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PRIVATE HEALTH INSURANCE

Employer Coverage Trends Signal Possible Decline in Access for 55- to 64-Year-Olds

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Private Health Insurance: Employer Coverage Trends Signal Possible Decline in Access for 55- to 64-Year-Olds

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you explore access to health insurance by near-elderly Americans aged 55 to 64. Increasingly, public attention has focused on the health insurance status of the near elderly. A series of age-related transitions heightens the importance of health insurance to 55- to 64-year-olds and could place them at greater risk of losing coverage or paying considerably more than younger age groups. 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, disengagement from the labor force may necessitate looking for another source of coverage. The alternatives to employer-based coverage for the near elderly are (1) individually purchased insurance, (2) temporary continuation coverage through an employer, (3) public programs such as Medicare and Medicaid, and (4) becoming uninsured. Among those aged 55 to 64, Medicare and Medicaid are available only to disabled or some very poor persons.

My comments today are based on our report, prepared at your request, that examined the evidence on the near elderly's

- health, employment, income, and health insurance status;
- ability to obtain employer-based health insurance if they retire before they are eligible for Medicare; and
- access to individually purchased coverage or employer-based continuation insurance and the associated costs.[1]

In preparing that report, we analyzed the March 1997 Current Population Survey (CPS); 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 our previous reports.

In summary, the overall insurance picture of the near elderly is no worse than that of other segments of the under-65 population and is better than that of some younger age groups. The current insurance status of the near elderly is largely due to (1) the fact that many current retirees still have

[1]Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds (GAO/HEHS-98-133, June 1, 1998).

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 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.

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 continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the individual market. From a retiree perspective, COBRA, which allows a former worker to continue employer-based health coverage, has certain limitations. It is only available to retirees whose employers offer health benefits to active workers, and coverage is temporary, ranging from 18 to 36 months. 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. 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 is relatively low.

With respect to individual insurance, the cost may put it out of reach for some 55- to 64-year-olds—an age group whose health and income is in decline. The near elderly who are in poor health may pay even higher premiums than healthy 55- to 64-year-olds, be offered less comprehensive coverage, or be denied coverage altogether. Some states have taken steps to make individual insurance products more accessible by either limiting the variation among premiums that insurers may offer to individuals or guaranteeing individuals the right to purchase coverage. Without such guarantees, we found that conditions such as chronic back pain and glaucoma are commonly excluded from coverage or result in higher premiums. 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. Since the new federal protections under HIPAA hinge on exhausting COBRA, the incentives for enrolling and the length of time enrolled could change. 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.

