percent of jumbo firms reported that they offered retiree health benefits. With one exception, Foster Higgins reported that early retiree coverage has declined between 9 and 20 percentage points among firms of all sizes since 1993. For firms with between 1,000 and 4,999 workers, however, the offer rate for early retiree health insurance increased by as much as 10 percentage points, but by 1997 was only 1 percentage point higher than in 1993. As with the overall trend data shown in figure 3.1, Peat Marwick reported more variability by firm size, especially in the 1992 to 1995 time frame, with most firm sizes showing an increased offer rate in 1995. One benefit consultant we met with was very skeptical about the Foster Higgins trend data for firms with 1,000 to 4,999 workers, suggesting that the increase represented health benefits related to early retirement incentive programs.

[53]According to an official at Foster Higgins, one would expect that as the number of employers offering coverage to most retirees declines, the percentage indicating that they have terminated coverage for future retirees would rise. The fact that it has remained steady at 3 to 5 percent each year suggests that survey respondents are not always differentiating clearly between the status of current and future retirees.

[54]Retirement Benefits of American Workers: New Findings From the September 1994 Current Population Survey, p. 108. This reason for discontinuing coverage was not used in the 1988 CPS supplement. There have been no additional CPS supplements since 1994 focusing on retiree health issues. Also, note that this estimated number could vary by as much as about 45 percent.

Foster Higgins data indicate that the offer rate for early retiree coverage declined among most industry categories between 1993 and 1997. Government, the only category showing an increase, was among the most likely to offer such benefits in the first place. An increasing share of the labor force works for firms from the service sector and a decreasing share works for firms in the manufacturing and transportation sectors. The former are less likely to provide their workers with retiree health benefits.

Table 3.3: Percentage of Firms Offering Early Retiree Health Coverage, by Type of Industry, 1993 and 1997

Industry	1993	1997
Government	59	78
Transportation, communication, and utilities	55	47
Financial services	68	57
Manufacturing	44	39
Services	42	35
Wholesale and retail	27	14
Health care	28	23

Source: Foster Higgins.

Cost of Coverage for Early Retirees

As noted in chapter 2, a person's utilization of health care services tends to increase with age. Consequently, providing health benefits to retirees is much more expensive than covering younger workers. However, because Medicare is the primary payer for beneficiaries 65 and older, employer costs for retirees drop dramatically once they become Medicare-eligible. Thus, early retirees are about three times as expensive for an employer as retirees enrolled in Medicare. Because of the significant cost differences between early and Medicare-eligible retirees, the proportion of early retirees in the mix of retirees can dramatically affect an employer's average per-retiree cost. Overall, about 75 percent of retirees in 1994 were over age 65, and thus any employer-based coverage supplemented Medicare benefits; the remaining 25 percent were early retirees not yet eligible for Medicare.

Since 1993, both Foster Higgins and Peat Marwick have reported on the average employer cost for early retiree health coverage. For firms that could distinguish between the cost of retirees and active workers, Foster Higgins indicated that the average annual early retiree premium in 1996 was $5,210, having shown almost no change since 1993. Costs fell slightly to $4,985 in 1997, a drop attributed to increased HMO enrollment among early retirees. Foster Higgins does not report on cost variation for early

retiree coverage by firm size, region, or industry. Peat Marwick reported that average annual costs for early retirees declined between 1993 and 1995, falling from $5,748 to $5,460. It attributed the decrease to the overall slowdown in inflation in the private sector and to the growth in managed care enrollment among early retirees. As shown in table 3.5, however, costs varied considerably by firm size, industry, and region. Thus, the average early retiree premium in 1995 ranged from a low of $4,500 in the health care industry to a high of $6,180 among finance firms. Peat Marwick's 1997 report did not include comparable data.

Table 3.4: Average Annual Costs for Early Retiree Coverage

Foster Higgins		Peat Marwick (family)	
1993	1997	1993	1995
$5,216	$4,985	$5,748	$5,460

Source: Foster Higgins and KPMG Peat Marwick.

Table 3.5: Variation in Average Annual Costs for Early Retirees, 1995

Category	Annual cost for family coverage
Firm size (200-999 workers to 5,000 or more workers)	$5,340 to $5,916
Industry	$4,500 (health care) to $6,180 (finance)
Region	$5,160 (northeast) to $5,760 (west)
Overall	$5,460

Source: KPMG Peat Marwick, unpublished data.

Decline in Offer of Retiree Health Benefits Accompanied by Efforts to Control Costs

The cost escalation of the 1980s and early 1990s stimulated employers to become more aggressive in controlling the growth in their health care expenditures.[55] Coincidentally, as was discussed earlier in this chapter, new accounting rules also made employers more conscious of the costs associated with offering retiree health benefits. Though the reaction of some employers was to discontinue or to not offer retiree coverage, those that still provide such benefits have often changed the terms under which they are offered. The objective, as with a similar restructuring of active workers' benefits, was to help control costs. Three commonly cited changes involve increasing cost sharing, changing eligibility requirements, and reshaping plan choice. While employers have been increasing cost sharing and reshaping plan choice for both active workers and retirees,

[55] See Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures (GAO/HEHS-97-122, July 24, 1997) and Health Insurance: Management Strategies Used by Large Employers to Control Costs (GAO/HEHS-97-71, May 6, 1997).

changes in eligibility requirements generally have been confined to retirees. Those eligibility changes, however, may also have cost-sharing implications.

Active management of health benefit costs for retirees focused initially on the costs associated with future retirees—an outgrowth of litigation in the 1980s that made firms more cautious about changing health benefits for individuals who are already retired. In order to avoid court challenges over benefit changes, employers began to explicitly reserve the right in plan documents to modify those benefits—for both future and current retirees. Today, virtually all employers have done so. Often, older groups of retirees were grandfathered into existing, more generous, health plans and changes were only applicable to new hires or individuals who retired after a certain date. In 1992, one researcher estimated that the benefits of about two-thirds of retirees with employer-based coverage seemed secure because they became effective before employers added escape clauses reserving the right to make subsequent changes. However, the 1998 decision in the case brought by General Motors salaried retirees may call into question any commitment by employers to provide previously promised retiree health benefits.

According to benefit consultants and employers, many of the modifications made to retiree health plans date from the late 1980s and early 1990s. Employer surveys, as well as our interviews with a judgmental sample of large companies, suggest that firms are continuing to make changes to reduce their overall liability for retiree health care costs—changes that they attribute to their competitive or financial situations. Despite the poor quality of the data available to assess the impact of coverage changes, the bottom line is that future retirees will (1) pay more for coverage and (2) find it harder to become eligible for benefits. And retiree surveys suggest that higher costs for individuals could lead to lower participation rates in employer-based retiree health benefits when such coverage is available.

Cost-Control Changes Made to Retiree Health Benefits

Each year, Foster Higgins tracks the changes made in the past 2 years by large firms that offer retiree coverage. Table 3.6, which summarizes selected changes reported since 1993, suggests that popular cost-control methods are (1) increased retiree cost sharing—both the percentage of premium paid by retirees and the amount of copayments and deductibles, (2) tightened eligibility rules for participating in the employer-based health plan, and (3) provision of a fixed (defined) employer contribution toward

the cost of retiree health insurance in lieu of covering whatever medical services are used during the year (often referred to as a defined benefit). More recently, employers have attempted to control costs by moving retirees into managed care plans. Additional cost-control measures noted in other employer surveys include lower limits on the total amount of health care costs that will be covered during the lifetime of the retiree and capping employer contributions—a step that may be the prelude to introducing a defined contribution.

Table 3.6: Cost-Control Changes Made to Retiree Benefits in Preceding 2 Years

	1993	1994	1995	1996	1997
Raised retiree contribution	23	30	16	16	12
Increased copayments and deductibles	15	16	12	11	6
Tightened eligibility rules	7	13	7	8	4
Changed to defined contribution	2	3	3	[a]	[a]
Moved retirees into managed care	[a]	[a]	[a]	7	8

[a]Data were not reported for this year.

Source: Foster Higgins.

A 1992 survey conducted by William Mercer suggests that though cost-control changes are being implemented for both current and future retirees, they are often directed at the latter. Further evidence for the tendency of employers to target future retirees is found in data reported by Peat Marwick. Between 1992 and 1993, the percentage of firms that grandfathered current retirees into plans different from those available to future retirees increased from 20 percent to 47 percent.[56] As noted earlier, employers may find it difficult, despite reservations in plan documents that alert retirees to the possibility of changes, to modify benefits for current retirees because of ethical or public relations concerns.

Evidence on Increased Cost Sharing Is Sketchy

Only limited data are available on the nature of the financial responsibility being shifted to future retirees. Reporting differences make it difficult to judge the consistency of the data across various surveys, and the data's aggregate nature sometimes obscures the variability of changes among firms. More importantly, the limited results often lack a context for

[56]KPMG Peat Marwick, 1994 Retiree Health Benefits: The Uncertainty Continues (Washington, D.C.: KPMG Peat Marwick, 1994).

judging their impact on the affordability of increased cost sharing. Income and asset data for the affected retirees would be required for such a study. However, a comparison of reported cost sharing for retirees with trends for active workers does suggest that retirees are being asked to shoulder a higher portion of the health benefits premium when they leave the workforce. Finally, the Labor Department's analysis of CPS supplements suggests that retiree participation rates have already been affected by increased cost-sharing requirements.

Evidence of Changes in Employer-Retiree Responsibility for Costs

Typically, surveys report on the extent to which retirees or firms are responsible for the cost of health benefits, that is, whether the cost is shared or whether the firm or employee is responsible for all of the cost. Given the reported shift in costs from employers to retirees, one would expect the data to show that fewer employers are paying the entire cost of coverage and more retirees are paying the whole premium themselves. A comparison of data on employer-retiree cost sharing from three different surveys, however, demonstrates that the proportion of retirees responsible for the entire premium has been relatively steady or may have actually decreased. On the other hand, two of these surveys show that fewer employers pay the entire premium, suggesting that costs are not being shifted entirely to the retiree but are being shared.

Compared With Active Workers, Early Retirees Pay More for Coverage

Compared with active workers, retirees with employer-based coverage do appear to be shouldering responsibility for a higher portion of the overall premium. Peat Marwick reported that active employee contributions for family coverage increased from 26.6 percent in 1993 to 32.4 percent in 1995. In contrast, early retiree contributions for family coverage rose from 39 percent to 45 percent over the same time period.[57] Thus, on average, early retirees in 1995 were contributing about $2,340 annually toward the cost of family coverage—about $655 more than active workers. Appendix V uses income data from the March 1997 CPS to estimate the percentage of total family income that a 55- to 64-year-old would have to commit to cost sharing under employer-based coverage using 1995 Peat Marwick estimates of the lowest, highest, and average retiree contribution. The average retiree contribution is 4.7 percent of the 1996 median family income of 55- to 64-year-old married couples. On average, Americans under age 65 spent about 4 percent of household income in 1994 on health care—an amount that includes not only insurance premiums or employer-required cost sharing but also out-of-pocket expenses for

[57]In 1993, Foster Higgins reported that active employees at large firms paid 33 percent toward the cost of family coverage in an indemnity plan or an HMO, compared with 38 percent for early retirees regardless of the plan chosen. In 1997, Foster Higgins noted that, in general, employers ask their retirees to pay more of the cost of coverage than their active employees.

copayments, deductibles, and services not covered by health insurance. As shown in table 3.7, costs varied considerably by firm size, type of industry, and region.[58]

Table 3.7: Variation in Early Retiree Contribution for Family Coverage, by Firm Size, Industry, and Region, 1995

	Percentage contribution	Annual contribution
Firm size (200-999 workers to 5,000+ workers)	41 percent to 53 percent	$2,040 to $3,048
Industry	27 percent (transportation/ communications) to 55 percent (services)	$1,680 to $2,556
Region	19 percent (northeast) to 56 percent (west and midwest)	$972 to $3,012
Average	45 percent	$2,340

Source: Peat Marwick.

Increased Cost Sharing May Be Reducing Participation Rates

Department of Labor analyses of CPS supplements indicate that factors other than the actual availability of coverage account for an undetermined portion of the decline in retirees with employer-based health benefits. According to the Labor Department, the propensity for retirees to enroll in employer-based plans when they are offered has dropped because of the increased costs retirees are being asked to shoulder by employers. In both the 1988 and 1994 surveys, individuals who declined employer-based coverage at retirement were asked to articulate the reasons for their decision. Of the approximately 5.3 million retirees who discontinued employer-based benefits in 1994, an estimated 27 percent cited the expense as a factor—an increase from 21 percent who cited this reason in the earlier survey. Moreover, there was a 6-percentage-point increase over the same time period in the number of such retirees who indicated that they still had health insurance through a plan other than that of their former employer. Thus, some retirees who find coverage from their own employer too expensive may be switching to plans with lower cost sharing available through a working or retired spouse.

Shift to a Defined Contribution

Traditionally, employer-based health benefits have been an open-ended commitment by employers to pay for covered medical services. The liability represented by such a commitment as well as the escalating costs of medical services over time has stimulated employers to look for ways to limit their financial obligation, or at least to make it more predictable. The

[58]More recent Peat Marwick employer surveys do not contain comparable statistics.

shift toward capitated health plans represents one approach.[59] Another technique is for an employer to translate the benefit offered into a cash value either by instituting an aggregate cap on expenditures or by offering retirees a fixed cash benefit.[60] Such an approach is often referred to as a defined contribution. Though several surveys—notably Hewitt (1997) and Mercer (1992)—have addressed the issue of employer caps, others such as Foster Higgins and Peat Marwick have limited data on this phenomenon.[61] The following Hewitt data must be considered with the recognition that it is largely based on information from clients and as a result may overstate the prevalence of employer dollar caps.

According to Hewitt, employers began to introduce dollar caps on their future retiree health obligations in the early 1990s, largely in response to new accounting rules that require them to report the accrued obligation for retiree health benefits. Few large employers had such caps in 1991, but by 1996, 36 percent had some form of dollar cap on their subsidy for early retirees, and 39 percent had caps for post-age-65 retiree coverage.[62] Hewitt reports that the caps can take many forms, including

- caps on total costs: the company will not spend more in total for retiree health coverage than twice what was spent as of a certain date;
- per capita caps: the subsidy per person will not exceed a fixed amount; and
- caps with service component: the employer share is fixed at a specified dollar amount that is then multiplied by years of service.

