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SCRAMBLING FOR HEALTH INSURANCE COVERAGE: HEALTH SECURITY FOR PEOPLE IN LATE MIDDLE AGE

HEARING

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CONTENTS

	Page
Opening Statement of Senator Ron Wyden	1
Opening Statement of Senator Gordon Smith	1
Opening Statement of Senator Thomas Carper	72

PANEL I

Mike Roach, owner, Paloma Clothing, Portland, OR	5
Lee Anne Fitzpatrick, employee, Paloma Clothing, Lake Oswego, OR	9
Benjamin Lindner, owner, Nutshell Enterprises, Redmond, OR	13

PANEL II

Paul Fronstin, director of Health Research and Education Program, Employee Benefit Research Institute (EBRI), Washington, DC	24
Jeanne Lambrew, associate professor, LBJ School of Public Affairs, Austin, TX	36
John Sheils, senior vice president, The Lewin Group, Falls Church, VA	53

APPENDIX

Mike Roach Responses to Senator Smith's Questions	79
Lee Ann Fitzpatrick Responses to Senator Smith's Questions	79
Paul Fronstin Responses to Senator Smith's Questions	79
Jeanne Lambrew Responses to Senator Smith's Questions	82

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THURSDAY, APRIL 3, 2008

UNITED STATES SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC

The Committee met, pursuant to notice, at 10:36 a.m., in Room SD-608, Dirksen Senate Office Building, Hon. Ron Wyden presiding.

Present: Senators Wyden, Carper, and Smith.

OPENING STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. The Senate Special Committee on Aging will come to order.

The ranking minority member, Senator Smith, who has a longstanding interest in these issues, is here, and I think he is being summoned to the floor. I think what I would like to do is recognize him first for his comments. Then I will have my opening statement.

We are very pleased to have a terrific group of Oregonians here, and we are anxious to have their comments in a moment.

But let's recognize Senator Smith first.

OPENING STATEMENT OF SENATOR GORDON SMITH, RANKING MEMBER

Senator SMITH. Thank you, Senator Wyden.

Mr. Chairman, I appreciate so much your courtesy and more I appreciate your laser-like focus on health care. There just simply is not a more pressing problem in our country, both for the health of our people, particularly, as is the focus of this Committee, on elder Americans, but also for the health of our economy, and there are many senators and elected representatives who are trying to get a handle around this, and there are probably as many ideas as there are members. But there is a convergence coming, and that is why this hearing and Senator Wyden's focus and mine, as well, is timely and appreciated.

With your permission, Mr. Chairman, because I am being asked to come to the floor to speak literally in 10 minutes with Senator Kerry on an important housing amendment that we have, I would like to put my statement in the record.

Senator WYDEN. Without objection, that will be so ordered.

[The prepared statement of Senator Smith follows:]

PREPARED STATEMENT OF SENATOR GORDON SMITH

Good morning and thank you all for being here today.

I would like to extend a personal welcome and thank you to Ms. Lee Anne Fitzpatrick, Mr. Mike Roach and Mr. Benjamin Lindner for traveling all the way from Oregon to be with us. I look forward to hearing from each of you this morning.

I also would like to thank Senator Wyden for chairing this important hearing and for his on-going efforts to make health care reform a top priority of this Congress.

As Senator Wyden and I know from our many years of working together, to truly make progress on improving the health of this nation, lawmakers must put partisanship aside and work towards a common goal.

I commend Senator Wyden for his bipartisan efforts to reform the current health care delivery system; and I appreciate the ideas he has put forth.

Over my tenure as a United States Senator, I have fought year after year to protect both Medicaid and Medicare for our most vulnerable individuals. But now it is time to turn our attention toward crafting new solutions.

Today's discussion will focus on the challenges that some individuals in their late middle age face to maintain or access health insurance coverage, and on the challenges that small business employers' face to provide health care benefits to their employees.

We understand that while individuals in this age group have more health problems than other age groups; fortunately they also are more likely to be insured—67.4 percent have employment-based insurance.

However, their health problems can have a significant financial impact on them and their employers, especially for those with small businesses.

Of the 46 million Americans without health insurance, more than 27 million, or nearly 60 percent, are small business owners, their employees or dependents.

Small business owners and their employees are disproportionately burdened by the current structure of our health care system and health care costs.

Under current law they do not enjoy the same tax breaks, coverage or pooling options as large businesses and corporations, and on average, they pay 18 percent more for the same healthcare benefits.

To deliver real and meaningful healthcare reform we must recognize the challenges faced by small business and develop reform proposals that support them.

Before becoming a Senator, I managed a small company called Smith Frozen Foods. I was fortunate to be able to provide health care to my employees. I do, however, understand the difficulties small business owners face in offering quality health care coverage to their employees without bankrupting the business.

I know that small business owners want to provide health care, they just need an affordable way to do it. That is why I have been working on legislation that will partner the federal government with states and small businesses to deliver comprehensive health care coverage to small businesses at an affordable rate.

Just by focusing on small businesses, we can cut the ranks of the uninsured in America by more than half.

While a more comprehensive approach, like the one offered by my colleague Senator Wyden, certainly could be ideal, it's important to point out that America's health insurance system was established incrementally. For this reason, it very well may take incremental steps to improve it to ensure all Americans have access to care.

Senator Wyden and I share the same goal of providing high-quality health care in this country that is accessible and affordable for all Americans. We understand that finding real solutions require the cooperation of diverse, bipartisan groups willing to work together for change.

I look forward to learning more from our panelists about these issues and to discuss what options we, as a government, have in order to improve upon our health care delivery system.

With that, I turn to Senator Wyden.

Senator SMITH. I would like to personally welcome Ms. Lee Anne Fitzpatrick, Mr. Mike Roach, and Mr. Benjamin Lindner, who are all the way with us from Oregon. The Oregon Trail is a long way, and you appreciate the ride that Senator Wyden and I make on a weekly basis. But your testimony—I have reviewed it, and you have added measurably and competently to the record of the United States Senator, and so I thank you for that.

I thank you, Mr. Chairman.

Senator WYDEN. I thank you, Senator Smith, and I know you have a tight schedule, been there and done that, in terms of trying to get to the floor. If it is possible for you to come back, we would welcome you.

Today, the Senate Special Committee on Aging is going to look at an increasingly stressed part of American health care, the spectacle of hundreds of thousands of Americans between the ages of 55 and 64 scrambling to obtain quality, affordable health coverage in the strongest and richest country on earth.

In helping to arrange this hearing, we are grateful to Chairman Kohl who has done outstanding work on a score of senior issues ranging from ending Medicare private insurance marketing abuses to the quality of long-term care for older people.

We also want to thank Senator Smith because all of those initiatives have been bipartisan, and Senator Smith has had a great interest in these matters.

I have been told that this is the first time that the Senate Special Committee on Aging has actually held a hearing on the issue of health coverage for those who are in the late middle age period. I am certain with the prospect of troubled economic waters leaving more Americans between 55 and 64 without a health care lifeboat, this hearing is not going to be the last time this matter is considered.

The big question before the Committee on Aging is straightforward: How can it be that so many Americans between 55 and 64 are falling between the widening crack of American health care? They are not old enough for Medicare, they are not poor enough for Medicaid, and many of them, if they work for an employer, are often one rate hike away from losing the even limited health coverage that they have.

I was struck, in fact, in putting together the Healthy Americans Act, which we are going to talk about some today, by how many older people came up to me at home, at town hall meetings, and would say, "Ron, I just hope my employer can hang on to my health coverage until I am 65 and I am eligible for Medicare." Increasing numbers of employers in this country have not been able to live up to that hope.

According to the Kaiser Family Foundation, between 2000 and 2007, 9 percent fewer employers offered health coverage for their workers. Even more prevalent has been the problem of employers facing crushing increases in their health care costs, keeping the coverage they have for the employees, but constantly whittling that coverage down with more co-payments and more deductibles.

So fresh approaches for addressing the health needs of workers in late middle age is especially important right now. The facts show that in tough economic times, the job market is especially harsh on the older worker. A recent study of the challenges facing older workers during the last two recessions, 1981 and 1982 and the early 1990s, found that in each recession, older workers lost significant ground. Serious economic downturns, according to researchers, can be used as an excuse to get rid of older workers who finds themselves pushed towards the door under the guise of "corporate restructuring."

The pressures that dedicated older workers and their sympathetic employers are under are illustrated by the testimonies of the Oregonians who have joined us—Lee Anne Fitzpatrick, Mike Roach, and Ben Lindner. I consider you all the human faces of this scramble for health coverage for folks between 55 and 64, and we really appreciate your making the trek back here to Washington.

I was struck—and Mr. Roach will go into it a bit further—about how so often it seems that for these workers in late middle age, what they mostly have is hope. I think, as Mr. Roach points out, hope is not exactly an effective game plan, if that is all you have, to make it through those years in terms of what you need in health care.

The desperation that workers feel is also illustrated by some especially important accounts offered by the journalist Reed Abelson. Ms. Abelson has described what I thought was a particularly telling example of how a retiree who was not eligible for Medicare. He could not find private insurance because of a previous illness so he started down the road with the COBRA program, the federal program to continue coverage with a former employer.

He still was not eligible for Medicare after his first stint with COBRA coverage expired. So he went back to work for the same employer again, thereby earning eligibility for COBRA coverage once more. After finishing this round of work with the employer, he retired, again getting COBRA once more. Finally, he became eligible for Medicare after turning 65.

As I read this and have heard from so many folks at home, I had to ask myself, "Is this the best America can do for these patriotic, dedicated citizens?" Pushing workers into some kind of COBRA-orama just to get health coverage in the middle-aged years.

Now, fortunately, some employers have been championing the cause of quality health coverage. We know at home, for example, Intel, a very important employer in our home state, offers retirees options to buy a fine health care package, but, obviously, most companies have not been able to afford it.

So, today, we have two excellent panels to talk about a variety of approaches to address the needs of workers. I am very pleased that this was the special focus of what we tried to do in the Healthy Americans Act. Fourteen United States senators—seven Democrats, seven Republicans have sponsored the legislation. We believe that several of the key features of the Healthy Americans Act—cost-containment guarantee of coverage, insurance reform, portability, and the largest subsidies to low-income people that have been proposed to date—go at least part of the way to meet the needs of this very vulnerable group.

We are going to hear from a panel of people with a lot of good ideas, on how to approach meeting the needs of this age group, and we will enjoy having them here.

So our first panel: Ms. Fitzpatrick and Mr. Roach of Paloma Clothing in Portland; Mr. Lindner, the owner Nutshell Enterprises in Redmond, OR. Then our next panel of witnesses includes three of the most influential and thoughtful people who have looked at health care for many years: Paul Fronstin, director of health research and education programs at the Employee Benefit Research Institute; Jeanne Lambrew, associate professor at the LBJ School

of Public Affairs; and John Sheils, senior vice president of The Lewin Group.

So we have a very fine group. Why don't we just begin at this time?

Let us start with you, Mr. Roach. Welcome. Let me thank you for the many, many hours you gave us as part of the group of small employers that worked as we tried to develop the Healthy Americans Act. So please proceed.

STATEMENT OF MIKE ROACH, OWNER, PALOMA CLOTHING, PORTLAND, OR

Mr. ROACH. Chairman Kohl, Mr. Wyden, Ranking Member Smith, and members of the Committee, thank you for inviting me here today to share my experiences as a small business owner navigating the small employer health insurance market.

My wife, Kim Osgood, and I own and operate Paloma Clothing in Portland, OR, and we have been in business for over 30 years. Paloma Clothing specializes in dressing middle-aged women and older and, as such, most of our employees are also of the same age group. This presents a particular set of problems when shopping for health insurance, including but not limited to pre-existing conditions and higher premiums.

When my mother and I started the business in 1975, we did not offer health insurance to our employees. At the time, I paid out of pocket for an individual health insurance plan. In 1980, I chose to drop my individual coverage and opt in to my wife's less expensive employer-sponsored health insurance. In 1982, my wife left her job and joined our business. At that time, we purchased a family plan that was very expensive.

We began offering our employees health insurance in 2006. We did this not because we could afford it, but in order to retain our highly valued manager, Lee Anne Fitzpatrick, seated beside me. Lee Anne was previously covered by her husband's employer-sponsored insurance, but he was laid off from his job and they subsequently lost their coverage. Lee Anne explained to me that she would need to find a new job that would provide her and her husband with health insurance.

Because of Lee Anne's commitment to Paloma Clothing, I have been able to spend much more time with my family, I have been able to coach my daughter Isabel's soccer team from kindergarten through 8th grade, volunteer in her school every Monday from kindergarten through high school, and very rarely miss any of her important activities and special events.

It is solely in the effort to retain quality employees like Lee Anne that we made the choice to offer health insurance. We felt it was our duty as her employer to help her meet her health care needs. Unfortunately, offering health insurance was not a simple or an affordable decision to make.

When our accountant, David Downs, cautioned that he felt that, should sales and profits decline at all, the cost of group health insurance would seriously threaten the financial health of our business, I made it clear to David that losing Lee Anne would be even more threatening to the financial health of our business, not to mention the quality of life of both of our families. David reluctantly

agreed that we could move forward with buying group health insurance coverage for our employees.

Fortunately, sales and profits increased that year by just enough to cover most of the cost of our group health insurance. As Lee Anne accurately predicted, offering health insurance has helped us attract and retain the best customer service team our business has ever employed in our 33 years of doing business. But only in the past few years has our revenue per employee grown to a point that we can barely afford to offer group health insurance.

As we head into the uncharted waters of a clearly troubled economy, we, like all other small locally owned mom-and-pop businesses offering employee health insurance, hope that our revenues can grow enough to keep pace with the seemingly unending increases in health insurance costs. While hope would not normally be considered a viable small business strategy, hope is really all we have at this point.

I want to thank you again for holding this hearing today and shining a spotlight on the health care crisis facing small businesses. I greatly appreciate your interest and your willingness to listen to my story.

[The prepared statement of Mr. Roach follows:]

Testimony of Mike Roach
before the
Senate Select Committee on Aging
on the date of April 3, 2008
on the subject of
Scrambling for Health Insurance Coverage:
Health Security for People in Late Middle Age

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Thank you again for holding this hearing today and shining a spotlight on the health care crisis facing small businesses. I greatly appreciate your interest and your willingness to listen to my story.

Senator WYDEN. Mike, thank you. Again, you have been so helpful. As a member of NFIB, the National Federation of Independent Business, at home, your voice on these issues has been really constructive. We thank you for it.

Mr. ROACH. Thank you.

Senator WYDEN. Ms. Fitzpatrick, welcome. We will get your microphone set. It works. There we go.

STATEMENT OF LEE ANNE FITZPATRICK, EMPLOYEE, PALOMA CLOTHING COMPANY, PORTLAND, OR

Ms. FITZPATRICK. Thank you.

Senator WYDEN. All right.

Ms. FITZPATRICK. Chairman Kohl, Mr. Wyden, Ranking Member Smith, and members of the Committee, thank you for inviting me here today to share my story with you.

My name is Lee Anne Fitzpatrick, and I am 57 years old. When I was 5, I was in a serious accident, and two surgeries were required to save my life. The accident has left me with pre-existing conditions, which have presented me with additional problems when looking for insurance.

As Mike already explained, I currently have insurance, but that has not always been the case. Before joining Paloma Clothing, I worked for 10 years as a nurse, owned my own restaurant for 12 years and a flower shop for one year. When I was self-employed, I applied for an individual health insurance plan from Blue Cross. They sent me a letter stating that they would insure me, except for most of my internal organs.

Senator WYDEN. Can I make sure I understand that? They sent you a letter saying that they would insure you for a part of your body?

Ms. FITZPATRICK. Yes.

Senator WYDEN. OK. Could you make that letter a copy of the record? Do you still have it?

