



Insuring the Near Elderly: The Potential Role for Medicare Buy-In Plans

Richard W. Johnson, Amy J. Davidoff, and Marilyn Moon

As Americans born during the early baby boom years approach retirement, health insurance coverage for the near elderly is becoming an increasingly important policy issue. The near-elderly—defined here as those aged 62 to 64—are not old enough to qualify for Medicare (unless they are disabled), yet they are much more likely than younger people to experience serious health problems. In addition, many near-elderly persons have already retired, limiting their insurance options. Although most working Americans receive health benefits from their employers, many employers do not provide coverage after retirement. And many individuals without employer-sponsored insurance face problems obtaining coverage in the private nongroup market because of age and health concerns.

One widely debated solution is to offer tax credits to help the uninsured buy private insurance. The Bush administration has proposed refundable tax credits of up to \$2,000 for low- and moderate-income families and up to \$1,000 for individuals who purchase nongroup coverage. Even with these financial incentives, however, nongroup premiums would remain unaffordable

to many near-elderly Americans, especially those with health problems (Simantov et al. 2001). Other individuals would continue to face pre-existing-condition exclusions or would be denied coverage altogether because of their health status.

An alternative approach to help older uninsured Americans obtain coverage is to create a Medicare buy-in plan allowing persons below the age of full eligibility to purchase Medicare coverage. The Clinton administration offered several versions of a Medicare buy-in plan, and it was one of Al Gore's campaign promises during the 2000 presidential election. More recently, in March 2001 Senator Rockefeller (D-WV) introduced a bill to create a buy-in program for near-elderly Americans.

This brief describes findings from a recent study that examined potential participation rates in alternative Medicare buy-in plans and measured the potential impact of these plans on rates of uninsurance.¹ The study found that many individuals younger than 65 would purchase Medicare coverage if a buy-in plan were available. But without subsidies, participation would be limited to those who could afford substantial premiums and who have difficulty buying insurance in the private market because of health problems. Only a Medicare buy-in that provided subsidies to make the plan affordable to low-income people would significantly reduce uninsurance rates among the near elderly.

Coverage for the Near Elderly

The near elderly obtain health insurance from a mix of public and private sources. Retirement and the relatively high risk of health problems they face, however, limit their coverage options.

Employer-Sponsored Coverage and Retiree Health Insurance Benefits

By the time individuals reach their early 60s, many have stopped working. In 1998, about half of men and about two-thirds of women aged 62 to 64 no longer worked. Some firms continue to contribute toward their workers' health benefits

after retirement. These retiree health insurance (RHI) benefits generally continue until age 65, when Medicare coverage begins, and sometimes supplement Medicare benefits after age 65.

Unfortunately, RHI benefits are not available to most Americans. In 1998, only 37 percent of men and 34 percent of women aged 50 to 54 reported having access to RHI from their own employers or their spouses' employers after retirement (Johnson 2001). Even those offered RHI may not be able to afford it. RHI benefits are usually less generous and require more cost sharing than do health benefits provided to active workers. About one in ten early retirees offered RHI benefits turns them down because they are too expensive (Loprest 1998). And recent declines in the availability of RHI may further erode employer-sponsored coverage for the near elderly (Hewitt Associates 1999).

Most retirees who lack access to RHI can continue to receive their employer-sponsored coverage for a limited time. Under federal law, employers with 20 or more employees must provide continuation coverage to former workers for up to 18 months (or 29 months if the worker is disabled). However, the cost to the beneficiary can be high because former workers assume full responsibility for up to 102 percent of the premium.² These costs contribute to the low take-up rate for continuation coverage (Flynn 1994).

Public Sources

Near-elderly persons who lack job-related health benefits have limited public insurance options. Nonelderly adults can qualify for Medicare or Medicaid benefits only if they are disabled. In addition, Medicaid benefits are subject to strict income and asset limits, and Medicare benefits do not begin until at least 29 months after the onset of disability.

Private Nongroup Coverage

Given these constraints, many near-elderly persons without employer coverage turn to the private nongroup market. Indeed, people aged 55 to

64 are more than twice as likely to have private nongroup coverage than people aged 35 to 54 (Brennan 2000). However, relying upon the private nongroup market at older ages has important drawbacks, including the high price of coverage (especially for those in poor health), the limited benefits provided by many plans, and the possibility that coverage may be denied altogether.

