Health Insurance Coverage of People Aged 55 to 64: Implications for a Medicare Buy-In

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January 14, 2010

Congressional Research Service
7-5700
www.crs.gov
RL34596

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

Approximately 4.3 million adults between the ages of 55 and 64 were estimated to be without health insurance in 2008, according to the U.S. Census Bureau's Current Population Survey (CPS). This amounts to approximately one out of eight (12.5%) of these adults, often called the "near elderly."

The near elderly have the lowest uninsured rate among adults aged 19 to 64. This may be driven, at least in part, by where this group is in their life cycle. At this point in their lives, many of the near elderly may be in their peak earning years and be able to access employer-sponsored coverage. At the same time, however, many may be facing important and personally unprecedented health and work decisions, some of which could undermine their access to employer-sponsored coverage. These decisions may be affected by some new challenges this age group faces at this point in their lives: (1) a greater prevalence of chronic conditions; (2) a greater likelihood of certain acute conditions, such as a heart attack and stroke; and (3) more assets to protect from catastrophic health care costs. This report shows that the near elderly are significantly more likely than other nonaged adults to be in fair or poor health, and to have had a heart attack or stroke. More than two-thirds of the near elderly (68.0%) have one of six chronic conditions, a significantly higher percentage than even the next highest age group, 45- to 54-year-olds (51.2%). The near elderly are also more likely to have assets, compared with all other nonaged adult age groups.

Average per capita health care spending among the near elderly in 2004 ($7,787) was 50% more than among 45- to 54-year-olds ($5,210) and more than double that of 19- to 44-year-olds ($3,370). These spending levels carry over into their health insurance costs. In the nongroup market in 2009, the near elderly faced deductibles averaging $3,022 and annual premiums averaging $5,349. This average premium level exceeded those faced by 45- to 54-year-olds by more than $1,500, and was nearly triple the premiums for 25- to 34-year-olds. The near elderly were more likely than their younger adult counterparts to spend more than 10% of their after-tax income on health care and health insurance premiums. In fact, for those with private nongroup coverage, 69% of the near elderly were in families that spent more than 10% of their after-tax income on health care and health insurance premiums.

Compared with uninsured 25- to 54-year-olds, the 4.3 million near elderly uninsured are more likely to be female or native-born. This is true even after accounting for underlying population differences between the near elderly and 25- to 54-year-olds. The near elderly uninsured are also more likely to have a household income below $25,000 and to be in poor or fair health.

Uninsurance can have more severe consequences for the near elderly, considering their increased needs for health care and asset protection. Yet, even the near elderly who have health insurance face much greater financial burdens from these costs than younger adults.

Extending Medicare eligibility has been one legislative proposal to protect this population from being uninsured or subject to the high costs of the individual insurance market. To keep costs down for the government, it has been proposed that the expansion involve buying into Medicare by paying premiums that cover the actuarial cost of the program. Depending on the specifics of the program, a Medicare Buy-In could raise several potential issues, including adverse selection, high costs to the beneficiary or to the government, additional financial pressures on health care providers and health insurance companies, and incentives for retiring early.

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Approximately 4.3 million adults between the ages of 55 and 64 were estimated to be without health insurance in 2008, according to the U.S. Census Bureau's Current Population Survey (CPS). This amounts to approximately one out of eight (12.5%) of these "near elderly" adults. Excluding the elderly, nearly all of whom are enrolled in Medicare, the near elderly have the lowest percentage of uninsurance of any adult age group. Yet, uninsurance can have more severe consequences for the near elderly, considering their increased needs for health care and asset protection. Some have suggested that the best method to protect this potentially vulnerable population is to allow them to buy into Medicare eligibility.[1] To explore these and other issues, this report describes the health insurance, health, and health care spending of the near elderly, particularly as compared with other nonelderly (under age 65) adults. The report also briefly describes Medicare expansion proposals for the near elderly. Unless specified otherwise, all comparisons in this report are among nonelderly adults aged 25 to 64.[2]

Sources of Health Insurance of the Near Elderly

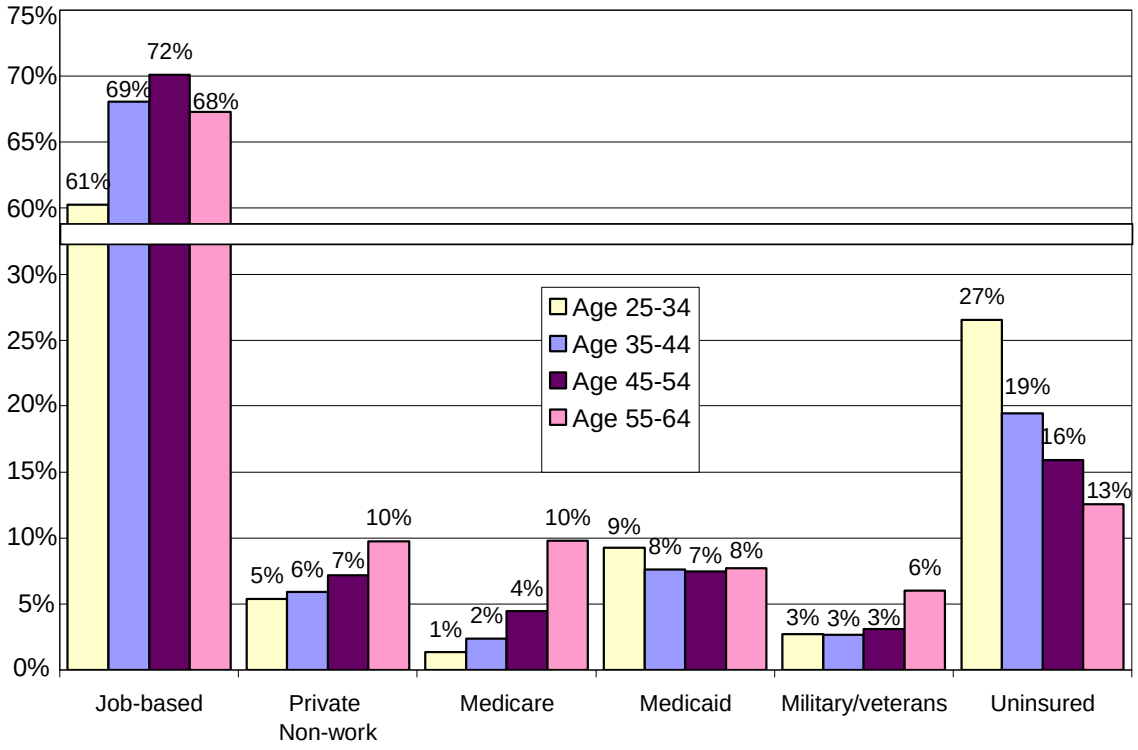
Approximately two-thirds of the near elderly (68%) have job-based coverage, a similar rate as the entire adult population between 25 and 64 years of age. However, the near elderly are much more likely to have non-work-related private coverage (10%), as shown in **Figure 1**. For those under age 65, Medicare eligibility is mostly restricted to the disabled who have received cash disability payments for at least two years.[3] The rate of Medicare enrollment among the near elderly (10%) is more than double the next highest age group (4% among 45- to 54-year-olds). The near elderly also have much higher rates of military/veterans coverage. However, the percentage of near elderly covered through Medicaid, the Children's Health Insurance Program (CHIP), or other means-tested public health insurance programs is the same as the nonelderly adult population overall.