Ms. FITZPATRICK. I doubt if I have it. I actually should have looked for it, but it was, quite a few years ago. But they listed the organs they would not cover and the organs they would cover.

Senator WYDEN. They went organ by organ?

Ms. FITZPATRICK. Yes.

Senator WYDEN. OK. Please go ahead.

Ms. FITZPATRICK. They would not cover my internal organs because of the accident I had when I was 5 years old and the health problems that resulted from it. I did not purchase the insurance and instead went without health insurance for about a year until my husband, Chip, got a job that gave us health insurance.

Soon after, I was admitted to the hospital where I spent the next month and had two surgeries. The bill was around $75,000. Thankfully, about 80 percent of the cost was paid for by my insurance. After being discharged, I was unable to work for three months. I remember how fortunate I felt to have had insurance when I became ill.

During Chip's last year at Intel, he was diagnosed with cancer and underwent surgery to treat it. In 2006, my husband was laid off from his job. At that time, Paloma Clothing did not offer a health insurance plan, so we chose to go on to COBRA to avoid los-

ing insurance. Our monthly payment was the entire cost of the premium, almost $1,000.

When my husband was laid off, I explained to Mike that I would need to find a new job with health benefits. I did not want to leave my job, but the fear of being uninsured and the burden of paying out of pocket for insurance for two adults with pre-existing conditions, as well as a history of illness, made it necessary. I am fortunate to have an employer who cares enough about his workers to make the difficult and costly decision to offer them health insurance.

As Mike has stated, our accountant gave the green light or blinking red light to obtain coverage, and I undertook the task of finding a plan that would work for me and the other employees. Much of my original research on insurance was conducted via word-of-mouth referrals and calling insurance companies directly. Plan comparisons took a great deal of time and involved a subjective decision-making process. All had big bucks riding on making the right decision for Mike's business.

Paloma Clothing is in the midst of changing insurance providers due to an increase in cost. Under our old coverage, Mike paid 85 percent of the monthly cost of the plan, or $2,662. Under the new plan, Mike will still pay 85 percent, but his monthly cost will fall by about $450 a month, to just over $2,200 per month.

Even with the reduction in cost, offering insurance to employees will continue to be a stress on the financial security of Mike's business. As he mentioned, all we can do now is hope that the business makes a profit greater than the cost of the health insurance.

It baffles me that in a country of such opportunity and wealth, so many of us live in fear of losing our financial security due to the lack of access to health insurance. My husband and I are lucky that I work for an employer who with considerable financial difficulty is able to offer me health insurance. Not all employers are in his position. As a small-business employee, I believe that we must find a solution to the ever-increasing cost of health care in our country.

I hope that the testimony given today will inform and guide you to crafting a solution that will lift the costly burden of health care, as well as reduce our fear and uncertainty.

Thank you.

[The prepared statement of Ms. Fitzpatrick follows:]

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before the
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Chairman Kohl, Mr. Wyden, and members of the Committee, thank you for inviting me here today to share my story with you.

My name is Lee Anne Fitzpatrick and I am 57 years old. When I was five, I was in a serious accident, and two surgeries were required to save my life. The accident has left me with "pre-existing conditions," which have presented me with additional problems when looking for insurance.

As Mike already explained, I currently have insurance but that has not always been the case. Before joining Paloma Clothing, I worked for 10 years as a nurse, owned my own restaurant for 12 years and a flower shop for one year. When I was self-employed, I applied for an individual health insurance plan from Blue Cross. They sent me a letter stating that they would insure me, except for most of my internal organs. They would not cover my internal organs because of the accident I had when I was five years old and the health problems that resulted from it. I did not purchase the insurance, and instead went without health insurance for about a year until my husband, Chip, got a job that gave us health insurance. Soon after, I was admitted to the hospital, where I spent the next month and had two surgeries. The bill was around $75,000. Thankfully, about 80 percent of the cost was paid for by my insurance. After being discharged, I was unable to work for three months. I remember how fortunate I felt to have had insurance when I became ill. During Chip's last year at Intel, he was diagnosed with cancer and underwent surgery to treat it.

In 2006, my husband was laid off from his job. At that time, Paloma Clothing did not offer employees a health insurance plan, so we chose to go on to COBRA to avoid losing insurance. Our monthly payment was the entire cost of the premium – almost $1,000.

When my husband was laid off, I explained to Mike that I would need to find a new job with health benefits. I did not want to leave my job but the fear of being uninsured and the burden of paying out-of-pocket for insurance for two adults with pre-existing conditions, as well as a history of illness, made it necessary. I am fortunate to have an employer who cares enough about his workers to make the difficult and costly decision to offer them health insurance.

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I hope that the testimony given today will inform and guide you to crafting a solution that will lift the costly burden of health care, as well as reduce our fear and uncertainty. Thank you.

Senator WYDEN. Thank you. It is very helpful to hear your account.

Mr. Lindner, welcome.

STATEMENT OF BENJAMIN LINDNER, OWNER, NUTSHELL ENTERPRISES, REDMOND, OR

Mr. LINDNER. Good morning, Senator Wyden. Thank you for this opportunity to testify before this committee.

It is my hope that my testimony may shed some light on the challenges faced by small business owners and more mature Americans in obtaining health insurance. I would particularly like to highlight the difficulties faced by those with pre-existing medical conditions obtaining health care insurance. I would also like to touch on some of the challenges that we as consumers have experienced in accessing insurance benefits.

By way of background, my wife and I founded a small business in 1993 and live and work in central Oregon. We have had one health insurance provider supplied through our business and one type of policy since 1993. Prior to 1993, we had been continuously insured through previous employers or personal policies.

In 1993, when we contracted for our small business insurance policy our annual out-of-pocket expenses, including premiums, were approximately $5,000 combined. Today, we have the same healthcare policy. However, our annual expenses are now about $21,600. This works out to $5.19 per hour per person in health care costs.

From a national perspective, I believe that this level of cost constitutes a significant disincentive to employing mature workers. Mature workers raise the average age and corresponding health care costs of a company's workforce. Businesses then have further incentive to retire older workers and staff with younger employees or to outsource.

Every year at our policy renewal period, we search for a better rate from insurance providers. Unfortunately, the market is such that health insurers now pick and choose whom they wish to insure, rejecting any potential client that they view as unprofitable.

I have psoriasis and psoriatic arthritis, chronic inflammatory diseases that affect my skin and joints. Seven-and-a-half million other Americans suffer from these conditions. If my psoriasis were not treated, my ability to work would be severely impacted.

My business partner and wife, Leslie, has cancer. As a result of these pre-existing conditions, we are simply uninsurable through any means other than continuing the business policy that we have had for 15 years. Frankly, we are thankful that we can obtain this insurance coverage at any price. We are, in fact, captive not only by our insurance company, but to staying in business in order to maintain our coverage. We are lucky to have access to excellent medical care in our area.

Unfortunately, the barriers to accessing that care erected by our insurance company are formidable. The amount of time invested by us in resolving claim issues and by our health care providers in justifying treatments and prescriptions represents a significant burden and expense to all of us. I believe that the tug of war between our health care providers and our insurance company is re-

sponsible for a substantial portion of the cost of care. The expenditures in time that we as consumers make in this area are tremendous. My wife has been on a first-name basis with claims representatives at our insurance company for 5 years since her diagnosis.

An example of the frustrations connected with these methods of operation occurred when Leslie was recently diagnosed as being in renal failure. Her physician ordered an immediate MRI. Our insurance company initially refused coverage for this test. We assumed financial responsibility and had the test performed. Some time later, the insurance company reconsidered and approved the claim.

Regarding prescriptions, our insurance company's adherence to Nancy Reagan's policy of "Just say no to drugs" can be relied on to reject any prescription other than the most routine generic drugs. Remarkably, even after an appeal process in which coverage has been granted, a subsequent refusal may occur.

Our insurance company utilizes an exceptionally complex formula for calculating drug co-pays. This allows assessments of co-pays for cost differentials for branded drugs that are four time or more higher than what is represented and what would be expected.

The health care cost system in general is so complex and obtuse as to be indecipherable to even the most sophisticated consumer. This is because of the practice of cost shifting to insured by providers.

As an example, I compared the costs of a procedure recently. An uninsured individual was charged $1,000. An insured individual was charged $700. The same procedure at a clinic that does not accept insurance costs $175. I think tiered pricing should be eliminated and cost information readily available to consumers.

A structure in which an insurance company can arbitrarily choose to exclude all those but the most desirable risks is really the antithesis of what insurance is. We need inclusive access for all people, not exclusive acceptance. In short, we need all Americans to be insured.

[The prepared statement of Mr. Lindner follows:]

Testimony of Ben Lindner
Before the
Senate Select Committee on Aging
April 3, 2008
Scrambling for Health Insurance Coverage:
Health Security for People in Late Middle Age

Good morning Chairman Kohl and Senators. Thank you for the opportunity to testify before this committee.

It is my hope that my testimony may shed some light on the challenges faced by small business owners and more mature Americans in obtaining health insurance. I would particularly like to highlight difficulties faced by those with pre-existing medical conditions concerning the accessibility of health care insurance. I would also like to touch on the challenges that we as consumers have experienced in accessing insurance benefits.

By way of background, my wife and I founded a small business in 1993 and live and work in Central Oregon. We have had one health insurance provider supplied through our business and one type of policy since 1993. Prior to 1993 we had been continuously insured through previous employers or personal policies.

In 1993 when we contracted for our small business insurance policy our annual out of pocket expenses, including premiums, were approximately $5,000.00 combined.

Today we have the same healthcare policy. However, our annual expenses are about $21,600.00. This works out to $5.19 per hour per person in healthcare costs. From a national perspective I believe that this level of cost constitutes a significant disincentive to employing mature workers. Mature workers raise the average age and corresponding healthcare costs of a company's workforce. Businesses then have further incentive to retire older workers and staff with younger employees or to outsource.

Every year at our policy renewal period we search for better rates from other insurance providers. Unfortunately the market is such that health insurers now pick and choose whom they wish to insure, rejecting any potential client that they view as unprofitable.

I have psoriasis and psoriatic arthritis, chronic inflammatory diseases that affect my skin and joints, 7.5 million other Americans suffer from these conditions. If my psoriasis were not treated my ability to work would be severely impacted. My business partner and wife Leslie has cancer. As a result of these pre-existing conditions we are simply uninsurable through any means other than continuing the business policy that we have had for 15 years. Frankly we are thankful that we can obtain this insurance coverage at *ANY* price. We are in fact captive not only by our insurance company but to staying in business in order to maintain our coverage.

We are lucky to have access to excellent medical care in our area. Unfortunately the barriers to accessing that care erected by our insurance company are formidable. The amount of time invested by us in resolving claim issues and by our healthcare providers in justifying treatments and prescriptions represents a significant burden and expense to all of us. I believe that the tug of war between our healthcare providers and our insurance company is responsible for a substantial portion of the cost of care. The expenditures in time that we as consumers make in this area are tremendous. My wife has been on a first name basis with claims representatives at our insurance company for five years since her diagnosis.

An example of the frustration connected with these methods of operation occurred when Leslie was recently diagnosed as being in renal failure. Her physician ordered an immediate MRI. Our insurance company initially refused coverage for this test. We assumed financial responsibility and had the test performed. Some time later the insurance company reconsidered and approved the claim.

Regarding prescriptions, our insurance company's adherence to Nancy Reagan's policy of "Just say no to drugs" can be relied on to reject any prescription other than the most routine generic drugs. Remarkably, even after an appeal processes in which coverage has been granted, a subsequent refusal may occur.

Our insurance company utilizes exceptionally complex formulas for calculating drug co-pays. This allows assessments of co-pays for cost differentials for branded drugs that are four times higher or more than what is represented and what would be expected.

The healthcare cost system in general is so complex and obtuse as to be indecipherable to even the most sophisticated consumer. This is because of the practice of cost shifting to the insured by providers. As an example, I compared the costs of a procedure recently. An uninsured individual was charged $1,000. An insured individual was charged $700. The same procedure at a clinic that

does not accept insurance costs $175. I think tiered pricing should be eliminated and cost information readily available to consumers.

A structure in which an insurance company can arbitrarily choose to exclude all those but their most desirable risks is really the antithesis of what insurance is. We need inclusive access for all people, not exclusive acceptance. In short, we need all Americans to be insured.

Senator WYDEN. You all are probably being too logical for much of Washington, but I think you have said it very, very well, and I just so appreciate what you have described. I think what you have really highlighted is essentially how much of the health care system in our country is melting down on people. We have to make some changes. What I am going to do now is ask some questions to kind of highlight what I think are the most important things to change.

First, Ms. Fitzpatrick, beginning with you, I am still unclear about the coverage that you can get. Are you still faced with insurance companies saying that they will only cover certain body parts and not cover others? Can you now get coverage, for your entire body?

Ms. FITZPATRICK. A private policy or a group policy?

Senator WYDEN. Yes, either one.

Ms. FITZPATRICK. Well, group policies, most of them, as long as I have been continually covered, then I would be continually covered completely. But if I tried to get a private policy, I would be pretty much waivered between, I always say, my neck and the top of my legs, so most of my internal organs probably because I have had continual problems because of my surgeries and because of the accident that I had.

So, no, I would be covered probably, but it may be very high premiums and also I have not actually tried to get a private policy for so many years because it was so scary when I was told that I would not be covered that I have not tried and I have not been in the position that I had to.

Senator WYDEN. I think what you and Mike have described, are a dedicated, capable worker and a compassionate employer who wants to stand up for the worker. Your testimonies sort of highlight how broken our health care system is and how important it is to modernize the employeremployee relationship.

Mike, you have spent some time thinking about this. Some questions for you: First, it sounds to me like you are one rate hike away from having to either drop coverage or whittle it down very dramatically. Is that right?

Mr. ROACH. If you ask our accountant, yes. I mean, when I initially showed him the numbers on what it could be—again, we did not know exactly how many employees were going to opt in to the plan—but when I initially showed him, he was very skeptical that we should go forward with it, and, you know, we sort of argued back and forth, and he finally said, "Okay. If you want to do it, but, boy, things better go right or you are going to be in trouble." So far, so good.

But it is a cost that is a really significant burden to trying to stay in business, and you do have this constant fear that you are suddenly going to be unable to offer the insurance, and then you are letting your employees down, you may lose your employees, they go to some larger employer that can offer insurance that buys it generally at a much more favorable rate.

So, for small businesses, small locally owned businesses like ours, if we can do the group health insurance, it is a way to attract capable employees, and if you cannot offer it, it is much more difficult to attract the kind of talent to deliver the customer service

that our customers expect when they walk into our store. So it is a tough situation.

Senator WYDEN. I would assume that this also makes it very hard for you to grow your business because you would like some predictability and some certainty about where you would be in terms of your workers and how much you would have to pay for their expenses, health and others. It also sounds to me like the crushing cost that you have throws your entire business plan out of whack.

Mr. ROACH. It is absolutely an issue, and as I think Ben maybe alluded to, there is an incentive to always want to have fewer employees instead of more. Even when you can identify where you could move your business forward with more employees, you have this nagging thing, more employees, higher health care costs. It is not just what you are going to pay the employee for their wage. You have the added burden.

Then as Ben pointed out, in our business, we really need to have middle-aged workers to serve middle-aged customers, and we know that they add the most to the insurance cost when we hire, when we add on a middle-aged employee, and yet that is the kind of employee that best serves our customers.

Senator WYDEN. You have talked to me in the past, Mike, about this phenomenon known as job lock. In effect, both a worker, like Ms. Fitzpatrick, and yourself, to some extent, are paralyzed in terms of your options. Can you talk to me a little bit more about that and how prevalent the problem is?