Hewitt suggests that many employer caps on retiree health expenditures are fixed dollar caps without a built-in adjustment for inflation. Since a fixed-dollar cap dramatically reduces a firm's liability for retiree coverage

[59]Rather than paying for each medical service, an employer pays a fixed amount per enrollee. Though capitated plans such as HMOs are generally less costly than other alternatives, their rate of premium growth over time is similar.

[60]Atkins noted that there are drawbacks to a cash benefit under the current pay-as-you-go system for financing health benefits. Retirees will be at a disadvantage if the cash value is not equivalent to the health benefit value, which is dynamic and grows in both real and nominal terms. On the other hand, if the cash benefit could be accrued over the working life—that is, prefunded, vested, and made portable—then retirees' security might actually be enhanced, even if the cash value was not equivalent to the health benefit value. See "The Employer Role in Financing Health Care for Retirees."

[61]A 1992 William M. Mercer employer survey with about 800 respondents reported that 23 percent had capped the firms contribution for existing or future retirees or for both. Between 1993 and 1995, Foster Higgins reported that 2 to 3 percent of employers had instituted a defined contribution in the past 2 years. In 1996, Foster Higgins dropped this question from its survey. Though Peat Marwick does not discuss employer caps in its published reports on retiree health issues, an unpublished 1995 study stated that "many employers have capped their contribution for retiree coverage."

[62]Twenty-eight percent of employers in the Hewitt sample have instituted a defined dollar approach that is limiting current costs, while 8 percent have set the cap to begin at some future date.

by shifting the responsibility for future cost increases to retirees, Hewitt believes that there will be significant pressure to revisit these expenditure limits in the future. However, if the caps are not adjusted, retirees will shoulder any future cost increases. Hewitt emphasized that the dollar caps introduced since 1991 are largely intended to control "accounting costs" for purposes of FAS 106.

A variation on an expenditure cap is a maximum lifetime benefit. In 1994, Peat Marwick reported that some employers had more restrictive maximum lifetime benefits for their retiree population. Thus, compared with 57 percent of active workers, only 47 percent of retirees have no maximum lifetime benefit or one that is equivalent to $1 million or more. On the other hand, Peat Marwick also reported that retiree lifetime limits were increased for 38 percent of retirees in 1993, with only 2 percent of retirees receiving a decrease.

Eligibility Requirements Have Been Tightened

Employers have used changes in participation rules to reduce their liability for retiree health coverage and to differentiate their treatment of workers with varying lengths of service. While the cost implications of these new eligibility rules are clear for employers, their impact on the affordability of coverage is less so.[63] Moreover, changes in labor force mobility could result in fewer active workers ever qualifying for a benefit that is, at the same time, becoming less widely available.

In the past, retiree health coverage was treated as a benefit that accrued at retirement. Under those eligibility rules, workers with only a few years of service and those with many years were often treated equally. Because retirement was the only test, the responsibility and cost of a retiree's health care were borne fully by the last employer.[64] More recently, employers have modified their eligibility requirements by tying them to years of service. The three most common methods employers use to determine eligibility for retiree health benefits are (1) length of service, (2) age, or (3) some combination of the two. Peat Marwick has reported that the proportion of retirees enrolled in plans with both a minimum service and age requirement increased from 56 to 79 percent between 1992 and 1997. In 1996, Foster Higgins reported that the most common service and age requirements were 10 years and 55 years old, respectively. When

[63]For example, one firm told us that it lowered its liability by tens of millions of dollars simply by instituting a minimum eligibility age for retiree health benefits of 45.

[64]G. Lawrence Atkins, "The Employer Role in Financing Health Care for Retirees," in Providing Health Care Benefits in Retirement, p. 111.

the requirement is the sum of age and service, Foster Higgins indicated that firms commonly require 75 "points." For example, an individual at age 55 with 20 years of service would receive 75 points.

More stringent eligibility requirements have potentially serious implications for future retirees. First, if workers change jobs frequently, especially as they become older, they may not qualify for retiree health benefits at all. In 1994, 2 percent of workers (over 100,000 individuals) who did not continue employer-based coverage into retirement reported that they failed to meet either the age or the service requirement or some other prerequisite. Second, full health benefits may not accrue at retirement. Thus, some employers tie cost sharing to years of service. For example, an official we interviewed at one company said the company requires 35 years of service to qualify for the maximum employer contribution—75 percent. Retirees with only 19 years of service qualify for a substantially lower employer contribution—30 percent.

Recent Jump in Early Retiree Enrollment in Managed Care

Many large employers adopted a managed care strategy in the late 1980s to help combat double-digit health care inflation.[65] Thus, between 1987 and 1996 managed care enrollment in employer-sponsored health plans nearly tripled, from 27 percent to 75 percent, and has continued to grow. Until more recently, elderly Americans have lagged behind younger age groups in the extent to which they are enrolled in managed care, but this situation appears to be changing rapidly, especially in the case of early retirees. It is not clear what is accelerating the move of early retirees into managed care. Cost sharing and lack of choice may both be contributing, but we do not know how much.

In 1996, Foster Higgins reported that the movement of retirees into managed care is helping to slow down the overall growth in employers' health insurance costs.[66] By 1996, over half of covered early retirees were enrolled in a managed care plan—either a preferred provider organization

[65]That inflation has decelerated substantially. By 1996, premium changes had reached record lows. While the precise impact of managed care continues to be debated, some studies contend that it has been a contributing factor to the slowdown because HMO plans generally cost less than other health plans, and many managed care organizations control health care utilization. Managed care includes one or more of the following common cost-control features: (1) physician and hospital networks with explicit criteria for inclusion, (2) alternative payment methods and rates that often shift some financial risk to providers, and (3) utilization controls over hospital and specialist physician services. In general, HMOs tend to use more stringent controls than preferred provider organization or point-of-service plans. However, there is variation among the three different types of managed care plans, and as a result, some HMOs have weaker controls than preferred provider organization or point-of-service plans.

[66]Before 1996, Foster Higgins did not report on managed care plan enrollment by retirees.

(PPO), a point-of-service (POS) plan, or an HMO. Only 1 year later, managed care enrollment had grown to 70 percent, largely because of the increase in the number of early retirees joining HMOs. Foster Higgins attributed decreased costs for early retirees of 4.3 percent in 1997 to the jump in HMO enrollment. Table 3.8 compares early retiree health plan enrollment for 1996 and 1997 with that of active workers. According to Foster Higgins, the transition of early retirees into managed care plans has been even more rapid than the earlier shift by active workers.

Table 3.8: Comparison of Percentage of Covered Early Retirees and Active Workers Enrolled in Managed Care Plans

	Fee-for-service	PPO	POS	HMO
Early retirees				
1996	48	21	16	15
1997	30	25	19	26
Active employees				
1997	15	35	20	30

Source: Foster Higgins.

It is not obvious what is motivating early retirees to move so quickly into managed care plans such as HMOs. Clearly, the fact that employers have reserved the right to make changes to early retiree health benefits has increased employers' flexibility, allowing them to manage the cost of those benefits much as they do for active workers. Moreover, some large employers no longer view early retirees as an extension of their active employee population but recognize that the per capita costs of early retirees make them the most expensive component of their overall health benefit costs.

In the case of active workers, employers recognized that financial incentives could be an important tool in encouraging managed care enrollment. Thus, in a 1997 report, we noted that some large employers now vary their subsidy according to the cost of the coverage option, making it cheaper for a worker to enroll in a managed care plan.[67] Interviews with a sample of large employers suggest that some firms are applying this same technique to early retirees. Thus, in one industry, early retirees are now in a separate risk pool, with premiums 30 to 40 percent higher than for active workers. These higher costs are passed on through the cost-sharing formula to early retirees who choose a non-HMO product. However, for an early retiree who selects a community-rated HMO, the cost is the same as that for an active employee.

[67]GAO/HEHS-97-71, May 6, 1997, p. 61.

Individual Insurance: Unaffordable or Unavailable Alternative for Many Near Elderly

As a growing number of employers reduce or eliminate their support for retiree health benefits by scaling back premium contributions or increasing cost sharing, many affected retirees look to the individual market for coverage until they become eligible for Medicare. Also, access to affordable coverage in the individual insurance market is a concern for those 55- to 64-year-olds who have primarily relied on this market for coverage, including some of those who are self-employed and those who were guaranteed access to an individual product under HIPAA. As demonstrated by our March 1997 CPS analysis, the near elderly already rely on the individual market to a greater extent than younger Americans. However, many of the near elderly may encounter difficulty in obtaining a comprehensive plan at a reasonable price or in obtaining any plan at all.

Significant differences exist between the individual and employer-sponsored health insurance markets, and these differences may have significant implications for some consumers. In the individual market, the near elderly must choose from among a number of complex products and pay for the entire cost of coverage. For employer-based coverage, the burden of selecting and paying for the products is significantly eased by employer contributions and payroll deductions. Although states and the federal government have undertaken a wide range of initiatives to increase access to the individual market, the ability of carriers in many states to continue to charge higher premiums to applicants who are older or who have certain health conditions may have particularly adverse effects on those aged 55 to 64. These individuals may be denied coverage, may have certain conditions or body parts excluded from coverage, or may pay premiums that are higher than the standard rate, depending on demographic characteristics or health status.

Some Near Elderly Face a Broad Range of Choices

Purchasing insurance through the individual market can be a complex process for even the most informed consumer. However, it may pose a considerable challenge for 55- to 64-year-olds who have previously depended on their employer for coverage. In addition to the multiple ways the near elderly may access the market, such as through agents or associations, they are confronted with products offered by dozens or even a hundred or more different carriers. Once they choose a carrier and a product, consumers must then select among a wide range of deductibles and other cost-sharing options.

Multiple Carriers Offer Individual Products

In our November 1996 report, we found that in the seven states we visited, consumers, including the near elderly, could choose from plans offered by no fewer than 7 to well over 100 carriers.[68] While the number of carriers operating in states may vary significantly, it is important to recognize that fewer carriers do not necessarily equate to fewer choices for consumers. For example, over 140 carriers in Illinois may offer individual products, but these products are not available to all consumers because of medical underwriting. In contrast, New Jersey has 27 carriers offering one or more comprehensive products to which every individual market consumer in the state is guaranteed access.

Consumers May Lower Premiums by Increasing Their Financial Risk

In contrast to employer-based group insurance, individuals may choose from multiple cost-sharing arrangements and are generally subject to relatively high out-of-pocket costs. Under employer coverage, the range of available deductibles is narrower, and total out-of-pocket costs are capped at a lower level than under most individual market products. For example, for non-HMO plans offered by medium and large employers, annual deductibles are most commonly between $100 and $300, and a significant percentage have no deductible.[69] In contrast, annual deductibles in the individual market are commonly between $250 and $2,500.

The cost-sharing arrangement selected by the consumer is a key determinant of the price of an individual insurance product, and the higher the potential for out-of-pocket expenses, the lower the premium. In November 1996, we reported that carrier and insurance department representatives thought that the level of consumer cost sharing had been increasing in recent years, reflecting consumers' efforts to keep premiums affordable.[70] A representative of one national carrier said that among its new enrollees in 1995, 40 percent chose $500 deductibles, 50 percent chose $1,000 deductibles, and the remaining 10 percent chose deductibles ranging from $2,500 to $10,000. Also, individual market reforms enacted in New Jersey originally limited carriers to offering only standard plans with deductibles of $150, $250, $500, or $1,000 and with prescribed ranges of cost-sharing options. An insurance department official said that because

[68] Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996).

[69] Department of Labor, Bureau of Labor Statistics, Employee Benefits in Medium and Large Private Establishments, 1995 (Washington, D.C.: Department of Labor, 1997), http://stats.bls.gov/special.requests/ocwc/ebs/ebsml95.htm (cited Feb. 13, 1998). In contrast to non-HMO policies, HMOs do not commonly include deductibles.

[70] GAO/HEHS-97-8.

consumers showed little interest in the lower-deductible plans, New Jersey no longer offers the $150 and $250 deductible options for new individual insurance applicants. Instead, beginning on September 1, 1997, the state offers deductibles of $1,500, $2,250, $2,500, $3,000 and $4,500[71] in addition to the original $500 and $1,000 deductible options. In fact, the official said that consumers requested a deductible option of $5,000. If the $2,500 option proves to be popular, the official said the state would consider introducing plans with larger deductibles in the future.

Amount of Premiums and Health Status May Affect Access of Near Elderly

Certain aspects of the individual insurance market, such as restrictions on who may qualify for coverage and the premiums charged, can have direct implications for consumers seeking to purchase coverage, especially those who are retired but not yet eligible for Medicare. These aspects of the individual market are often exacerbated by the fact that individuals must absorb the entire cost of their health coverage, whereas employers usually pay for the majority of their employees' coverage. A consumer may not find affordable coverage, or may find coverage only if it is conditioned upon the permanent exclusion of an existing health condition.

Premium Variation Due Largely to Demographic Differences

Unlike the employer-sponsored market, where the price for group coverage is based on the risk characteristics of the entire group, premium prices in the individual markets of most states are based on the characteristics of each applicant. To determine rates in both markets, carriers commonly consider age, gender, geographic area, tobacco use, and family size. For example, on the basis of past experience, carriers anticipate that the likelihood of requiring medical care increases with age. Consequently, a 57-year-old in the individual markets of most states pays more than a 30-year-old for the same coverage. In the group market, however, this older individual would usually pay the same amount as the other members of the group, regardless of the individual's age.

