



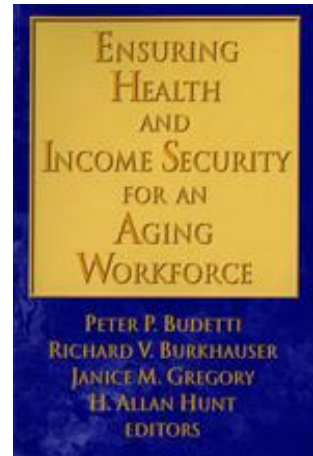
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## Extending Health Insurance Coverage for Older Workers and Early Retirees

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# **Extending Health Insurance Coverage for Older Workers and Early Retirees**

## **How Well Have Public Policies Worked?**

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Our voluntary system of health insurance, regulated by a patchwork of federal and state laws, leaves many gaps for older Americans. There are gaps of access—that is, coverage can be denied or made more difficult to obtain specifically because of a person’s advancing age and declining health. There also are gaps of affordability faced by uninsured Americans of all ages who have low incomes and who simply cannot afford the cost of health insurance.

This chapter does not attempt to measure the prevalence of problems of access and affordability faced by older Americans. Such problems are a distinct possibility for older Americans, and when they do arise, they can have tragic results. Many of us take comfort in the conventional wisdom that the uninsured do, eventually, somehow, obtain the health care they need. This conventional wisdom is wrong.

The American College of Physicians–American Society of Internal Medicine recently compiled and summarized the findings of over 100 scientific studies documenting that “lack of health insurance is not simply an inconvenience . . . [It] is a public health risk that results in poorer health and earlier death” (ACPI–ASIM 1999). Mortality and morbidity are higher among the uninsured. People who lack coverage delay or forego care and medications that they need, but cannot afford. They suffer greater complications and unnecessary hospitalizations when manageable health conditions go untreated. Cancer is detected at later stages, diminishing treatment options and the chances for sur-

vival. And the uninsured who manage to get hospital care nevertheless are much more likely to die than are people who are privately insured.

This mounting evidence notwithstanding, we do not have a guarantee of health security in America for people under the age of 65. Instead we have adopted a patchwork of public policies, federal and state, that seem to help some people in some circumstances and leave gaps in assistance for others. This chapter examines the health and insurance status of older workers and early retirees, aged 55–64. It reviews the menu of public policies we have adopted to promote access to and affordability of coverage. It concludes that some of these public policies have added tangible protections for the near-elderly, while others have not, and that significant gaps in health security remain for older workers and early retirees in the United States.

## **HEALTH STATUS AND COVERAGE OF THE NEAR-ELDERLY**

A recent report to the Congress by the General Accounting Office documented the health status and the health insurance status of Americans between the ages of 55 and 64. Relative to other non-elderly Americans, people between these ages have the highest rate of health insurance coverage. In 1996, 13.8 percent of this near-elderly age cohort were uninsured, compared with almost 18 percent of all non-elderly Americans. Further, health coverage for the near-elderly has remained relatively stable over time, while the proportion of uninsured has climbed steadily for younger age groups (GAO 1998, p. 38).

The near-elderly's relative advantage in health insurance status should not, however, necessarily be viewed as a health security success story. It may well be that because their need for health insurance coverage is so pressing that people in this age bracket will tolerate higher expenses, job lock, deferred retirement, or other inconveniences or hardships in order to maintain coverage. Indeed, researchers at the Urban Institute who studied how health insurance needs are factored into retirement decisions found that both the availability and affordability of coverage were important considerations that shape people's plans for retirement (Loprest and Zedlewski 1998).

This finding is not at all surprising, given the health care needs of the near-elderly. Advancing age tends to bring a decline in health status. Less than half of the near-elderly report themselves to be in excellent health, compared with almost three-quarters of 25- to 34-year-olds. Almost one-quarter of the elderly report themselves to be in poor health, compared with 6 percent of 25- to 34-year-olds (GAO 1998, pp. 27–29). The incidence of serious and chronic health conditions is far more prevalent among the near-elderly than among younger people. Ironically, the onset of these health conditions, which make the need for health coverage more pressing, also makes the near-elderly more “uninsurable” (Table 1).