Mr. ROACH. Well, I guess, as a locally owned business owner for 33 years, I see an awful lot of benefits to having a lot of locally owned businesses in your community. You know, it is sort of like the more, the merrier. The locally owned business owners are the ones who volunteer to do a lot of the civic work. They volunteer on school boards. They volunteer on a lot of different things.

So to me any person who is locked into a job who wants to start their own business but cannot because they feel like if they go off, if they are over 50, 55, they know what they are going to have to pay for health insurance costs, and the thought of going out there and leaving their health insurance behind is frightening.

Senator WYDEN. Well, that is bad.

Mr. ROACH. It holds them back.

Senator WYDEN. That is bad for our economy then.

Mr. ROACH. Exactly. I mean, I have been in business with my wife now for a long time, and I see the benefits that we have. The skills we have developed in managing a family, we are able to apply to running our business. I will not say that having employees is like having children, but, to some degree, it is, and so to me couples—older couples—could be the best people, best group in this country to successfully start businesses, albeit they are older, but they life experience, they generally have good credit and so on.

But for a couple to go out at 55 and say, "Okay. We are quitting our jobs, and we are going to go start a business," they go, "Well, what about health insurance? Do you know what that is going to cost us?" It is a significant added cost of startup capital that they would have to have set aside, so most couples do not do it.

But I feel like you know, the couples I see that run their businesses together do very well. They already have complete trust in each other. There is no question about trusting your partner, and I want to say if you have managed to get your kids through adolescence, that is a pretty significant skill that probably would help you manage employees as well and manage a business.

So I really feel like if we could remove the huge health cost burden for couples that want to start a business of their own, they have always dreamed of that—but by the time they are 65 and eligible for Medicare, they are probably not going to have the energy to start that business, but at 50, 54, 57, they have still got energy, they have life skills, they could be successful. But the health insurance burden is too great today.

So somehow if we can get that burden to go to something reasonable and not scary, I think you would see business formation among older couples could be a whole new source of entrepreneurship in this country and not leave it just to the 20-something who do not even have to think about health insurance and generally do not even have it.

Senator WYDEN. I so appreciate your making that argument because I think it really has not been highlighted in the past. What people have heard so often in the past is, "We have older people. They have tremendous health costs. Let's figure out a way to meet them." Rather we should look at the fact that if we did this right and if we modernized the employer-employee relationship, a lot of those older people that you have described who have entrepreneurial skills could go off and set up some of their own small businesses, and put people to work. Not only would we be able to deal with health care more efficiently, but we would also give our economy a boost this is going to be very, very important, given what we see now continually in the morning newspapers.

Mr. ROACH. I would just throw in it might end up saving some marriages. You know, it gives you something to work on together after your kids are gone. You have something to focus on.

Senator WYDEN. I have made virtually every claim for the Healthy Americans Act that I could. Now I will talk about how it is—[Laughter.]

Pro marriage.

Mr. ROACH. Okay. All right.

Senator WYDEN. Thank you.

Ms. Fitzpatrick, tell me a little bit more about the situation that you are faced with. You have been just jostled around by the health care system as far as I can tell for years and years. You and Mike have sat down and with Herculean efforts managed to secure coverage.

But what is going to happen if Mike has those, rate hikes, as you know, in a very fragile economic situation in Oregon? What is going to happen if any of these things tip in a way that is not favorable to you?

Ms. FITZPATRICK. Well, I try not to think about the unknown and try to work on, what I can do, and I feel like I kind of have had to develop a lot of skills which has been interesting and great. But I think it is a very scary feeling for myself and my husband, especially since Chip's developed cancer and as we get older.

But I think Mike is, you know, a really important key to my wellbeing and the business, and I feel like I have a very important role in making sure our business stays, growing, but faced with not having health insurance, I have to say because I am kind of an entrepreneur myself, it has stopped me from going out and starting another business.

It is not so much the fear as my responsibility to myself and other people that would, you know, maybe need to help take care of me, and I feel like I should be responsible for what I do in my life, and so I will stay probably with Mike as long as we can keep health insurance.

Senator WYDEN. Now your husband has cancer.

Ms. FITZPATRICK. Yes.

Senator WYDEN. How are you all dealing with that in terms of meeting your expenses? I mean, when you think of cancer, of course, it just means that the whole family drops everything they are doing to try to deal with it. Do you think about catastrophic coverage and these very large bills? How are you all wrestling with that?

Ms. FITZPATRICK. You know, some parts of us kind of look the other way about it and just try to concentrate on our day-to-day life, but it is difficult.

Senator WYDEN. Do you all have catastrophic coverage?

Ms. FITZPATRICK. No, no, no. We have worked really hard both of our lives and, Chip does have a job now. He became employed again, and we are just, hoping that he will stay employed. Chip's on his own policy with the work that he does, but you just really, I guess, hope.

The closer I get to 65, it seems like it is farther away than ever in some aspects, and sometimes that is kind of scary because I enjoy working, and I want to continue working, but probably if I had my choice and we both had health insurance right now, I would start another business. I love business, and I enjoy it.

Senator WYDEN. You would be able to do something that would be better for you and your husband. It would also be better for the country at a time when we so need entrepreneurship and extra jobs in a sluggish economic situation where in the daily paper you read about the prospect of recession.

That is why those studies from 1981 and 2001 and 2002 are so important. That is, there is no question the tough economic circumstances are especially punishing on older workers and will accelerate the problems that we are talking about, today because it is those older workers. They are the first to be laid off. When companies run into extra expenses, coverage is further whittled down.

So you two have, I think, been especially helpful because you have highlighted how in an ideal situation where a caring employer and dedicated talented workers want to work hand in hand, it still is an enormous challenge to navigate in these kinds of troubled health care times. So we really appreciate what you are doing, and we thank you.

Let me turn to you, Mr. Lindner. I mean, what you have described, is bureaucratic water torture where your wife is on, a first-name basis wish everybody in the claims department. This is a

story we hear continually. I gather that you cannot change insurance companies at all at this point. Is that right?

Mr. LINDNER. We have a company insurance policy, and each year we examine other company insurance policies. We do not even bother to apply because, in general, there is no advantage financially, and we have no chance of getting a personal policy. Personal policies are substantially less money, but we are unacceptable risk candidates for those types of policy. So we are stuck.

Senator WYDEN. So these so-called small employer market policies or the individual, non-group market policies are just not available to you?

Mr. LINDNER. No. They will not accept any pre-existing conditions.

Senator WYDEN. You said you and your wife paid $21,000 a year plus for the coverage you have?

Mr. LINDNER. That is correct.

Senator WYDEN. What do you get for your $21,000?

Mr. LINDNER. We actually have fairly extensive coverage. We do the calculations every year and determine what deductibles are economical and things like that, and we generally end up with just about the maximum coverage that you can purchase.

Senator WYDEN. What would you like to see most out of this upcoming effort to fix American health care? I mean, you have seen most of the big challenges. We need to fix the insurance market, obviously. There needs to be a stronger containment of costs. I feel very strongly about portability. I cannot tell you how critically needed that is.

This country essentially set up the employer-based system in the 1940s pretty much by accident because there were wage and price controls. We did not have the situation we have today with workers. A typical worker today changes a job seven times by the age 35. What Mike and Lee Anne have described are instances where older people want to be able to change jobs, but it has not been possible to get a portable product.

The coverage today as it relates to portability is not very different than it was in 1948 where somebody went to work at 19 years old and stayed put for 40 years. Then you gave him a steak dinner and a big retirement watch. I think we have to have portability.

So, Mr. Lindner, what would you like to see most in this upcoming effort to fix health care?

Mr. LINDNER. Well, actually, I think we are interested in the same things by different names. You call it portability. I call it accessibility. If someone had access to health care insurance through all stages of their life and through all health challenges, that would give the flexibility necessary for people to move around. So if I did want to change professions or directions in my life right now, I could not because of the structure of the insurance. So accessibility is critical, in my view.

I believe that the cost shifting that is occurring that I mentioned really is a contributing factor to this not only accessibility but cost, and then, obviously, the cost of insurance as well. If everybody were insured, the premiums would drop, and if everybody were in

the program, so to or if everybody was insured, the whole system would work a lot better, in my opinion.

Senator WYDEN. A great way to wrap up this excellent panel is to have a group of Oregonians talking about how you cannot fix American health care unless you cover everybody. It is very clear that if you do not do that, just as Mr. Lindner has described, the people who are uninsured shift their bills to the people who are insured. They shift the most expensive bills, and, of course, that is what goes on today as a result of a federal statute. A federal statute actually requires that hospital emergency rooms serve people who do not have coverage, and those costs are shifted.

So, once again, Oregonians sum up the big challenges very well. It has been an excellent, excellent panel. You three are really the face of this scramble. You know, Lee Anne, you have faced so much. Mike, you have described the many efforts you have done. I love the fact that I can go home and I can see you in the stands at the high school football game. All your life you have backed every good cause around.

Mr. ROACH. Thank you.

Senator WYDEN. You try to work with your workers. The question remains about how to make this system work.

Mr. Lindner, I know that you see things much the same way, and a big part of what we want to do in 2009 is to fix the health system. I think you have called it accessibility. I think people sometimes call it portability. I think the point is we have to deal with the costs and we have to make sure people are covered. It has to be done more efficiently, and, boy, are you on target when you talk about getting information about costs and quality out to people because, right now, it is possible to get a lot more information about buying a washing machine than it is to find out about health care costs and quality. So we will keep your answer in mind.

Mr. LINDNER. Actually, Senator, for time reasons, I had to remove a sentence in my statement that was just about exactly that. You can access information about a car repair more easily than health care.

Senator WYDEN. Right.

Thank you all. It has been great. I appreciate it.

Let's bring our next panel up: Paul Fronstin, director of health and research and education benefits of the Employee Benefit Research Institute; Jeanne Lambrew, associate professor of the LBJ School; and John Sheils, senior vice president of The Lewin Group.

We will make prepared remarks a part of the hearing record. I know you three have testified once or twice in the course of your very distinguished careers. So why don't you, if you would, summarize your principal points and we will have some time for questions.

Mr. Fronstin, welcome.

STATEMENT OF PAUL FRONSTIN, DIRECTOR OF HEALTH RESEARCH AND EDUCATION PROGRAMS, EMPLOYEE BENEFIT RESEARCH INSTITUTE (EBRI), WASHINGTON, DC

Mr. FRONSTIN. Thank you.

Chairman Kohl, Senator Wyden, Senator Smith, and members of the Committee, thank you for the opportunity to appear before you today.

My written testimony includes information on trends in coverage for workers. So I am going to limit my comments to trends in coverage for persons ages 55 to 64.

Older workers and individuals are particularly vulnerable, as we have heard, if they were to lose health insurance. Older workers may lose coverage because of job displacement and may be unable to afford or obtain health insurance on their own due to either their age or health status. Furthermore, retirees will be less likely than in the past to have access to retiree health benefits as employers have been cutting back on this benefit.

Despite the vulnerabilities that older individuals face when it comes to health insurance, they are the least likely age group among adults to be uninsured. In 2006, nearly 13 percent of individuals ages 55 to 64 were uninsured This is lower than the overall uninsured rate of roughly 18 percent among individuals under age 65 and lower than all other age groups except for children.

Workers between the ages of 55 and 64 have experienced a slight erosion in coverage and a slight increase in the likelihood of being uninsured. In 2006, over 78 percent of workers between the ages of 55 and 64 were covered by an employment-based health plan, down from 80 percent in 2003, but higher than the levels seen in the late-1990s. The percentage uninsured increased from nearly 10 percent in 1999 to 11 percent in 2006, which is essentially the same uninsured rate among these workers from back in 1994.

We have not seen an overall erosion in health insurance coverage rates among retirees between the ages of 55 and 64. The percentage of these retirees with employment-based health benefits from either a former employer or other family member, mostly a spouse, has bounced around between 56 percent and 60 percent between 1994 and 2006.

In 2006, 58 percent of 55- to 64-year-old retirees had some form of employment-based health benefit. During this time period, the uninsured rate for this group bounced around between 13½ percent and 16½ percent. In 2006, nearly 15 percent of retirees ages 55 to 64 were uninsured.

It does appear, however, that retirees ages 55 to 64 are becoming more likely to get employment-based coverage through another family member and less likely to get it through a former employer. For the most part, the percentage of retirees with coverage through a former employer or through a spouse did not show a clear trend between 1994 and 2006. However, the percentage of retirees with coverage through a former employer was at about 35 percent in 2006, the lowest point between 1994 and 2006 with the exception of 2000. The percentage of retirees with coverage through a family member was nearly 23 percent in 2006, which is essentially the highest level during the same time period.

Given the erosion in availability of retiree health benefits, it might be surprising that the percentage of retirees ages 55 to 64 with health benefits through a former employer have not fallen more than we have seen. Rates of retiree health benefits coverage may not be falling for a number of reasons.

First, there is a strong link between the availability of retiree health benefits and the decision to retire early. Workers often remain in the labor force longer than expectedto maintain health insurance. EBRI's Health Confidence Survey has found that 30 percent of workers expecting to retire before becoming eligible for Medicare would not do so if they did not receive retiree health benefits.

The declining availability of retiree health benefits may also, in part at least, explain the rising labor force participation rate among individuals 55 to 64. Between 1996 and 2006, the labor force participation rate for men increased from 67 percent to nearly 70 percent, while for women, it increased from nearly 50 percent to 58 percent.

The percentage of retirees with health coverage from a former employer may not be declining as quickly as the availability of retiree health benefits because workers without access to this benefit may be remaining in the labor force longer than workers with access to retiree health coverage.

Thank you.

[The prepared statement of Mr. Fronstin follows:]

Statement Before the

U.S. Senate Special Committee on Aging

Hearing on
"Scrambling for Health Insurance Coverage: Health Security for People Between 55–64 Years of Age"

April 3, 2008
562 Dirksen Senate Office Building

Testimony by:

Paul Fronstin, Ph.D.
Director, Health Research and Education Program
Employee Benefit Research Institute
T-150

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Highlights

- In 2006, nearly 162 million individuals under age 65 had health insurance through an employment-based plan. Sixty-two percent were covered by an employment-based health plan, with 70.9 percent of workings adults covered, 37.5 percent of nonworking adults covered, and 57.1 percent of children covered.
- In 2005, 59 percent of employers with 3–199 employees offered health benefits, down from 68 percent in 2000. The decline in employer sponsorship followed an expansion in sponsorship that occurred between 1996 and 2000. Between 2005 and 2007, the percentage of employers with 3–199 employees that offered health benefits remained constant at about 59 percent.
- The percentage of workers reporting that they have access to health benefits through their job is largely unchanged from the mid-1990s. In 2005, 74 percent of workers who were not self-employed reported that they were eligible for health benefits through their own job, up slightly from 73.6 percent in 1995, but down from 77.8 percent in 1988.
- Between 1994 and 2000, the percentage of workers with health benefits through an employer held steady at between 73 percent and 75 percent. Since 2000, the percentage of workers with health benefits has fallen to about 71 percent.
- Despite the vulnerabilities that older individuals face when it comes to health insurance coverage, they are the least likely age group among adults to be uninsured. In 2006, 12.7 percent of individuals ages 55–64 were uninsured.
- Like the overall trend for workers, workers ages 55–64 have experienced a slight erosion in coverage and a slight increase in the likelihood of being uninsured. In 2006, 78.4 percent of workers ages 55–64 were covered by an employment-based health plan, down from 80.1 percent in 2003, but higher than the levels seen in the late-1990s. Similarly, the percentage uninsured increased from 9.7 percent in 1999 to 11.1 percent in 2006, which is essentially the same uninsured rate among these workers (11.3 percent) from back in 1994.
- There was no erosion in health insurance coverage rates among retirees ages 55–64. The percentage of these retirees with employment-based health benefits from either a former employer or spouse has bounced around between 56 percent and 60 percent between 1994 and 2006. During this time period, the uninsured rate for this group bounced around between 13.6 percent and 16.4 percent.
- Retirees ages 55–64 are becoming more likely to get employment-based coverage through another family member and less likely to get it through a former employer. The percentage of retirees with coverage through a former employer was at 35.4 percent in 2006, the lowest point between 1994 and 2006 except during 2000. Similarly, the percentage of retirees with coverage through a family member was 22.6 percent in 2006, essentially the highest level during 1994–2006.