Table 4.1 demonstrates for selected carriers the range in premiums charged in the individual markets of four states to applicants based solely on differences in their ages. The low end of the range represents the

[71]The official said that the $1,500 and $2,250 deductible options were added to comply with the HIPAA provision that allowed for high-deductible plans (defined as those plans with deductibles between $1,500 and $2,250 for individuals) to be used in conjunction with the purchase of a medical savings account (MSA). An MSA is an account, which may be tax deductible, into which an individual deposits funds for later payment of unreimbursed medical expenditures. The $3,000 and $4,500 deductible options were added for the same reason for husband and wife, family, and adult and child policies. Carriers, however, are not required to offer these deductible options, and in February 1998, only 3 of the 27 carriers operating in the individual market chose to do so.

carrier's premium for a 24-year-old nonsmoking, male applicant, while the upper end of the range indicates the premium price charged for the same coverage to a nonsmoking male applicant aged 60. Depending on the carrier and the plan chosen, a 60-year-old could pay over four times more than the younger applicant for the same coverage.

Table 4.1: Examples of Variation in an Individual's Standard Monthly Premium Due to Differences in Age

	Deductible (plan type)	Range in monthly premium[a]
Carrier A	$500 (PPO)	$81-$373
Carrier B	$250 (PPO)	$66-$253
Carrier C	$250 (Indemnity)	$80-$236
Carrier D	$0 (HMO)	$101-$302

[a]Although the range in prices listed represents differences attributable to age only, each of these carriers varies its rates for other demographic characteristics as well. In addition to adjustments for differences in age, carrier A also varies rates for gender, geographic area, tobacco use, and family size; carrier B for gender, geographic area, and family size; carrier C for geographic area and family size; and carrier D for family size.

Medical Underwriting Affects Premiums and May Bar Access to the Individual Market

Where no state or federal restrictions apply, a carrier may also evaluate the health status of each applicant to determine whether it will increase the standard premium rate, exclude a body part or an existing health condition from coverage, or deny coverage to the applicant altogether. This process is called medical underwriting.

A carrier may deny coverage to applicants determined to be in poorer health and more likely to incur high medical costs. Individuals with serious health conditions such as heart disease are virtually always denied coverage. Similarly, those with such non-life-threatening conditions as chronic back pain and varicose veins may be denied coverage. The most recent declination rates for carriers with whom we spoke ranged from zero in states where guaranteed issue is required to about 23 percent. Carriers in those states that do not prohibit medical underwriting typically deny coverage to about 15 percent of all applicants.

Table 4.2: Most Recent Declination Rates of Selected Individual Market Carriers in Seven States

State	Percentage of applicants denied coverage[a]
Arizona	
Carrier A	15
Colorado	
Carrier A	15
Carrier B	5
Illinois	
Carrier A	17.5
New Jersey	
All carriers	0[b]
New York	
All carriers	0[b]
North Dakota	
Carrier A	22.5
Vermont	
All carriers	0[b]

Note: For a discussion about how we selected the states and insurance carriers, see the objectives, scope, and methodology section of chapter 1.

[a]Carrier representatives provided these approximations of the percentage of applicants who are denied coverage.

[b]The declination rate is zero since state laws require carriers to offer all products they sell to all individuals who apply for coverage. This requirement is referred to as guaranteed issue.

These declination rates could be understated for two reasons. First, the rates do not take into account carriers who attach riders to policies to exclude certain health conditions or carriers that charge unhealthy applicants a higher, nonstandard rate for the same coverage. Thus, although a carrier may have a low declination rate, it may attach such riders and charge higher, nonstandard premiums to a substantial number of applicants. For example, while one carrier with whom we spoke declines only about 15 percent of all individual applicants, it attaches exclusionary waivers to the policies of 38 percent of the non-HMO applicants it accepts. Thus, persons with chronic back pain, glaucoma, or diabetes may have all costs associated with the treatment of those conditions excluded from coverage. Insurance agents are also generally aware of which carriers medically underwrite and have a sense as to whether applicants will be accepted or denied coverage. Consequently, they will often deter individuals with certain health conditions from

applying for coverage from certain carriers. When this occurs, the declination rate is not an accurate indicator of the proportion of potential applicants who are ineligible for coverage.

Table 4.3: Examples of Health Conditions for Which Carriers May Decline Coverage or That May Be Excluded From Coverage

Condition for which coverage may be declined	Condition that may be excluded from coverage
Alzheimer's disease	Asthma
Diabetes	Glaucoma
Hernia	Impotence
Hypertension	Parkinson's disease
Migraine headaches	Substance abuse
Rheumatoid arthritis	Ulcers
Stroke	Varicose veins

The ability of carriers in some states to underwrite applicants may have the most adverse effects on those aged 55 to 64. Because of the existence of certain health conditions, many of these individuals have retired or work only part time, and consequently, may have fewer resources with which to purchase insurance. For these individuals, carriers' underwriting practices may often result in premiums priced prohibitively high, or even worse, denial of coverage altogether.

Access to Individual Market Varies Among States, Affecting Near Elderly Differently

As discussed, without state restrictions that prohibit the practice, carriers generally base premium rates on the demographic characteristics and health status of each applicant. Table 4.4 demonstrates premium price variation stemming from age differences and includes examples of what the near elderly with varying health conditions might experience in terms of availability and affordability of coverage in the individual insurance markets of these states. The baseline is the monthly premium charged to a healthy 25-year-old male.

Table 4.4: Selected Carriers' Monthly Premium Price Variations Attributable to Age and Specified Health Characteristics

	Gender, age				Preexisting condition or characteristic			
Plan type/deductible	Baseline healthy male, 25	Healthy male, 55	Healthy female, 60	Healthy male, 64	Chronic back pain	Preexisting diabetes	Cancer within 3 years of application	High-risk pool, male, 60
Arizona								
PPO/$250	$66	+$153	+$177	+$187	Exclude condition or deny coverage	Exclude condition or deny coverage	Deny coverage	Not available
Colorado								
HMO	$105	+$147	+$197	+$197	Deny coverage	Deny coverage[a]	Deny coverage	+$445[b]
PPO/$500	$51	+$95	+$94	+$110	Not available	Exclude condition	Deny coverage	+$499[b]
Illinois								
PPO/$500	$87	+$212	+$206	+$286	Charge higher premium	Charge higher premium	Deny coverage	+$638
New Jersey								
FFS/$1,000	$214-$602 (low end-high end)[c]	0	0	0	0	0	0	Not applicable
New York								
HMO	$160-$309 (rural/ urban)[d]	0	0	0	0	0	0	Not applicable
North Dakota								
FFS/$250	$80	+$112	+$156	+$156	Deny coverage	Deny coverage	Deny coverage	+$316[e]
Vermont								
FFS/$1,000	$192	0	0	0	0	0	0	Not applicable

(Table notes on next page)

[a]Coverage is denied if the applicant is insulin-dependent and acquired his/her diabetes after the age of 55.

[b]This is for an applicant who selects the $300 deductible option and lives in Denver. For the Colorado HMO plan, the premium price differential may be understated, since, unlike the high-risk-pool plan, it has no deductible.

[c]The range represents the lowest and highest premium prices for the most popular plan in the state's individual insurance market. The premium prices charged by all carriers who sell this product fall within this range.

[d]The premiums listed represent the range in prices for the standard HMO product in different geographic areas in New York. The lower end of the range represents one carrier's price for this product in a rural county in the state, while the upper end represents one carrier's price for this product in the New York City metropolitan area.

[e]This difference may be understated because the high-risk-pool plan has a $500 deductible, whereas the plan with which we compared it has a $250 deductible.

Because carriers anticipate that the likelihood of needing medical care increases with age, all carriers in the states listed except those that were prohibited by law from doing so charged higher premiums to older applicants. For example, an Arizona PPO plan costs a 25-year-old male $66 a month and a 64-year-old male $253 for the same coverage, a difference of $187. Similarly, a 64-year-old male would have paid $286 more than the 25-year-old male for a PPO product from one Illinois carrier. As the table indicates, all applicants in New Jersey, New York, and Vermont, regardless of age, would pay exactly the same amount for the same insurance coverage from the same carrier. The individual insurance reform legislation enacted in these states requires community rating, a system in which the cost of insuring an entire community is spread equally among all members of the community, regardless of their demographic characteristics or health status. Given the median income of the near elderly, rates in the individual market may pose an affordability problem to some. For example, the premiums for popular health insurance products in the individual markets of Colorado and Vermont are at least 10 percent and 8.4 percent, respectively, of the 1996 median family income of married near-elderly couples. Typically, Americans under age 65 spent about 4 percent of household income in 1994 on health care—an amount that includes not only insurance premiums or employer-required cost sharing but also out-of-pocket expenses for copayments, deductibles, and services not covered by health insurance. (See app. V for a comparison of the affordability premiums in the individual market with cost sharing under employer-based coverage.)

Without state restrictions, carriers will also evaluate the health status of each applicant to determine whether to charge an increase over the standard premium rate, to exclude a body part or existing health condition from coverage, or to deny the applicant coverage altogether. For example, while four of the carriers automatically deny coverage to an applicant with preexisting diabetes or exclude from coverage all costs associated with treating this condition, one carrier will accept the applicant but will charge him or her a significantly higher premium to cover the higher expected costs. Also, an applicant who had cancer within the past 3 years would almost always be denied coverage from all carriers we interviewed except those in the guaranteed-issue states of New Jersey, New York, and Vermont.

In non-guaranteed-issue states, applicants who have a history of cancer or other chronic health conditions are likely to have a difficult time obtaining coverage. Since the near elderly are more likely to use medical services and develop such conditions as they grow older, they may have an even more difficult time accessing coverage in the individual markets of certain states. However, high-risk insurance pools have been created in a number of states and act as a safety net to ensure that otherwise uninsurable individuals can obtain coverage, although at a cost that is generally 125 to 200 percent of the average or standard rate charged in the individual insurance market for a comparable plan.[72] Although the near elderly in Colorado, Illinois, and North Dakota who are denied coverage from one or more carriers may obtain coverage through the high-risk pool, they may be required to pay $316 to $638 more each month for this coverage. Arizona is the only state that we examined that did not have either guaranteed issue or a high-risk pool.[73] The near elderly in this state, especially if they are unhealthy, are not guaranteed access to any insurance product and consequently may become uninsured.

State and Federal Initiatives Attempt to Expand Accessibility to This Market

Most states and the federal government have undertaken a wide range of initiatives to increase access to the various segments of the health insurance market. While almost all states have enacted reforms designed to improve access to small employer health insurance, they have been slower to introduce similar reforms to the individual market. In our 1996 report, we noted that some states (1) had passed reforms designed to,

[72]The premium in a high-risk pool, however, may still fall short of covering the expected cost of high-risk enrollees. A subsidy mechanism is commonly in place to cover these shortfalls.

[73]However, under HIPAA, carriers in Arizona are required to guarantee-issue certain individual market products to eligible individuals.

among other things, improve portability, limit waiting periods for coverage of preexisting conditions, and restrict rating practices in the individual market; and (2) operated high-risk insurance pools to provide a safety net for otherwise uninsurable individuals. In addition, certain states had provided all individuals a product on an open enrollment basis through their Blue Cross and Blue Shield plan. Nevertheless, as many as six states may have no insurance rating restrictions, an operational high-risk pool for which all in the state are eligible, an insurer of last resort, or any method through which all individuals are guaranteed access to an individual insurance product.

Also, a number of state and federal laws guarantee individuals leaving employer-sponsored group health plans access to continued coverage and, ultimately, to a product in the individual market. First, similar to COBRA, some states extend continuation requirements to groups of fewer than 20, and several states require carriers to offer individuals a product comparable to their group coverage on a guaranteed-issue basis. HIPAA further guarantees access to individual market coverage for eligible individuals leaving group health plans. This group-to-individual portability is only available to eligible individuals who have exhausted their available COBRA or other conversion coverage and who meet several other eligibility criteria. HIPAA, however, does not explicitly restrict the premiums carriers may charge, nor does its guarantee of coverage extend to those who have always relied on the individual market for coverage.

About Half of the States Have Passed Individual Insurance Reforms, but Provisions Vary

In our 1996 report, we identified 25 states that at the end of 1995 had passed one or more reforms in an effort to improve individuals' access to this market. Since that time, additional states have enacted reforms. These reforms sought to restrict carriers' efforts to limit eligibility and charge higher premiums because of an individual's health history or demographic characteristics. We found substantial variation in the ways states approached reform in this market, although reforms commonly passed included guaranteed issue, guaranteed renewal, limitations on preexisting condition exclusions, portability, and premium rate restrictions. Among all reforms, guaranteed issue and restrictions on premium rates are provisions that most directly affect individuals' access to this market and the affordability of the products offered to them. Guaranteed issue requires all carriers that participate in the individual market to offer at least one plan to all individuals and accept all applicants, regardless of their demographic characteristics or health status. See appendix VII for an

updated summary of state initiatives to increase access to the individual market.

In our 1996 report, we found that 11 states required all carriers participating in this market to guarantee-issue one or more health plans to all applicants. Since that time, we have identified an additional two states that require carriers to guarantee-issue selected products.[74] Such a provision, however, does not necessarily guarantee coverage to all individuals on demand. To limit adverse selection, carriers in most states do not have to accept individuals who are eligible for employer or government-sponsored insurance, and in some states carriers are only required to accept applicants during a specified, and usually limited, open enrollment period.

Twenty of the states that have passed some reform in the individual market included a provision in their legislation that attempts in some way to limit the amount carriers can vary premium rates or the characteristics they may use to vary these rates. This number represents an increase of 2 states (Massachusetts and South Dakota) from the 18 we previously had identified. Most of these states allow carriers to vary, or modify, premium rates charged to individuals within a specified range according to differences in certain demographic characteristics such as age, gender, industry (type of employment), geographic area, and use of tobacco. For example, while New Hampshire only allowed carriers to modify rates on the basis of age, South Carolina allowed carriers to use differences in age, gender, geographic area, industry, use of tobacco, occupational or avocational factors, and any additional characteristics not explicitly specified, to set premium rates. Most of the 20 states, however, limit the range over which carriers may vary rates among individual consumers. In fact, at least three of these states require carriers to community-rate their individual products, with limited or no exceptions. Under community rating, carriers establish premiums at the same level for all plan participants, regardless of their age, gender, health status, or any other demographic characteristic. See appendix VIII for a description of the rating restrictions in the states that have passed such reforms.