The near-elderly, like other Americans, rely primarily on employer-sponsored insurance (ESI) for their health coverage. Two-thirds of people aged 55–64 have employer-based health coverage. ESI is more common among the near-elderly who work full time, but early retirement does not necessarily mean the loss of ESI. Almost half of the near-elderly who do not work have employer-based coverage, through a working or retired spouse, through their own employer-spon-

**Table 1 Number of Health Conditions per 1000 People among Four Age Groups**

Condition	25–34 yr.	35–44 yr.	45–54 yr.	55–64 yr.
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: GAO 1998, p. 30. Data derived from the NCHS 1994 Health Interview Survey.

sored retirement health benefits, or through COBRA. Even so, the rate of ESI coverage is lower for the near-elderly than for most younger people. As a result, the near-elderly today rely disproportionately on individually purchased health insurance coverage and on Medicare. This is especially the case for the oldest near-elderly, i.e., between the ages of 62 and 64 (Table 2).

Trends suggest this reliance on individual coverage and public programs may increase over time. In particular, the prevalence of employer-sponsored retiree health benefits has declined over the past decade and shows evidence of continuing to do so. Fewer employers are offering such benefits to retirees and, among those that do, eligibility standards and required retiree contributions are becoming more stringent (McArdle et al. 1999). People who retire without employer-sponsored health benefits before the age of Medicare eligibility are more likely to be uninsured (Table 2).

**Table 2 Percentage of Insured and Uninsured Individuals by Source of Insurance and Age Group, 1996**

Age group	Employer-based coverage	Individual	Medicare	Medicaid	Military/veteran	Uninsured
25-34	65.1	4.0	0.9	6.2	1.5	22.3
35-44	71.0	4.6	1.4	5.3	1.3	16.3
45-54	73.7	5.3	2.0	3.7	1.6	13.7
55-64	65.3	8.6	5.9	4.4	1.9	13.8
Near-elderly subgroups						
55-61	67.4	8.0	4.9	4.6	1.9	13.2
62-64	59.6	10.1	8.5	4.0	2.1	15.5
Work full time	81.3	7.4	0.2	0.7	1.4	9.0
Not working	46.1	8.1	15.2	10.1	2.3	18.2

GAO 1998, pp. 40, 41, 44.

## **WHAT PUBLIC POLICIES HAVE BEEN ADOPTED TO PROMOTE HEALTH INSURANCE ACCESS AND AFFORDABILITY?**

Private health insurance markets tend to distinguish customers based on their health and risk status, and they sell (or renew) coverage accordingly. Low-cost, low-risk customers are the most profitable, and insurers will try to attract them—and discourage high-cost, high-risk customers—through their medical underwriting practices, benefit design, and premium pricing. Left unregulated, these practices make it more difficult for the near-elderly to obtain health insurance and leave them vulnerable to losing the coverage they have as they age and as health declines. Risk segmentation and selection practices are less of a threat to a near-elderly person in large group coverage (where the impact of any one person on an entire group’s premium will be less) but become more so as group size declines. Access and affordability are most problematic in the individual market, where an older person with preexisting health conditions is unlikely to find standard coverage at standard rates and may find it unavailable at any price.

Over the past 15 years, states and the federal government have enacted health insurance reform laws to curb risk segmentation and selection practices. How well these policies have improved protections for older workers and early retirees depends on the type of health coverage and where it is obtained.

### **Access to Group Coverage**

#### **COBRA<sup>1</sup>**

As noted above, early retirees depend primarily on employer-sponsored health insurance for their coverage. When retirement health benefits are not offered, many early retirees have the option under COBRA of remaining in their former group plan for a limited time. Assuming for a moment that an early retiree may be leaving work because of health problems, this option becomes especially important. It allows people not only to remain covered, but to keep their current policy—with its covered benefits and providers—on which they already depend.

COBRA requires some group health plans to offer temporary continuation of coverage for people who would otherwise lose it due to a qualifying event. A recent study estimates that at any time, some 4.7 million people rely on COBRA for their health coverage (Levitt and Gabel et al. 1999).

Workers and their dependents qualify for COBRA continuation coverage when employment ends due to retirement, voluntary separation, layoff, or when eligibility for health benefits ends due to a reduction in hours worked. COBRA continuation coverage resulting from these qualifying events can last up to 18 months. In some cases, when a disability causes the end of employment or reduction in hours worked, COBRA continuation can extend an additional 11 months.

Dependents also qualify for continuation coverage when they become divorced or widowed from a covered worker, when they age out of dependent status, or when the covered worker relinquishes coverage upon reaching Medicare eligibility. Under these qualifying events, COBRA continuation can last up to 36 months. Each covered worker and dependent has an independent right to elect COBRA. Continuation coverage must be the same as that offered to active workers.