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

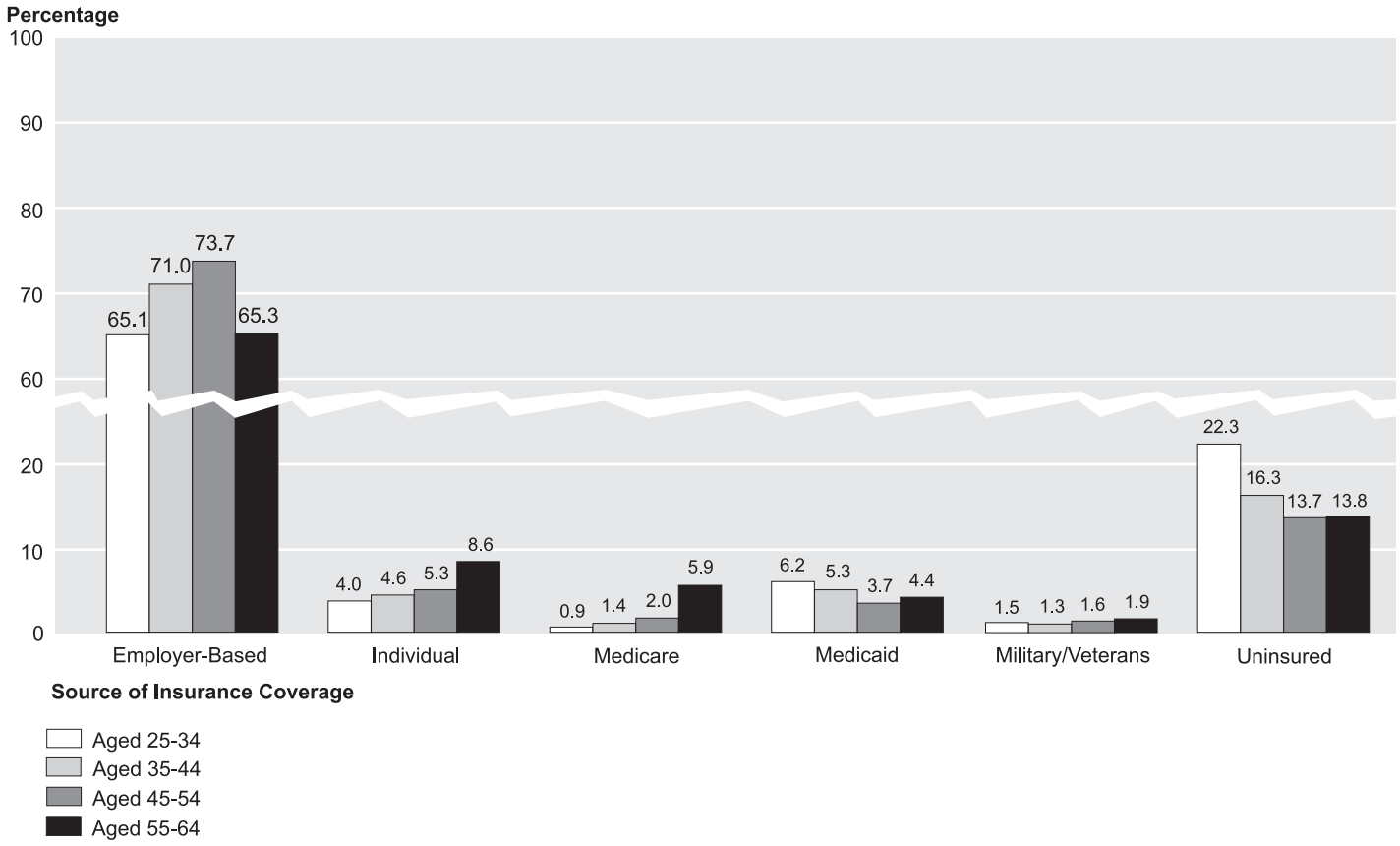
About 14 percent of the near elderly are uninsured—a rate comparable to that of 45- to 54-year-olds and lower than that among the entire nonelderly population. Differences in labor force attachment, health status, and family income, however, distinguish the near elderly from younger Americans and foreshadow 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 (see app. I). 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. 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. 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; in fact, their uninsured rate is lower than for the entire under-65 population (see fig. 1). A key difference between the near elderly and younger age groups, however, 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. It is not surprising that the near elderly are among the most likely age groups to have insurance and the least likely to be uninsured. Because aging is associated with greater use of health care services, the importance attached to having health insurance should increase with age. In fact, the extent to which the near-elderly purchase individual insurance suggests that this is the case.

Figure 1: Percentage of Insured and Uninsured Individuals, by Source of Insurance and Age Group, 1996



Note: The March 1997 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 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 health maintenance organization, 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.

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 with those who purchased individual insurance, twice as many with public coverage had incomes under $20,000. The relationship between insurance status and income is not entirely predictable, however, since about 20 percent of the uninsured near elderly had family incomes of $50,000 or more, while almost one-third of those with individual insurance earned less than $20,000. Despite their limited resources, about the same share of the near elderly with low incomes purchased individual insurance as did those with higher incomes. Given the cost of comprehensive coverage in the individual market, those with lower incomes may be purchasing less expensive, limited-benefit products. At the same time, however, income alone may not be the only resource available to individuals.

Table 1 profiles 55- to 64-year-olds by source of insurance. 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 public sources of coverage 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, or had 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 private 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, as the uninsured were more likely to work, be married, have better health, and have higher incomes than those with public insurance.