[74]For a summary of these reforms by state, see ch. 5 of GAO/HEHS-97-8, Nov. 25, 1996. To update our 1996 summary of individual insurance reforms passed by states, we relied on a survey conducted by the Blue Cross and Blue Shield Association published in January 1998, State Legislative Health Care and Insurance Issues: 1997 Survey of Plans. We did not independently verify whether additional states passed similar reforms.

High-Risk Pools May Be an Option for Those Denied Coverage

In addition, at least 27[75] states have created high-risk insurance programs that act as a safety net to ensure that individuals who need coverage, including the near elderly, can obtain it. However, the cost is generally 125 to 200 percent of the average or standard rate charged in the individual insurance market for a comparable plan. To qualify for the high-risk pool, applicants usually have to demonstrate they have been rejected by at least one carrier for health reasons or have one of a number of specified health conditions.[76]

These high-risk pools, however, have historically enrolled a small number of individuals. In all but one of the states with such pools, less than 5 percent of those under age 65 with individual insurance obtain coverage through the pool. Only in Minnesota does enrollment in the pool approach 10 percent of the individually insured population. The relatively low enrollment in these pools may be due in part to limited funding, their expense, and a lack of public awareness. For example, California has an annual, capped appropriation to subsidize the cost of enrollees' medical care and curtails enrollment in the program to ensure that it remains within its budget. Also, although these programs provide insurance to individuals who are otherwise uninsurable, they remain relatively expensive, and many people are simply unable to afford this coverage.

Several "Blues Plans" Act as Insurers of Last Resort

In addition to the states that require all carriers to guarantee-issue at least one health plan to all individuals, the Blue Cross and Blue Shield plans in eight states and the District of Columbia offer at least one product to individuals during an annual open enrollment period, which usually lasts 30 days. Although these plans accept all applicants during the open enrollment period, they are not limited in the premium they can charge an individual applicant. For individuals not eligible for guaranteed access to individual market coverage under HIPAA, these plans may provide their only source of coverage.

[75]Tennessee high-risk-pool participants have been merged into the TennCare Medicaid program. By June 30, 1995, coverage in the high-risk pool, which had been in operation since 1987, had been phased out and most of these "medically uninsurable" individuals were enrolled in TennCare. TennCare, which also provides coverage to the state's Medicaid population and the uninsured, does not separately track the number of high-risk individuals in the program.

[76]To fulfill HIPAA requirements, approximately 22 states have chosen to use their high-risk pool to provide guaranteed access to coverage for eligible individuals who lose group coverage.

Six States Have Passed No Initiatives That Guarantee Unhealthy Individuals Access to the Market

Our analysis also showed that at the end of 1997, six states had passed no reforms that attempted to increase the access of all persons to the individual insurance market (for example, guaranteed issue and premium rate restrictions), had no operational high-risk pool for which all individuals in the state were eligible for coverage, and had no Blues plan that acted as insurer of last resort. In these states, individuals who are unhealthy and not eligible for coverage under HIPAA, and thus most likely to need insurance coverage, may be unable to obtain it. These states are Alabama,[77] Arizona, Delaware, Georgia, Hawaii,[78] and Nevada.

Federal Legislation Increases Some Individuals' Access to Coverage in the Individual Market

Through HIPAA, signed into law on August 21, 1996, the Congress sought to provide a set of minimum protections that would apply to all states and to coverage sold in all insurance markets. ERISA exempts self-insured employer group plans, which cover about 40 percent of all insured workers, from the insurance reforms passed by most states; since HIPAA established federal standards, they apply to such self-funded firm plans.

HIPAA guarantees those leaving group coverage access to coverage in the individual market—"group-to-individual portability"—under certain specified circumstances. This guarantee applies to those who had at least 18 months of aggregate creditable coverage, most recently under a group plan, and without a break of more than 63 days, and who have exhausted any COBRA or conversion coverage available. Individuals who meet these criteria are eligible for guaranteed access to coverage, regardless of their health status and without the imposition of coverage exclusions for preexisting conditions. However, only about 11 percent of those who elect COBRA coverage remain enrolled for the maximum period. Furthermore, HIPAA offers no guaranteed access to the individual market for retirees whose benefits were terminated before its July 1, 1997, implementation or to those who have traditionally relied on the individual market for coverage.

To meet HIPAA's group-to-individual portability requirement, states could choose between two approaches, the "federal fallback" and "alternative mechanism" approaches. Under the federal fallback approach, which HIPAA specifies and which 13 states are using, carriers must offer eligible

[77]Alabama recently created a high-risk pool, but enrollment in the pool is limited to HIPAA eligibles. Thus, those not previously covered by an employer group plan are not eligible for coverage in the pool.

[78]Hawaii is the only state with mandated employer-sponsored health insurance. Therefore, almost all employed individuals have access to health insurance through their employer, and a relatively small percentage of the population must rely on the individual insurance market as their sole source of coverage.

individuals (1) all their individual market plans, (2) their two most popular plans, or (3) two representative plans—a lower-level and a higher-level coverage option. The remaining 36 states[79] and the District of Columbia chose an alternative mechanism under which the law allows a wide range of approaches as long as certain requirements are met. Twenty-two states decided to use their high-risk pool as their alternative mechanism.

Under the federal fallback approach, HIPAA does not explicitly limit the premium price carriers may charge eligible individuals for coverage. In fact, we recently reported that in several of the 13 states using the federal fallback approach, the premium prices charged to HIPAA-eligibles ranged from 140 to 400 percent or more of the standard premium.[80] Similar to the experience of non-HIPAA-eligibles who rely on the individual market for coverage, carriers in the federal fallback states typically evaluate the health status of applicants and offer healthier HIPAA-eligibles access to standard products. Although these products may include a preexisting condition exclusion period, they may cost considerably less than the HIPAA product and will likely attract the healthier individuals. Unhealthy HIPAA-eligibles in these states may have access to only the guaranteed access product, and some may be charged an even higher premium on the basis of their health status. However, a similarly situated individual who was not eligible for a HIPAA product may still be denied coverage or have certain conditions excluded from coverage. So, while an early retiree whose employer eliminated coverage would typically be eligible for one of these guaranteed access products, no similar guarantees of access to coverage exist for those who historically have relied on the individual market as their sole source of coverage. These individuals may still encounter significant obstacles in their efforts to obtain an individual insurance product.[81]

In comparison, individuals in the 22 states that will use a high-risk pool as their alternative mechanism to comply with HIPAA may face less steep

[79]Kentucky has until July 1, 1998, to implement group-to-individual guaranteed access, since its legislature was not in session during 1997. Thus, Kentucky is not included in the total.

[80]We reported on a number of concerns that were raised during the first year of HIPAA implementation. For a thorough discussion of these concerns, see Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators (GAO/HEHS-98-67, Feb. 25, 1998) and Health Insurance Portability and Accountability Act of 1996: Early Implementation Concerns (GAO/HEHS-97-200R, Sept. 2, 1997).

[81]HIPAA also includes a guaranteed renewal provision, which requires carriers to renew all individual coverage. The law supersedes the guaranteed renewal requirement in states with less far-reaching renewal provisions and requires health plans to renew a product, provided it meets specified criteria. HIPAA does allow health plans to terminate coverage in the case of fraud, nonpayment of premiums, noncompliance with contribution requirements, market exit, and service area limitations.

premium prices than those in the federal fallback states, regardless of their particular health status. Coverage through a high-risk pool typically costs more than standard coverage, but state laws limit the premiums carriers may charge, generally at a cost that is 125 to 200 percent of the average or standard rate charged.

COBRA Provides Temporary Access for Some Near Elderly

Although a company's decision to offer health coverage to workers is essentially voluntary, legislation enacted in 1986 mandates the temporary continuation of employer-based benefits under certain circumstances. Such continuation coverage is known by the acronym COBRA.[82] The mandate applies only to firms with 20 or more workers that choose to offer coverage, and the mandate ceases to apply if an employer terminates health benefits.[83] Though available to the near elderly, COBRA was targeted at a broader group. Thus, continuation coverage extends participation in employer-based group coverage for individuals of all ages who experience a transition resulting in the loss of health benefits, such as unemployment, retirement, death of a spouse, or divorce. The legislation was enacted in response to increasing concern about the large number of Americans who lack health insurance. Those who elect COBRA are responsible for the entire premium plus a 2-percent surcharge to cover associated administrative expenses. Although the mandate does not oblige firms to share in the cost of continuation coverage—a major difference from most employer-based health benefits, which are commonly heavily subsidized—employers contend that there is an implicit subsidy because sicker, more costly individuals are likely to elect COBRA.[84]

Categories of the near elderly who might potentially benefit from continuation coverage include those who (1) are laid off, (2) experience a cutback in hours that makes them ineligible for health benefits, (3) retire, or (4) are younger spouses of individuals who become eligible for Medicare and thus relinquish employer-based health insurance for their entire family.[85] An attractive feature of COBRA for the near elderly is its

[82]This provision was added to ERISA by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 29 U.S.C. 1161-1169. For this reason, continuation coverage is commonly referred to as COBRA.

[83]COBRA applies to state and local governments that receive funds under the Public Health Service Act. Taft-Hartley trusts, which are union-organized plans that provide health coverage under collectively bargained agreements, are also subject to COBRA. Continuation requirements similar to COBRA are applicable to federal employees enrolled in plans under the Federal Employees' Health Benefits Program. The District of Columbia government, territories and possessions of the United States, and church plans are exempt. Before the enactment of federal legislation, 23 states had continuation coverage legislation for laid-off workers, but the laws varied as to who was covered and for how long. Moreover, self-insured firms were exempt from state laws as a result of ERISA. State continuation laws, however, may apply to small firms with fewer than 20 employees.

[84]Though companies may charge COBRA enrollees the full premium, group insurance rates for a comprehensive medical plan with reasonable deductibles and copayments are generally advantageous to older individuals or to those with health problems. If comparable coverage is available in the individual market, the premium may be adjusted for both age and health status. Moreover, certain medical conditions may result in the denial of coverage or may be excluded from any policy issued.

[85]COBRA coverage is not available to individuals whose employers terminate their health insurance after retirement.

ability to temporarily fill the gap in coverage that exists when an employer provides health benefits to active workers but not to retirees. Moreover, COBRA may be used as a bridge to Medicare by individuals who coordinate their retirement age with the eligibility period.

Because the employer is not required to pay any portion of the premium, COBRA may be an expensive alternative for the near elderly—especially since the loss in employer-based coverage is probably accompanied by a decrease in earnings. The limited information available on eligibility for and use of COBRA by Americans in general and the near elderly in particular is based on past experience and may not reflect incentives to elect and exhaust continuation coverage created by the implementation of HIPAA. Moreover, the information leaves many important questions unanswered. In general, the near elderly appear to be more likely to elect COBRA than younger age groups. Analysis of two studies that examined data from special CPS supplements suggests that COBRA use by the near elderly in 1988 and 1994 was relatively small compared with the size of this age group. On the one hand, these estimates represent the lower boundary of COBRA use by the near elderly since neither includes both retired and nonretired 55- to 64-year-olds. On the other hand, both may overestimate the use of continuation insurance, since employers have told us that some individuals only elect COBRA to receive dental or vision coverage—benefits that are not always offered to those with access to employer-based retiree health insurance. A proprietary database whose results cannot be generalized to the whole population suggests that, on average, 61- to 64-year-olds only keep continuation coverage for a year. Finally, although there is a strong rationale for those near elderly who lack an alternative source of coverage and who can afford the premium to elect COBRA, there is no systematically collected evidence on the extent to which such elections affect employer costs.

Terms and Conditions of COBRA Coverage

The terms and conditions of COBRA eligibility are complex, in part because of (1) its broad scope, (2) the fact that it addresses coverage for individuals and families whose connection to an employer has been broken, and (3) the protections for enrollees built into the election process.

There are two broad categories of qualifying events under COBRA, with the coverage period linked to the type of event:

- Work-related. Voluntary separation, including retirement; involuntary separation other than for gross misconduct; or a decrease in the number of hours worked that results in loss of heath insurance.
- Family.[86] Divorce or legal separation from or the death of an insured worker, Medicare entitlement for a covered employee resulting in the loss of employer-provided coverage to a dependent, or loss of dependent child status.[87]

Generally, a work-related event provides benefits for 18 months. However, in the case of separation or reduction in hours as a result of a disability, coverage can be extended for an additional 11 months if the disability is determined under the Social Security Act and existed during the first 60 days of COBRA coverage.[88] The cost for those additional 11 months rises from 102 percent to 150 percent of the applicable premium. Dependents are also eligible for the full 29 months of coverage. For those who qualify on the basis of family events, coverage is available for up to 36 months. Finally, in the case of multiple qualifying events, coverage is limited to 36 months.

Three factors make COBRA administration complex for firms: the lack of personnel departments at smaller firms, the detachment of enrollees from the active workforce, and the election time frames and notification requirements. COBRA eligibility rules must be implemented not only by large firms with established personnel and benefit staffs but also by small businesses where benefit management may be an ancillary duty. Further complicating administration of COBRA is the fact that firms must create systems and procedures for individuals who are no longer on their payroll and who may be more difficult to contact than an employee who reports for work. For example, payroll deductions, the typical means of collecting an employee's share of the health insurance premium, are not an option

[86]A Bureau of Labor Statistics survey of medium and large employers conducted in 1985, before the enactment of COBRA, suggests that a majority of firms continued health benefits for families of deceased workers, but the length of this coverage varied considerably. Some large employers told us that their own continuation benefits are, in some instances, more generous than those mandated under COBRA. In effect, COBRA establishes a minimum floor for all employers with more than 20 workers.

[87]Women's organizations were strong advocates of COBRA enactment. The Congressional Research Service points out that in 1977, the last year for which relevant data are available, only 50 percent of all widows and 33 percent of all divorcees aged 35 to 64 who were unemployed had private insurance. Our analysis of the March 1997 CPS indicates that regardless of work status, about 18 percent of widows and divorcees were uninsured. Approximately 60 percent had private insurance and about 19 percent had public coverage. See Beth C. Fuchs, Health Insurance Continuation Coverage Under COBRA, Congressional Research Service Issue Brief, updated July 10, 1997.