Chairman Kohl and members of the committee: My name is Paul Fronstin. I am director of the Health Research and Education Program of the nonpartisan Employee Benefit Research Institute (EBRI). I am pleased to appear before you today to testify on trends in health care coverage for workers and retirees. Established in 1978, EBRI is committed exclusively to data dissemination, policy research, and education on financial security and employee benefits. EBRI does not lobby or advocate specific policy recommendations; the mission is to provide objective and reliable research and information. All of our research is available on the Internet at www.ebri.org. All views expressed are my own, and should not be attributed to EBRI.

Introduction

There is a strong link between health benefits and employment. As a result, employment-based health benefits are the most common form of health insurance for nonpoor and nonelderly individuals in the United States. In 2006, nearly 162 million individuals under age 65 had health insurance through an employment-based plan (Fronstin, 2007a). Just over 62 percent of individuals below age 65 were covered by an employment-based health plan, with 70.9 percent of workings adults covered, 37.5 percent of nonworking adults covered, and 57.1 percent of children covered.

It was during World War II that many employers began to offer health benefits. Because the National War Labor Board froze wages, employers sought ways to get around the wage controls in order to attract scarce workers. In 1943, the National War Labor Board ruled that employer contributions to insurance did not count as wages, and, thus, were not subject to the wage controls. Health insurance became an attractive means to recruit scarce workers.

Today, employers provide health benefits voluntarily. They offer health benefits to attract and retrain workers based on the generally accepted view that most employees desire them more than the equivalent cash compensation and evidence that they outrank every other employee benefit in importance (Helman and Fronstin, 2004). Employers also offer health benefits in order to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury, to promote health, and to increase worker productivity. They generally regard health benefits as a voluntary compensation arrangement dependent on business priorities, and their level of commitment to this benefit fluctuates in response to a variety of economic pressures. However, they also have a motivation to provide health benefits as a means of protecting their investment in workers. The cost of absenteeism and presenteeism related to health status reduces productivity and can trigger other costs, such as sick pay and disability costs.

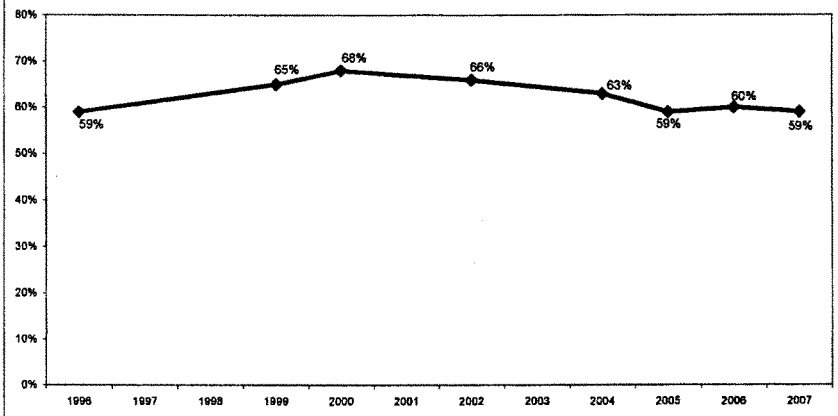
Trends in Coverage for Workers

The question of whether employers have reached a tipping point with health benefits is starting to be asked (Fronstin, 2007b). The question is coming up for various reasons but is being primarily driven by the ever-increasing cost of providing health benefits to workers. Between 2000 and 2007, the cost of providing health benefits doubled, while workers' wages and overall inflation increased only 25 percent and 21 percent, respectively.[1] While the growth rate in the cost of providing health benefits fell between 2003 and 2007 from 13.9 percent to 6.1 percent, growth in the cost of providing health

benefits to workers continues to run double the growth in workers' earnings and is also double the rate of overall inflation.

Because of the rising cost of providing benefits, there has been some erosion in the availability of health insurance through smaller employers (in large part, all large employers offer health benefits to workers). In 2005, 59 percent of employers with 3–199 employees offered health benefits, down from 68 percent in 2000 (Figure 1). The decline in employer sponsorship followed an expansion that occurred between 1996 and 2000. Between 2005 and 2007, the percentage of employers with 3–199 employees offering health benefits remained constant at about 59 percent.

Figure 1
Percentage of Employers With 3–199 Employees Offering Health Benefits, 1996–2007

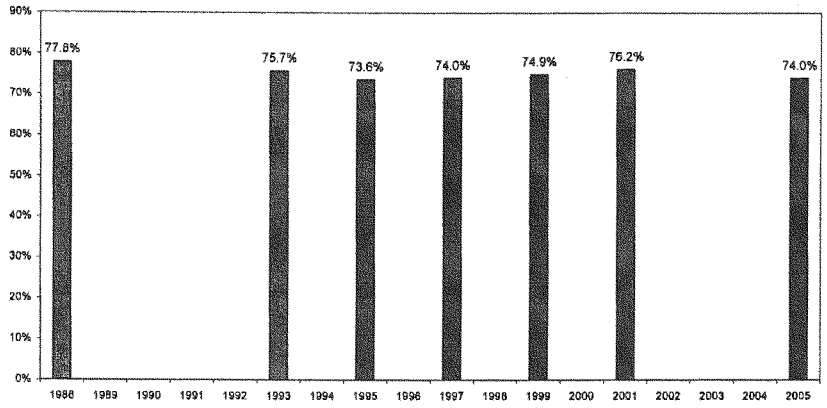


Source: Kaiser Family Foundation.

While there has been an erosion of availability of health benefits at the small employer level since 2000, the percentage of workers reporting that they have access to health benefits through their job is largely unchanged from the mid-1990s and down only slightly from the late-1980s. In 2005, 74 percent of workers who were not self-employed reported that they were eligible for health benefits through their own job, up slightly from 73.6 percent in 1995, but down from 77.8 percent in 1988 (Figure 2).

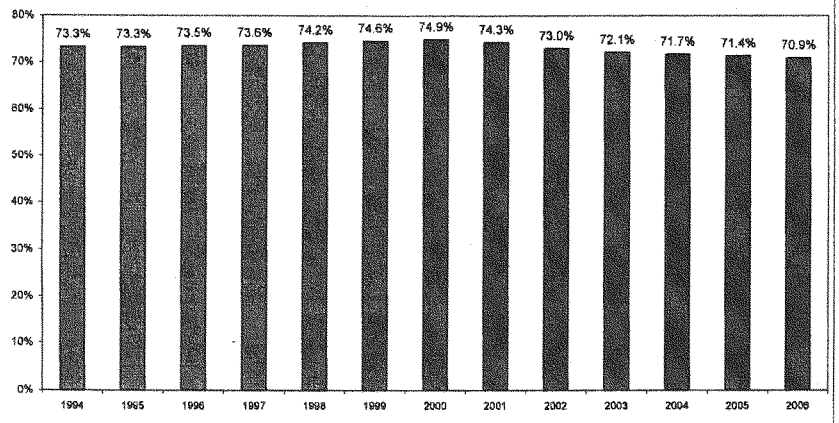
In terms of whether workers have health insurance coverage, for the most part, the percentage of workers with coverage either from their own employer or from someone else's employer has been remarkably stable, considering what has happened with the cost of providing health benefits and the fact that fewer small employers have offering coverage since 2000. Between 1994 and 2000, the percentage of workers with health benefits through an employer held steady at between 73 percent and 75 percent (Figure 3). Since 2000, the percentage of workers with health benefits has fallen to about 71 percent.

Figure 2
Worker Eligibility Rate for Own Employer Health Benefits, Wage and Salary Workers Ages 18–64, 1988–2005 (Select Years)



Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey.

Figure 3
Percentage of Workers, Ages 18–64, With Employment-Based Health Benefits, 1994–2006



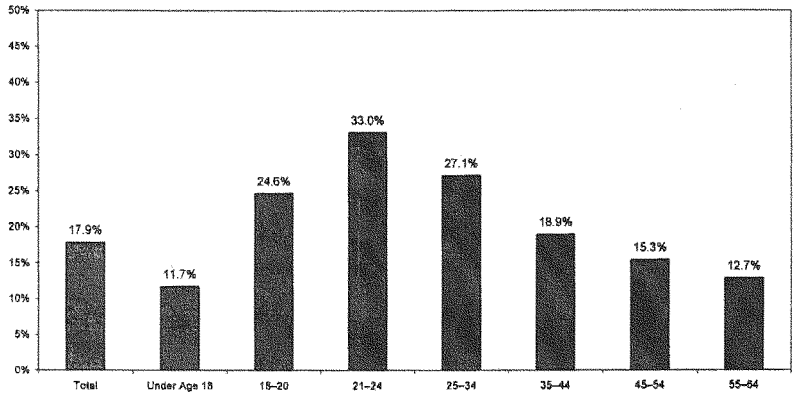
Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey, March Supplement.

Trends in Coverage for Individuals 55–64

While workers have for the most part experienced a small erosion in coverage, older workers and individuals are particularly vulnerable if they were to lose health insurance coverage. Older workers may lose coverage because of job displacement and may be unable to afford or obtain health insurance on their own due to their age and/or health status. Furthermore, retirees are less likely than in the past to have access to retiree health benefits as employers have been cutting back on this benefit (Fronstin, 2006).

Despite the vulnerabilities that older individuals face when it comes to health insurance coverage, they are the least likely age group among adults to be uninsured. In 2006, 12.7 percent of individuals ages 55–64 were uninsured (Figure 4). This is lower than the overall uninsured rate of 17.9 percent among persons under age 65, and lower than all other age groups except for children.

Figure 4
Percentage Uninsured, by Age, 2006



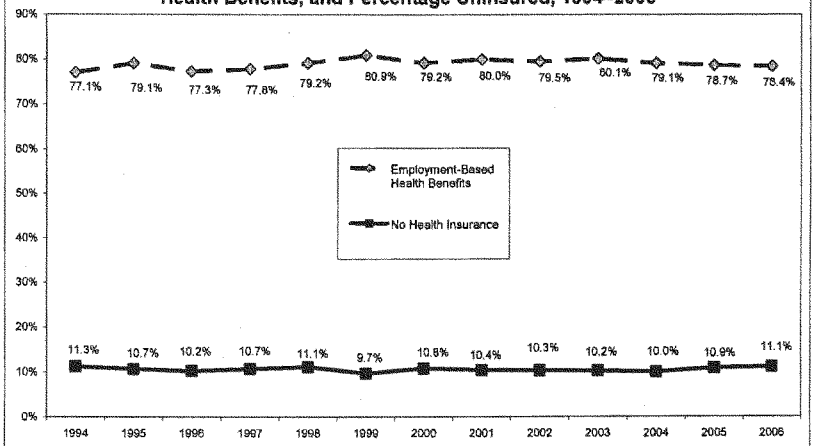
Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey, March 2007 Supplement.

Like the overall trend for workers, workers ages 55–64 have experienced a slight erosion in coverage and a slight increase in the likelihood of being uninsured. In 2006, 78.4 percent of workers ages 55–64 were covered by an employment-based health plan, down from 80.1 percent in 2003, but higher than the levels seen in the late-1990s (Figure 5). Similarly, the percentage uninsured increased from 9.7 percent in 1999 to 11.1 percent in 2006, which is essentially the same uninsured rate among these workers (11.3 percent) from back in 1994.

There is no erosion in health insurance coverage rates among retirees ages 55–64. The percentage of these retirees with employment-based health benefits from either a former employer or spouse has bounced around between 56 percent and 60 percent between 1994 and 2006 (Figure 6). In 2006, 58 percent of 55–64 year old retirees had

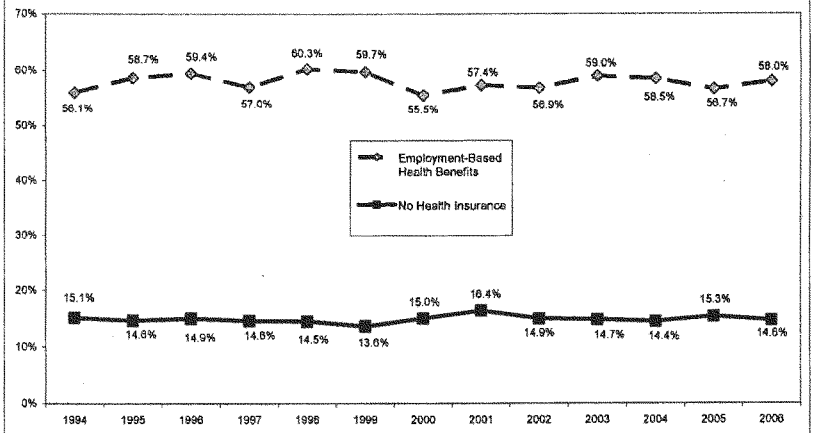
some form of employment-based health benefit. During this time period, the uninsured rate for this group bounced around between 13.6 percent and 16.4 percent. In 2006, 14.6 percent of retirees ages 55–64 were uninsured.

Figure 5
Percentage of Workers Ages 55–64 With Employment-Based Health Benefits, and Percentage Uninsured, 1994–2006



Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey, March Supplement.

Figure 6
Percentage of Retirees Ages 55–64 With Employment-Based Health Benefits, and Percentage Uninsured, 1994–2006

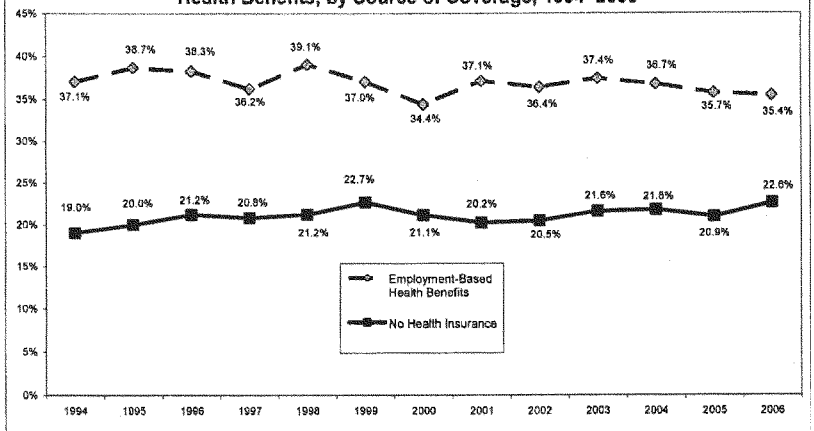


Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey, March Supplement.

It does appear, however, that retirees ages 55–64 are becoming more likely to get employment-based coverage through another family member and less likely to get it through a former employer. For the most part, the percentage of retirees with coverage through a former employer or through a spouse did not show a clear trend between 1994 and 2006 (Figure 7). However, the percentage of retirees with coverage through a former employer was at 35.4 percent in 2006, the lowest point between 1994 and 2006 except during 2000. Similarly, the percentage of retirees with coverage through a family member was 22.6 percent in 2006, essentially the highest level during 1994–2006.