COBRA's protections have limits. First, certain changes can operate to cut short COBRA continuation coverage. COBRA coverage ends when the employer ceases to offer health benefits to active workers. If an older worker retires involuntarily, for example, when a firm goes out of business, there may no longer be a health plan in which to continue. COBRA also ends if a covered person moves out of their COBRA health plan's service area. Early retirees who are "snow birds" need to consider whether they can use their COBRA coverage if they move.

Second, COBRA applies to group health plans offered by employers with 20 or more workers. People separating from coverage sponsored by smaller firms don't have federal COBRA protections. However, 38 states have enacted "mini-COBRA" laws requiring continuation coverage under small-employer plans for fewer than 20 workers. Some of these state laws mirror federal COBRA protections. Others offer shorter periods of continuation coverage (e.g., three to six months).

Finally, individuals electing COBRA must pay the full premium, including the portion formerly contributed by the employer, plus an

administrative charge of up to 2 percent. While COBRA's guarantee of access to group rates generally makes coverage more affordable than it would otherwise be in the nongroup market, the sticker shock of losing the employer's premium subsidy can be considerable. In general, about one in five people eligible for COBRA coverage elect it. This election rate increases with age, however; reaching 38 percent for those age 61 or older (Flynn 1992 and Loprest 1997, as cited in GAO 1998, p. 89). One study suggests that COBRA election is very high (up to 75 percent) among early retirees who have no other coverage options (Gruber and Madrian 1993, as cited in GAO 1998, p. 89)

On average, 61- to 64-year-olds who elect COBRA remain in that coverage for 12 months (Flynn 1992, as cited in GAO 1998). This suggests COBRA may be an important bridge helping early retirees to remain covered until Medicare eligibility begins.

## **HIPAA**

Another potentially important contribution to the health security of the near-elderly—when they are covered under group health plans—was made by the Health Insurance Portability and Accountability Act of 1996, or HIPAA.<sup>2</sup> HIPAA established national standards to protect access to group health coverage. These national standards apply to all group health plans sponsored by employers with two or more workers. They include

- **Nondiscrimination:** Employers and group insurance carriers may not set rules for group members' eligibility for health coverage based on any health status–related factor. Nor can plans and carriers vary benefits or premium contributions for enrollees based on health status–related factors. These factors include medical history, claims experience, evidence of insurability, and genetic information.
- **Limits on preexisting condition exclusions:** No group health plan can impose a preexisting condition exclusion period longer than 12 months (or 18 months for late enrollees). HIPAA defines a preexisting condition as one for which diagnosis, medical advice, care, or treatment was actually recommended or received in the six-month period immediately preceding enrollment in the group plan.



- **Portability:** HIPAA limits the repeated imposition of preexisting condition exclusion periods by group health plans by requiring that persons get credit for qualifying prior coverage. Most prior coverage (including group and individual coverage, Medicare, and Medicaid) is creditable as long as it was not interrupted by a lapse of more than 63 days in a row.
- **Special enrollment periods:** All group health plans must offer individuals who previously declined coverage a special opportunity of at least 30 days to enroll in group coverage when their insurance or family status changes. For example, special enrollment periods must be offered to people when they marry or have a child, or when they lose other coverage due to a change in jobs or expiration of COBRA benefits. Enrollment during these special periods is not considered a late enrollment.
- **Certificates:** So people can document their coverage history, HIPAA requires health plans and carriers to issue certificates of creditable coverage. Certificates must describe the content and length of coverage and must be issued automatically when coverage ends. Certificates also must be provided at other times on request.

Older workers and early retirees are more likely to rely on HIPAA group health plan protections, given their poorer health status. Though not prevalent in group health plans prior to HIPAA, lifetime exclusions of preexisting conditions were not unheard of. HIPAA limits on such exclusion periods could be important to older workers and early retirees. HIPAA requirements for portability and special enrollment periods can help people manage the transitions of work and family status that arise increasingly in this age group.

Enactment of this federal law was an important contribution because these protections were not applicable in all states and all health plans before 1996. Prior to HIPAA, states had been active in enacting similar reforms in their small group markets. State reforms varied widely and often were not as comprehensive as the federal law required (Pollitz et al. 1999; Institute for Health Policy Solutions 1998). Only a handful of states applied insurance reforms in the large group market and, of course, no states could regulate coverage under self-insured employer plans. Thus, the enactment of HIPAA expanded legal protec-

tions for all Americans in group health plans. Older workers and early retirees who maintain group coverage and who need to switch between group health plans can be assured of more consistent and comprehensive protections no matter where they live or what level of government regulates their group coverage.