Premiums are generally higher for private nongroup plans than group policies because risk pooling is more limited, administrative costs are higher, and employer subsidies are generally unavailable. For example, among 62- to 64-year-olds, we found that individuals who were not offered job-related health benefits or public insurance faced average annual premiums of \$5,100 in the private market. By contrast, workers with employer-sponsored coverage averaged just \$650 per year in out-of-pocket premium contributions for their benefits. Health problems also increase the risk-rated premiums individuals face in the nongroup market. Because health problems are more common among the low-income population, the poor often face especially high nongroup premiums.

To offset the high price of private nongroup coverage, many individuals purchase plans that offer limited coverage, but carry high deductibles and coinsurance. For those with low incomes, the lack of comprehensive coverage can limit access to care. Many insurers also exclude coverage for pre-existing health conditions, further limiting the comprehensiveness of benefit packages. We estimate that about 12 percent of Americans aged 55 to 64 with private nongroup coverage have restricted policies because of pre-existing conditions. Consequently, many near-elderly persons with nongroup coverage may be underinsured, leaving them vulnerable to high out-of-pocket costs if they become seriously ill.

Even when near-elderly Americans are able to afford the high cost of private nongroup coverage, they may be denied coverage by insurers. According to a recent study of the nongroup health insurance market in 10 states, insurers

often deny coverage to those suffering from such health problems as rheumatoid arthritis, chronic headaches, kidney stones, angina, heart disease, and stroke (Chollet and Kirk 1998).

The Near-Elderly Insurance Gap

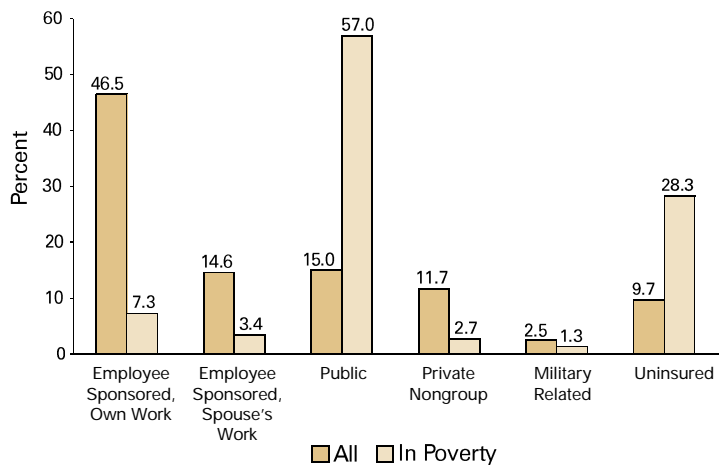
Because private nongroup coverage is expensive, especially for individuals with health problems, a Medicare buy-in could help insure many of the near elderly who lack access to public insurance or job-related health benefits. In 1998, about 47 percent of persons aged 62 to 64 received coverage from their own employers, either as active workers or as retirees (see figure 1). Another 15 percent received coverage through their spouses' employers. The public sector provided coverage for about 15 percent of near-elderly Americans, primarily in the form of disability-related Medicare benefits. About 12 percent purchased private nongroup coverage in 1998, while 10 percent were uninsured.³ Thus, about one in five persons aged 62 to 64 (those who lack coverage or rely on the private nongroup market) could potentially benefit from the introduction of a Medicare buy-in plan.

Coverage rates are closely related to income, which limits the effectiveness of policies designed to increase coverage by encouraging individuals to purchase unsubsidized insurance. About 28 percent of persons aged 62 to 64 in poverty were uninsured in 1998, compared with only 3 percent of those with family incomes exceeding 400 percent of the federal poverty level. Rates of coverage by public insurance, in the form of Medicare and Medicaid benefits, are much higher among the poor than among those with substantial incomes, but not high enough to offset the low rates of employer-sponsored coverage among those with limited incomes.