[88]Individuals who qualify for disability under the Social Security Act must wait 5 months to receive benefits and 24 months to become eligible for Medicare, but COBRA enrollment generally ceases after 18 months. The additional 11 months of COBRA eligibility ensures that there is no gap in coverage.

for a former worker. Finally, the terms under which an employer must proffer continuation coverage add to the administrative burden. The employer has 14 days to notify individuals that they qualify for COBRA. After notification of eligibility, an individual has 60 days to elect coverage and 45 days to make a retroactive payment for covered health services—benefits that may actually have already been accessed by the enrollee 4 months earlier. As discussed in the following section, some employers are concerned that these election time frames contribute to adverse selection.[89]

Limited Evidence on Use of COBRA by the Near Elderly

More than 10 years after the establishment of continuation coverage on a nationwide basis, there is a dearth of systematically collected data on (1) how many individuals are eligible, (2) how many enroll, (3) the demographic characteristics of those who elect coverage, or (4) the average health care costs of COBRA enrollees. Since eligibility is not conditioned on age, the handful of studies on COBRA often examine its use in general rather than focusing on the near elderly. Information from CobraServe, a third-party COBRA administrator, provides insights on the election rates of retirees who become eligible for COBRA compared with younger age groups, but the data are not nationally representative.[90] The only nationally representative data on the use of COBRA by the near elderly are special supplements to the CPS conducted in 1988 and again in 1994.[91] However, because they used different methodologies, the two studies

[89]One employer characterized the 60- and 45-day waiting periods for COBRA election and payment of the first retroactive premium as akin to "allowing someone to purchase automobile insurance after the accident."

[90]Patrice Flynn, "Employment-Based Health Insurance: Coverage Under COBRA Continuation Rules," in Health Benefits and the Workforce (Washington, D.C.: Dept. of Labor, 1992).

[91]The CPS supplements focus on health insurance status at a particular point in time providing direct information on both worker and dependent coverage through a former employer. Though the 1988 and 1994 CPS supplements only sampled adults aged 40 and older, that is not a limitation for addressing COBRA usage by the near elderly. However, since the CPS only captures individuals who elected COBRA, no information is available on how many Americans were eligible but declined coverage or their reasons for not enrolling. COBRA usage is inferred from the length of coverage (18 to 36 months or less) since respondents were not asked directly if they had continuation coverage. The Survey of Income and Program Participation (SIPP), a nationally representative survey conducted by the Census Bureau, has also been used to estimate COBRA usage. A longitudinal survey, it captures changes in health insurance coverage over time by following a large panel of households over a 28-month period. However, SIPP provides no direct information on how many workers or their families have elected COBRA coverage, nor does it distinguish between health insurance coverage provided by a current or previous employer. It only permits an estimate of the number of unemployed and uninsured who would qualify for COBRA if their previous employers offered health insurance.

based on these data only provide a rough estimate of COBRA use by 55- to 64-year-olds.[92]

According to the CobraServe data, the near elderly appear to be more likely than other age groups to elect COBRA, but the number doing so is relatively small. About 10 percent of the over one-half million workers in the database became eligible for COBRA between October 1, 1990, and September 30, 1991, and approximately 21 percent enrolled.[93] We presumed enrollees to be near elderly if they elected coverage at retirement or when a spouse became eligible for Medicare. Using these assumptions, approximately 1,600 of the 12,536 enrollees were near elderly.[94] The election rates of the near elderly were high—33 percent for retirees and 60 percent for spouses of those who became eligible for Medicare. However, the actual number of near-elderly enrollees was small. For example, only 196 individuals elected COBRA because a spouse became eligible for Medicare. Overall, the election rate of those aged 61 and older was 38 percent, while the election rate for those under age 40 was 17 percent. In addition, the length of the enrollment period was higher for older individuals from 1987 to 1991. The 61- to 64-year-olds used COBRA for an average of 12 months—4 months longer than those aged 41 to 60. Only 11 percent of all beneficiaries remained enrolled for the full 18 to 36 months allowed. Several hypotheses can be offered for the higher election rates by older, compared with younger, individuals. First, the near elderly may be more willing to sacrifice current income to pay the insurance premium, given their greater medical needs. Second, younger workers may have access to health insurance through another family member. Finally, the longer election rates by older individuals suggest that they are less likely than younger Americans to obtain other employment.

[92]Patrice Flynn, "Employment-Based Health Insurance: Coverage Under COBRA Continuation Rules," and Pamela Loprest, Retiree Health Benefits: Availability From Employers and Participation by Employees (Washington, D.C.: The Urban Institute, Oct. 1997).

[93]Almost one-half of employees in the 1990-91 database worked for firms with more than 5,000 workers, and 21 percent were employed at firms with between 51 and 500 employees.

[94]Looking at CobraServe data from 1987 to 1991, Flynn also found that about 13 percent of elections were for retirees and individuals whose spouses became eligible for Medicare. Presumably, those retirees who elected COBRA were not offered retiree health coverage and did not have access to insurance through a spouse. As noted earlier, there is no data as to why individuals did not elect continuation coverage—that is, coverage was available through a spouse or former employer or COBRA was unaffordable. Gruber and Madrian use Flynn's analysis to suggest that retirees without an alternative source of health insurance are quite likely to elect continuation coverage. Thus, they estimated that 75 percent of those most likely to be covered by COBRA actually are. See Jonathan Gruber and Brigitte C. Madrian, "Health Insurance and Early Retirement: Evidence From the Availability of COBRA Coverage," Working Paper No. 4594 (Cambridge, Mass.: National Bureau of Economic Research, 1993).

Analysis of two studies that examined data from special CPS supplements suggests that COBRA use by the near elderly in 1988 and 1994 was relatively small compared with the size of this age group. On the one hand, these estimates represent a lower boundary of estimated COBRA use by the near elderly, since neither study includes both retired and nonretired 55- to 64-year-olds. On the other hand, both may overestimate the use of continuation insurance since employers have told us that some individuals only elect COBRA to receive dental or vision coverage—benefits that are not always offered to those with access to employer-based retiree health insurance. For those who were not retired in 1988 and whose continuation coverage lasted for no more than 36 months, an estimated 443,000 were enrolled in COBRA—about 2 percent of the near elderly. Among those who were retired in 1994 and whose continuation coverage was for no more than 18 months, an estimated 65,000 used COBRA—about 1.5 percent of the 4.4 million retirees in 1994.[95]

Proof of Adverse Selection More Intuitive Than Systematic

Employers believe that per capita costs for COBRA enrollees are higher than those for active workers because of adverse risk selection—the propensity of sicker individuals with greater health care costs to elect coverage. Even though the enrollee typically pays the full premium plus an administrative surcharge, employers contend that there is an implicit subsidy in continuation coverage because enrollee costs typically exceed that premium, raising average costs per enrollee.[96] Notwithstanding the concern about higher costs as a result of the COBRA mandate, few employers appear to collect data to substantiate their concerns. Some employers told us that they believe such efforts would be fruitless because COBRA is unlikely to change—in fact, legislative interest appears to be focused on COBRA expansions.[97] And employers point out that demonstrating adverse selection is made all the more difficult by the enrollment growth in capitated health plans, which often lack the claims data necessary to compute average costs for those who elect COBRA.

Logic suggests that adverse risk selection, a well-recognized factor in the individual insurance market, may be encouraged by the terms and

[95]Sixty-three percent of retirees received coverage through a former employer or a spouse and 15 percent turned to the individual market. The remaining 20 percent were either uninsured or were enrolled in Medicare or Medicaid.

[96]There might have been more debate about establishing a premium in excess of 100 percent if COBRA had targeted the elderly. One proposal introduced during the debate over COBRA in 1985 did suggest establishing the premium at 110 percent.

[97]See app. VI for a description of past COBRA expansions.

conditions established for continuation coverage. At the same time, the fact that risk-averse individuals may elect coverage is also relevant to predicting employer costs. The election of COBRA coverage by the near elderly in the absence of other insurance alternatives may, in some instances, reflect an antipathy to living without health insurance, given their greater risk of illness. Since COBRA election is associated with turnover, the demographics of a firm or industry will also have a significant impact on COBRA costs. Taking all these factors into consideration, some analysts have suggested that it is not possible to predict whether COBRA will lead to higher or lower net costs for an employer. The limited quantitative data available tend to highlight the random nature of the high costs often attributed to COBRA.

Cost Calculus for a COBRA Enrollee

COBRA is an adjunct to employer-based group coverage, but its incentive structure may have more in common with the operation of the individual insurance market. Table 5.1 compares the characteristics of group and individual coverage. While the purchase of an individual health insurance policy is purely voluntary, coverage in the group market is tied to employment. Group insurance rates are often considerably lower than rates in the individual market where, absent state reforms prohibiting the practice, premiums usually reflect the demographic and health characteristics of the purchaser. In contrast to individual rates, employer-based costs typically reflect the experience of the entire group. Thus, there is an inverse relationship between group size and the impact of employees with high health care costs: the larger the group, the smaller the impact (see table 5.2). From the perspective of individuals contemplating the purchase of continuation coverage, the absence of an employer subsidy places COBRA on a par with individual insurance: it is similarly expensive but cheaper than individual coverage because COBRA permits enrollees to maintain the group rate. In summary, the high cost and voluntary nature of COBRA suggest that individuals will go through a personal calculus in deciding whether to elect coverage: Individuals whose expected medical expenses exceed the premium are more likely to elect continuation coverage.[98]

[98]Some argue that the absence of a subsidy increases the likelihood that only those with high expected health care costs will enroll. Thus, the cost calculus for a healthy individual suggests that the costs outweigh the benefits.

Table 5.1: Comparison of Characteristics of Employer-Based Group Health Insurance and Individually Purchased Coverage

Employer-based coverage	Individual coverage
Tied to employment	Voluntary
Group rate	Rate often based on age and health status
Often subsidized	No subsidy
Relatively inexpensive for worker	Cost shouldered entirely by individual

Table 5.2: Sicker Employees Have Greater Impact on Average Health Care Costs of Smaller Employers

Number of workers	Total cost of health benefits (average cost = $2,000/year)	Average cost of health benefits if one of enrollees is costly (130% of average enrollee)
2	$4,000	$2,300
10	20,000	2,060
20	40,000	2,030
50	100,000	2,012
75	150,000	2,008
100	200,000	2,006
200	400,000	2,003

Some evidence suggests, however, that factors other than expected medical expenses play a role in who elects COBRA. Thus, some individuals may be risk-averse and willing to pay the high cost of continuation coverage. The near elderly might well be expected to fall into this category. Anecdotal evidence from employers suggests that parents whose children lose dependent child status may also be risk-averse. The health benefit manager at one large company told us that the firm's well-educated employees understand the value of health benefits, the randomness of catastrophic illness, and the financial consequences of being uninsured. Many of the firm's COBRA elections are young adults who lose health benefits under their parents' company policy when they graduate from college. The benefit manager at another firm told us that the COBRA premiums for her son who had just graduated from college were very high but that the financial risk of going without coverage was more worrisome to her than the cost. The CobraServe database referenced earlier indicates that election rates for loss of dependent child status are as high as those for retirees.

COBRA election is also influenced by affordability considerations. Since COBRA does not require employers to subsidize the premium, the enrollee is generally responsible for paying the full cost of coverage. For 1997,

Mercer/Foster Higgins reported that, on average, the total annual premium for employer-based coverage for an active employee was $3,820. This average cost would represent an enormous increase in out-of-pocket costs for a COBRA enrollee, considering that large employers typically contribute 70 to 80 percent of the premium for active workers.[99] However, aggregate premium data hide the considerable variation in health benefit costs across firms and thus the potential expense to COBRA enrollees. Firm size, benefit structure, locale, and aggressiveness in negotiating rates all affect a company's health care premiums.

At one large, New England-based firm that does not negotiate with health plans but rather accepts a community rate for HMO coverage, we were told that the full premium for family coverage was approximately $5,000 per year; in contrast, the company's indemnity plan would cost a COBRA enrollee about $12,000 annually. According to the firm's benefit manager, an individual enrolled in the indemnity plan who became eligible to elect COBRA would not be allowed to select the less expensive HMO option until the next annual open enrollment period. The full premium for family coverage for retiree health plans offered by the Milwaukee-based Pabst Brewing Company ranged from about $5,646 to $7,933 per year. In 1996, Pabst terminated health benefits for 750 early retirees. Since Pabst had paid the total cost of practically all of the health plans it offered to retired workers, the COBRA cost would have come as a rude awakening to affected retirees.[100] Assuming an obligation for such high premiums occurs at a time when individuals eligible for COBRA are undergoing a transition—a transition that may be associated with a reduction in family income. As a result, Marquis and Long hypothesized that COBRA participation will rise with age because of higher liquid assets and because of the need to protect those assets from potentially high health expenditures.[101]

Since the cost of COBRA coverage is associated with a particular firm, the demographic profile of a company will affect both its average health care expenditures and the costs associated with COBRA. Thus, a firm with an older workforce that does not offer retiree health benefits or a company with a large number of women in their childbearing years might expect to incur higher expenditures than a firm consisting of young, healthy males.

[99]Although health benefit payments by employers are tax deductible and thus paid with pre-tax dollars, employees who elect COBRA pay with after-tax dollars.

[100]In fact, the affected Pabst retirees were not eligible for COBRA since the requirement to provide continuation coverage does not apply to firms that terminate health benefits to retired workers.

[101]Stephen H. Long and M. Susan Marquis, "COBRA Continuation Coverage: Characteristics of Enrollees and Costs in Three Plans," in Health Benefits and the Workforce (Washington, D.C.: U.S. Dept. of Labor, 1992).

And the number of COBRA enrollees who actually do become pregnant or suffer from an expensive illness associated with old age will raise an employer's average health insurance costs.