### **State insurance reforms beyond HIPAA**

Some states have gone beyond the national floor of group health protections guaranteed by HIPAA. These additional state protections may be most helpful for older workers or early retirees who decide to establish their own business or who work for very small firms. Because these protections vary so widely, however, it is important for older workers and early retirees to familiarize themselves with the laws in their own state.

Fifteen states (Arizona, Colorado, Connecticut, Delaware, Florida, Maine, Maryland, Massachusetts, New Hampshire, New Mexico, North Carolina, Rhode Island, South Carolina, Vermont, and Washington) have applied some or all of their group market reforms to the self-employed or groups of one. In Arizona, Colorado, North Carolina, and Rhode Island, the self-employed are guaranteed access only to certain small-group policies; they are not guaranteed the issuance of all products as HIPAA requires for groups of 20–50. In Maryland, the self-employed are guaranteed access to small-group policies only during semiannual open seasons. In New Mexico, the self-employed can be considered a group if they buy family coverage, but only through the state's small-employer purchasing alliance. In South Carolina, spouses who work together in a family-owned business can be considered a group of two. For older workers who leave a job to set up their own business, these state reforms can be very helpful.

Most states also have gone beyond HIPAA's requirements to establish rating limits in their small-group markets. It is in small groups that one older worker's age or poor health may have a more tangible impact on the entire group's premium. State small-group rating reforms also vary considerably. Two states (New York and Vermont) require pure community rating, under which neither the age nor the health status of workers may cause a small group's premium to vary. Ten states require modified community rating, which permits no premium variation due to health status but allows variation based on other demographic fac-

tors such as age. In three states (Hawaii, Michigan, and Pennsylvania), community-rated coverage is available only through certain carriers. Thirty-one states impose rate bands that allow limited rate variation based on health status, as well as variations based on age and other demographic factors. Two states (Arizona and New Mexico) require modified community rating for some small-group products and rate bands for others. Virginia imposes rate bands on only two products sold to only certain small groups. Only Illinois and the District of Columbia have no small group rating restrictions at all (Pollitz et al. 1998).

### **Affordability of Group Coverage**

In addition to guaranteeing access to group coverage that is offered by employers, federal law does provide one protection that may improve the affordability of health coverage for some older workers and early retirees in limited circumstances.

The Family and Medical Leave Act (FMLA) was passed in 1993 primarily to help workers balance the needs of job and family.<sup>3</sup> It may also provide important, though short-lived, assistance to older workers who leave the workforce involuntarily due to illness or to care for a sick relative.

The FMLA guarantees up to 12 weeks of job-protected leave for workers when they become ill or disabled or when they need to care for a newborn or for a sick or disabled family member. The law guarantees only unpaid leave, although people must be allowed to draw sick pay, vacation pay, or disability income insurance benefits they have accrued. The law also requires employers to continue health benefits during leave. Unlike HIPAA and COBRA, therefore, the FMLA does provide for a subsidy to make group coverage affordable.

According to the Bipartisan Commission on Family and Medical Leave, family leave to care for a seriously ill family member and medical leave for one's own health accounts for almost 80 percent of all leave taken by employees. When surveyed about their future need for family and medical leave, about 40 percent of employees responded that they expect to need such leave within the next five years. The most frequently cited reason was to care for a seriously ill parent. While the length of leave varies depending on the reason for taking leave, the

median length for all leave-takers is 10 days. Eighty-four percent of people taking leave return to work, 10 percent remain on leave, and only 6 percent do not return to work (Bipartisan Commission on Family and Medical Leave 1996).

The FMLA can offer some early retirees a brief bridge of affordable health coverage before they move on to COBRA or other group or individual insurance. However, because the law only applies to firms with 50 or more employees, because the benefit guarantees are so time limited, and because it is structured primarily to be a reform to help people return to work, it is unlikely that FMLA health coverage provides much of a lifeline to very many individuals.

### **Access to Individual Coverage**

As noted above, the near-elderly rely more heavily on nongroup coverage than do younger people. Reliance on individual coverage may increase if current trends toward declining employer-sponsored retirement health benefits continue. Individual insurance markets are much less tightly regulated than group markets, and the near-elderly will tend to be vulnerable purchasers of coverage in individual markets.