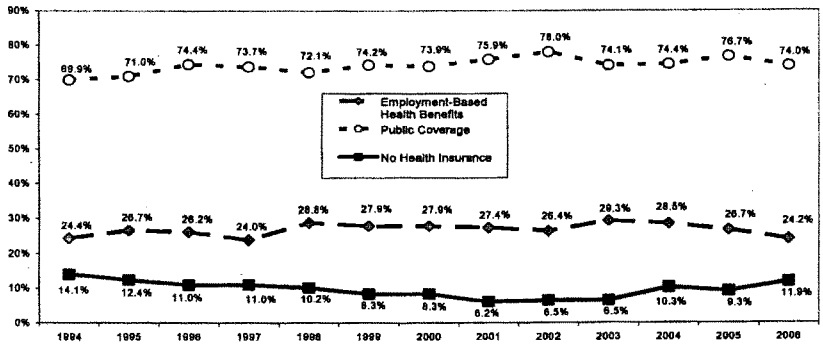
Some individuals ages 55–64 are not working because of their health status. They do not report being retired, but instead report that they are not working because of an illness or disability. About three-quarters of these individuals get health insurance through a public program, such as Medicare or Medicaid (Figure 8). The recent trend for these individuals is that public programs are becoming less prevalent. Between 2002 and 2006, the percentage covered by a public program fell from 78 percent to 74 percent. This occurred after an expansion of public program availability, increasing from about 70 percent in 1994. The percentage of these individuals who are uninsured increased between 2003 and 2006, rising from 6.5 percent to 11.9 percent. Prior to 2003, the uninsured rate among these individuals had been falling. It was 14.1 percent in 1994. Employment-based coverage is less prevalent for persons not working because of illness or disability, and it has fallen from 29.3 percent in 2003 to 24.2 percent in 2006.

Figure 7
Percentage of Retirees Ages 55–64 With Employment-Based Health Benefits, by Source of Coverage, 1994–2006



Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey, March Supplement.

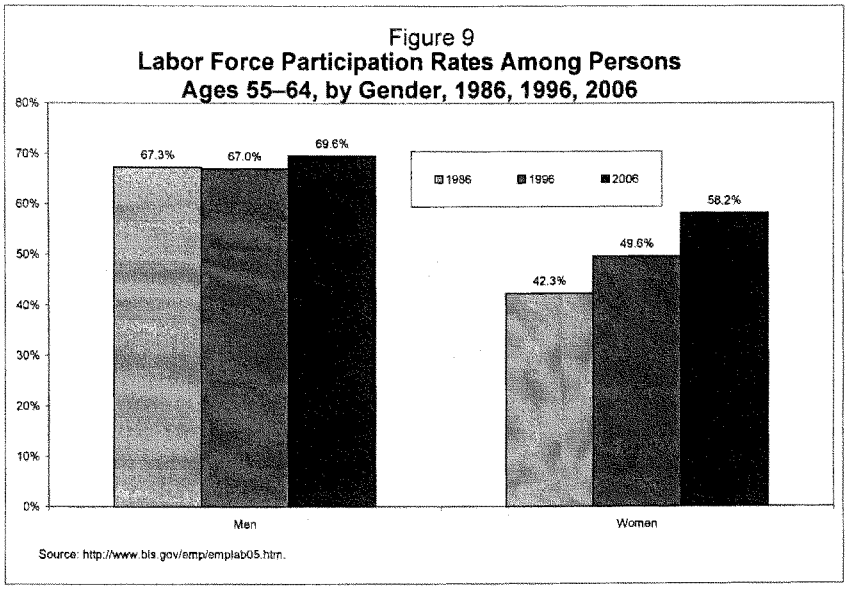
Figure 8
Percentage of Persons Ages 55–64 Not Working Because of Health Status With Employment-Based Health Benefits and Public Coverage, and Percentage Uninsured, 1994–2006



Source: Employee Benefit Research Institute estimates based on data from the Current Population Survey, March Supplement.

Given the erosion in availability of retiree health benefits it might be surprising that the percentage of retirees ages 55–64 with health benefits through a former employer have not fallen more than we have seen. Rates of retiree health benefits coverage may not be falling for a number of reasons. First, there is a strong link between the availability of retiree health benefits and the decision to retire early. Workers often remain in the labor force longer than expected to maintain health insurance. EBRI's Health Confidence Survey (HCS) has found that 30 percent of workers expecting to retire before becoming eligible for Medicare would not do so if they did not receive retiree health benefits.[2]

The declining availability of retiree health benefits may in part explain the rising labor force participation rate among individuals 55–64. Between 1996 and 2006, the labor force participation rate for men increased from 67 percent to 69.6 percent, while for women it increased from 49.6 percent to 58.2 percent (Figure 9). The percentage of retirees with health coverage from a former employer may not be declining as quickly as the availability of retiree health benefits because workers without access to this benefit may be remaining in the labor force longer than workers with access to retiree health coverage.



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Endnotes

[1] See http://www.kff.org/insurance/7672/index.cfm.

[2] See http://www.ebri.org/pdf/surveys/hcs/2003/03hcspq.pdf.

Senator WYDEN. Thank you very much, Mr. Fronstin. We will be talking to you in a few minutes, and I know we will be talking to you often in the months ahead as well.

Ms. Lambrew, welcome.

STATEMENT OF JEANNE LAMBREW, ASSOCIATE PROFESSOR, LBJ SCHOOL OF PUBLIC AFFAIRS, AUSTIN, TX

Ms. LAMBREW. Thank you.

Thank you, Chairman Kohl, Senator Smith, distinguished members of this Committee, for holding a hearing on this important topic of health security for people in late middle age. But I especially want to thank you, Senator Wyden, for your leadership, not just on this narrow slice of health coverage, but for your focus and persistence in trying to address the broad-based problems in our health system starting with the uninsured.

I would argue that this population is the window into a larger system crisis, and, in fact, it is often that proverbial canary in the coal mine showing where our system cracks are and how hard it is to solve them.

What I would like to do is briefly profile some of the facts that Paul did not talk about in terms of the health and risk profile of this group, talk about incremental options for addressing this population because I think that John will talk about the comprehensive policies as well, and to present some pros and cons and tradeoffs of these options, but to start with a few facts.

We cannot forget that this age group is growing rapidly. As the baby boomers move through this age cohort, the number of people ages 55 to 64 will increase by 50 percent between 2000 and 2010 alone. This is not just a big demographic change. It is a very high-risk group.

The risk of having health problems when you turn age 55 increases more than you would expect. We know that people in this age group compared to people ages 45 to 54 have twice the death rate, the highest rate of obesity, and in addition have greater functional limitations. As a result, they have higher health costs, 50 percent higher than the next age group below them, in addition to having high out-of-pocket spending.

We heard in the previous panel the issues of being underinsured. We know that people with private insurance spend twice as much in this age bracket than the next youngest generation.

So to talk about the options for beginning to address this population, as Senator Smith noted, there are numerous options out there. What I would like to talk about is the four major incremental low-cost options that could be considered by Congress, one of which we heard about already, which is extending COBRA.

The Consolidated Omnibus Budget Reconciliation Act of 1986 requires employers to allow certain former employees and dependents to purchase into that coverage for up to 18 months. This option could be extended. There have been past proposals that would allow people to continue to buy this coverage for longer than 18 months, maybe as a bridge to Medicare.

A second option is to extend an existing group insurance purchasing pool to these people. Group purchasing pools offer people a choice of plans at a fair premium with equal access to com-

prehensive benefits. Probably the only group large enough to accept the 55- to 64-year-old age cohort is the Federal Employees Health Benefit Pool, being the largest purchasing pool in the country. This could be done by charging a different premium or using risk adjustment to bring this population in, as another option.

A third option would be to make individual health insurance more accessible and affordable for this group. We heard previously about some of the challenges people face getting access to this market. This could be changed through regulation that limits pre-existing condition exclusions. It could be done by limiting age rating, the practice of charging higher premiums to older people, or it could be done through some sort of reinsurance or risk pool to reduce the high risk in this group.

A fourth option often considered is an early Medicare buy-in, the idea of letting people join Medicare earlier than the age of 65 with some sort of premium that would effectively be self-funded; with participants paying a premium when they join the program prior to age 65 and paying a so-called risk premium after they retire.

How do we assess these four options? There are very simple questions: Who pays for the high-risk people, who is most helped, and what are the political prospects for change?

In incremental reform, we basically do not necessarily have the option of spreading the cost of these people across the entire population. You have to spread the cost over the group that you are adding them to. What we know about COBRA is that you are basically backloading the cost on active workers, potentially making it harder for those workers and employers to continue offering that coverage.

With group purchasing pools, you have a broader base across which you are spreading the risk, but there is really no connection among participants and there are concerns that come up with this politically.

In the individual market, you are shifting the cost down to younger workers who are a members of that market. With the Medicare buy-in, you are pushing the cost to later life. So you are spreading the risk in different ways.

Who is helped? COBRA basically helps only those people who were lucky enough to have the types of jobs that we just heard about with employer-based coverage, not small business workers, not many other workers. Individual market will effectively help your lower-risk people, while a group purchasing pool will help your higher-risk people. Medicare will help those people who are risk averse and really want to get into the program earlier.

Now we can go through the political implications in greater detail in the Q&A, but I would argue that this is a population for whom there is tremendous political pressure to figure out what we do as they move through this age cohort. What I think is the interesting question is: Will that pressure result in incremental policy changes that are difficult to implement given how these are the highest-cost people in the non-elderly population, or will it fuel ground efforts for major reform because, at the end of the day, the best way to help these people is probably comprehensive reform that gets them into the broad-based pool?

Thank you.

[The prepared statement of Ms. Lambrew follows:]

Testimony

For the Hearing Entitled,

"Scrambling for Health Insurance Coverage: Health Security for People in Late Middle Age"

Jeanne M. Lambrew, PhD

Associate Professor
Lyndon B. Johnson School of Public Affairs
University of Texas at Austin

Senior Fellow
Center for American Progress

Before the

Special Committee on Aging
United States Senate

April 3, 2008

Chairman Kohl, Senator Smith, and distinguished Members of the Committee, I thank you for the opportunity to testify on the topic of health security for people in late middle age. I also thank Senator Wyden for his interest in this topic, and my views on it, as well as the broader challenges facing our health system.

Often when designing policy, we focus on simple statistics such as where are the pockets of uninsured people and for whom can we get the biggest bang for the buck. Yet if a goal is preventing and managing illness, attention must be paid to those with high risks and tenuous coverage. People in their decade before Medicare eligibility are such a group. Moreover, the challenges this group faces in finding and affording health insurance shed light on the larger cracks in the system, the proverbial "canary in the coal mine." In this testimony, I will profile people ages 55 to 64, discuss the major health insurance options, and offer criteria for assessing them.

Demographics. As you know, the Baby Boom generation is large and approaching retirement. The first of the generation is expected to turn 65 in the year 2011. As you can see in Figure 1, Baby Boomers are now and in the near future moving through the 55 to 64 age bracket. Between 2000 and 2010 alone, the number of Americans ages 55 to 64 will increase by nearly 12 million or 50 percent (from 24.4 million to 36.2 million). This proverbial elephant being swallowed by the snake has in the past, present, and future stretched the systems in place to meet age-specific needs. In the 1950s and '60s, Baby Boomers required a massive expansion of the education system. By 2030, there will be twice as many seniors relying on the Social Security and Medicare. Today and in the near-term, the challenge is affordable health insurance.

Health Risks. Increased age is associated with increased health risk, although this relationship is not linear. Studies of older workers have found that those ages 55 to 64 are more experienced and less likely to be injured. However, the injuries that do occur tend to be more serious and recovery takes longer.[1] The death rate of people ages 55 to 64 is more than twice that of those ages 45 to 54. The percent of people reporting fair to poor health is over 50 percent higher among people ages 55 to 64 versus those ages 45 to 54.[2]

Moreover, risks rise dramatically. Among all adults, Americans ages 55 to 64 have the highest rate of obesity (Figure 2). The obesity rate among people age 55 to 64 increased dramatically over the last four decades (from 9.2 percent to 36.0 percent among men and 24.4 percent to 39.0 percent among women between 1960-62 and 2001-04). This makes older Americans susceptible to chronic illness.

In fact, the percentage of Americans with three or more chronic conditions is 2.4 times higher among those ages 55 to 64 compared to those ages 45 to 54 – a bigger increase than that which occurs in the decade after turning age 65 (the rate is 1.6 higher for those aged 65 to 74 than those aged 55 to 64).[3] Among the chronically ill, moving into the older age bracket causes an even greater increase in functional limitations (Figure 3).

Use, as well as need, increases with age. The percentage of people ages 55 to 64 with 10 or more doctor visits in a year is 20 percent higher than that of people ages 45 to 54. The rate of hospitalization experiences a similar jump when comparing these two age groups.[4]

Health Costs. Mirroring the increases in health problems and use of care, the cost of health care for people in late middle age is relatively high. In 2004, health spending for the average person age 55 through 64 was $7,787 – about 50 percent higher than the average for people ages 45 to 54, and 30 percent below those ages 65 to 74 (Figure 4).

In 2004, people ages 55 to 64 accounted for nearly 15 percent of total health spending in the United States.[5] However, in that year, they comprised about 10 percent of the population. Ten years from now, people age 55 to 64 will comprise 12.8 percent of the population. Moreover, if past trends persist, their health spending per capita will grow faster than other groups. Between 1987 and 2004, health spending per person ages 55 to 64 increased faster than all other age groups except children (6.6 percent on average). As such, it is possible that one out of every five health care dollars will be dedicated to this age cohort in the next decade.

Coverage Patterns. Because of their increased risk and costs, people ages 55 to 64 place a greater value on coverage. A recent public opinion poll found that, more than any other age group, including seniors, people ages 50 to 64 felt that presidential candidates' views on health care were very important.[6] Relative to younger workers, older workers are much more likely to participate in employer-sponsored health insurance when offered and eligible.[7] This is reflected in their coverage pattern. People ages 55 to 64 have the lowest uninsured rate among non-elderly adults (Figure 5).

However, people ages 55 to 64 are less likely to have employer-sponsored insurance than those between ages 35 and 54. This primarily is because people in this age group are beginning to detach from the workforce. Less than half of people ages 55 to 64 work full-time.[8] The proportion of part-time workers is higher in this age group than in younger ones as is the proportion of people in so-called "bridge jobs": self-employment or small-firm work as a way to generate income during a transition to retirement. These types of jobs typically do not come with employer-sponsored health insurance.

In addition, millions of workers fully retire before they reach age 65. A significant proportion of these "early retirees" has some source of health insurance. In 2004, nearly one in five people ages 55 to 64 was insured through retiree coverage. Only one in ten workers retiring early becomes uninsured.[9] Yet, the proportion of firms offering retiree coverage is plummeting. The proportion of large firms (with 200 or more workers) providing workers with some type of retiree coverage dropped from 66 percent in 1988 to 33 percent in 2007 (Figure 6). Only about 5 percent of firms with fewer than 200 workers offer retiree health benefits.[10] In addition, costs for this type of coverage have been skyrocketing. Median contributions for early retiree coverage quadrupled between 1994 and 2004, even after adjusting for inflation.[11] About half (46 percent) of firms cap their contributions to pre-65 health coverage.[12]

Access to employer-based health coverage for retirees younger than age 65 is likely to change in the near future for three reasons. First, new accounting rules were implemented last year that require governments to account for their current and future retirees health cost liability. A similar accounting rule for private-sector firms contributed to scaled-back coverage. Second, a recent ruling from the U.S. Equal Employment Opportunity Commission (EEOC) allows firms to

offer different health benefits for pre- versus post-65 retirees. Some argue that this will stabilize early-retiree coverage since employers can target resources to this group if they so choose. Others suggest that it provides an excuse for employers to drop both types of coverage. Third, unions and major auto companies have recently negotiated arrangements to limit employer cost liability in return for a firm commitment of up-front funding. Established as voluntary employee beneficiary associations (VEBAs), these arrangements, like the EEOC ruling, could affect access to early retiree health benefits over the long run.