[1] For example see "Rockefeller fights for Medicare Early Access Act," December 8, 2009. Available at http://rockefeller.senate.gov/press/record.cfm?id=320555 and "Rep. Weiner: Medicare at 65, Why Not 55, 45, 35?," December 7, 2009. Available at http://weiner.house.gov/news_display.aspx?id=1379.

[2] Twenty-five years of age was generally used as the minimum for adults in this analysis, primarily because adults aged 19 to 24 are so dissimilar to other adults, especially the near elderly, with respect to their health, health insurance, and health care spending that their inclusion would not be useful.

[3] Those with end-stage renal disease (ESRD) are also eligible for Medicare. Coverage for these individuals generally begins in the fourth month of dialysis treatments or the month of a kidney transplant. Persons under age 65 who receive cash disability benefits from Social Security or the Railroad Retirement systems for at least 24 months are also entitled to Medicare. (Because there is a five-month waiting period for cash payments, the Medicare waiting period is effectively 29 months.) The 24-month waiting period is waived for persons with amyotrophic lateral sclerosis (ALS, "Lou Gehrig's disease"). For more information, see CRS Report R40425, *Medicare Primer*.

Figure 1. Sources of Health Insurance, by Age, Among 25- to 64-Year-Olds, 2008



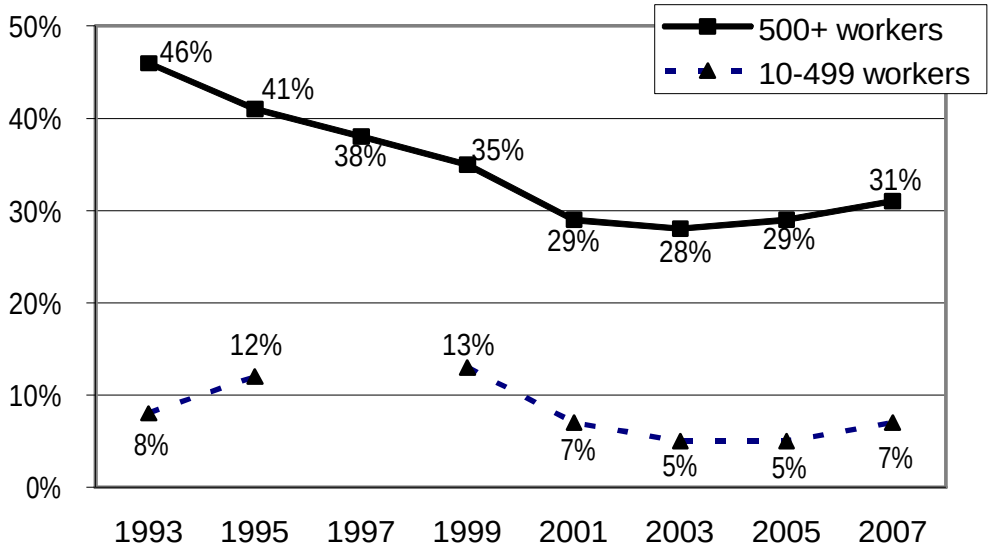
Source: CRS analysis of data from the March 2009 Current Population Survey (CPS).

Notes: Job-based coverage includes coverage from a spouse. Near elderly men have significantly higher rates of job-based and military/veterans coverage than near elderly women, while near elderly women have significantly higher rates of private non-work and Medicaid coverage. Combined, there is no statistically significant difference between the uninsurance rates of near elderly men and women. The percentages by age sum to more than 100% because people may have more than one source of coverage during the year.

Figure 2 shows the percentage of large firms (500 or more employees) offering health insurance that also offer retiree coverage to individuals before they become eligible for Medicare (that is, before they turn 65). In 1993, the percentage was 46%, dropping to 28% in 2003, but rising to 31% in 2007. The increase between 2005 and 2007 was a "[s]urprise uptick" driven by firms with 500 to 999 employees. In the other large firm-size groups (1,000+ employees), offer rates for pre-65 retiree coverage were unchanged between 2005 and 2007, or were significantly lower. According to Beth Umland of Mercer, "Employers in this [500-999] group may have decided to add retiree coverage in order to better compete for labor with larger employers, where retiree coverage is more common. They would have made the decision to add coverage for 2007 back in 2006 or 2005, when the economy was in better shape." Recent similar trends are also shown for small employers (10-499 workers), although with much lower pre-65 retiree-health offer rates.[4]

[4] Blaine Bos and Beth Umland, "Mercer's National Survey of Employer-Sponsored Health Plans 2007," p. 44. Also, personal correspondence with Beth Umland, July 2008.

Figure 2. Percentage of Firms That Offer Health Insurance to Retirees Under Age 65 (pre-Medicare), by Firm Size



Source: Blaine Bos and Beth Umland, "Mercer's National Survey of Employer-Sponsored Health Plans 2007," p. 44. Also, personal correspondence with Beth Umland, July 2008.

Note: 1997 data not available for smaller firms.

Changes over time in coverage of the near elderly

Despite declining rates over the past decade of employers offering pre-65 retiree coverage or health insurance generally, the near elderly were able to maintain similar levels of private and public coverage between 1996 and 2007, according to estimates from the Medical Expenditure Panel Survey (MEPS).[5] There were significant declines between 1996 and 2007 in the percentage covered by private coverage for 25- to 34-year-olds, 35- to 45-year-olds, and 45- to 54-year-olds; however, private coverage rates were not significantly different for the near elderly in 2007 than in 1996. In addition, there were significant increases between 1996 and 2007 in the uninsured percentage among 25- to 34-year-olds, 35- to 45-year-olds, and 45- to 54-year-olds; however, the uninsured rate for the near elderly was not significantly different in 2007 from what it was in 1996.

Declining pre-65 retiree offers may have been offset for the near elderly by other factors. For example, the near elderly may now be more likely to seek employment in firms with pre-65 retiree coverage and/or to accept that coverage when offered. The near elderly are also more likely to work than they were a decade ago,[6] perhaps focused in firms that offer coverage.

Even going back 20 years, job-based coverage among the *working* near elderly has not changed significantly. In 1987, 78% of near elderly workers had job-based coverage, which was the same

[5] For changes over time, MEPS was used rather than the CPS, because the latter has undergone changes over the past several years that tend to make the results not comparable. MEPS first provided data for 1996.

[6] Table 2, CRS Report RL30629, *Older Workers: Employment and Retirement Trends*, by Patrick Purcell.

percentage in 2006 and even higher (80%) in 2007. The statistically significant changes in health insurance among near elderly workers between 1987 and 2007 appear to be the decline in private non-work coverage (from 11% in 1987 to 5% in 2007) and the increase in the uninsured (from 9% in 1987 to 13% in 2007). But most of those changes occurred in the 1987-1996 period rather than the 1996-2007 period.[7]

Characteristics of the Uninsured Near Elderly

Table 1 shows the characteristics of the 4.3 million uninsured near elderly, comparing those characteristics to the *insured* near elderly, as well as to 25- to 54-year-olds, both insured and uninsured.

Characteristics of the uninsured near elderly, compared with uninsured aged 25 to 54

As a group, compared with uninsured 25- to 54-year-olds, the uninsured near elderly are more likely to be female, white, native-born, or to be in fair or poor health. The near elderly uninsured are less likely than their younger uninsured counterparts to be working or to have worked full time all year. The near elderly uninsured are also more likely to have annual *household* income[8] below $25,000, compared with the uninsured between 25 and 54 years of age.