Estimating the Impact of a Medicare Buy-In

We begin by testing how private nongroup coverage responds to changes in price, family income, and health status, controlling for demographic characteristics. These estimated effects are then used to simulate participation in a Medicare buy-

FIGURE 1.
Type of Coverage for Individuals Aged 62 to 64, by Poverty Status, 1998



Source: Johnson, Moon, and Davidoff (2002).

in plan and the impact of the buy-in on private nongroup coverage among individuals aged 62 to 64 in 1998. The model assigns limited private nongroup coverage, carrying high deductibles and cost-sharing requirements, to individuals who are predicted to purchase insurance but cannot afford standard coverage. The model also accounts for possible changes in labor supply that might result from the introduction of a buy-in plan. Estimates are based on data from the Health and Retirement Study, a large, nationally representative survey of noninstitutionalized Americans aged 51 and older conducted by the University of Michigan for the National Institute on Aging. The model also incorporates premium data from nongroup insurance providers.

We measure the sensitivity of participation in the Medicare buy-in plan to price by employing three different premiums—moderate, high, and low. The moderate premium is set at \$300 per month in 1998, almost equal to the level the Congressional Budget Office estimated as necessary to achieve cost-neutrality (i.e. premiums paid by participants fully cover program costs).⁴ The low premium is set at \$200 per month, and the

high premium at \$400 per month. The model also examines participation under a plan with income-related premiums that would charge only \$43.80 per month (the monthly Medicare Part B premium in 1998) for those with family incomes below 150 percent of the poverty level and \$300 per month for everyone else.⁵ The analysis assumes that only persons without access to employer-sponsored insurance or other types of public insurance could participate in the buy-in plan.

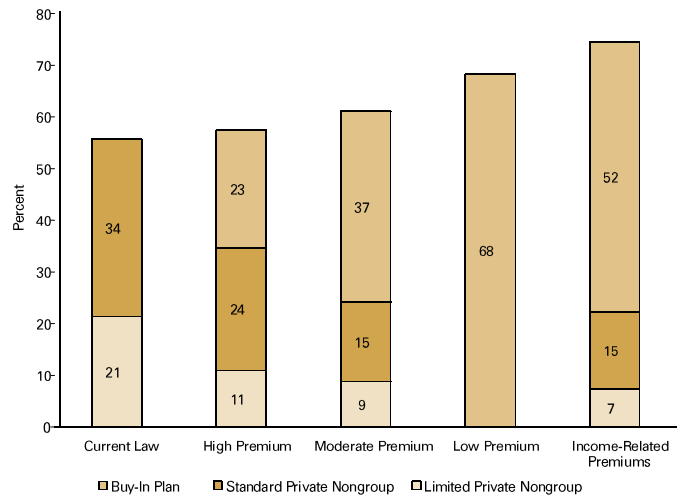
Participation in Medicare Buy-In Plans

The results of our model indicate that substantial numbers of near-elderly Americans would purchase Medicare coverage if it were available. As reported in figure 2, 37 percent of eligible persons, or 490,000, would participate in a moderately priced Medicare buy-in plan. Participation rates would fall to 23 percent, or 293,000 persons, if the plan charged higher premiums, and would rise to 68 percent, or 897,000 persons, if it charged lower premiums.

A moderately priced buy-in would not reduce uninsurance rates by much, however. Most participants would drop expensive private nongroup coverage in favor of the less costly Medicare coverage, reducing the number of near-elderly Americans who purchase private nongroup coverage by more than half. As a result, coverage rates among those without access to other types of public insurance or to employer-sponsored coverage would increase only modestly, from 56 percent to 61 percent. If the buy-in's premiums were low, the model predicts that no near-elderly Americans would purchase private nongroup plans, because premiums for all private plans would be higher than those for the low-cost buy-in plan.

Although an unsubsidized buy-in would have small effects on coverage rates, it would reduce costs and improve the quality of coverage for many near-elderly people. Under current law, in the absence of Medicare buy-in options, only 34 percent of near-elderly Americans without access to public or employer-sponsored insurance purchased standard nongroup coverage. However, if moderately priced Medicare coverage

FIGURE 2. Participation Rates under Current Law and Alternative Medicare Buy-In Plans among Eligible Individuals Aged 62 to 64, by Type of Coverage, 1998



Source: Johnson, Moon, and Davidoff (2002).