Limited Quantitative Data Highlight Randomness of Average COBRA Costs

There are only limited quantitative data on adverse selection attributable to COBRA. Though this evidence suggests that COBRA enrollees are on average more expensive than active employees, it is insufficient support for a generalizable conclusion. Instead, the evidence tends to underscore the randomness of high-cost cases at a particular firm and the relationship between the demographics of a firm and the number of high-cost cases they experience.

Marquis and Long analyzed the cost of individuals who elected continuation coverage at three different firms.[102] Their study found that costs for COBRA enrollees were higher than for active employees in all three plans by amounts ranging from 32 to 224 percent. Adjusting these costs for the demographic characteristics of participants, however, shows that health risk is not always higher among COBRA enrollees. Thus, in one of the firms, the higher cost of COBRA continuation coverage was entirely attributable to demographic differences, especially the much higher proportion of women among enrollees. Adjusting for those differences, COBRA enrollees actually had somewhat lower levels of health care spending than active workers. At a second firm, demographic differences, including the older age of COBRA enrollees, did not explain the higher costs, indicating that those on continuation coverage were indeed poorer health risks than the company's active employees.

In addition, Spencer, a Chicago-based benefit consulting firm, has conducted a survey of COBRA costs and experience among a small sample of firms since 1989. Unlike the Marquis and Long analysis, Spencer does not attempt to distinguish between the impact of health risk and demographics on firms' costs. Among its limitations, the survey sample is not random and only about 5 percent of firms contacted responded to the questionnaire. The respondents include a mix of small, medium, and large companies with no apparent oversampling of smaller firms, whose size would magnify the impact of adverse selection on their future premiums. Of the limited number of questionnaires returned in 1997 (191), fewer than one-half were able to supply cost data, and six very large employers represented 71 percent of the total COBRA elections. The survey has consistently shown that (1) costs vary radically and unpredictably among

[102]"COBRA Continuation Coverage," in Health Benefits and the Workforce.

employers; and (2) overall, the costs of COBRA enrollees are higher than those of active workers. Since 1991, average COBRA costs have hovered at about 150 percent of active employee costs. The official responsible for the survey told us that he is constantly struck by the randomness of an individual firm's experience from year to year. Thus, a firm could have 10 COBRA elections during a year and no claims, or one election and $150,000 in associated medical expenditures. In 1997, about 25 percent of respondents reported that COBRA costs were lower than for active workers, while 75 percent reported that COBRA costs were higher.

Observations

Forecasting the insurance status of future generations of near elderly is inherently risky. Since it is not entirely clear why employers are continuing to reassess their commitment to retiree health insurance, it is possible that unforeseen developments will halt or even reverse the erosion that has occurred over the past decade. Among potential scenarios that could affect the incentives for both employers and near-elderly individuals are (1) a tightening of labor markets as a result of having a smaller active labor force or a low unemployment rate, (2) changes in the tax treatment of retirement income, and (3) a postponement of retirement because of insufficient postretirement income.

In addition to events that could affect the erosion in employer-based retiree coverage, use of the HIPAA guaranteed-access provision by eligible individuals may improve entry into the individual market for those with preexisting health conditions who lack an alternative way to obtain a comprehensive benefits package. Depending on the manner in which each state has chosen to implement HIPAA, however, cost may remain an impediment to such entry. Since group-to-individual portability is only available to qualified individuals who exhaust available COBRA or other conversion coverage, HIPAA may lead to an increased use of employer-based continuation insurance. Moreover, additional state reforms of the individual market may improve access and affordability for those who have never had group coverage or who fail to qualify for portability under HIPAA rules.

Despite the possibility of countervailing trends, however, the evidence available today suggests that future generations of retirees are less likely to be offered health benefits when they leave the active workforce. With the number of 55- to 64-year-olds estimated to grow from 8 percent of the population today to 13 percent by 2020, the impact, in the absence of affordable and accessible alternatives, could lead to an increase in the number of uninsured near-elderly Americans. At the same time, the evidence also suggests that those with continued access to employer-based retiree health coverage will shoulder more—in some instances significantly more—of the financial burden. Compared with premiums in the individual market, the typical cost-sharing requirements faced by retirees with employer-based coverage today do not appear to be greatly out of line with those faced by active employees. However, cost-sharing policies being implemented by some firms could eventually create affordability problems for those who retain access to employer-based coverage. If more firms base their financial contribution to retiree coverage on years of service, workers who change jobs

frequently throughout their careers may find the employer subsidy small in relation to the overall premium. Some experts suggest that the traditional employer-employee contract has already been fundamentally altered, with both parties less likely to view the work contract as a lifelong arrangement.

A major unknown that could also affect the continued commitment of employers to retiree coverage is the federal government's response to the Medicare financing problem—a dilemma created by the imminent retirement of the baby-boom generation. Experts are divided about the impact on employer-based coverage of actions that shift costs to the private sector, such as increasing the eligibility age for Medicare. In responding to Medicare's financial crisis, policymakers need to be aware of the potential for the unintended consequences of their actions.

Limited Federal Protection of Employer-Based Retiree Health Benefits

The Employee Retirement Income Security Act of 1974 (ERISA) covers both the pension and health benefits of most private sector workers. The voluntary nature of these employer-based benefits as well as the manner in which coverage is funded has important regulatory implications. Consistent with the lack of any mandate to provide health benefits, nothing in federal law requires an employer to offer coverage or prevents cutting or eliminating those benefits. In fact, an employer's freedom to modify the conditions of coverage or to terminate benefits is a defining characteristic of America's voluntary, employer-based system of health insurance.[103] Moreover, employer-based health benefits are typically funded on a pay-as-you-go basis. In contrast, the sheer magnitude of accumulated employer-employee contributions to retirement funds demonstrates the importance of greater regulation of pension benefits. Thus, ERISA not only requires employers to fund their pension plans but gives employees vested rights upon meeting certain service requirements. Health benefits, on the other hand, are excluded from such funding and vesting requirements.[104]

Although ERISA was passed in response to concerns about the solvency and security of pension plans, some of its provisions, including federal preemption of state regulations, also apply to employer-sponsored health coverage. The preemption effectively blocks states from directly regulating most employer-based health plans, while allowing states to oversee the operation of health insurers.[105] ERISA does, however, impose some federal requirements on employer-based health plans. For example, employers must

[103]The demise of traditional fee-for-service indemnity coverage and the growth in managed care enrollment exemplifies the ability of employers to modify their health benefit programs. Between 1987 and 1996, employer-based managed care enrollment rose from 27 percent to 74 percent as employers (1) altered the type and mix of health plans offered, sometimes eliminating the traditional fee-for-service indemnity option; (2) changed employee financial incentives; and (3) used the information provided to employees to influence their selection of health plans. See Health Insurance: Management Strategies Used by Large Employers to Control Costs (GAO/HEHS-97-71, May 6, 1997) for a discussion of the flexibility of large employers as well as the constraints they face in modifying their health benefit purchasing strategies.

[104]Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (GAO/HRD-93-125, July 9, 1993).

[105]Federal preemption is valued by employers, especially those who self-fund their health benefit plans, because they can avoid certain taxes, are exempt from mandated state benefits, can offer a uniform benefit plan to company employees located in different states, and are not subject to certain medical malpractice lawsuits. Because of the sometimes obscure distinction between prohibiting states from directly regulating employer health coverage but allowing them to set rules for health insurers, the courts have had to determine many of the actual implications of ERISA preemption. See Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995).

- provide participants and beneficiaries access to information about the plans,
- have a process for appealing claim denials,
- make available temporary continuation coverage for former employees and dependents, and
- meet specific fiduciary obligations.

While ERISA protects the pension benefits of retired workers at U.S. companies, it offers only limited federal safeguards to retirees participating in a firm's health benefit plan. ERISA requires companies to make a Summary Plan Description (SPD) available to health plan participants within 90 days of enrolling. For retirees, the SPD that was in effect at the time of retirement is typically the controlling document. The SPD must clearly set out employee rights, including "information concerning the provisions of the plan which govern the circumstances under which the plan may be terminated." According to Labor, employers are free to cut or terminate health care coverage unless they (1) have made a clear promise of specific health benefits for a definite period of time or for life and (2) have not reserved the right to change those benefits. However, the recent decision in the 1989 case brought by General Motors salaried retirees may call into question any commitment by employers to provide previously promised retiree health benefits.[106]

[106]Sprague v. General Motors Corporation, Nos. 94-1896, 94-1897, 94-1898, and 94-1937, U.S. Sixth Circuit Court of Appeals, Jan. 7, 1998.

Characteristics of Public and Private Health Insurance Surveys

We examined a number of public and proprietary surveys that include information on the near elderly, such as their (1) demographic characteristics and access to insurance; (2) ability to obtain retiree health insurance through a former employer; and (3) likelihood of experiencing certain medical conditions, use of services, and levels of health care expenditures. The surveys we relied on were broad and current, and allowed the most precise estimates.

Surveys on the Characteristics of the Near Elderly and Their Access to Insurance

Information on the demographic characteristics of the near elderly and their access to insurance is available through the following national surveys either conducted or financed by the federal government: (1) the March supplement of the Current Population Survey (CPS), (2) the Survey of Income and Program Participation (SIPP), (3) the August 1988 and September 1994 supplements to the CPS, (4) the National Medical Expenditure Survey (NMES), (5) the Medical Expenditure Panel Survey (MEPS), and (6) the Health and Retirement Survey (HRS). Table II.1 compares selected aspects of these six surveys.

Table II.1: Selected Characteristics of Six Surveys of the Near Elderly and Their Access to Health Insurance

Characteristic	CPS-March supplement	SIPP	CPS-Aug. 1988/Sept. 1994 supplements	NMES—household survey	MEPS—household component	HRS
Sponsor and date established	Census Bureau, 1968	Census Bureau, 1983	Labor Department, conducted by the Census Bureau, 1988	AHCPR, 1977	AHCPR and NCHS, 1996	National Institute on Aging and Institute for Social Research, Univ. of Michigan, 1992
Frequency	Annual.	Continuing survey with respondents interviewed every 4 months.	1988 and 1994.	1977 and 1987, succeeded by MEPS.	New panels established annually.	Every 2 years.
Latest publicly available data	1996	1996	1994	1987	1996 for some data	1994
Sample design	Nationally representative, cross-sectional.	Continuous series of nationally representative panels, each from 2.5 to 4 years. As of 1996, each panel is 4 years.	Nationally representative, cross-sectional.	Nationally representative panel lasting about 16 months.	Nationally representative overlapping panels, each lasting about 2.5 years.	Nationally representative panel of 51- to 61-year-olds/ spouses as of 1992. Panel ongoing.
Sample size	About 54,000 eligible households/ 100,000 people for the 1997 CPS March supplement. Hispanics are oversampled.	Typically about 14,000 to 20,000 households. For the 1996 panel, about 36,700 households/ 77,000 people.	About 56,000 households in 1988, and about 57,000 households in 1994.	About 14,000 households/ 35,000 people.	About 10,500 households, or 25,000 people. Blacks and Hispanics are oversampled. Overall sample increased every 5 years.	Over about 7,600 households/ 12,600 people. Hispanics, blacks, and Florida residents are oversampled.
Response rate	About 90% of the individuals.	About 74% for the 1993 panel.	About 95% in 1988 and about 94% in 1994.	About 72%.	About 78% for round 1.	About 82% for wave I and 93% of wave I members for wave II.

As a result of its breadth, currency, and precision, we relied on the March 1997 CPS supplement for our analysis of the demographic and insurance status of the near elderly. The March supplement is based on a sample of about 54,000 households with approximately 100,000 individuals. As shown in table II.1, the CPS is one of the largest surveys and

allows comparisons of the insurance and demographic characteristics of 55- to 64-year-olds and younger age groups. It also allowed us to make observations about two subgroups—those aged 55 to 61 and 62 to 64. It is among the surveys with the most current data and addresses health status and income, categories not covered by some of the other surveys.

The CPS is based on a sample designed to be nationally representative of the civilian noninstitutional population of the United States. As a result, any estimates about that population are subject to sampling errors. To minimize the chances of citing differences that could be attributable to sampling errors, we highlight only those differences that are statistically significant at the 0.05 level.

In addition to sampling errors, another source of variability that affects the interpretation and quality of survey data is the coverage and response rates. The coverage ratio is a measure of the extent to which persons are represented in the sample according to demographic characteristics such as age or race. For the age groups reported in our study, these ratios ranged from 0.855 to 0.998. The response rate for the CPS is an overall measure of the extent to which houses and persons selected for the sample are actually represented in the sample of respondents. For the March 1997 CPS, the response rate was about 90 percent. This response rate is reasonable and somewhat higher than for most of the other surveys.

A major difference between the CPS March supplement and surveys such as SIPP and HRS is that the latter are designed to follow a group of respondents (often referred to as a "panel" of individuals) over a period of time—2-1/2 to 4 years for the SIPP and 10 to 12 years for HRS—while the CPS is primarily designed to be cross-sectional, largely focusing on the 12 months preceding the interview.[107] As a result, we did not use the CPS to directly measure how the health, income, and insurance status of individuals or groups change over time. To better understand the estimates we reported in chapter 2, it is important to be aware of how some of the CPS questions are worded and the responses categorized. The following explains four categories of questions.

Insurance Status. The CPS questions that we used to determine insurance status ask whether respondents were covered through various sources of insurance (for example, employer-based, individual, and Medicare). However, they do not ask for the length of coverage or whether the

[107]By design, about 50 percent of the sample for the CPS March supplement is selected for interview the following year. As a result, between-year comparisons are possible for a subset of the CPS respondents.

individual was covered through these sources at the time of the interview. Thus, the results of these questions overestimate the size of the insured population because respondents are considered insured for the entire year if they were insured at all during the preceding 12-month period—regardless of their insurance status at the time of the interview or the length of time they were insured. Conversely, the wording of these questions produces an underestimate of the uninsured population because, regardless of their insurance status at the time of the interview, a respondent must have been uninsured for the entire year to be categorized as uninsured.