Characteristics of the uninsured near elderly, compared with *insured* near elderly

Compared with the near elderly who are insured, the uninsured near elderly are *less* likely to be white or native-born. The near elderly uninsured are also less likely to be working or to have worked full time all year, compared with their insured peers. The near elderly uninsured are also more likely than their insured peers to be in fair or poor health. They are also more likely to have annual income below $25,000, compared with the insured near elderly. Approximately 54% of the uninsured near elderly have annual *family* income below $25,000, compared with 19% of their insured peers.[9]

[7] CRS analysis of the 2007 MEPS and of estimates presented in Alan C. Monheit et al., "Moving To Medicare: Trends In The Health Insurance Status Of Near-ElderlyWorkers, 1987—1996," *Health Affairs*, vol. 20, no. 2, pp. 204-213 http://content.healthaffairs.org/cgi/reprint/20/2/204.pdf.

[8] Household income refers to the income of everyone in the household, regardless of whether or not they are related.

[9] "Family income" is based on only the income of the near elderly, their spouse, and dependent children in the home. This definition is more precisely referred to as the income of "health insurance units" (HIU). This term distinguishes it from how the CPS defines "family," which treats everyone in the household who is related as a single family. Under the HIU definition, more than 90% of the uninsured near elderly are adults living without dependent children. The HIU definition of family income is often considered more useful for health-policy analyses, because it tends to mirror eligibility for family coverage in the private market as well as the definition of family income for some means-tested programs.

Effect of being uninsured and near elderly, beyond the underlying population differences between the near elderly and 25- to 54-year-olds [10]

As previously discussed, **Table 1** shows comparisons of the uninsured near elderly and uninsured 25- to 54-year-olds. Although it may not be surprising to find these two uninsured groups differ significantly in many of their characteristics, how much of these differences are simply attributable to the fact that the near elderly differ from younger adults generally? In other words, are there certain characteristics that the uninsured near elderly have, beyond what one might expect *after* taking into account the underlying population differences between the near elderly and 25- to 54-year-old populations? The answer is sometimes yes, sometimes no.

Instances where the uninsured near elderly are significantly different from uninsured 25- to 54-year-olds, even after accounting for differences in the underlying populations, are that the uninsured near elderly are still more likely to be female and native-born citizens. After accounting for differences in the underlying populations, the uninsured near elderly are still less likely than their 25- to 54-year-old uninsured counterparts to be Hispanic.

However, certain other general population differences between the near elderly and younger adults wash away differences between their uninsured populations. For example, the initial comparison showed that the near elderly uninsured were more likely to be white or to not work, compared with their younger uninsured counterparts. But after adjusting for the underlying population differences between the two age groups, the proportion of near elderly uninsured who were white or did not work was not significantly different than uninsured 25- to 54-year-olds. In other words, the reason the uninsured near elderly were more likely to be white or not work, compared with younger uninsured adults, was related to the characteristics of their respective age groups rather than their insurance status.

Interestingly, adjusting for the underlying population differences actually reverses some of the comparative results. For example, **Table 1** shows the uninsured near elderly were significantly less likely than uninsured 25- to 54-year-olds to have worked full time for the entire year—43.4% compared with 53.7%, respectively. However, 25- to 54-year-olds work full time all year in much larger proportion overall, compared with the near elderly. Adjusting for these population differences reveals that the uninsured near elderly actually have a greater likelihood of working full time all year, compared with uninsured 25- to 54-year-olds.

[10] This portion of the report is based on a method referred to as difference-in-differences. For the sake of simplicity, these results and the corresponding significance testing are not displayed in the tables.

Table 1. Characteristics of the Insured and Uninsured, by Age, Among 25- to 64-Year-Olds, 2008

	Age 25-54		Age 55-64	
	Insured	**Uninsured**	**Insured**	**Uninsured**
Sex				
Male	48.2%	55.6% *	48.0%	**49.2%**
Female	51.8%	44.4% *	52.0%	**50.8%**
	100.0%	100.0%	100.0%	**100.0%**
Race/Ethnicity				
White	69.8% *	45.4% *	78.2% *	**59.0%**
Black	11.4%	14.9% *	9.8% *	**11.9%**
Hispanic	11.8% *	32.5% *	7.0% *	**20.3%**
Other	7.0% *	7.2% *	5.0% *	**8.9%**
	100.0%	100.0%	100.0%	**100.0%**
Citizenship status				
Native-born	86.0% *	67.3% *	89.7% *	**74.4%**
Naturalized	6.6% *	7.3% *	7.0% *	**11.9%**
Non-citizen	7.4% *	25.4% *	3.4% *	**13.8%**
	100.0%	100.0%	100.0%	**100.0%**
Firm size				
Did not work	8.3% *	16.4% *	24.2% *	**30.6%**
Less than 10 employees	10.7% *	31.1%	12.4% *	**32.0%**
10 - 99 employees	18.2%	24.4% *	14.4% *	**16.7%**
100+ employees	62.7% *	28.2% *	49.0% *	**20.7%**
	100.0%	100.0%	100.0%	**100.0%**
Employment status				
Did not work	8.3% *	16.4% *	24.2% *	**30.6%**
Worked full-time, full-year	76.7% *	53.7% *	58.8% *	**43.4%**
Worked, not full-time, full year	15.0% *	30.0% *	17.0% *	**26.1%**
	100.0%	100.0%	100.0%	**100.0%**
Reported health status				
Excellent or very good	67.0% *	52.5% *	50.5% *	**36.2%**
Good	23.2% *	34.1% *	29.3% *	**38.0%**
Fair or poor	9.8% *	13.4% *	20.2% *	**25.9%**
	100.0%	100.0%	100.0%	**100.0%**
Household income				
Less than $25,000	10.0% *	29.3% *	14.2% *	**36.9%**
$25,000 to less than $50,000	18.5% *	33.2% *	20.1% *	**28.4%**

	Age 25-54		Age 55-64	
	Insured	Uninsured	Insured	Uninsured
$50,000 to less than $75,000	21.4% *	17.0% *	19.7% *	**15.0%**
$75,000 to less than $100,000	17.3% *	9.4% *	14.6% *	**7.7%**
$100,000 or more	32.8% *	11.1%	31.4% *	**12.1%**
	100.0%	100.0%	100.0%	**100.0%**
Family (HIU) income				
Less than $25,000	16.7% *	55.8%	19.2% *	**54.2%**
$25,000 to less than $50,000	22.2% *	28.3% *	21.8% *	**24.9%**
$50,000 to less than $75,000	20.4% *	9.0%	18.8% *	**10.1%**
$75,000 to less than $100,000	14.8% *	3.3%	13.6% *	**4.1%**
$100,000 or more	26.0% *	3.6% *	26.6% *	**6.8%**
	100.0%	100.0%	100.0%	**100.0%**

Source: CRS analysis of data from the March 2009 Current Population Survey (CPS).

Notes: Asterisk indicates statistically significant differences ($p<0.05$) with the near elderly. Household income includes everyone in a household, regardless of whether they are related. Family income, using "health insurance units" (HIU), includes only the income of the individual, spouse, and dependent children.