Individual insurance markets are characterized by the aggressiveness of their carriers' underwriting practices. Where such practices are not regulated, individual market insurers may deny coverage altogether to an applicant determined to be a bad risk. Insurers also may sell coverage that temporarily or permanently excludes coverage for a health condition or an entire body part or system. In addition, they may charge higher (substandard) premiums based on an applicant's health status. Premiums may be further increased, typically by a factor of three or higher for people in their early 60s, due to age and other demographic factors (Chollet and Kirk 1998, p. 44). For older workers and early retirees who need to buy insurance on their own, these underwriting and rating practices can pose substantial barriers to access. Consider the story of one 52-year-old woman who recently "retired" to Florida.

We moved to Florida with insurance [under my husband's COBRA plan] and tried to buy individual coverage. [I] was turned down by no less than 5 companies because of a preexisting

condition that was corrected 30 years ago! Was told by BC/BS of Florida to get a job or get arrested. Since I don't like stripes, I took a job. Since my husband and I had just retired from New York, I was not amused, but I am now insured. Our concern now, is what . . . will [happen] . . . to us AFTER COBRA! My husband is going to be 62 in 1/00! I've found many of my neighbors in our new community have the same problem. We all didn't come with "retirement insurance" from our companies, and due to some minor problems (i.e., heel spurs) many have returned to work because they cannot get insurance here!<sup>4</sup>

Federal health reforms have done little to improve this situation, though some states have acted to secure access to coverage for the near-elderly and other individuals.

## HIPAA

While HIPAA added significantly to people's legal protections under group health plans, it added little to their protections when buying individual coverage. Whether this result was intended is hard to know. On the one hand, early retirees and older workers leaving group coverage to set up their own businesses were typical of the people Congress sought to help through HIPAA. On the other, as an incremental reform, HIPAA was limited and incomplete by design. Congress also was especially deferential to the goal of state flexibility when it drafted HIPAA's individual-market provisions. The combination of HIPAA's small reform increment and great state flexibility left people in the individual market with little more real protection under the new federal law than they had before.

HIPAA contained two key protections in the individual market. First, it required all coverage, including individual policies, to be guaranteed renewable. That is, carriers are prohibited from canceling or refusing to renew coverage due to advancing age or declining health. Second, HIPAA contains "portability" protections for people leaving group coverage to buy individual insurance when they have maintained a substantial and continuous coverage history. These people, called *federally eligible individuals*, must have had at least 18 months of continuous coverage that was not interrupted by a lapse of more than 63 days in a row. Their most recent day of coverage must have been under a group health plan, and they must have elected and exhausted any

available COBRA continuation benefits. Once people become federally eligible, they must purchase individual coverage within 63 days. HIPAA guarantees federally eligible people access to all policies sold in the individual market. States can adopt an alternative mechanism for guaranteeing access to health coverage for federally eligible individuals, and 39 states did so.

HIPAA lacked one key protection for people buying individual coverage: rating limits. Consequently, while all individual policies are now guaranteed renewable in all states, nothing in federal law prohibits insurers from raising renewal rates so high as to deter people from continuing their coverage. Only where states had already acted to limit this practice do people have such protections.

The lack of rating protections also made hollow HIPAA's right of guaranteed issue to private individual coverage. Eleven states and the District of Columbia adopted this new guaranteed issue protection for their federally eligible residents. None of these dozen jurisdictions have individual market rating reforms, however.<sup>5</sup> Consequently, policies sold to federally eligible individuals in these areas are priced as high as 400 to 600 percent of standard rates (Scanlon 1998).

In the 39 alternative-mechanism states, people do have some rating limits but few new access protections. HIPAA's requirements were so flexible that all but a few states simply made minor adjustments to the reforms they had previously enacted. As a result, most people in these states have the same or similar right of access to individual coverage after HIPAA as they did before (Pollitz et al. 1999).

In summary, where HIPAA granted a new access protection for people in the individual market, it was rendered almost meaningless because the lack of rating reforms let carriers deter access by changing prohibitive premiums. And, where HIPAA deferred to states in designing individual market access protections, most states decided to keep reforms they already had in place. The result for older workers and early retirees is that coverage options remain about the same.

### **State-legislated protections**

For the near-elderly, then, like other Americans, access to individual market coverage remains a function of health status and geography. Some states offer greater access protections than others. The woman quoted above who retired to Florida might have found it easier to

obtain individual coverage had she moved to one of the other states described below.