Another confounder in understanding access to insurance for people in their late middle age is marital status. Among those ages 55 to 64, 83 percent of those who are married have private insurance, compared to only 60 percent of those who are widowed, separated, divorced or single.[13] Women also tend to be at greater risk in this age group. They are more likely to be insured as dependents. This means they could lose coverage with a change in marital status or work status of their spouses. A number of women whose older spouses gain Medicare coverage themselves lose dependent status and employer-based health insurance. This helps explain why older women tend to purchase individual coverage more than men.[14]

People ages 55 to 64 are the most likely of any age group to rely on the individual market for health coverage. However, only about 7 percent of this age group purchases this coverage and this percent has declined since the year 2000. Cost is the likely culprit. One study found that the premium for a single, individual-market policy for a 55 to 64 year old, on average, was 30 percent higher than that of a 40 to 54 year old, and over twice as high as that of an adult younger than age 40 (Figure 7). Premiums in this market have increased more for the older group than the younger groups.[15] In general, people with health problems have a harder time accessing affordable coverage in this market. One survey found that over 70 percent of people in poor health found it very difficult or impossible to find affordable, individual-market coverage.[16] Another study using statistical corrections for selection bias found that, compared to people in excellent health, premiums in the individual market are 13 percent to 16 percent higher for people with modest health problems, and 43 percent to 50 percent higher for people with major health problems.[17]

Under-Insurance and Uninsurance. The high rate of coverage among people ages 55 to 64 masks two challenges faced by this population. The first is high out-of-pocket spending, even among those with health insurance. Median out-of-pocket spending on health care among those ages 55 to 64 ($636) is over twice as high as that of people ages 35 to 54, 3.5 times higher than people ages 18 to 34, and over ten times higher than that of children. Both the pattern and amount of out-of-pocket spending is similar for those with private insurance. Not counting premiums, cost sharing for privately insured people ages 55 to 64 was nearly twice that of those ages 45 to 54 (Figure 8).[18] One study found that the high out-of-pocket health spending has caused a significant number of older Americans to delay retirement as a means of funding such costs.[19]

The relatively small uninsured population in this age bracket should also not be neglected. In 2006, 12.7 percent of people in this age group lacked health insurance at a point in time, or 4.1 million people. The uninsured rate is slightly up since 2000, mostly reflecting a decline in the percent of this population getting health insurance through the individual market. The higher

health risks for those ages 55 to 64 make the consequences of lacking health insurance more serious. Studies have found that uninsured near-elderly are at a greater risk of premature death than insured people, making it a leading cause of death in this age group.[20]

Delayed prevention and management of chronic care has long-run implications as well. Chronically ill people turning age 65 who were previously uninsured report worse health status than those who were insured.[21] Gaining health insurance can compensate for some of health limitations from being uninsured prior to Medicare eligibility. A recent study found that half of the health disparity from being uninsured could be erased by being insured by Medicare after five years.[22] However, being uninsured prior to enrollment means higher use and cost among the chronically ill, exacerbating Medicare's cost crisis.

Policy Options. Pressure to create options for affordable coverage for people ages 55 to 64 is as inevitable. For presidential candidates and some in Congress, solutions for this population have generally been folded into broad-based plans. This may be the best solution for this targeted group given the challenges they face in accessing and affording health insurance. Here, I discuss several basic incremental, relatively low-cost ideas that might be enacted as either part of – or short of – comprehensive reform.

Extend employer-based coverage through COBRA: One option is to extend the existing policy that allows workers to continue buying coverage through their former employer's health plan. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires private employer with 20 or more employees to allow certain former employees, retirees, spouses, former spouses, and dependent children to purchase health coverage at group rates. The rate charged for this continuation coverage is no more than 102 percent of the premium for workers, with no employer contribution. Qualified individuals can purchase this coverage for up to 18 months generally, although certain people can purchase it for up to 36 months (some at a higher premium of 150 percent of the standard rate).

COBRA has served as "bridge" coverage for people losing or changing jobs, as well as their family members. It guarantees access to what are usually comprehensive benefits at a group premium rate. The coverage is usually considered expensive by those who are unemployed or can purchase underwritten individual-market coverage. However, for people ages 55 to 64 who have few affordable alternatives, the current option as well as an expanded one, may be attractive.

As such, Congress could expand COBRA for people ages 55 to 64. It could allow people to stay on their former employer's plan until they qualify for Medicare (i.e., removing the 18 month limit). This would be limited to those who previously had employer-based coverage and have no other group health insurance option. The premium increase (2 percent on top of the full cost) might also be raised to help offset some of the higher cost of this population.

Extend a group insurance purchasing pool: A related idea would be to allow people ages 55 to 64 to enroll in private health plans offered through a group purchasing pool. In such pools, individuals choose from an array of health plans that vary, within limits, their benefit designs and

premiums. All eligible individuals have equal access to the plans and pay the same premiums for each plan.

A number of bills have been proposed to create purchasing pools. Some, like that of the Wyden-Bennett bill, are state-wide pools that include large numbers of people since they replace employer and Medicaid coverage and are part of comprehensive reform. Others, like Association Health Plans, are incremental and allow the pools to be created by selected employers at the sub-state level, exempt from state regulation. Given the high health risks of people ages 55 to 64, it is unlikely that a voluntary purchasing pool could be created that just included this population; it would suffer from adverse selection. Similarly, the smaller the pool, the greater the cost to already-insured people of allowing this population group to buy into it.

As such, probably the only incremental option would be to allow people ages 55 to 64 to buy into the largest existing private insurance purchasing pool, the Federal Employees Health Benefit Plan (FEHBP). This system insures more than 9 million people – about twice the number of uninsured people ages 55 to 64. Using this system guarantees choice of plans by tapping into the leverage of the existing group. A key policy choice concerns premiums. This group could be added to the Federal employees' pool, paying the same premiums as current enrollees. However, this would likely raise the premiums for Federal employees given the likelihood that, without financial assistance, only high-income and high-risk people ages 55 to 64 will join. Alternatively, some type of risk adjustment or reinsurance could be targeted to this group to limit the impact on Federal workers' premiums.

Make individual-market insurance more accessible and affordable: Third, policy makers could build on the individual (i.e., "non-group") health insurance market for coverage for late middle-age people. Already, people ages 55 to 64 purchase this type of coverage at a slightly higher rate than that of younger people. It is totally delinked from the employer system, offering greater choices of benefit design and plan type.

Policies have been proposed to build on this market for the general population (e.g., plans by Senators McCain and Coburn). They generally consist of two parts: a tax credit to make coverage affordable, and de-regulation of individual-market insurance to encourage competition. This de-regulation takes the form of allowing insurers to sell products using any state's rules, including the one with the least regulation. It would be a challenge to apply these policies incrementally for people ages 55 to 64. A fixed-dollar tax credit based on average costs will not be enough for this group, since its costs are higher than average. In addition, given the greater proportion who have health risks, the loosening of regulations could make it harder for people ages 55 to 64 to access policies.

One way to improve the accessibility and affordability of individual market coverage is strengthening consumer protections. Policy makers could limit age rating, meaning the practice of charging higher premiums to older people. They could also strengthen the regulations for portability of coverage to prevent pre-existing conditions from keeping this population uninsured. A third option is to create a reinsurance program for individual-market coverage. Given the high cost of people ages 55 to 64, they will disproportionately benefit from any system that targets high-cost enrollees.

Allow for an early buy-in to Medicare: Lastly, people ages 55 to 64 could be allowed to buy into Medicare early. Medicare will eventually cover this population and offers some of the advantages of the other options: portability, guaranteed eligibility, the same premium irrespective of circumstances, and broad access to providers. It is also a popular and trusted program.

Numerous bills have been introduced to create some type of Medicare buy-in. Some restrict eligibility to those who also receive Social Security benefits (i.e., ages 63 and 64); others offer this option to anyone in the 55 to 64 year-old age bracket. Most limit enrollment to those who lack access to another source of group health insurance. Premiums could be set in a number of ways. The Clinton Administration proposal in 1998 would have charged enrollees a relatively low monthly premium prior to age 65, with a "risk premium" for any extra costs being added on to the Medicare premium once that enrollee turns age 65. Other proposals would have added a tax credit for the option.

Possible Criteria for Assessing Options. These options are presented in a summary way and their full implications cannot be assessed without greater specificity. Other options (e.g., high-risk pool expansions) exist as well. However, they are illustrative of the major approaches. And, three basic questions about them can be addressed (Figure 9).

Who Pays for High-Risk People: A main purpose of health insurance is to prevent financial catastrophe by spreading high costs over time and across populations. Incremental proposals to insure people ages 55 to 64 have to confront the question of "who will pay" more so others for two reasons. First, this age group has higher costs than other potential targets (e.g., covering more children). Second, incremental policies usually strive to have no to low Federal budget costs. Federal spending in this context would spread the risk of health costs for people ages 55 to 64 across all taxpayers. Without this option, risk spreading has to occur over smaller and different types of populations.

In the COBRA option, active workers would help pay for the cost of continuation coverage for older participants. Even if there is a premium add-on (e.g., 2 to 50 percent of the base employee rate), it is likely that only older people whose costs are greater than the add-on will participate, raising the base premium. Similarly, Federal workers would likely cross-subsidized older people purchasing into the FEHBP under the second option. There are more Federal workers than active workers in most firms, which suggests that the amount of the potential risk sharing is smaller. However, more people ages 55 to 64 could join FEHBP than the COBRA option that only allows former employees and their dependents the choice.

If the approach to expanding the individual market were regulatory, then the premium reductions for people ages 55 to 64 would be offset by premium increases for younger, healthier enrollees in this market. A case can be made low-risk people should pay more so they themselves gain the protections for high-risk people when they move into this category. Others argue that this will make such coverage unaffordable for low-risk people, causing them to leave the market and possibly become uninsured.

The Medicare buy-in is the only proposal that aims to spread the cost of high-risk people over time rather than across a larger pool of people. Participants themselves would pay a premium add-on for the costs not covered by the pre-65 premium.

Who Is Most Helped: Incremental, voluntary proposals, by design, help some but not all of the target population. This raises the question of who would most likely benefit from the policy, as well as who would be left out. This is affected by both eligibility rules and the approach to coverage.

The COBRA option would exclusively benefit those people ages 55 to 64 who had employer-sponsored insurance for a firm with 20 or more workers. Self-employed, small business workers as well as those with loose attachment to the workforce would not gain access under this option.

The pool option would likely benefit any individual who lacked an alternative source of group coverage. Since coverage is guaranteed at community-rated premiums, it is likely that the pool option would be most attractive to high-risk people ages 55 to 64. This is especially true since the benefits for Federal employees tend to be generous and thus the unsubsidized premium may be high.

Since the proposals are designed be incremental, the option to build on the individual market would likely help the low-risk among the people ages 55 to 64. This is because incremental policy is unlikely to make this market work for the highest-cost people in the highest-cost age bracket.

The Medicare buy-in, in general, would resemble the pool option in whom it would help. However, given its risk premium and Medicare's reputation as a predictable program, this option would likely attract people who are risk adverse. They are willing to join this program early, even knowing that they will have to pay a permanent premium surcharge later, because they value health security.

Irrespective of the option, it is important to note that, in the absence of publicly-funded, income-related premium assistance, low-income people ages 55 to 64 would be left out of all of the options. As with other age groups, those with low-income have the highest rate of uninsured within the age bracket. As such, without subsidies, none of the options would likely make a large dent in the uninsured problem among people ages 55 to 64.

What are the Politics and Prospects: Lastly, incremental proposals may have less of an impact than comprehensive ones, but, in my opinion, face almost equal political challenges. This is because the same ideological and special-interest group concerns apply irrespective of the size of the proposal.

The COBRA and pool options raise fewer partisan than special-interest concerns. Businesses do not like the existing COBRA policy and would oppose expanding it to this group. Similarly, Federal employees have resisted FEHBP buy-ins for years, arguing that their system is a health benefit program for workers, not a public program that could be tapped into for other purposes. Both options expand private insurance which conservatives support and group health insurance

which progressives support. However, the COBRA option will be cast as a "unfunded mandate" by opponents, and the pool option will raise concerns about its viability given the high-risk profile of likely participants.

The individual insurance and Medicare buy-in options face stiff ideological opposition. The political left does not believe that sufficient regulation could be achieved to make the individual market viable for at-risk groups like people ages 55 to 64 – and they do not believe that market competition can achieve this result. Insurers generally support expanding the individual market but would oppose it if it meant increased regulation. The political right opposes government-run health care, including an expansion of Medicare, even if it is not publicly subsidized. They argue that costs will inevitably be higher than expected and seniors who did not benefit from the early buy-in will be forced to pay for it.

That said, the Baby Boom population is one of the most politically power generations in recent memory. Against the odds, they have achieved policy changes throughout their life spans and will likely continue to do so. In the near future, the policy change that will be most needed is improving access to health insurance. As such, what seem like insurmountable technical and political barriers may be taken down.

Of the incremental options discussed here, I'd argue that the Medicare buy-in is the most viable, for one reason: it does require other populations to pay for this high-risk group. It gives participants the choice of getting coverage now and paying later. It requires no new infrastructure to run, and is unique in that people ages 55 to 64 would be the "young ones" in the Medicare pool. Most importantly, it does not risk disruption of coverage for other populations. The political opponents to a Medicare buy-in have been successful for the last decade, primarily on ideological grounds. Concerns about ideology may be outpaced by concerns about health security as the pressure for change rises.

That said, this pressure may, instead of advancing incremental reform, fuel the fire for comprehensive change. Baby Boomers may demand the benefits that can only be offered through systemic reform. They may want to have private plan options as well as a Medicare buy-in. They may support greater personal responsibility and public financing in return for affordability in a system that covers all Americans. And, they may prefer to focus on what is driving their high costs – a failure to focus on prevention, promote high-value care, and reduce cost shifting in the system – rather than patch a gap in the insurance system.

Irrespective of how the pressures and politics may evolve, the reality is that incremental reform for people ages 55 to 64 is difficult to achieve from a policy perspective. This population is in need of help and, because of it, is hard to help short of comprehensive reform. At-risk people ages 55 to 64 fall through the deepest cracks in our health system which band-aid solutions can do little to solve. Incremental options do exist and should be acted on – but only if consideration of systemic reform is delayed.