Health, Health Care Spending, and Health Insurance for the Near Elderly

Among the reasons people seek health insurance are the following: (1) to pay for and provide access to health care in the case of an unexpected health event, (2) to pay for and provide access to health care for expected and/or chronic health care needs, and (3) to protect one's financial assets from being drained by health care expenses. All three of these reasons are potentially more important for the near elderly than other nonelderly age groups because of the near elderly's greater use of health care, higher health care spending, and greater assets.

Table 2, which shows characteristics of individuals regardless of their health insurance status, demonstrates how self-reported health status worsens with age. The prevalence of most chronic conditions increases with age (except for asthma, as shown in **Table 2**). The near elderly are also significantly more likely to ever have had a stroke or heart attack, compared with younger individuals.[11]

As a result, the near elderly had average health care spending of $7,787 in 2004. This is 50% more than 45- to 54-year-olds' per-capita spending ($5,210) and more than double the spending for 19- to 44-year-olds ($3,370).[12]

[11] CRS analysis of the 2005 Medical Expenditure Panel Survey (MEPS). When 2005 MEPS data are used in this report, it is because the publicly available 2006 MEPS data do not yet include those particular variables.

[12] "Total Personal Health Care Spending, by Age Group," Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, available at http://www.cms.hhs.gov/NationalHealthExpendData/ (continued...)

Table 3 shows, as expected, the near elderly are more likely to have assets and, when they have them, to have more. This is true across all sources of health insurance. **Table 3** also shows that the near elderly who have private health insurance are significantly more likely to have assets than those with public coverage or without coverage. In fact, this is true for all the age groups. It is difficult to determine how much of the motivation to purchase private coverage was due to the desire to protect assets versus the desire to ensure that necessary care would be received and paid for.[13] In every age group, those with public coverage were least likely to have assets—even less than the uninsured. Most of the near elderly enrolled in Medicaid are subject to limitations on their countable assets. Those in Medicare are mostly disabled and will not have worked for at least two years, potentially depleting some of their assets before obtaining coverage.

The findings above, broken down by age, are consistent with the notion that the need and desire for health insurance increases with age, resulting in relatively greater coverage—although often at a much higher price, as discussed below.

Table 2. Health Status and Disease Incidence, by Age, 2007-2008

Health Status/ Disease Incidence	Age 25-34		Age 35-44		Age 45-54		Age 55-64
Self-reported health status							
Excellent/ very good	71.2%	*	65.8%	*	55.9%	*	**48.7%**
Good	22.3%	*	24.8%	*	28.9%	*	**30.4%**
Fair/Poor	6.5%	*	9.5%	*	15.3%	*	**20.9%**
Ever diagnosed with certain chronic condition(s)							
Any of the six below	*230.%*	*	*34.3%*	*	*51.2%*	*	***68.0%***
High blood pressure	7.9%	*	15.7%	*	29.7%	*	**46.7%**
High cholesterol	8.5%	*	18.0%	*	31.4%	*	**44.9%**
Diabetes	1.7%	*	3.7%	*	8.2%	*	**15.9%**
Asthma	9.8%		8.9%		8.7%		**9.0%**
Chronic heart conditions	0.3%	*	0.8%	*	3.4%	*	**6.9%**
Emphysema	0.1%	*	0.4%	*	1.3%	*	**3.0%**
Ever experienced certain acute conditions							
Heart attack	0.1%	*	0.4%	*	2.9%	*	**4.9%**
Stroke	0.3%	*	0.7%	*	2.1%	*	**4.0%**

Sources: CRS analysis of 2008 data from the March 2009 Current Population Survey (CPS) and the 2007 Medical Expenditure Panel Survey (MEPS).

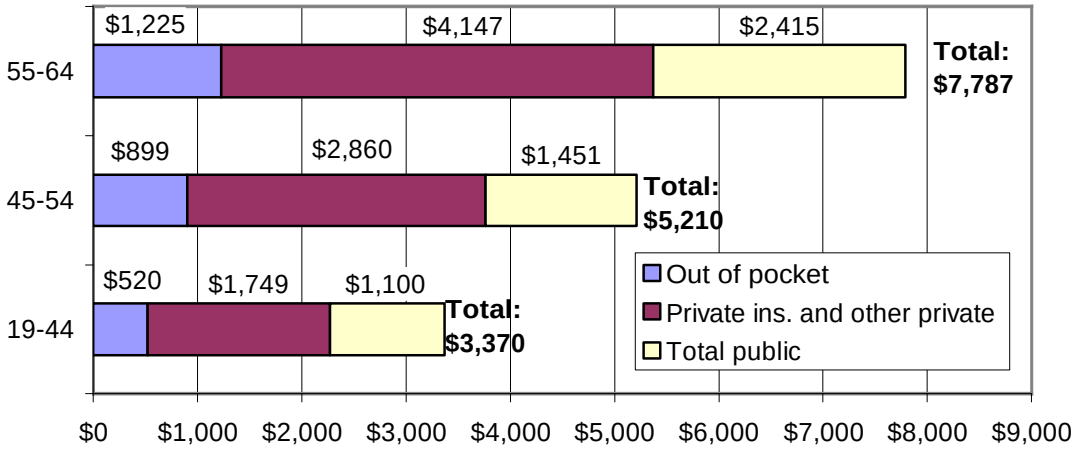
(...continued)

downloads/2004-age-tables.pdf. Health care spending does not include payments for premiums, which finance this spending.

[13] See discussion and 2002 results from MEPS in Didem Bernard et al., "Wealth, Assets, and the Affordability of Health Insurance," Agency for Healthcare Research and Quality (AHRQ) working paper, June 18, 2007.

Notes: An asterisk indicates estimates that are significantly different from those in the 55- to 64-year-old category ($p<0.05$). Conditions are included in MEPS as "priority conditions." "Chronic heart conditions" are coronary heart disease and angina.

Figure 3. Personal Health Care Spending Per Capita, by Age, 2004



Source: "Total Personal Health Care Spending, by Age Group," Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf.

Table 3. Percentage of Nonelderly Adults Who Live in a Household with Assets and, If So, Median Amount of Those Assets, by Insurance Status and Age, 2005

Insurance Status	Age 25-34		Age 35-44		Age 45-54		Age 55-64
Percentage with savings or investments							
All	*78%*	*	*81%*	*	*84%*	*	***85%***
Privately insured	88%	*	89%	*	90%		**91%**
Public coverage	49%		48%	*	51%		**54%**
Uninsured	60%	*	58%	*	62%	*	**70%**
Median savings and investments among those with such amounts							
All	*$4,000*		*$8,000*		*$13,000*		***$22,250***
Privately insured	$5,500		$11,000		$18,000		**$30,800**
Public coverage	$640		$400		$500		**$600**
Uninsured	$1,400		$1,280		$2,000		**$2,200**
Percentage with positive wealth							
All	*89%*	*	*93%*	*	*94%*	*	***96%***
Privately insured	93%	*	96%	*	97%	*	**98%**
Public coverage	75%	*	73%	*	75%		**80%**
Uninsured	84%	*	86%	*	87%	*	**92%**

Insurance Status	Age 25-34	Age 35-44	Age 45-54	Age 55-64
Median wealth among those with positive wealth				
All	*$50,830*	*$117,630*	*$180,700*	***$222,200***
Privately insured	$69,280	$149,920	$220,900	**$267,000**
Public coverage	$6,400	$12,180	$18,190	**$20,990**
Uninsured	$18,910	$38,220	$53,490	**$81,470**

Source: CRS analysis of Survey of Income and Program Participation (SIPP), with core data (sources of health insurance, age) from September 2005 and assets data from Topical Module for wave 6.