Access to all individual market policies is guaranteed for all residents in six states. In all of these states, individual policies must be priced according to community rating or modified community rating (Figure 1).

In five other states, all residents are guaranteed access to at least some products sold by some carriers (for example, a Blue Cross/Blue Shield plan). One of these states does not limit rates that can be charged for these policies (Figure 2).

Seven jurisdictions require periodic open seasons during which residents are guaranteed access to some or all individual market products (for example, some states require HMOs to conduct annual open enrollment periods.) Rating protections exist in only four of these seven states (Figure 3).

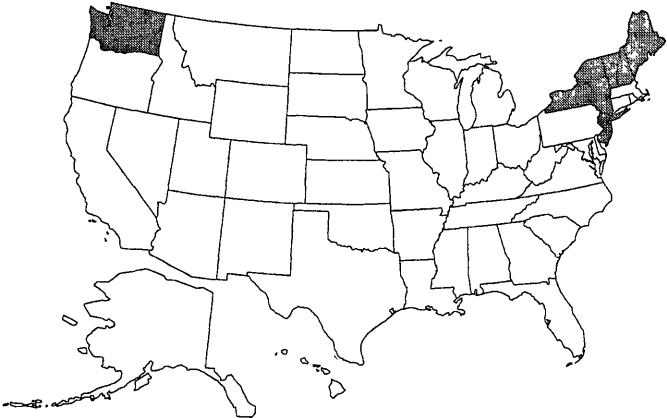
Other states have enacted access protections in the individual market to people who were previously insured. Residents in six states have broader portability rights than under HIPAA. For example, residents in these states typically are guaranteed access to some or all individual coverage whenever they switch health plans, not just when they switch from group to individual coverage as HIPAA permits. Often only several months to one year of prior coverage is required to gain such portability rights. Again, however, rating protections are only applied in five of the six states (Figure 4).

In 31 states, early retirees and other leaving group coverage are guaranteed conversion rights, meaning their group carrier must issue them an individual policy regardless of health status. Only 10 of these states limit premiums that can be charged for conversion coverage. In the other 21 states, conversion rights tend to be hollow (Figure 5).

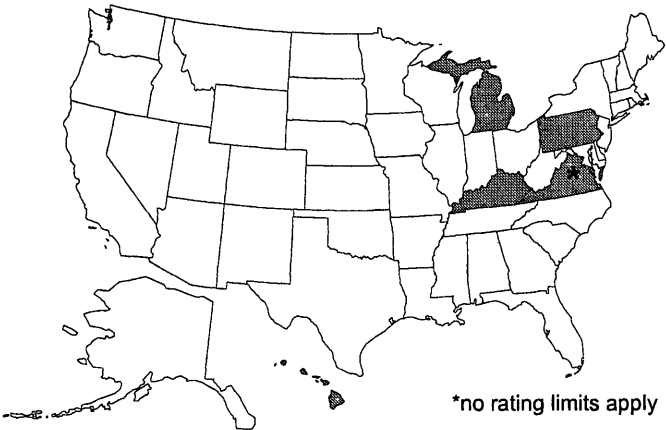
### **Affordability of Individual Coverage**

In addition to guaranteeing access to coverage, a few states offer subsidies for private individual coverage purchased by low-income residents. These programs, funded with state-only dollars, tend to be fairly small. Health Access New Jersey, for example, subsidizes the purchase of commercial health insurance by people under age 65 having family incomes below 150 percent of the poverty level. The pro-