Table 1: Demographic Profile of Vulnerable Near-Elderly Americans, by Insurance Status, 1996

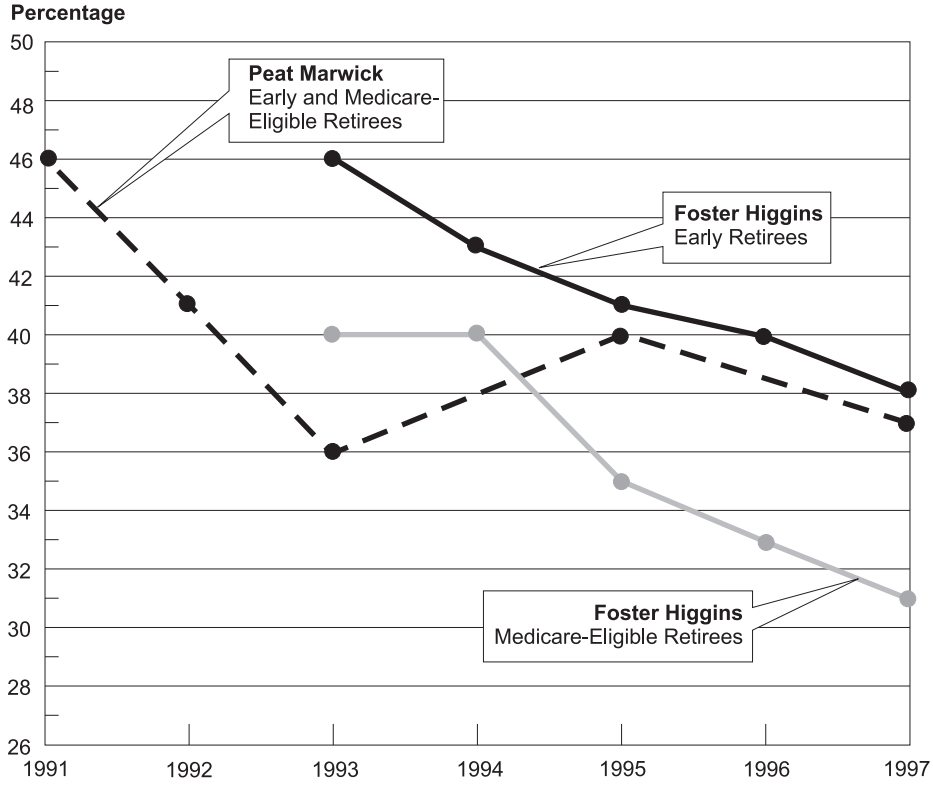
	Percentage with each characteristic			
Characteristic	Employer-based	Individual	Public	Uninsured
Family income under $20,000[a]	10.9	29.8	68.8	46.3
Female	49.7	58.7	56.8	57.5
Minority	16.3	13.0	38.8	38.0
Not working	25.0	33.4	87.1	46.5
Poor health	14.8	15.4	68.9	29.2
Unmarried	21.3	34.2	60.8	38.0

[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.

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. Surveys from two benefit consulting firms show that the number of employers offering coverage to early retirees dropped by 8 to 9 percentage points between 1991 and 1997 (see fig. 2). 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 Department of Labor suggests that very few of those who were retired in 1994—only about 2 percent—had lost coverage as a result of an employer's subsequent decision to terminate retiree coverage.

Figure 2: 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 decline in the number of large firms that offer retiree health benefits has been accompanied by cost-control efforts stimulated by dramatic premium increases during the 1980s and early 1990s. Commonly cited changes involve cost sharing 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. (App. II compares the affordability of employer-based early retiree health insurance with that purchased in the individual market.) 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 we 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 employer contribution. Furthermore, 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 health benefits from a former employer.

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 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 eligible for Medicare. 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. In 1997, the annual per-employee cost of health insurance for employer-based coverage was about $3,800. However, there is significant variation in premiums as a result of differences in firm size, benefit structure, locale, demographics, or aggressiveness in negotiating rates. For early retirees in one company, annual premiums in 1996 for family coverage ranged, depending on the plan, from about $5,600 to almost $8,000. 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.

The limited information available on eligibility for and use of COBRA by Americans in general and the near elderly in particular leaves many important questions unanswered. On the one hand, the data suggest that relatively few near elderly use COBRA; on the other hand, compared with younger age groups, 55- to 64-year-olds are more likely to elect continuation coverage. One database suggests that, on average, 61- to 64-year-olds only keep continuation coverage for a year.