Notes: "Savings and investments" consists of interest-earning assets held in banking and other institutions, equity in stocks and mutual fund shares, equity in other assets, and equity in IRA and Keogh accounts. "Wealth" includes these amounts as well as home equity, net equity in vehicles, business equity, and equity in real estate other than one's own home. An asterisk indicates estimates that are significantly different from those in the 55- to 64-year-old category ($p<0.05$). Significance testing was not performed on the median amounts.

Figure 4 shows average premiums and deductibles in the nongroup market in 2009.[14] The average deductible faced by the near elderly ($3,022) was 36% more than the other age groups' lowest average deductible, $2,223 among 25- to 34-year-olds. But this difference paled in comparison to the premium differences, where the near elderly ($5,349) paid nearly triple the average premium of 25- to 34-year-olds ($1,860).[15] The average annual premiums for the near elderly in private nongroup coverage was $1,563 more than those for 45- to 54-year-olds, although the deductible levels were similar (**Figure 4**). This is among those who actually obtain nongroup coverage. **Figure 5** shows that the near elderly are most likely to be denied nongroup coverage based on medical underwriting.

[14] Based on a survey of health insurers providing nongroup coverage by America's Health Insurance Plans (AHIP).

[15] In other words, the premium ratio between the near elderly and 25- to 34-year-olds was 2.88:1. If the deductible levels were the same, the ratio would be higher—perhaps 3:1. Once the private market reforms are fully implemented, H.R. 3962 would permit nongroup premiums to vary for age by no more than 2:1, while S.Amdt. 2786 to H.R. 3590 would permit premium variation by age of up to 3:1.

Figure 4. Nongroup Premiums and Deductibles, by Age, 2009

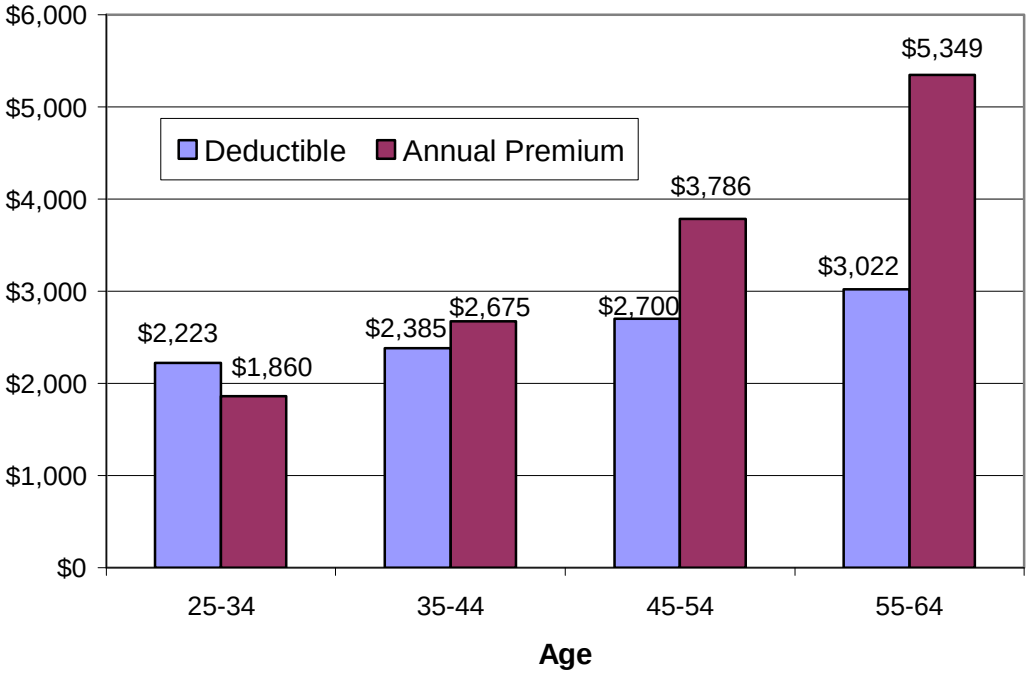
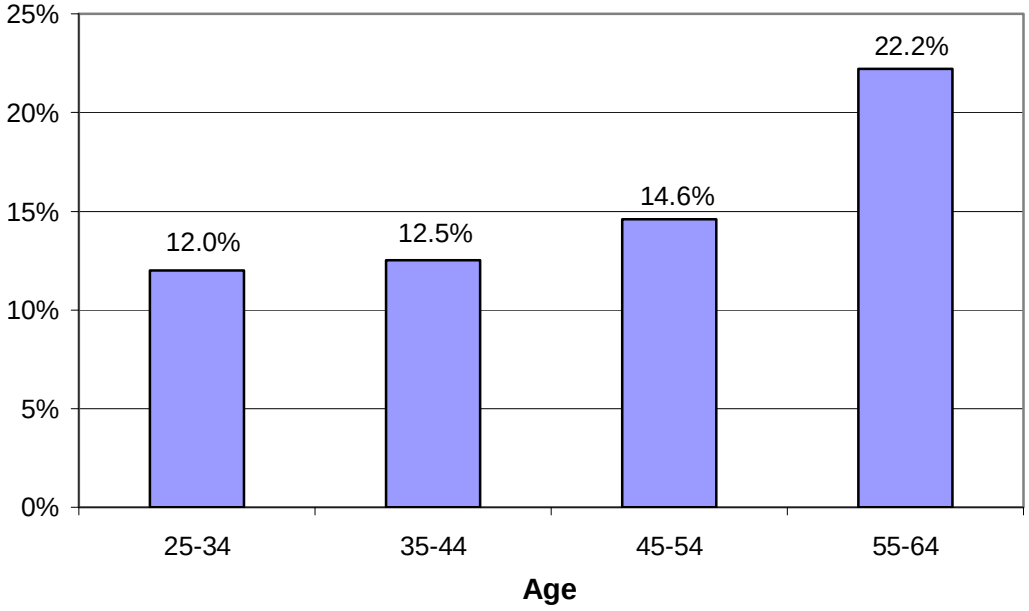