Notes: Monthly premiums are set at \$400 for the high-premium buy-in plan, \$300 for the moderate premium plan, and \$200 for the low-premium plan. Income-related premiums are set at \$43.80 per month for those with incomes below 150 percent of the poverty level and at \$300 per month for everyone else. The buy-in plans would be available only to persons aged 62 to 64 without access to employer-sponsored coverage or to other types of public insurance. Buy-in plans are not available under current law.

were available, 52 percent would have standard coverage, either through the public or private sector.

Unless premiums were related to income, few low-income Americans would participate in a Medicare buy-in program. If participants at all income levels faced moderate premium prices, only 6 percent of poor persons and 14 percent of near-poor persons eligible for the buy-in would participate. However, if premiums were related to income, with low-income persons charged \$43.80 per month and everyone else charged \$300 per month, 63 percent of poor eligible persons and 46 percent of near-poor eligible persons would participate.

Because health insurance is most valuable to those in poor health, many purchasers of Medicare benefits would have health problems. For example, 64 percent of participants in a moderately priced buy-in plan would have at least one serious health problem, compared with only 38 percent of those eligible for the buy-in. This

adverse selection problem, which drives up insurance costs because those who purchase coverage are most likely to utilize health services, highlights the difficulty of designing a cost-neutral buy-in program. Raising the price to cover costs discourages even more healthy people from participating in the program and may make the plan unaffordable to those who need it most. We estimate that 93 percent of participants in the high-priced buy-in plan would have serious health problems.

Effects of Medicare Buy-Ins on the Uninsured

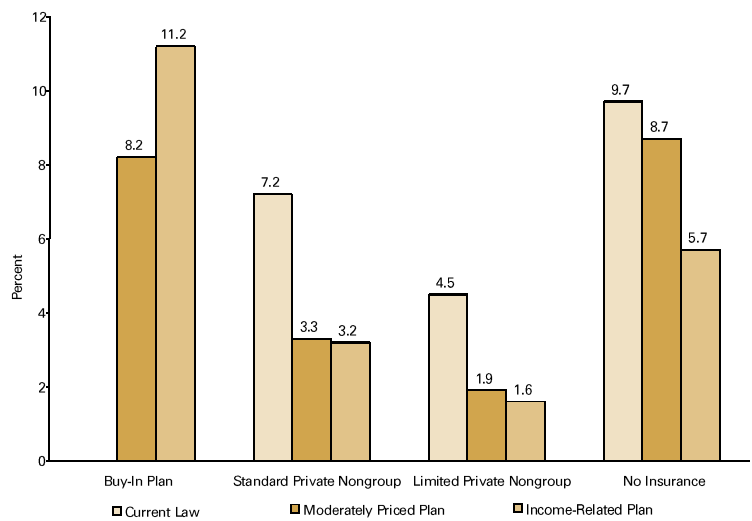
The introduction of a buy-in plan would reduce uninsurance rates among the near elderly, but the effects would be small unless the plan was heavily subsidized. As reported in figure 3, uninsurance rates would fall from 10 percent under current law to 9 percent after the introduction of a moderately priced buy-in plan, reducing the number of uninsured near-elderly Americans by about 60,000. Overall, 8 percent of the near elderly would participate in a moderately priced buy-in plan, and 5 percent would purchase private nongroup coverage. Participants in the buy-in program would far outnumber the newly insured, because most buy-in participants would purchase private plans if they were unable to buy into Medicare. However, the buy-in plan would raise the overall quality of coverage, with many participants replacing limited private nongroup coverage with more comprehensive Medicare benefits. As a result, a moderately priced buy-in option would reduce the portion of the near-elderly population without standard coverage from 14 percent to 11 percent.

Because many uninsured individuals have limited resources, the effect of the buy-in on coverage rates would be larger if monthly premiums were related to income. A buy-in plan with income-related premiums would reduce overall uninsurance rates for the near elderly to 6 percent, with about 180,000 people acquiring coverage (relative to coverage in 1998 under current law). The effect would be even more pronounced among the near-elderly poor, whose uninsurance rates would fall from 28 percent to 12 percent.