**Figure 1 States that Require Guaranteed Issue of All Individual Market Policies at Community Rates to All Residents**

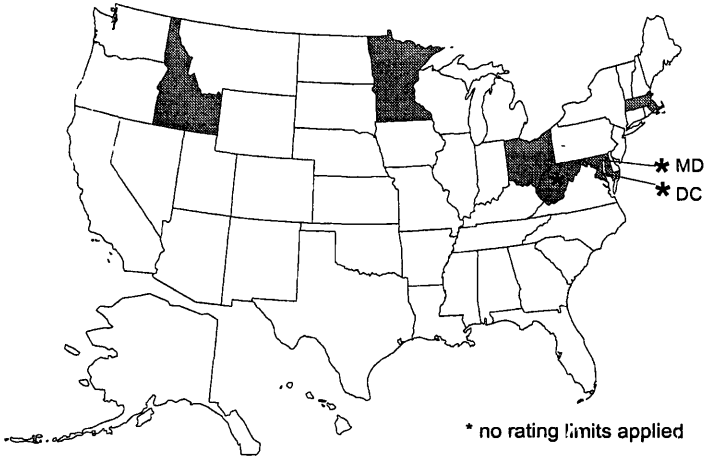


**Figure 2 States Where All Residents are Guaranteed Issue of Some Individual Products**

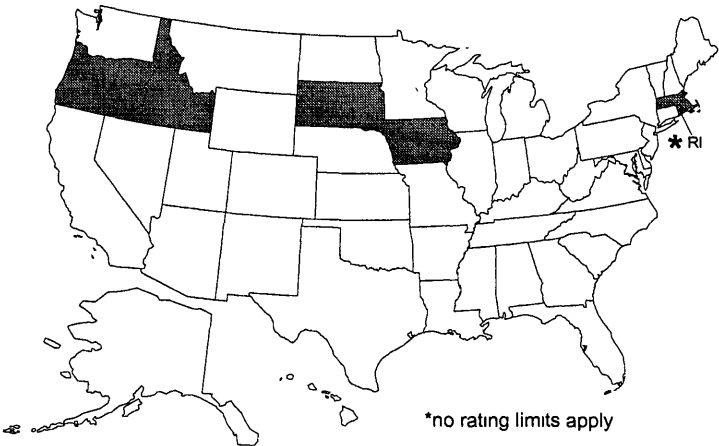




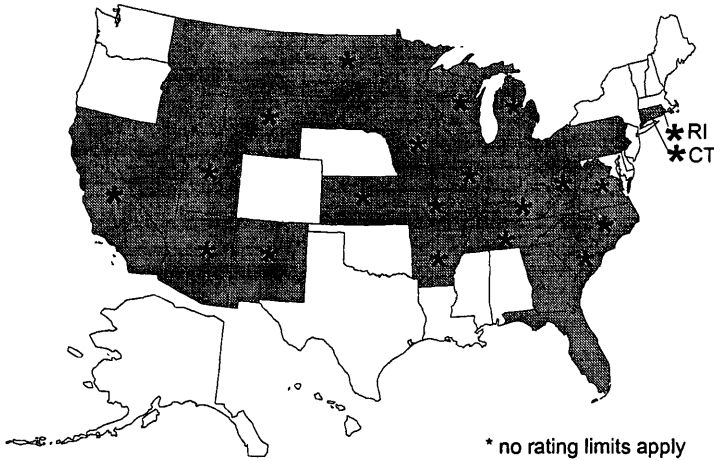
**Figure 3 States Requiring Open Season Enrollment for Some or All Individual Market Policies**



**Figure 4 States with Portability Protections for Previously Insured Residents that are Greater than HIPAA Requires**



**Figure 5 States Requiring Conversion Rights for Individuals Leaving Group Coverage**



gram had over 14,000 enrollees in 1997. In Massachusetts, the Medical Security Plan makes subsidized coverage available to people under age 65 having family incomes below 200 percent of the poverty level. This program also provides partial premium subsidies for COBRA continuation coverage for families with incomes below 400 percent of the poverty level. Over 15,000 Massachusetts residents participated in this program in 1997 (Summer 1998).

**Public Coverage Options**

Public coverage options tend to offer both access and affordability. Eligibility under these programs, even entitlements, is limited, so older workers and early retirees may not always be eligible.

**Federal initiatives**

Coverage under the federal Medicare program is only available to people before the age of 65 if they are disabled or suffer from end-

stage renal disease. As noted earlier, about 6 percent of people aged 55–64 qualify for Medicare coverage this way.

Medicaid also offers coverage to certain low-income people who become disabled and can no longer work. In the closing days of 1999, Congress enacted the Work Incentives Improvement Act to expand access to Medicare and Medicaid for some disabled individuals who want to return to work.<sup>6</sup> People under age 65 who have left the workforce because of a disability may now have the option of returning to work because of the enactment of this law. It gives states the option to permit working individuals with a medically improved disability to buy into Medicaid and to eliminate income, asset, and resource limitations for those workers who do. It also provides \$400 million for demonstration programs and incentive grants to states to encourage the expansion of these Medicaid buy-in options. In addition, the law permits disabled Medicare beneficiaries who return to work to continue their Medicare coverage for six and one-half years, which is significantly longer than the current 24 months. This extension of health coverage through public plans may address a key cause of involuntary retirement and enable more people to return to work without jeopardizing their health insurance.