Figure 1

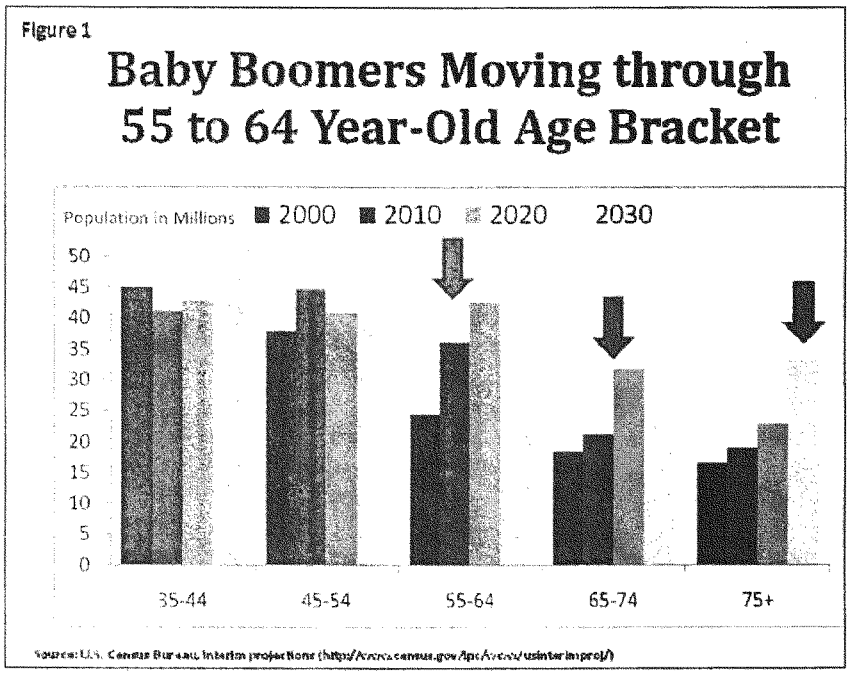


Figure 2

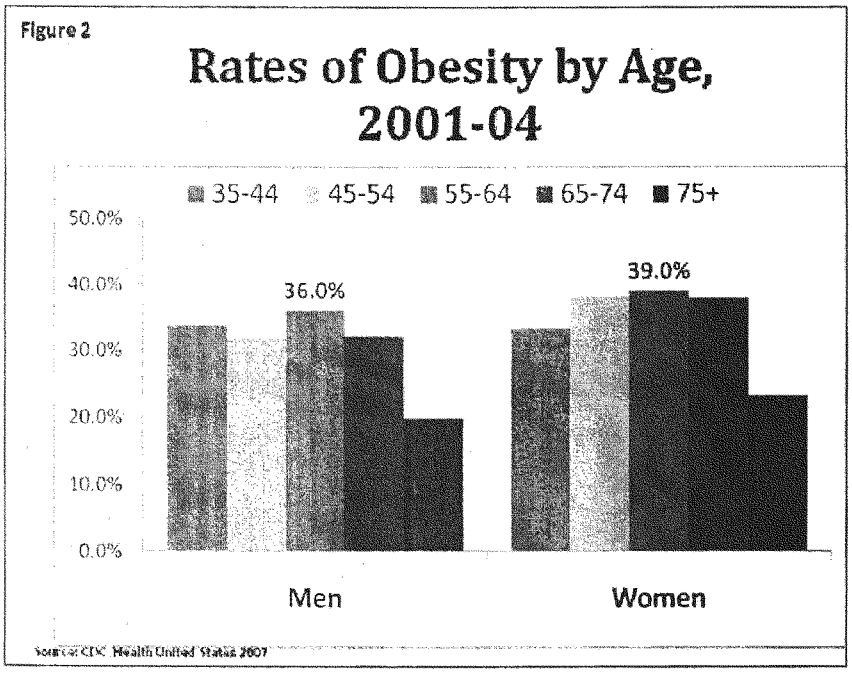
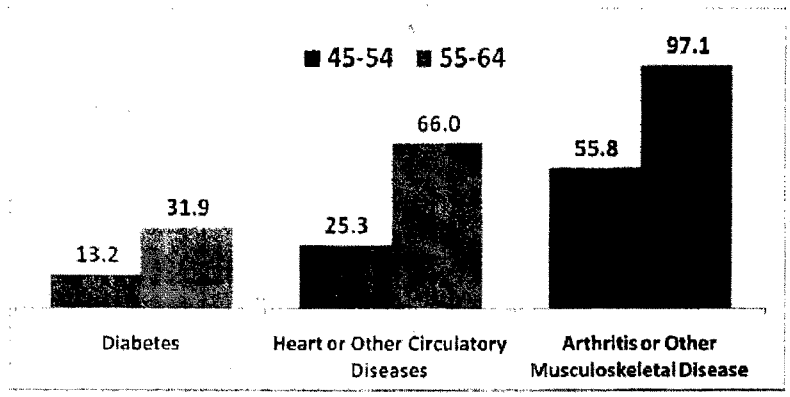


Figure 3

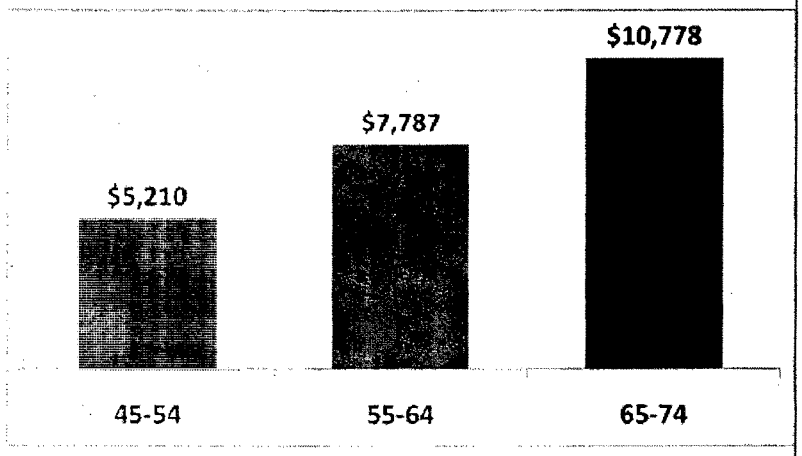
Functional Limitations per 1,000 People by Disease and Age, 2004-05



Source: CDC. Health United States 2007

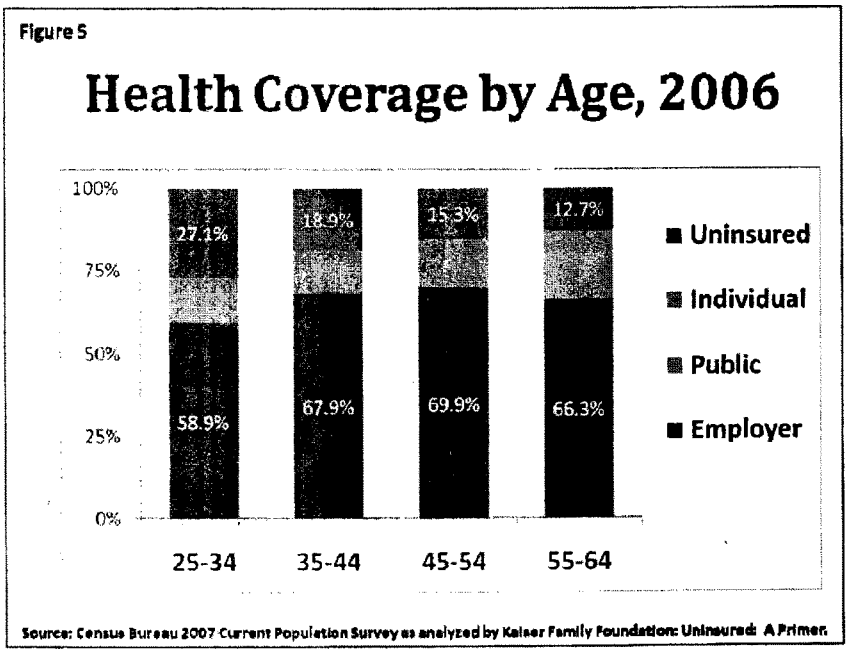
Figure 4

Health Spending Per Capita by Age, 2004



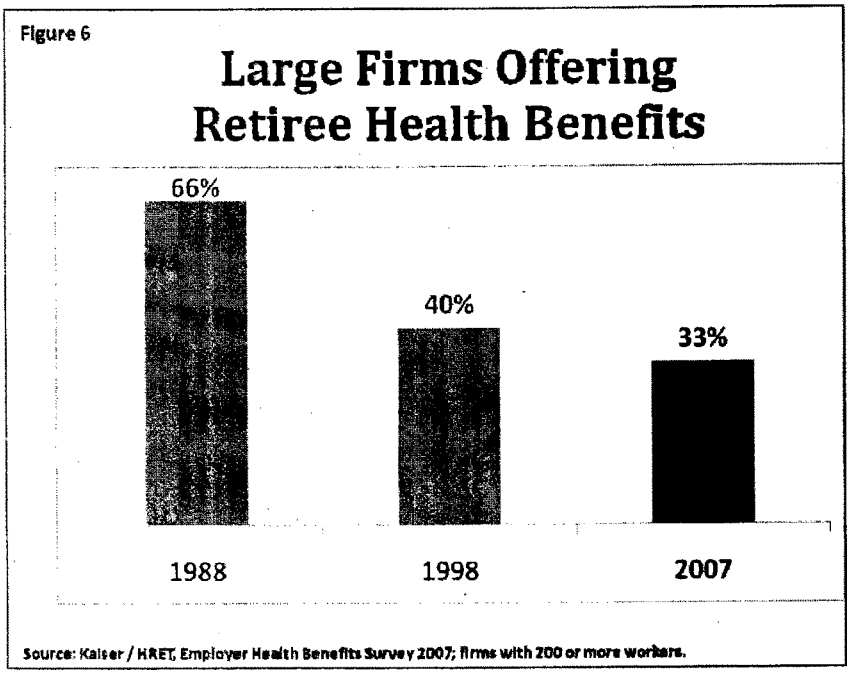
Source: CMS. National Health Expenditures by Age

Figure 5



Source: Census Bureau 2007 Current Population Survey as analyzed by Kaiser Family Foundation: Uninsured: A Primer.

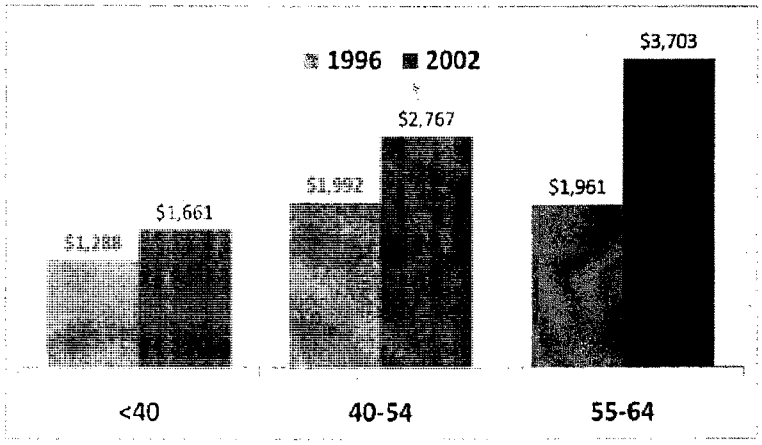
Figure 6



Source: Kaiser / HRET, Employer Health Benefits Survey 2007; firms with 200 or more workers.

Figure 7

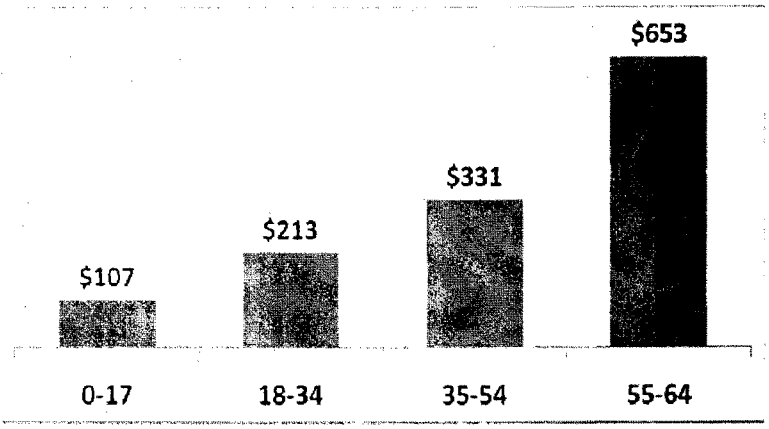
Individual Market Premiums by Age



Source: MEPS Statistical Brief #72, March 2005.

Figure 8

Median Out-of-Pocket Health Spending among Privately Insured People by Age, 2004



Source: MEPS Statistical Brief #159, January 2007.

Figure 9

Options and Assessment

OPTION	Who Pays	Who's Helped	Politics
COBRA	Workers with employer-based coverage	People who had job-based insurance	Employer opposition, concern about "mandate"
Group Pool	Pool participants	High-risk people	Federal worker concern, hard to make work incrementally
Individual Market	Younger, healthier participants	Low-risk people	Insurers oppose regulation Left opposes approach
Medicare Buy-In	Themselves when older	Risk-adverse people	Seniors may fear cost shift Right opposes approach

Notes:

[1] National Institute for Occupational Safety and Health, *Occupational Risks* (Atlanta: Centers for Disease Control and Prevention, undated). Available at: http://www.cdc.gov/niosh/programs/ohd/risks.html)
[2] National Center for Health Statistics, *Health United States, 2007.* (Atlanta: Centers for Disease Control and Prevention, 2007).
[3] National Center for Health Statistics, *Health United States, 2007.* (Atlanta: Centers for Disease Control and Prevention, 2007).
[4] National Center for Health Statistics, *Health United States, 2007.* (Atlanta: Centers for Disease Control and Prevention, 2007).
[5] Centers for Medicare and Medicaid Services, "Total Personal Health Care Spending, by Age Group,", available at: http://www.cms.hhs.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf
[6] Sara R. Collins and Jennifer L. Kriss, *The Public's Views on Health Care Reform in the 2008 Election.*(New York: The Commonwealth Fund, January 2008).
[7] Lisa Clemans-Cope and Bowen Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation, 2001 to 2005.* (Menlo Park, CA: Kaiser Family Foundation, December 2006).
[8] Richard W. Johnson, "What Happens to Health Benefits After Retirement?" *Work Opportunities for Older Americans.* (Boston, MA: Boston College Center for Retirement Research, February 2007).
[9] Richard W. Johnson, "What Happens to Health Benefits After Retirement?" *Work Opportunities for Older Americans.* (Boston, MA: Boston College Center for Retirement Research, February 2007).
[10] Kaiser Family Foundation / HRET, *Employer Health Benefits 2007 Annual Survey.* (Menlo Park, CA: Kaiser Family Foundation, 2007).
[11] Richard W. Johnson, "What Happens to Health Benefits After Retirement?" *Work Opportunities for Older Americans.* (Boston, MA: Boston College Center for Retirement Research, February 2007).
[12] Kaiser Family Foundation / Hewitt, *Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits.* (Menlo Park, CA: Kaiser Family Foundation, December 2006).
[13] National Center for Health Statistics, *Health United States, 2005.* (Atlanta: Centers for Disease Control and Prevention, 2005).
[14] Elizabeth M. Patchias and Judy Waxman, *Women and Health Coverage: The Affordability Gap.* (New York: The Commonwealth Fund, April 2007).
[15] Didem Bernard, "Premiums in the Individual Health Insurance Market for Policyholders under Age 65, 1996 and 2002," *MEPS Statistical Brief #72.* (Rockville, MD: U.S. Agency for Healthcare Research and Quality, March 2005).
[16] S. Collins et al., "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families" (New York: The Commonwealth Fund, 2006).
[17] J. Hadley and J.D. Reschovsky, "Health and the Cost of Non-Group Insurance," *Inquiry,* 40 (3) (2003): 235-53.
[18] Didem Bernard, "Out-of-Pocket Expenditures on Health Care among the Nonelderly Population, 2004," *MEPS Statistical Brief #159.* (Rockville, MD: U.S. Agency for Healthcare Research and Quality, January 2007).
[19] Richard W. Johnson, Rudolph G. Penner, Desmond Toohey, *Do Out-of-Pocket Health Care Costs Delay Retirement?* (Washington, DC: The Urban Institute, March 14, 2008).
[20] J. Michael McWilliams et al., "Health Insurance Coverage and Mortality Among the New-Elderly," *Health Affairs* 23, no. 2 (July / August 2004): 223-33.
[21] J. Michael McWilliams et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine* 357, no. 2 (July 12, 2007): 143-53.
[22] J. Michael McWilliams et al., "Health of Previously Uninsured Adults After Acquiring Medicare Coverage," *JAMA* 298, no. 24 (December 26, 2007): 2886-94.

Senator WYDEN. Very well said, and I think it is especially helpful to have you and John Sheils coming together to talk to us about some of the specific options and the role of comprehensive reform. It is a good way to trigger the debate.

So, Mr. Sheils, welcome. You have done wonderful work for so many years, and we appreciate your involvement today.

STATEMENT OF JOHN SHEILS, SENIOR VICE PRESIDENT, THE LEWIN GROUP, FALLS CHURCH, VA

Mr. SHEILS. I thank the Committee for inviting me. It is a real privilege to be here.