If premiums were not related to income, coverage rates for those with limited incomes would not improve significantly (see figure 4). For example, a buy-in plan that charged all participants moderate premiums would not reduce uninsurance rates at all for the poor or near poor, although the quality of their coverage would improve slightly, as some low-income individuals would drop limited private nongroup coverage for more comprehensive Medicare benefits. Thus, a buy-in plan that ties premiums to income better targets benefits to the near elderly than a plan charging the same premium to all participants.

Even without special targeting, the introduction of a Medicare buy-in plan would substantially reduce uninsurance rates for those with health problems. With a moderately priced buy-in plan, uninsurance rates would fall from 9 percent to only 6 percent for those with two or more serious health problems and from 8 percent to 5 percent for those who described their overall health status as poor. Uninsurance rates would fall even further if premiums were related to income, to 3 per-

FIGURE 3.
Coverage Rates among Near Elderly under Current Law and Alternative Buy-In Plans, by Type of Insurance, 1998



Source: Johnson, Moon, and Davidoff (2002).

Notes: In the moderately priced buy-in plan, all participants pay \$300 per month. Income-related premiums are set at \$43.80 per month for those with incomes below 150 percent of the poverty level and at \$300 per month for everyone else. Only persons aged 62 to 64 without access to employer-sponsored coverage or to other types of public insurance would be eligible for the buy-in. Buy-in plans are not available under current law.

cent among those with two or more serious health problems. Strong demand for insurance among those with health problems, and the high premiums they face in the private nongroup market, drive these improvements in coverage.

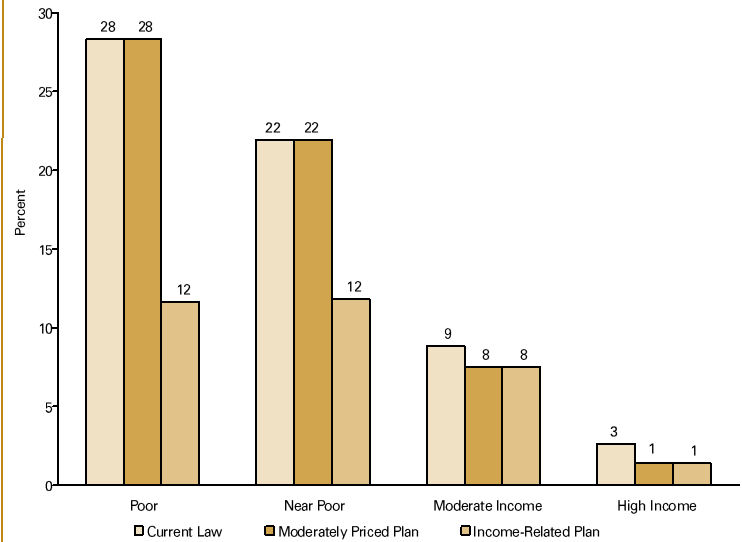
Effectiveness Linked to Subsidies

Allowing individuals younger than 65 to buy into the Medicare program could help reduce the number of persons without insurance in the United States. Without subsidies, this approach would largely benefit persons who could afford to pay substantial premiums but have trouble buying insurance in the private market because of health problems. With subsidies, the benefits of a buy-in could extend to limited-income individuals, who have much higher rates of uninsurance. Thus, the success of a Medicare buy-in program would depend upon the level of subsidies provided to make coverage more affordable. But higher subsidies raise the costs of the program, and they could prove difficult to implement.

Our estimates indicate that a Medicare buy-in for persons aged 62 to 64 would only modestly reduce uninsurance rates for the near elderly if taxpayers did not bear some of the costs. Although many near-elderly Americans would choose to participate in a cost-neutral plan, most participants would replace private nongroup coverage with the less expensive (and often more comprehensive) Medicare coverage. Very few of them would have been uninsured in the absence of a buy-in plan, and two-thirds would have high incomes.