Some people may receive coverage from several sources. To avoid double counting, we prioritized the source of coverage reported by the CPS. For our analysis, employment-based coverage was considered primary to other sources of coverage, and respondents were classified as having employment-based coverage even if they also had other types of coverage. The other types of health insurance coverage were prioritized in the following order: Medicare, Medicaid, military/veterans, and individual insurance. Also, with respect to coverage through the individual insurance market, the CPS questionnaire does not distinguish between comprehensive and more limited policies that are available.

Employment Status. The CPS questions that we used for employment status are similar to those on insurance status. Specifically, respondents are considered employed if they worked at all in the year, and not employed only if they did not work at all during the past 12 months. As a result, these questions overestimate the employed population and underestimate the number who did not work.

Health Status. The CPS asks respondents to categorize their health as excellent, very good, good, fair, or poor. The question is worded in the present tense and implies an answer relating to the respondent's health at the time of the interview. In our analysis, however, we correlated health status with other characteristics such as employment and insurance status, which, as noted, had a different temporal context. In general, poor health equated to a weakened workforce attachment and to an increased likelihood of having public coverage or being uninsured. To the extent a respondent's health status at the time of the interview differed from that during the preceding 12 months, the relationship between the two variables is weakened. Consequently, when we report differences in employment or insurance status relative to health status, we are probably

underestimating the extent to which the latter has affected these other characteristics.

Income Status. The gross income data we report overstates the amount of disposable income available to nonelderly Americans because it does not take into account the taxes they must pay. On the other hand, income alone is an incomplete measure of wealth and the ability of individuals to afford individual market premiums or employer-imposed cost sharing. Although the inclusion of assets such as homes, investments, and savings would provide a more comprehensive measure of affordability, such data are not available through the CPS. Moreover, income comparisons between different age groups are complicated by differences in family size and financial obligations. For example, a married couple in their thirties with several children and a mortgage may earn more than a near-elderly couple whose children are grown and who own their home, but their financial obligations are clearly not comparable. And the younger couple may have fewer assets, other than current income, on which to draw.

Surveys on the Extent to Which Employers Offer Retiree Health Insurance

Information on the extent to which employers offer health coverage to retirees as well as the conditions under which coverage is made available is captured in private surveys conducted by benefit consultants. The Foster Higgins and KPMG Peat Marwick employer surveys are based on random samples with results that can be generalized to a larger population of employers. Neither survey reports information on the precision of its estimates. Other employer surveys we examined are based on a sample of clients, which statistically limits the results to that client base. In general, we report data from the Foster Higgins and KPMG Peat Marwick surveys. However, these two surveys did not always capture important changes in the conditions under which retiree health benefits are made available. Thus, we occasionally include information from client-based surveys but note that the latter must be used cautiously since they are not generalizable.

In addition to proprietary surveys, some information on employer-based retiree health benefits is also available from a biennial survey conducted by the Bureau of Labor Statistics (BLS) and from special supplements to the CPS. Although the BLS survey is based on a sample that can be generalized to a larger population, the sample focuses on establishments rather than unique firms. Thus, different branches or offices of the same firm could be included in the sample. Moreover, rather than reporting the number of establishments that offer retiree coverage, the results are

presented in terms of how many workers have access to retiree health benefits. In contrast to the firms and establishments surveyed by benefit consultants or BLS, the unit of analysis for the CPS supplements is individuals. These individuals were asked whether they continued employer-based coverage at retirement or later during retirement and to identify the reason they discontinued coverage. In 1994, "retiree coverage not offered by employer" was added to the list of reasons, but it was not used in the 1988 questionnaire. Table II.2 compares selected characteristics across three employer surveys. Characteristics of the August and September CPS supplements are included in table II.1.

Table II.2: Characteristics of Employer Surveys Used in Our Analysis

	Survey		
Characteristic	**Foster Higgins**	**KPMG Peat Marwick**	**Bureau of Labor Statistics**
Date established	1986, although results before 1993 are not comparable to later surveys, which were based on random samples.	1991.	1980.
Frequency	Annual.	Data on trends in retiree health coverage were reported for 1991-93, 1995, and 1997.	Annually, with small establishments surveyed in 1 year and medium and large establishments surveyed in the next year.
Latest data available	1997.	1997.	1995.
Sample design	Stratified random sample of public and private employers with 10 or more workers.	Stratified random sample of public and private employers with 200 or more workers.	Two-stage probability sample of establishments and occupations. Establishments with 100 employees or more are selected for the survey of medium and large private establishements. Establishments with fewer than 100 employees and state and local governments are selected for the survey of small establishments.
Sample size	3,676 in 1993; 3,156 in 1997.	About 1,800 in 1993; 2,500 in 1997.	3,447 medium/large establishments in 1993 and 3,092 small establiments in 1994.
Response rate	78 percent in 1993; 50 percent in 1997.	55 percent in 1993; 60 percent in 1997.	About 67 percent in 1993; about 70 percent in 1994.

Surveys on Health Conditions, Health Care Expenditures, and Use

We obtained information on the prevalence of health conditions, and health care expenditures and use from surveys conducted by the National Center for Health Statistics (NCHS) and Agency for Health Care Policy and Research (AHCPR). Specifically, we used the

- 1994 National Health Interview Survey (NHIS) for the prevalence of health conditions,
- 1994 National Hospital Discharge Survey (NHDS) for the number of hospital discharges and days of care,
- 1996 National Hospital Ambulatory Medical Care Survey (NHAMCS) for the number of visits to emergency rooms and outpatient departments,
- 1996 National Ambulatory Medical Care Survey (NAMCS) for the number of physician office visits, and
- 1987 NMES for health care expenditures.

The NMES data we reported were "aged" by AHCPR to represent 1998 dollars. Table II.3 compares selected characteristics for the NHIS, NHDS, NHAMCS, and NAMCS. Information on the NMES was reported in table II.1.

Table II.3: Selected Characteristics of Surveys on Health Conditions, Expenditures, and Utilization

	Survey			
Characteristic	**NHIS**	**NHDS**	**NHAMCS**	**NAMCS**
Sample design	A national multistage probability design with continuous weekly samples so that each is representative of the target population and additive over time.	A national multistage probability design based on primary sampling units (PSU) used in the NHIS, hospitals within the PSUs, and a systematic random sample of inpatient records. Also, all hospitals with 1,000 beds or more or 40,000 discharges or more annually are included in the sample.	A national multistage probability design based on PSUs, hospitals within these PSUs, emergency rooms and clinics within outpatient departments, and patient visits.	A national multistage probability sample based on PSUs, physician practices in those PSUs, and patient visits.
Sample size	49,000 households with 127,000 people. Blacks are oversampled.	512 hospitals.	486 hospitals, of which 438 had an emergency room or outpatient department.	3,000 physicians, of which 2,142 were eligible.
Response rate	94%	93%, representing 277,000 discharge records from 478 respondents.	95%, representing 21,092 emergency room records and 29,806 outpatient department records.	70%, representing 29,805 patient record forms.

Demographic and Insurance Profiles of the Near Elderly and Those Aged 55 to 61 and 62 to 64

Table III.1: Key Demographic Characteristics of the Near Elderly, by Insurance Status

	Insurance status—numbers in millions (percent)			
Characteristic	Employer-based	Individual	Public	Uninsured
Income				
Less than $10,000	0.34 (2.4%)	0.23 (12.3%)	0.85 (38.5%)	0.72 (24.0%)
$10,000 - $19,999	1.20 (8.5%)	0.32 (17.5%)	0.67 (30.3%)	0.66 (22.3%)
$20,000 - $49,999	5.31 (37.8%)	0.76 (41.3%)	0.46 (21.0%)	0.97 (32.5%)
$50,000 - $74,999	3.32 (23.6%)	0.27 (14.6%)	0.17 (7.5%)	0.36 (12.2%)
$75,000 or more	3.87 (27.6%)	0.27 (14.4%)	0.06 (2.8%)	0.27 (9.0%)
Gender				
Male	7.06 (50.3%)	0.76 (41.3%)	0.95 (43.2%)	1.26 (42.5%)
Female	6.97 (49.7%)	1.08 (58.7%)	1.25 (56.8%)	1.71 (57.5%)
Widowed female	0.69 (4.9%)	0.18 (9.6%)	0.31 (14.3%)	0.26 (8.8%)
Divorced female	0.91 (6.5%)	0.17 (9.0%)	0.30 (13.6%)	0.30 (10.0%)
Race				
White	11.75 (83.7%)	1.61 (87.0%)	1.35 (61.2%)	1.84 (62.0%)
Black	1.17 (8.3%)	0.89 (4.8%)	0.43 (19.4%)	0.40 (13.6%)
Hispanic	0.69 (4.9%)	0.82 (4.4%)	0.31 (14.0%)	0.51 (17.3%)
Other	0.42 (3.0%)	0.68 (3.7%)	0.12 (5.3%)	0.21 (7.1%)
Employment				
Full-time	7.44 (53.0%)	0.68 (36.8%)	0.08 (3.6%)	0.83 (27.8%)
Part-time	3.08 (22.0%)	0.55 (29.8%)	0.21 (9.3%)	0.76 (25.7%)
Did not work	3.51 (25.0%)	0.62 (33.4%)	1.92 (87.1%)	1.38 (46.5%)
Health status				
Excellent	7.59 (54.1%)	0.91 (49.4%)	0.26 (11.6%)	1.08 (36.4%)
Good	4.36 (31.1%)	0.65 (35.2%)	0.43 (19.5%)	1.02 (34.4%)
Poor	2.08 (14.8%)	0.28 (15.4%)	1.52 (68.9%)	0.87 (29.2%)

Table III.2 displays the characteristics of three subgroups of the near elderly: (1) 55- to 61-year-olds, (2) 62- to 64-year-olds, and (3) 62- to 64-year-olds who elected Social Security benefits at a reduced annuity. The estimated numbers of individuals in these three subgroups are 15.7 million, 5.8 million, and 3.0 million, respectively. As mentioned in chapter 2, just over one-half of those eligible elected Social Security before age 65.

Table III.2: Selected Characteristics of 55- to 61-Year-Olds and 62- to 64-Year-Olds

Numbers in millions

Characteristic	Number with characteristic (percent)		
	55- to 61-year-olds	62- to 64-year-olds	62- to 64-year-olds with reduced Social Security annuity
Income			
Less than $10,000	1.51 (9.6%)	0.68 (11.8%)	0.33 (11.3%)
$10,000 - $19,999	1.95 (12.5%)	0.96 (16.5%)	0.64 (21.7%)
$20,000 - $49,999	5.41 (34.6%)	2.28 (39.2%)	1.32 (44.5%)
$50,000 - $74,999	3.18 (20.3%)	0.99 (17.1%)	0.43 (14.3%)
$75,000 or more	3.62 (23.1%)	0.89 (15.4%)	0.24 (8.2%)
Gender			
Male	7.53 (48.1%)	2.73 (47.1%)	1.31 (44.4%)
Female	8.14 (51.9%)	3.07 (52.9%)	1.65 (55.6%)
Widowed female	0.89 (5.7%)	0.59 (10.2%)	0.36 (12.1%)
Divorced female	1.32 (8.4%)	0.37 (6.4%)	0.18 (6.0%)
Race			
White	12.34 (78.7%)	4.57 (78.8%)	2.43 (82.0%)
Black	1.56 (9.9%)	0.56 (9.6%)	0.28 (9.5%)
Hispanic	1.2 (7.6%)	0.42 (7.2%)	0.18 (6.2%)
Other	0.57 (3.7%)	0.25 (4.3%)	0.07 (2.3%)
Employment			
Full-time	7.61 (48.6%)	1.53 (26.4%)	0.16 (5.3%)
Part-time	3.43 (21.9%)	1.29 (22.2%)	0.74 (24.9%)
Did not work	4.63 (29.6%)	2.98 (51.4%)	2.07 (69.8%)
Insurance			
Employer-based	10.57 (67.4%)	3.46 (59.6%)	1.54 (52.1%)
Individual	1.26 (8.0%)	0.59 (10.1%)	0.36 (12.0%)
Medicare	0.76 (4.9%)	0.50 (8.5%)	0.43 (14.7%)
Medicaid	0.72 (4.6%)	0.23 (4.0%)	0.11 (3.8%)
Military/veterans	0.29 (1.9%)	0.12 (2.1%)	0.07 (2.4%)
Uninsured	2.07 (13.2%)	0.90 (15.5%)	0.44 (15.0%)
Health status			
Excellent	7.65 (48.8%)	2.37 (40.8%)	1.05 (35.3%)
Good	4.65 (29.6%)	1.95 (33.5%)	0.98 (33.1%)
Poor	3.37 (21.5%)	1.49 (25.6%)	0.94 (31.6%)

Impact of Health Benefits on Early Retirement

Analysts have attempted to show that access to health benefits is an important factor influencing the retirement decision.[108] It is not difficult to imagine an individual in poor health continuing to work to maintain access to employer-based benefits that are not available to retirees. Similarly, it appears that the near elderly would be averse to leaving the workforce without health benefits. But does the availability of coverage actually encourage retirement earlier than it might otherwise occur? Despite the limitations of most studies, they all agree that there is a positive correlation between access to health benefits and the retirement decision. However, they disagree, often substantially, on the extent of the impact, suggesting a need for additional empirical research.

First, a 1993 study by Hurd and McGarry found that the availability of retiree health insurance at least partly funded by the employer reduced the probability that an individual would be working full time after age 62 by between 18 and 24 percent.[109] In addition, a 1994 study by Karoly and Rogowski found that the availability of postretirement health benefits would increase the probability of men retiring early by 50 percent.[110] However, their study may overestimate the effect because the availability of retiree health insurance was imputed, and the estimated retirement impact of health benefits may be highly correlated with retirement decisions for reasons other than health insurance, such as pension plan provisions. Third, using a life-cycle model of retirement that incorporates the value of retiree health benefits and also includes information on pension accruals, Gustman and Steinmeier found that employer-based coverage lowers male retirement age by about 1.3 months.[111] The authors acknowledged that their methodology may tend to underestimate the effect of health benefits on retirement. Furthermore, a 1994 study by Madrian reported that individuals with access to health insurance retired between 5 and 16 months earlier than those lacking coverage and that the probability of retiring before age 65 was between 7 and 15 percentage

[108]See Paul Fronstin, "Health Insurance Portability: COBRA Expansions and Job Mobility," Issue Brief (Washington, D.C.: Employee Benefit Research Institute, Feb. 1998), p. 15.