Medicare and Medicaid eligibility have not yet been changed to extend coverage for non-disabled older workers who prefer to take early retirement. In 1997, President Clinton proposed legislation to establish a Medicare buy-in option at actuarially neutral premiums for certain people between the ages of 55 and 64, but it was not enacted.

### **State programs offering subsidized coverage**

A number of states have used Medicaid 1115 waivers to make low-income uninsured adults eligible for Medicaid coverage. For example, Hawaii's Quest program offers subsidized coverage for low-income uninsured individuals under age 65 with incomes below 300 percent of the poverty level. MinnesotaCare offers limited benefit coverage at discounted premiums for adults under 175 percent of poverty and for parents of minor children with family incomes below 275 percent of poverty (Summer 1998).

Washington offers subsidized public coverage funded entirely with state money. The Basic Health Plan offers comprehensive coverage for a sliding scale premium based on income. Residents with gross

monthly income up to about \$2300 (for a family of 3) could qualify for eligibility in 1999. Approximately 128,000 residents were enrolled at the end of last year (Washington State Health Care Authority 1999).

### **State high-risk pools**

Twenty-five states have high-risk pools to guarantee access to coverage for the medically uninsurable. Most of these state pools operate with limited funding, however, and enrollment in all but a few is very small (under a few thousand individuals). For older workers and early retirees, the access guarantee offered by many state high-risk pools might seem particularly incomplete. All state high-risk pools price premiums using age rating. Premiums for a 64-year-old range from two to five times higher than those charged for a 24-year-old. Depending on the state and benefit package, it is not uncommon for the near-elderly to face premiums in excess of \$500/month under high-risk pools. A number of state high-risk pools have other shortcomings. Covered benefits under seven state high-risk pools are subject to significant limitations (such as an annual cap of \$75,000 on covered services in California). Six state high-risk pools set premiums at 200 percent of standard rates before adjustments for age and other demographic factors are applied. Two states cap enrollment under their high-risk pools, and so deny access to coverage for the uninsurable when state funding runs short.<sup>7</sup> However, two states (Connecticut and Wisconsin) do offer premium subsidies through their high-risk pools (Pollitz et al. 1998; Communicating for Agriculture 1999).

## **CONCLUSION**

As Americans age, their need for health insurance grows but, coverage opportunities may decline. People leaving the workforce need both access to health insurance coverage and the means to pay for it. The erosion of employer-provided retirement coverage may make both access and affordability more problematic in the future, and as the baby-boom generation ages, these problems will be faced by greater numbers of people.

Some federal efforts to promote health insurance access have been significant. The enactment of COBRA and HIPAA group market reforms in particular have created a floor of protections, though limited in scope, that people can count on no matter where they live. The near-elderly, most of whom are covered by employer-sponsored health insurance, are among those whose access protections have been enhanced as a result.

Older workers and early retirees do rely disproportionately on individual coverage. In these health insurance markets, their age and higher risk status threatens their access to coverage. HIPAA did not add significantly to individual market protections, however, so people's coverage options were left pretty much unchanged.

Neither of these federal reforms provide subsidies, which are key to the low-income uninsured gaining private coverage. One recent federal initiative did improve access and affordability of public coverage for those disabled older retirees who qualify for Medicare or Medicaid and who may wish to return to work. Federal policy has not changed public coverage options for nondisabled older workers and retirees.

Some states continue to try to fill some of the gaps in access and affordability left by limited federal reforms. However, state efforts are limited, too, and their success varies. For older Americans, especially those who relocate later in life only to find themselves covered by a new and different set of rules, this patchwork of state rules and protections may seem particularly unreliable and confusing. Without the enactment of more sweeping federal reforms, it seems likely that there will continue to be no guarantee of health care access or affordability for the near-elderly.

## Notes

1. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. Among other things, this law amended ERISA to require temporary group health continuation coverage. COBRA amendments to ERISA are found at 29 U.S.C. 1161 et. seq.
2. P.L. 104-191.
3. P.L. 103-3.
4. This comment was left anonymously by a visitor to Georgetown's Health Insurance Consumer Guide home page, [www.georgetown.edu/research/ihrp/hippa](http://www.georgetown.edu/research/ihrp/hippa). October 1999.

5. The state of Maryland does limit rates that can be charged only for certain policies sold to federally eligible individuals
6. P.L. 106-170
7. In Illinois, where the high-risk pool is part of the state's alternative mechanism under HIPAA, the enrollment cap may not be applied to people who are federally eligible.

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