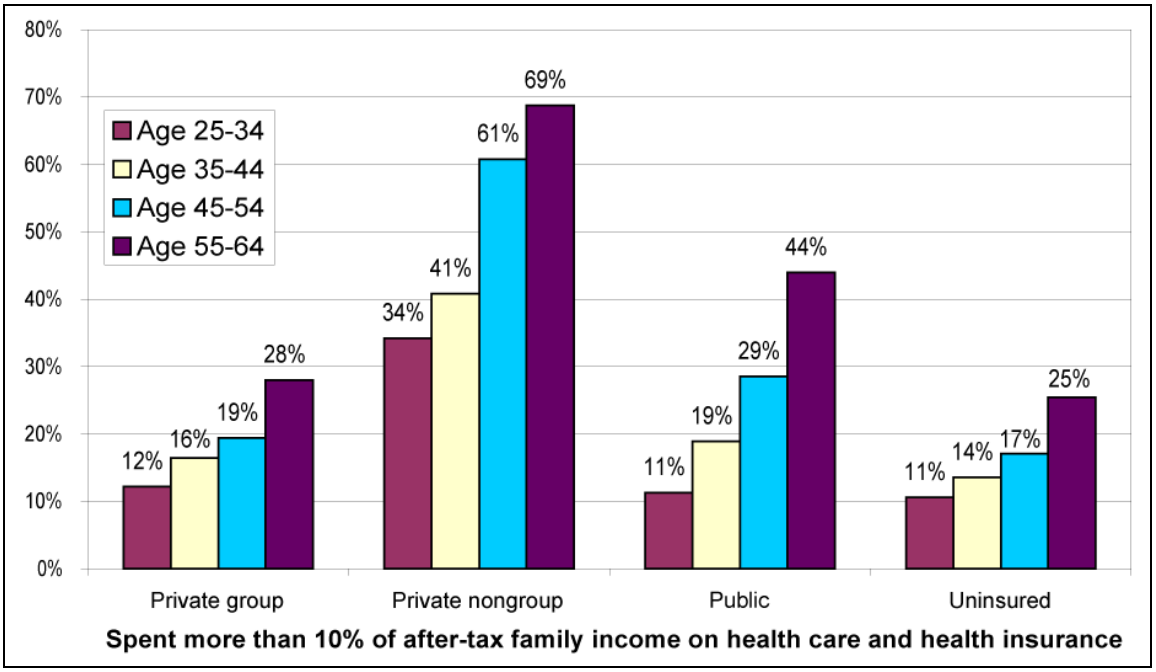
Figure 5. Percentage of Medically Underwritten Applicants for Nongroup Coverage Who Were Denied, 2008



Source: Analyses by America's Health Insurance Plans (AHIP) of survey of nongroup insurers, described in "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits," AHIP Center for Policy and Research, October 2009, available at http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.

Putting aside how much of their own expected health care spending the near elderly *should* pay, researchers from the Agency for Healthcare Research and Quality (AHRQ) have examined how much of their after-tax income they *do* pay for health insurance premiums and out-of-pocket health care costs.[16] **Figure 6** shows the percentage of individuals where the family spent more than 10% of its after-tax income on out-of-pocket health insurance premiums and health care. The percentage was significantly higher for the near elderly than all the other age groups, regardless of health insurance, with the exception of 45- to 54-year-olds with private nongroup coverage. These significant differences occurred because of one or more of three factors affecting the near elderly: higher out-of-pocket spending on health care, higher out-of-pocket payments for premiums, and lower incomes. (For additional information, see the **Appendix**.)

Figure 6. Financial Burden of Health Care and Health Insurance, by Insurance and Age, 2005



Source: Analysis by Agency for Healthcare Research and Quality (AHRQ) using 2005 Medical Expenditure Panel Survey (MEPS), based on methods used and described in J.S. Banthin, P. Cunningham, and D.M. Bernard, "Financial Burden of Health Care, 2001—2004," *Health Affairs*, vol. 27, no. 1, January/February 2008, pp. 188-195, at http://content.healthaffairs.org/cgi/reprint/27/1/188.pdf.

Notes: For more information, see the **Appendix**. Compared with 55- to 64-year-olds, all other age-group percentages are significantly different ($p<0.05$) except for private nongroup in the 44- to 54-year-old category.

[16] Estimates provided to CRS by AHRQ, using the same methodologies employed in J.S. Banthin, P. Cunningham, and D.M. Bernard, "Financial Burden of Health Care, 2001—2004," *Health Affairs*, vol. 27, no. 1, January/February 2008, pp. 188—195, available at http://content.healthaffairs.org/cgi/reprint/27/1/188.pdf.

Medicare Buy-In

Under current law, individuals are eligible for Medicare if they or their spouse worked for at least 40 quarters in Medicare-covered employment,[17] are 65 years old, and are a citizen or permanent resident of the United States. The near elderly, and other individuals less than 65 years of age, may also qualify for coverage if they have a permanent disability, have end-stage renal disease (ESRD),[18] or have amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease).[19] To best understand Medicare's premium and cost sharing structures, it is helpful to know about the structure of services covered under each part of the program. Part A covers inpatient hospital care, skilled nursing facilities after a hospital stay, religious nonmedical health care institutions, hospice services, and home health care services. Part B generally covers outpatient medically necessary services not covered under Part A, such as physician offices visits. Medicare Part D covers most self-administered prescription drugs.

With respect to costs, in 2009, most Medicare beneficiaries paid no Part A premiums and $96.40 per month in Part B premiums.[20] In 2009, the Part A deductibles were $1,068 for the first 60 days of inpatient care, $267 per day for 60 to 90 days, and $534 per day for additional days. The Part B deductible was $135 for the year, and most Part B services also have a 20% coinsurance payment.[21] Premiums and cost sharing in Part D vary by plan, and on average premiums were about $37 per month for stand alone drug plans in 2009.[22] The latest available data indicate that Part D enrollees had an estimated $48.70 per month in out-of-pocket non-premium drug costs in 2006.[23] What a beneficiary actually pays out-of-pocket varies by health status and access to supplemental coverage. Using the latest data available from the Medicare Current Beneficiary Survey, the Medicare Payment Advisory Commission (MedPAC) found that, in 2005, beneficiaries' average total annual out-of-pocket costs ranged from $873 for Medicare/Medicaid dual eligibles in good health to $5,796 for beneficiaries with private Medicare supplemental

[17] Refers to employment where the individual paid the Federal Insurance Contributions Act (FICA) tax. FICA is a payroll tax imposed by the federal government on both employees and employers to fund Social Security and Medicare.

[18] ESRD refers to a benefits term for the chronic stage of kidney impairment that is irreversible. Individuals of any age with ESRD who receive dialysis on a regular basis or a kidney transplant are eligible for Part A (and are deemed enrolled for Part B unless such coverage is refused) if they file an application. Entitlement usually begins after a 3-month waiting period has been served, defined as the first day of the third month after the month in which a course of regular dialysis begins. Entitlement begins before the waiting period has expired if the individual receives a transplant or participates in a self-dialysis training program during the waiting period.

[19] For a more detailed background on Medicare see CRS Report R40425, *Medicare Primer*, coordinated by Hinda Chaikind.

[20] According to the Centers for Medicare and Medicaid Services, approximately 99% of Medicare beneficiaries do not pay the Part A premium as a result of having at least 40 quarters of employment paying the FICA tax. However, other seniors and certain people under age 65 with disabilities who have fewer than 30 quarters of coverage may obtain Part A coverage by paying a monthly premium of $443 per month for 2009. In addition, seniors with 30 to 39 quarters of coverage, and certain disabled persons with 30 or more quarters of coverage, pay a premium of $244 per month in 2009. Part B premiums are adjusted upward for beneficiaries who file an individual tax return with income greater than $85,000 and beneficiaries who file a joint tax return with income greater than $170,000. http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3272.

[21] "CMS Announces Medicare Premiums and Deductibles for 2009," CMS Office of Public Affairs, September 19, 2008.

[22] CRS Report R40611, *Medicare Part D Prescription Drug Benefit*, by Patricia A. Davis.

[23] Wesley Yin et al. "The Effect of the Medicare Part D Prescription Benefit on Drug Utilization and Expenditures," *Annals of Intern Medicine*, 2008: Vol. 148, P.169-177.

coverage and in poor health.[24] Thus, depending on supplemental coverage and service utilization driven by health status, Medicare out-of-pocket costs may or may not be favorable compared to the out-of-pocket costs for the near elderly in the private marketplace.