The impact of a buy-in on coverage rates would be greater if the plan were better targeted to individuals with limited incomes. Many of the near elderly who lack insurance under current law receive little income and would be unable to afford Medicare coverage that carried substantial premiums. If premiums were related to income, so that those with family incomes below 150 percent of the poverty level were charged \$43.80 per month, uninsurance rates for the poor would fall from 28 percent under current law to 12 percent. However, these subsidies would cost the government more than \$3,000 per low-income partici-

FIGURE 4. Simulated Uninsurance Rates among Near Elderly under Current Law and Alternative Buy-In Plans, by Income, 1998



Source: Johnson, Moon, and Davidoff (2002).

Notes: In the moderate premium buy-in plan, all participants pay \$300 per month. In the income-related plans, premiums are set at \$43.80 per month for those classified as poor if family income falls below the poverty level, near poor (income falls between 100 percent and 200 percent of the poverty level), moderate income (income falls between 200 percent and 400 percent of the poverty level), and as high income (income exceeds 400 percent of the poverty level).

part, much more than the tax credits proposed by the Bush administration. Even with these subsidies, premium costs for the poor would remain substantial. Under our income-related plan, premiums for an unmarried person with income equal to 75 percent of the poverty level in 1998 would amount to \$526 per year and equal more than 8 percent of his or her income. The effects of a Medicare buy-in plan on coverage rates for the poor would exceed our estimates if premiums were more heavily subsidized for low-income Americans.

The results also suggest that adverse selection into the buy-in program would complicate efforts to keep costs down while ensuring access to those with limited incomes. Participation rates would be higher among persons in poor health, who use more health services and incur more costs, than among those in good health. The adverse selection bias would become less severe if the plan incorporated an across-the-board subsidy and if those in better health with lower expected costs

chose to participate. The cost to taxpayers, however, could increase if the program charged lower prices.

Another drawback to a buy-in plan is that it might reduce RHI coverage. The value of employer-sponsored retiree benefits to workers will fall if the government provides subsidized health benefits at age 62. Firms might react by dropping benefits, accelerating the decline in RHI coverage evident over the past 15 years. But if current trends continue, few retirees will receive RHI benefits in the future, even without a buy-in measure.

Additional factors, such as private insurance reform, the role of Medicaid, the appropriate cut-off age, and other design features, could alter the effectiveness of any buy-in plan. If policymakers ever take a serious look at a buy-in as a way to improve coverage, they will need to examine these other factors closely.

Endnotes

1. The full report, *A Medicare Buy-In for the Near Elderly: Design Issues and Potential Effects on Coverage*, is available at the Henry J. Kaiser Family Foundation Web site (<http://www.kff.org>).
2. After workers separate, they pay the employer's group rate if they choose to continue their coverage, plus up to 2 percent to cover administrative costs. The firm typically pays at least part of the premium for active employees. For example, 31 percent of workers in medium-sized and large firms did not make any premium contributions for their health benefits in 1997, while monthly costs for those who did contribute averaged just \$39 (U.S. Bureau of Labor Statistics 1999). Of course, workers may implicitly pay more for employer-sponsored coverage if firms offset part of the cost of health benefits by paying lower wages than they would if they offered no benefits.
3. Uninsurance rates are lower for the near elderly than for those aged 35 to 54, 13.4 percent of whom lacked coverage in 1997 (Brennan 2000). Concern about coverage for the near elderly stems from the serious consequences of uninsurance at older ages, not from the relative size of the uninsured population aged 62 to 64.
4. The Congressional Budget Office estimated that a cost-neutral buy-in plan in 1999 would charge participants \$316 per month at ages 62 to 64, plus monthly surcharges of about \$23 from ages 65 to 84 (U.S. Congressional Budget Office 1992).

5. We model this plan to illustrate the potential impact of buy-ins that vary premiums with income. A better plan design would be to phase out subsidies gradually as income rises, instead of creating a single income level at which generous subsidies are abruptly eliminated. The plan we model imposes a large tax on those with incomes just above 150 percent of the poverty level, leaving them potentially worse off than others with less income and creating powerful work disincentives for those with incomes near that level.

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The Retirement Project is a research effort that addresses how current and proposed retirement policies, demographic trends, and private-sector practices affect the well-being of older individuals, the economy, and government budgets.