[109]Michael Hurd and Kathleen McGarry, "The Relationship Between Job Characteristics and Retirement," Working Paper No. 4558 (Cambridge, Mass.: National Bureau of Economic Research, 1993).

[110]Lynn Karoly and Jeannette Rugowski, The Effect of Access to Post-Retirement Health Insurance on the Decision to Retire Early, Rand Reprints: 94-13E (Santa Monica, Calif.: 1995).

[111]Alan L. Gustman and Thomas L. Steinmeier, "Employer-Provided Health Insurance and Retirement Behavior," Industrial and Labor Relations Review, 48(1) (Oct. 1994).

points higher for individuals with retiree health insurance.[112] Shortcomings of the study included (1) an inconclusive attempt to control for participation in a pension plan and (2) the fact that the results were based on the recollections of individuals who had been retired as long as 15 years and had to recall their pension and health insurance status at the time of retirement.

Finally, a 1993 study by Gruber and Madrian focused on the early retirement impact of state and federal COBRA coverage.[113] They found that continuation mandates have an effect on retirement among men aged 55 to 64. Specifically, 1 year of coverage raised the probability of being retired by 1.1 percentage point. However, they also reported that this additional year of coverage raises the probability of being insured by 6 percentage points, suggesting that many of these individuals would have retired in the absence of such coverage. Finally, contrary to basic intuition, the effects are not necessarily the strongest at older ages but decline with age.

[112]Brigitte C. Madrian, "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job Lock?" Quarterly Journal of Economics, Feb. 1994.

[113]Jonathan Gruber and Brigitte C. Madrian, "Health Insurance and Early Retirement: Evidence From the Availability of Continuation Coverage," Working Paper No. 4594 (Cambridge, Mass.: National Bureau of Economic Research, 1993).

Affordability of Health Insurance for the Near Elderly

Using data from the March 1997 CPS and 1995 and 1996 information on insurance premiums, we estimated the percentage of median income that a 55- to 64-year-old would have to commit to health insurance under a number of possible scenarios, including

- purchasing coverage through the individual market in a community-rated state (Vermont) as well as one that had no restrictions on the premiums that could be charged (Colorado) using 1996 rates for a commonly purchased health insurance product and
- cost sharing under employer-based coverage using 1995 Peat Marwick estimates of the lowest, highest, and average retiree contribution.

While no official affordability standard exists, research suggests that older Americans commit a much higher percentage of their income to health insurance than do younger age groups. Congressional Budget Office calculations based on data from the BLS Consumer Expenditure Survey indicate that between 1984 and 1994, spending by elderly Americans aged 65 and older on health care ranged from 10.2 percent to 12.9 percent of household income. In 1994, elderly Americans spent 11.2 percent of household income, about three times as much as younger age groups. These estimates include costs other than premiums or employer-imposed cost sharing—for example, copayments, deductibles, and expenditures for medical services not covered by insurance.

Table V.1 compares the cost of health insurance purchased in the individual market and employer-imposed cost sharing for early retirees with the median income of the near elderly in 1996.

Table V.1 Individual Market Premium and Early Retiree Share of Employer-Based Premium Compared With 1996 Median Income of the Near Elderly

Source and type of coverage	Annual cost of coverage for near elderly	Percentage of median income[a]
Individual market—Colorado		
Single person aged 55-64	$2,484 - $2,520	11.7 - 11.8
Married couple aged 55-64	$4,968 - $5,040	10.0 - 10.1
Individual market—Vermont[b]		
Single person	$2,100	9.9
Married couple	$4,200	8.4
Employer-imposed premium sharing		
Family—lowest cost	$972	2.0
Family—average cost	$2,340	4.7
Family—highest cost	$3,012	6.1

[a]In 1996, the median income for a near-elderly single person was $21,314. For married individuals, it was $49,774.

[b]One carrier's community-rated premium. With limited exceptions, all those who purchase individual insurance pay the same rate.

As demonstrated by table V.1, the near elderly's share of employer-subsidized coverage is generally lower than for coverage purchased through the individual market. For example, on average, employer-based family coverage for retirees at $2,340 annually represents 4.7 percent of median family income. In contrast, costs in the individual market can be significantly higher—in part, because they lack an employer subsidy. In Colorado, the annual premium for a commonly purchased individual insurance product in 1996 was about $2,500 for single coverage and $5,000 for a couple—representing about 12 percent and 10 percent, respectively, of median income for 55- to 64-year-olds.[114] While less expensive than the Colorado example, premiums for health insurance through the individual market in Vermont—a community-rated state—would represent 9.9 percent of median income for single coverage and 8.4 percent of median income for a couple.[115] For more than one-half of the near elderly, these individual market costs typically exceed average health care spending for Americans under age 65—in some cases significantly. In April 1998, the Center for Studying Health System Change reported that older adults who purchased individual coverage typically

[114]The Colorado carrier significantly increased rates between 1996 and 1998. The single and family premiums for 55- to 64-year-olds in 1998 were $3,024 to $3,624 and $6,048 to $7,248, respectively.

[115]Between 1996 and 1998, this carrier's premium only increased by $204 a year.

spent a considerably higher proportion of their income on premiums than other adult age groups—about 9 percent for the 60- to 64-year-old group.[116]

[116]Peter J. Cunningham, "Next Steps in Incremental Health Insurance Expansions: Who Is Most Deserving?" Issue Brief, No. 12 (Washington, D.C.: Center for Studying Health System Change, Apr. 1998), pp. 3-4.

Expansions of COBRA Coverage

Since 1986, COBRA eligibility has been expanded on a number of occasions:

- COBRA was made available to retirees whose former employer had declared bankruptcy (P.L. 99-509).
- Coverage was extended from 18 to 29 months for certain disabled COBRA enrollees (P.L. 101-239). A 1996 change clarified that the dependents of a disabled qualified beneficiary are also eligible for the additional 11 months of COBRA coverage and provided that the qualifying event of disability applies in the case of a qualified beneficiary whose disability is determined under the Social Security Act to exist during the first 60 days of COBRA coverage (P.L. 104-191).
- A 1990 change permitted states to use Medicaid funds to pay for COBRA premiums of certain low-wage beneficiaries (who had worked for an employer with 75 or more employees) whose income does not exceed 100 percent of the federal poverty level and whose resources are at or below the Supplemental Security Income level. The state must determine that the anticipated Medicaid savings from COBRA would exceed the COBRA premium costs (P.L. 101-508).
- COBRA continuation requirements were extended to the Federal Deposit Insurance Corporation (P.L. 102-242).
- Reservists and their dependents who would otherwise lose employer-based health benefits as a result of taking a leave of absence to serve in the armed forces were made eligible for 18 months of COBRA coverage (P.L. 103-353).
- The Health Insurance Portability and Accountability Act of 1997 (HIPAA) (P.L. 104-191) requires that any individual who exhausts COBRA continuation coverage is guaranteed the right to purchase insurance in the individual market without any preexisting exclusions or waiting periods.

State Initiatives to Increase Access to the Individual Insurance Market as of Year-End 1997

State	High-risk pool[a]	"Blues plan" acts as insurer of last resort	Guaranteed issue	Premium rate restrictions
Alabama	X[b]			
Alaska	X			
Arizona				
Arkansas	X			
California	X	X		
Colorado	X			
Connecticut	X			
Delaware				
District of Columbia		X		
Florida	X			
Georgia				
Hawaii				
Idaho			X	X
Illinois	X			
Indiana	X			
Iowa	X		X	X
Kansas	X			
Kentucky			X	X
Louisiana	X			X
Maine			X	X
Maryland		X		
Massachusetts		X	X	X
Michigan		X		
Minnesota	X			X
Mississippi	X			
Missouri	X			
Montana	X			
Nebraska	X			
Nevada				
New Hampshire			X	X
New Jersey			X	X
New Mexico	X			X
New York			X	X
North Carolina		X		
North Dakota	X			X
Ohio			X	X

(continued)

State	High-risk pool[a]	"Blues plan" acts as insurer of last resort	Guaranteed issue	Premium rate restrictions
Oklahoma	X			
Oregon	X			X
Pennsylvania		X		
Rhode Island		X		
South Carolina	X			X
South Dakota			X[c]	X
Tennessee[d]				
Texas	X			
Utah	X		X	X
Vermont			X	X
Virginia		X		
Washington	X		X	X
West Virginia				X
Wisconsin	X			
Wyoming	X			

[a]Communicating for Agriculture, Inc., Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, eleventh edition, 1997.

[b]Alabama's high-risk pool is available to HIPAA-eligible individuals only.

[c]People who had creditable coverage within the previous 63 days, including coverage through an employer-sponsored plan or Medicare, are guaranteed access to two health plans from each carrier operating in the individual market. Although broader in scope than HIPAA, this provision does not guarantee access to coverage to those who are not now insured or who have not had continuous coverage.

[d]Tennessee merged the participants of its high-risk pool into the TennCare Medicaid program as of June 30, 1995. Coverage for the "medically uninsurable" is available through this state program, as is coverage for the Medicaid population and the uninsured population (primarily lower-income workers where insurance is not provided).

State Restrictions Related to Individual Market Premiums

Idaho: Premium rates may not vary by more than 25 percent of the applicable index rate for age and gender only. The Director of Insurance may approve additional case characteristics.

Iowa: Premium rates may not vary by more than 100 percent from the applicable index rate for demographic characteristics approved by the Commissioner of Insurance. The legislation does not specify these characteristics, but an insurance department official said they may include age, gender, and geographic location.

Kentucky: Premium rates may not vary by more than a 5 to 1 ratio for all case characteristics. Allowable case characteristics (and maximum allowable variation, if specified) are age (300 percent), gender (50 percent), occupation or industry (15 percent), geography, family composition, benefit plan design, cost-containment provisions, whether or not the product is offered through an alliance, and discounts (up to 10 percent) for healthy lifestyles.

Louisiana: Adjusted community rating is required, with variation of +/-10 percent currently allowed for health status and unlimited variation allowed for specified demographic characteristics and other factors approved by the Department of Insurance.

Maine: Adjusted community rating is required, with variation allowed of no more than +/-20 percent of the community rate for age, tobacco use, occupation, industry, or geographic area.

Massachusetts: Adjusted community rating is required for carriers' guaranteed-issue health plans with maximum allowable variation ratio of 1.5 to 1 for geographic area and 2 to 1 for age. Effective December 1, 1999, the maximum allowable variation ratio for age will be 1.5 to 1.

Minnesota: Premium rates may vary from the index rate +/-25 percent for health status, claims experience, and occupation, and +/-50 percent for age. Premium rates may also vary by up to 20 percent for three geographic areas.

New Hampshire: Adjusted community rating is required with a maximum variation ratio of 3 to 1 allowed for age only.

New Jersey: Community rating is required.

New Mexico: Until July 1, 1998, premium rates may vary for age, gender (no more than 20 percent), geographic area of the place of employment, tobacco use, and family composition (by no more than 250 percent). Thereafter, every carrier must charge the same premium for the same coverage to each New Mexico resident, regardless of demographic characteristics or health status. The only allowable rating factor will be age—whether the person is over or under the age of 19.

New York: Pure community rating within specified geographic regions.

North Dakota: Premium rates charged to individuals within a class for the same or similar coverage may not vary by a ratio of more than 5 to 1 for differences in age, industry, geography, family composition, healthy lifestyles, and benefit variations.

Ohio: Premiums charged to individuals may not exceed 2.5 times the highest rate charged to any other individuals with similar case characteristics.

Oregon: Each carrier must file a geographic average rate for its individual health benefit plans. Premium rates may not vary from the individual geographic average rate, except for benefit design, family composition, and age. Legislation does not limit this variation, but indicates that age adjustments must be applied uniformly.

South Carolina: Premium rates charged to individuals with similar demographic characteristics may not vary by more than 30 percent. The legislation specifically states that age, gender, area, industry, tobacco use, and occupational or avocational factors may be used to set premium rates, but does not prohibit the use of additional characteristics. The only exception is durational rating, which is explicitly prohibited.

South Dakota: Carriers may establish up to three classes of individual business. Within a given rating period, the index rate for any class of business may not exceed the index rate for any other class of individual business by more than 20 percent. Within a class of business, the premium rates charged to individuals with similar case characteristics for the same or similar coverage may not vary from the index rate by more than 30 percent. A carrier may not use characteristics other than age, gender, lifestyle, family composition, geographic area, health status, height, and weight without the prior approval of the Director of Insurance. The maximum rating differential based solely on age may not exceed a ratio of

5 to 1. Adjustments based on these characteristics may result in premium rates that vary more than the set parameters noted.

Utah: A variation of +/-25 percent is allowed for health status or duration of coverage. Carriers may also vary premiums because of differences in age, gender, family composition, and geographic area by actuarially reasonable rates, as defined in National Association of Insurance Carriers guidelines. Premiums may also be rated-up 15 percent for industry. The index rates carriers use for their individual business may be lower than or equal to, but not any higher than, the index rates they use for their small-employer business.

Vermont: Adjusted community rating of indemnity plans is required, with maximum allowable variation of +/-20 percent for limited demographic characteristics. HMOs operating in the state must use pure community rating and thus are not allowed to vary rates.

Washington: Adjusted community rating is required, with variation allowed for geographic area, family size, age, and wellness activities. Permitted rates for any age group cannot exceed 400 percent of the lowest rate for all age groups on January 1, 1997, and 375 percent on January 1, 2000, and thereafter. The discount for wellness activities cannot exceed 20 percent.

West Virginia: Premium rates charged to individuals with similar demographic characteristics may not vary by more than 30 percent. The legislation specifically states that age, gender, geographic area, industry, tobacco use, and occupational or avocational factors may be used to set premium rates,but does not prohibit the use of additional characteristics. The only exception is durational rating, which is explicitly prohibited.

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