One previous proposal to expand insurance access, and reduce costs for the near elderly not already eligible for Medicare because of a disability, involved expanding eligibility by creating a Medicare Buy-In (MBI) option. Specifically, on February 2, 1998, President William J. Clinton proposed allowing Americans between the ages of 62 and 65 to buy into Medicare coverage by paying a premium based on an actuarially fair rate for that age group.[25] The President's proposal in the FY1999 budget also called for allowing displaced American workers between 55 and 62 years of age to buy Medicare coverage by paying a premium. The proposal was intended to be self-financing.

Subsequent to the FY1999 budget release, the Medicare Early Access Act of 1998 was introduced in the House of Representatives (H.R. 3470) and in the Senate (S. 1789) on February 17, 1998. These identical bills would have implemented an MBI program for individuals between the ages of 62 and 65 who are not eligible for coverage under group health plans or public health insurance, but would be Medicare-eligible if age 65, and for displaced workers and spouses between the ages of 55 and 62. The bills also would have directed the Secretary of Health and Human Services to determine premium rates for the program, and would have required the program to be self-financing through premiums and offsets from fraud and overpayments made in the rest of the Medicare program. Neither of the bills made it out of committee.

Legislative Activity in the 111th Congress

The Medicare Early Access Act of 2009 (S. 960) was introduced in the Senate on May 1, 2009, by Senator John D. Rockefeller, IV. The bill would amend Title XVIII of the Social Security Act to establish a new "Part E" intended to provide access to Medicare benefits for individuals 55 to 64 years of age who do not have coverage under a federal health insurance program or under a group plan. The bill would require enrollees to pay a premium based on the estimate of the average, national annual per capita amount of the cost of providing services to the population, as determined by the Secretary of Health and Human Services. The bill would create the Medicare Early Access Trust Fund to hold the premiums collected. The bill would also amend the Internal Revenue Code to allow enrollees to receive a 75% refundable credit to offset Medicare early access premium costs. Therefore, beneficiaries would be responsible for 25% of the premiums. The bill was read twice and referred to the Senate Committee on Finance. There are no related bills in the House of Representatives.

Earlier, Senator Max Baucus released the white paper "Call to Action: Health Reform 2009," which proposed an MBI for the near elderly.[26] The proposal would establish a temporary MBI until a health insurance exchange was established. Those already in the MBI would have the option of remaining in Medicare or choosing a plan in an exchange. The MBI proposal was not

[24] "A Data Book: Healthcare Spending and the Medicare Program," MedPAC, June 2009, http://www.medpac.gov/document_TOC.cfm?id=428.

[25] "Budget of the United States Government, Fiscal Year 1999," Executive Office of the President, Office of Management and Budget, February 2, 1998. Available at http://www.gpoaccess.gov/usbudget/fy99/browse.html.

[26] Senator Max Baucus "Call to Action: Health Reform 2009," November 12, 2008. Available at http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf.

included as a part of the health reform package developed by the Senate Committee on Finance, chaired by Senator Baucus. Media reports indicate that an MBI has been discussed as a potential option within the broader health reform package, although no formal amendments to the existing health reform bills have been proposed with an MBI for the near elderly.[27]

Issues for Consideration

Issues involving an MBI program can vary depending on specific elements, such as providing subsidies for the premiums charged. For example, if MBI premiums are not subsidized, then the cost of the coverage to potential enrollee will likely be too high and participation rates will therefore be low. Nevertheless, several common issues are worth considering irrespective of the specifics of the MBI proposal. The following provides a brief summary of the potential issues:

- **Adverse Selection.** Adverse selection in health insurance refers to the tendency of individuals who expect to have high costs to want more insurance in comparison to those who would expect to have low costs.[28] High-cost individuals could find Medicare particularly attractive since it does not have a restrictive provider network and generally does not utilize managed care techniques such as prior authorization.[29] If the premiums are affordable, the MBI will likely be even more attractive to high-cost individuals paying higher premiums in the individual private market. The result would be skyrocketing premiums in subsequent coverage years to cover the costs of a disproportionately high-risk pool.
- **Costs to the Beneficiary**. Since the near elderly are generally a high-risk population, and Medicare is a fee-for-service insurance plan lacking utilization management controls, a self-financing MBI program would be expected to have relatively high premiums. For example, the Congressional Budget Office estimated that the annual premium for single coverage in 2011 for an MBI for individuals between the ages of 62 and 64 would be about $7,600.[30] Premiums this high, combined with the cost sharing structure of Medicare, could lead to out-of-pocket costs similar to, or higher than, what the near-elderly experience in the private marketplace. Premium costs could be reduced for the beneficiary through tax credits or by some other subsidy mechanism. Subsidies would, however, increase the costs of the MBI program.

[27] "Pelosi backs Medicare buy-in plan in Senate health-care deal," by Amy Goldstein, Washington Post, December 11, 2009. Available at http://www.washingtonpost.com/wp-dyn/content/article/2009/12/10/AR2009121004077.html?hpid=topnews.

[28] National Bureau of Economic Research Working Paper 6107, *Adverse Selection in Health Insurance*, July 1997 by David Cutler and Richard Zeckhauser.

[29] Per 42 CFR § 424.510, health care providers must enroll into Medicare in order to receive payment. This enrollment process involves a detailed application. For example, see http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf for the clinic and group practice application. Per 42 CFR § 424.530, Medicare can only deny a provider's enrollment request for reasons that are not related to cost containment such as the provider has lost his/her license to practice. Medicare cannot charge additional cost sharing for seeing certain high cost providers. By contrast, private plans typically attempt to exclude high cost providers from their networks or establish higher cost sharing for high cost providers in an attempt to incentivize members to use lower cost providers.

[30] Congressional Budget Office, *Budget Options Volume I: Health Care*, December 2008. Available at http://www.cbo.gov/doc.cfm?index=9925.

- **Cost to the Government.** Costs to the government, especially the solvency of the existing Medicare program, are potential concerns. MBI proposals generally have called for the establishment of a new trust fund, thus theoretically creating a firewall between the Medicare expansion for the near elderly and the existing Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. Nevertheless, the financial pressures on the government could be significant due to the administrative costs of launching a new program, and if either the MBI premiums do not fully cover claims costs or if there are premium subsidies.
- **Potential Provider Impacts**. Medicare payment rates generally are less than private payers, and may not fully cover provider costs. According to MedPAC, Medicare payment rates for physicians have held steady at about 80% of payments made by private insurance companies between 2000 and 2008.[31] This differential could be an incentive for physicians to seek more private pay patients with a higher payment rate, thus potentially limiting access for Medicare beneficiaries. With respect to hospitals, MedPAC reports that the overall Medicare margin[32] has trended downward since 1997 and has been negative since 2003.[33] Similarly, the financial pressures on hospitals could limit access to Medicare beneficiaries.
- **Potential Impacts on Private Insurance**. If providers see reduced revenue due to having more patients at the lower Medicare payment rates they may in turn place additional pressure on private insurance plans to make up the difference. This phenomenon, called cost shifting, can result in higher premiums for individuals in the private insurance marketplace. "Crowd out" or the substitution of public health insurance for private health insurance could also be a concern if the MBI accepts currently insured individuals.[34] Crowd out can either harm the private sector market by reducing needed revenues, or it can result in increased profit margins by removing high cost individuals from the risk pool.
- **Incentivizing Early Retirement**. The near elderly may continue working in order to have access to employer sponsored health insurance. Extending Medicare to this group may be an incentive for early retirement, thus placing additional cost pressures on public retirement programs, and reducing employment and income related tax revenues.