The fact that it makes sense for the near elderly who lack an alternate source of coverage and can afford the premium to elect COBRA raises concerns among employers about the impact on overall employer health insurance costs. Employers contend that COBRA's voluntary nature and high costs that result from 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, there is no systematically collected evidence on the extent to which such elections affect employer costs. 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.

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 enrollee'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, a carrier may also adjust premiums on the basis of its assessment of the applicant's health status. This latter process is called medical underwriting.

Since health 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 we spoke in February 1998 ranged from zero in states where guaranteed issue is required to about 23 percent, with 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, for example, may have all costs associated with treatment of those conditions excluded from coverage.

To increase access to the individual market, a number of states as well as the federal government have undertaken a wide range of initiatives. Obtaining coverage, however, may remain expensive, especially for those with health problems and high expected costs. For example, 20 states have enacted individual market insurance reforms that attempt to limit premium rate variation and the demographic 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. (App. III shows selected carriers' monthly premium variations attributable to age and specified health characteristics.) 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. In contrast, the average retiree contribution for employer-subsidized family coverage is about one-half of these percentages. While at least 27 states have high-risk insurance pools that act as a safety net to help ensure that individuals with health problems can obtain coverage, 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.[2] Individuals 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 to state initiatives, federal standards established by HIPAA guarantee some people leaving group coverage access to the individual market—a guarantee referred to as group-to-individual portability. Each state establishes a mechanism so that these "HIPAA eligibles" have access to coverage regardless of their health status, and insurance carriers 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 exhausting COBRA coverage. Since HIPAA changes the incentives for electing and exhausting COBRA coverage, past evidence may not be a guide to future use. However, depending on their state's mechanism, 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.

Conclusion

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. 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

[2]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.

baby-boom generation. Experts are divided about the impact on employer-based coverage of actions that increase costs for 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.

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 coverage. 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.

Mr. Chairman, this concludes my statement. I will be happy to answer your questions.

Comparison of the Health Status and Expenditures of 55- to 64-Year-Olds With the Experience of Younger Americans

Table I.1: Number of Health Conditions per Thousand 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 National Center for Health Statistics (NCHS) 1994 National Health Interview Survey.

Table I.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[b]				
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 I.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 the Agency for Health Care Policy and Research to represent 1998 dollars. Since the late 1980s, medical care has shifted away from hospital inpatient settings.

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 Bureau of Labor Statistics' 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 II.1 compares the cost of health insurance purchased in the individual market and employer-imposed cost sharing for early retirees with the median income for the near elderly in 1996.

Table II.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 II.1, the near elderly's share of employer-subsidized coverage is generally lower than that 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.[3] 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.[4] 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

[3]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.

[4]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.[5]

[5]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.

Selected Carriers' Monthly Premium Variations Attributable to Age and Specified Health Characteristics

	Gender, age	
Plan type/deductible	**Baseline healthy male, 25**	**Healthy male, 55**
Arizona		
Preferred provider organization/$250	$66	+$153
Colorado		
HMO	$105	+$147
Preferred provider organization/$500	$51	+$95
Illinois		
Preferred provider organization/$500	$87	+$212
New Jersey		
Fee-for-service/$1,000	$214-$602 (low end and high end)[c]	0
New York		
HMO	$160-$309 (rural/urban)[d]	0
North Dakota		
Fee-for-service/$250	$80	+$112
Vermont		
Fee-for-service/$1,000	$192	0

Gender, age		Preexisting condition or characteristic			
Healthy female, 60	**Healthy male, 64**	**Chronic back pain**	**Preexisting diabetes**	**Cancer within 3 years of application**	**High-risk pool, male, 60**
+$177	+$187	Exclude condition or deny coverage	Exclude condition or deny coverage	Deny coverage	Not available
+$197	+$197	Deny coverage	Deny coverage[a]	Deny coverage	+$445[b]
+$94	+$110	Not available	Exclude condition	Deny coverage	+$499[b]
+$206	+$286	Charge higher premium	Charge higher premium	Deny coverage	+$638
0	0	0	0	0	Not applicable
0	0	0	0	0	Not applicable
+$156	+$156	Deny coverage	Deny coverage	Deny coverage	+$316[e]
0	0	0	0	0	Not applicable

[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.

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