[31] "Assessing payment adequacy: Physician services" presentation by Cristina Boccuti, Hannah Neprash, and Kevin Hayes, December 10, 2009. Available at http://www.medpac.gov/transcripts/Physician%20Dec%2009%20pub.pdf.

[32] Refers to the difference between the Medicare payment amount and the hospital's costs for treating Medicare beneficiaries. This is a measure of profitability for Medicare patients served by the hospital.

[33] "Medicare Payment Policy: Report to Congress," Medicare Payment Advisory Commission, March 2009.

[34] The Medicare Early Access Act of 2009 proposal would not accept those with private group health plan coverage, but would accept persons with insurance from the individual market.

Appendix. Technical Data

Figure 5 in the main body of this report shows the percentage of individuals where the family spent more than 10% of its after-tax income on out-of-pocket health insurance premiums and health care. **Table A-1** below shows the detailed estimates on which the figure is based.

These estimates, broken down by age, were provided upon request by the Agency for Healthcare Research and Quality (AHRQ), using data from the 2005 Medical Expenditure Panel Survey (MEPS). Their methodology is described in detail in J.S. Banthin, P. Cunningham, and D.M. Bernard, "Financial Burden of Health Care, 2001-2004," *Health Affairs*, volume 27, number 1, January/February 2008, pp. 188-195, available at http://content.healthaffairs.org/cgi/reprint/27/1/188.pdf. The following descriptions summarize the relevant portions of the methodology described in the *Health Affairs* article.

The dollar amounts for income (after taxes) and for out-of-pocket health care spending and premiums are all measured at the family level. "Family income" defined this way is more precisely referred to as the income of "health insurance units" (HIU), which generally consists of the income of the individual, spouse, and dependent children. The HIU definition of family income is often considered more useful for health-policy analyses, because it tends to mirror eligibility and available resources for family coverage in the private market. It also reflects the definition of family income for some means-tested public programs. Ultimately, the resulting population estimates are reported at the person level; each person in the analysis is assigned the family-level measures.[35]

Everyone in the analysis was classified into a single category for their health insurance status. First, if they were without coverage all year, they were considered uninsured. Coverage was then assigned based on the number of months individuals had that type of coverage. Premiums amounts were prorated as necessary to account for the duration of coverage during the year.

Although medians are often used for analyses of income and expenditures, Banthin et al. use averages instead for a number of reasons—primarily so that the individual out-of-pocket amounts add to the total in each category. For additional detail on the methodology, one may refer to the *Health Affairs* article.

[35] The uninsured in **Table A-1** show positive out-of-pocket premium amounts. This is because, again, the dollar amounts are compiled at the family level. The positive out-of-pocket premium amounts reflect amounts paid by insured family members.

Table A-1. Percentage of Adults in Families with Out-of-Pocket Spending on Health Care and Health Insurance Premiums Exceeding 10% of After-Tax Income, by Insurance and Age, 2005

		Private Group			Private Nongroup			Public			Uninsured		
Age	**Characteristic**	**Average**	**Margin of error**		**Average**	**Margin of error**		**Average**	**Margin of error**		**Average**	**Margin of error**	
Total	After-tax family income	$59,343	± $1308		$52,499	$2,166		$17,331	$462		$26,790	$866	
25-64	OOP spending on care	$1,394	± $58	*	$2,071	$234		$1,226	$204	*	$1,016	$71	*
	OOP premiums	$2,041	± $93	*	$4,549	$223	*	$227	$20	*	$160	$16	
	Total OOP burden	$3,435	± $116	*	$6,620	$335	*	$1,453	$205	*	$1,176	$75	*
	% in families w/ high burdens	*18.7%*	*± 1.1%*	*	*52.6%*	*± 5.6%*	*	*25.0%*	*± 2.6%*	*	*15.2%*	*± 1.8%*	*
25-34	After-tax family income	$50,841	± $2086	*	$42,092	$4,040		$17,928	$748		$22,922	$933	
	OOP spending on care	$798	± $66	*	$1,052	$185	*	$336	$48	*	$499	$43	*
	OOP premiums	$1,505	± $105	*	$2,239	$240	*	$90	$15	*	$115	$25	
	Total OOP burden	$2,304	± $132	*	$3,291	$371	*	$427	$53	*	$614	$51	*
	% in families w/ high burdens	*12.2%*	*± 1.8%*	*	*34.2%*	*± 12.2%*	*	*11.3%*	*± 3.4%*	*	*10.6%*	*± 2.5%*	*
35-44	After-tax family income	$63,160	± $2234	*	$55,895	$3,995		$17,948	$1,053		$29,045	$1,428	
	OOP spending on care	$1,248	± $98	*	$1,310	$182	*	$1,728	$805		$1,007	$112	*
	OOP premiums	$2,164	± $176		$3,707	$390	*	$133	$28	*	$158	$37	
	Total OOP burden	$3,412	± $197	*	$5,017	$477	*	$1,861	$805		$1,165	$119	*
	% in families w/ high burdens	*16.4%*	*± 1.8%*	*	*40.8%*	*± 13.2%*	*	*18.9%*	*± 5.2%*	*	*13.5%*	*± 3.3%*	*
45-54	After-tax family income	$63,151	± $1820	*	$58,924	$4,532		$16,615	$791		$30,814	$1,724	*
	OOP spending on care	$1,654	± $99	*	$3,147	$762		$1,137	$125	*	$1,320	$164	
	OOP premiums	$2,101	± $147	*	$5,682	$474		$277	$47	*	$198	$33	
	Total OOP burden	$3,756	± $196	*	$8,830	$946		$1,414	$142	*	$1,518	$174	
	% in families w/ high burdens	*19.4%*	*± 2.1%*	*	*60.8%*	*± 10.5%*		*28.5%*	*± 5.2%*	*	*17.0%*	*± 3.5%*	*

Age	Characteristic	Private Group		Private Nongroup		Public		Uninsured	
		Average	Margin of error	Average	Margin of error	Average	Margin of error	Average	Margin of error
55-64	After-tax family income	$58,396	± $2456	$51,905	$3,454	$16,761	$1,071	$25,674	$1,597
	OOP spending on care	$1,894	± $155	$2,432	$236	$1,776	$191	$1,743	$283
	OOP premiums	$2,381	± $187	$5,975	$510	$437	$61	$210	$41
	Total OOP burden	$4,275	± $248	$8,406	$568	$2,214	$213	$1,953	$286
	% in families w/ high burdens	*28.0%*	*± 2.6%*	*68.7%*	*± 8.2%*	*43.9%*	*± 5.4%*	*25.4%*	*± 5.2%*

Source: Analysis by Agency for Healthcare Research and Quality (AHRQ) using 2005 Medical Expenditure Panel Survey (MEPS), based on methods used and described in J.S. Banthin, P. Cunningham, and D.M. Bernard, "Financial Burden of Health Care, 2001—2004," *Health Affairs*, volume 27, number 1, January/February 2008, pp. 188—195, available at http://content.healthaffairs.org/cgi/reprint/27/1/188.pdf.

Notes: The margins of error are calculated based on a 95% confidence interval. An asterisk indicates estimates that are significantly different from those in the 55-64-year-old category ($p<0.05$). "OOP" means out-of-pocket. "High burdens" means total out-of-pocket spending on health care and health insurance premiums exceeds 10% of the family's after-tax income.

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