My name is John Sheils. I am a senior vice president with The Lewin Group. We are a non-partisan group. We do not advocate for or against any particular legislation.

Today, I have been asked to talk about some of the ideas on how you could expand coverage for the group. There are about a dozen bills out there right now that would expand coverage in the country and all of them would touch on this age group.

Some of the background: There are about 5.1 million uninsured people age 55 to 64. Nineteen percent are below poverty. Twenty percent have out-of-pocket spending for health care in excess of 15 percent of their income. The average premium for a typical employer policy would be about $9,000 for someone in this group. That is about four-and-a half times as high as it would be for someone, say, under the age of 25, and that is what makes this group require special attention.

One of the proposals—more modest in size, but one of the proposals—to come out is something called a Medicare buy-in. People age 62 to 64 would be able to buy into the program by paying the full cost premium in a policy we looked at where there is a cap on what the premium would be to 10 percent of your income. That would cover only about 285,000 uninsured people, and the key reason for it is that even with the buy-in, the premium will still be very high relative to what most people are facing in their health care costs.

Another idea is to expand Medicaid to cover people in this age group. Right now—let's see—a non-disabled individual who does not have responsibility for a child is not eligible for the program regardless of their income, and one of the things you could do is—it has been proposed several times—to expand coverage under the program to the poverty level, for example. That would get you about 1.1 million uninsured people. You would still have a lot of people remain uninsured, and the reason for that is that even at 125 percent of poverty, premiums for health care in this group are going to be prohibitively high.

We have also seen some tax credit proposals that would essentially replace the tax exclusion for employer-provided benefits with a flat tax credit. An example would be a credit of about $2,000 with $5,000 per child. We looked at the impact of these, and we have estimated that this could cover perhaps 22 million uninsured people. About 2.2 million of those would be people 55 to 64, and that approaches 50 percent of the uninsured population.

The big problem here is that the credit is fixed at, let's say, $2,000, for example. That really does not give you very much help

in paying a premium if you are facing a $10,000 premium, as some people do, in some of these high risk pools. So we find that it is fairly ineffective. Also, the lower-income people in this group will require additional subsidies to purchase it.

Now, over the past year, I have had the privilege of working with Senator Wyden and helping them work through his bill, and this is a comprehensive health reform bill which I think is going to be particularly advantageous to this particular age group.

Under this bill, all individuals have to have insurance. Your benefits at work are cashed out, which means your wages are increased by the amount of what the employer has been spending on your health benefits. You then buy the insurance either through your own employer or through private health plans.

The program includes what we call community rating. Everybody pays the same premium, regardless of their age or health status characteristics. So the average premium would be, for example, $4,300 in the example I have been using. That compares with $9,000 for those 55 to 64. Of course, the youngest people spend more. They would spend $2,700 under the current law, but they would be paying $4,320 under this policy.

The program also provides subsidies through 400 percent of the poverty level, people between the poverty line and 400 percent of the poverty line. I think it is easy to argue that they need at least some level of subsidies to help them pay for their policies, and it is this combination of community rating and the subsidies to this higher income level that I think makes the bill unique, and I believe there are other bills that include features like this, but we are still working on them to figure what they would mean.

Thank you very much.

[The prepared statement of Mr. Sheils follows:]

Statement of John Sheils, Senior Vice President, The Lewin Group

Senate Special Committee on Aging

April 3, 2008

Expanding Health Insurance Coverage for the Near-Elderly

Good Morning. My name is John Sheils. I am a Senior Vice President with the Lewin Group specializing in analyses of proposals to expand health insurance coverage and reform the American health care system. I have been asked to discuss the likely impacts of health reform proposals on coverage and costs for people age 55 to 64, often referred to as the "near-elderly." The Lewin Group does not advocate for or against any legislation. I include at the end of my testimony supporting data for my remarks.

The population age 55 to 64 is highly diverse in terms of income, sources of health insurance and health status. Many in this group have well paying jobs and over 53 percent have employer-sponsored health insurance (ESI). Another 3.2 million are covered as early retirees under an employer health plan ***(Figure 1)***.[1] However, about 5.1 million people in this age group (16 percent) are uninsured and another 1.6 million (5.1 percent) are purchasing coverage on their own in the individual insurance market. This population is highly vulnerable to the onset of illness and its financial impacts.

The near-elderly are more likely to become ill or develop chronic health conditions than any other age group, except for those aged 65 and older. We estimate that nation-wide spending for personal health services (excluding long-term care) in 2008 will be about $9,440 per person age 55 to 64, compared with an average of about $3,710 for all others under the age of 55 ***(Figure 2)***.[2] While much of this cost will be covered by public and private insurance, about one in five people age 55 to 64 will have premium and out-of-pocket spending in excess of 15 percent of family income ***(Figure 3)***.[3] Premium and out-of-pocket spending for the near-elderly will average $5,060 per family in 2008.[4]

The uninsured in this group tend to be in poorer health and have lower incomes than their privately insured counterparts. About 19 percent of the uninsured age 55 to 64 have incomes below the Federal Poverty Level (FPL) (i.e., $10,400 for an individual and $21,200 for a family of 4), compared with 9.1 percent for all of those in this age group ***(Figure 4)***. About 22.4 percent of the uninsured age 55 to 64 report themselves to be in fair to poor health status compared to only about 11.7 percent among people with employer health coverage ***(Figure 5)***. There is also evidence that many of these

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1 Lewin Group Estimates using the pooled March Current Population Survey (CPS) data for 2005 through 2007.

2 Estimates include total spending for health services and supplies for primary and acute health care services and products such as prescription drugs. These figures exclude long-term care, insurance and program administration, public health, research and construction.

3 Includes out-of-pocket spending for health services (excluding long-term care), including deductibles, co-payments, and payments for non-covered services. Also includes family premium payments for public and private insurance, including the employee contribution for ESI coverage.

4 This is the average amount for families headed by someone age 55 to 64.

individuals delay receiving needed health care until they turn age 65 and qualify for Medicare.[5]

Private health insurance premiums can be very high for these people. We have estimated that the premium for a typical employer benefits package for someone age 55 to 64 would be about $744 per month (i.e., $8,928 per year), compared with an overall average of about $357 for all workers (***Figure 6***).[6] A family premium for a policy holder age 55 to 64 would be $1,363 per month, which equals about $16,356 per year.

People can purchase coverage from a former employer offering ESI for up to 18 months by paying a premium equal to 102 percent of the average cost for all workers in the firm (i.e., COBRA coverage). This can be a relatively good deal for the near-elderly because their premium is based upon the employer's pooled risk for all of their employees, regardless of age. However, these premiums are un-subsidized by the employer and can still be beyond the reach of many of those who are eligible.

The rising cost of health care has fueled a steady erosion of employer coverage affecting people in all age groups. The percentage of firms offering employer health benefits declined from 69 percent in 2000 to 60 percent in 2007.[7] The percentage of large firms offering retiree benefits also declined from 37 percent in 2000 to 33 percent in 2007. This is slowly increasing the number of people with individually purchased non-group insurance as their only coverage option.

Coverage in the individual market for people in this age group can be very expensive and difficult to find due to the practice of medical underwriting. Medical underwriting is a process whereby insurers deny coverage and/or increase premiums for people with a chronic illness. All but three states permit plans to deny coverage on the basis of health status, and all but two states permit health plans to increase premiums for people with health problems. Although many states limit the variation in premiums with health status, chronically ill people will typically pay much more for coverage than others.

It is important to recognize that for those who are healthy, medical underwriting can mean lower premiums due to the exclusion of higher-cost individuals from the carrier's risk pool. In many states with medical underwriting, the average premium for non-group coverage can be up to 20 percent lower than for employer coverage, due to the exclusion of the chronically ill from private non-group coverage.

There are few good options available to people in this age group who have a chronic health condition. For example, about 32 states have established "high risk" pools to

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[5] Jody Schimmel, "Pent-up Demand and the Discovery of New Health Conditions after Medicare Enrollment," University of Michigan; and Li-Wu Chen, et al. "Pent-up Demand: Health Care use of the Uninsured Near-Elderly.

[6] We assumed the Blue Cross / Blue Shield Standard Option PPO plan offered through the Federal Workers Health Benefits Program (FEHBP). We estimate that this plan is at the 60th percentile among plans in terms of actuarial value.

[7] "Employer Health Benefits: Annual Survey 2007," the Kaiser Family Foundation and the Health Research and Education Trust (HRET).

provide coverage to people who have been denied coverage due to their health status. Under these plans, people are typically required to pay a premium equal to about 150 percent of "standard risk", which is an estimate of what costs would be for an average individual of their age.[8] High risk pool costs generally exceed the amount of premium received, which are typically financed with an assessment on insurers operating in the state.

However, the premiums charged in high risk pools still can be prohibitive. For example, in the Iowa high-risk pool, the premium for a plan with a $1,000 deductible ranges between $569 per month ($6,828 per year) at age 55 and $870 per month ($10,440 per year) at age 64.[9] Even with a $10,000 deductible, the premium is still about $417 per month for someone age 64.

People who can establish that they are substantially disabled may be eligible for coverage through Medicare or Medicaid. Qualified disabled people generally can obtain coverage under Medicare, but only after a two-year waiting period. The disabled are also eligible for Medicaid if they have low incomes, typically less than 74 percent of the FPL, but only after nearly exhausting their assets. In fact, in all but about 6 states, non-disabled adults under age 65 who do not have custodial responsibilities for children are not eligible for Medicaid regardless of how little income they have.

A range of proposals have emerged in recent years that would help expand coverage for the near-elderly. One relatively modest proposal would be to allow people age 62 through 64 to buy-in to Medicare by paying the Medicare premiums up to a maximum of 10 percent of the applicant's family income. Based upon a prior study, we estimate that such a program would cover about 914,000 people age 62 to 64, of whom about 285,000 would be newly insured people. The program would cost the federal government about $3.0 billion per year. [10]

Another approach would be to expand eligibility under Medicaid for those aged 55 to 64 living below the FPL regardless of disability status. We have estimated that this would cover about 1.1 million of the uninsured in this age group at a cost of about $16.7 billion per year.[11] However, these analyses have shown that any program to achieve a broad expansion in coverage for the near-elderly must deal with the sharply higher cost of coverage for this group for those at both low- and moderate-income levels.

We have studied several Congressional bills that would provide a fixed dollar tax-credit for individually purchased non-group insurance of between $1,500 and $3,000 for individuals with incomes as high as 300 percent of the FPL. While these bills would

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[8] Premiums in high risk pools range between 150 percent and 200 percent of standard risk costs.

[9] Premium data for the Iowa Comprehensive Health Association.

[10] Updated estimates from: John Sheils, "The Potential Impact of the President's Medicare Buy-in Proposal on the number of Uninsured Persons and Medicare Program Costs," (report to the Commonwealth Fund), The Lewin Group, September 22, 2000.

[11] About 2.6 million people between the ages of 55 and 64 would be eligible of which about 1.7 million would enroll. Enrollees would include about 1.1 million uninsured people and about 600,000 people who would drop private coverage to enroll in Medicaid. Estimates assume no premium requirement for enrollees.

greatly improve access for millions of Americans, the tax credit would be far too small to assure the affordability of coverage for people age 55 to 64. Even a tax credit of $3,000 would fall far short of what is needed to pay a high risk pool premium of $10,000 per year for someone with a modest income. Conversely, the flat credit would cover most of the premium charged to younger and healthier adults. Thus, it will be important for the credit to reflect variations in the actual cost of coverage.

An alternative to varying the tax credit with the premium amount would be to couple the tax credit with a requirement for all insurers to guarantee the issue of coverage at a "community rate" for all applicants. This means that insurers must accept all applicants and are required to charge the same premium to all regardless of age, gender or health status (variation is typically permitted for family type and geography). This would substantially lower the premium for the near-elderly resulting in increased coverage for this group, but would simultaneously increase premiums for the young, causing some to drop coverage.

Any program requiring all people to have insurance coverage will need a comprehensive plan for assuring the affordability of coverage to assure that all individuals can reasonably comply with the mandate. This is likely to require a combination of insurance market reforms and premium subsidies for families with incomes as high as 400 percent of the FPL.

Over the past 15 months, I have had the privilege to collaborate with Senator Wyden and his staff in designing the "Healthy Americans Act" (HAA). The proposal would achieve near universal health coverage under private insurance for all Americans, including those now on Medicaid, except for those already covered through Medicare or the military. Participants would chose from a selection of competing private plans offered through newly created regional purchasing organizations called "Health Help Agencies" (HHAs). All Americans would have coverage at least as comprehensive as the coverage now provided to members of Congress and federal workers.

The bill assures the affordability of coverage through a combination of insurance market reforms and premium subsidies. Under the HAA, all Americans are required to have health insurance. Insurers are required to sell insurance on a guaranteed issue basis with community rated premiums. The program would fully subsidize the premium for those living below 100 percent of the FPL, with the premium phasing-in for people living between 100 percent and 400 percent of the FPL.

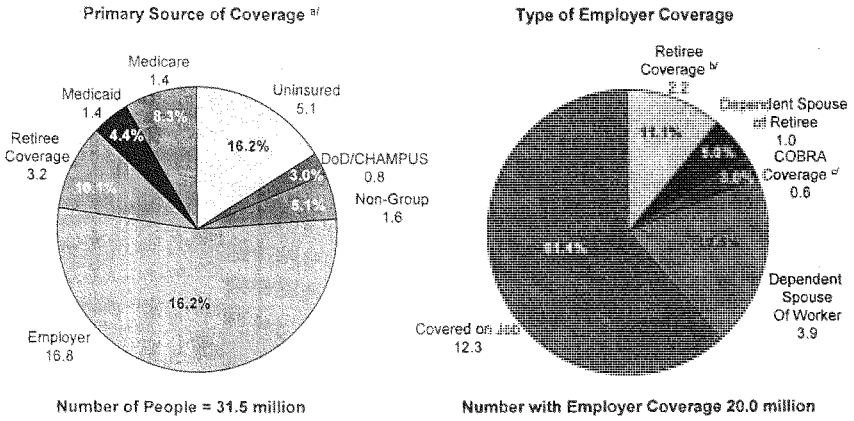
This combination of market reforms and premium subsidies is designed to assure the affordability of coverage across all age and income groups regardless of health status. People who do not have enough income to pay taxes are assumed to be eligible for the program with full subsidies, thus eliminating the need to apply separately for assistance as under the current Medicaid program. This approach is designed to simplify administration and assure high levels of enrollment in the program.

The act also seeks to change incentives for both consumers and providers to slow the rate of growth in health spending. Employers would be required to "cash-out" their

health plans by terminating their existing health coverage and paying the amount saved to their workers in the form of increased wages. People would then pay the full amount of the premium, less premium subsidies. The current tax exemption for employer provided health benefits is also eliminated to strengthen incentives for families to seek lower cost coverage. However, a new "health premium" tax deduction is created so that these wage increases do not increase federal personal income tax payments. To maintain incentives to control costs, the deduction is fixed and cannot be increased by purchasing more costly coverage.

Whatever approach is taken to expand health insurance coverage, it must be based upon a careful assessment of the affordability of coverage for all Americans and the near-elderly in particular. To be viable in the long-term, any program also must be accompanied with changes in patient and physician incentives that will help slow the rate of growth in health spending.

Figure 1
People Age 55-64 by Primary Source of Insurance: Average Monthly (millions)



a/ We assumed that Medicare is the primary source of coverage for persons reporting Medicare coverage. For others, DoD/TRICARE and employer coverage were assumed to be the primary source of coverage when reported. Medicaid was assumed to be the primary source of coverage if people reported Medicaid as their only sourse of coverage. Non-group coverage was assumed to be primary if this is the only source reported.

b/ People reporting that they have employer-based coverage in their own name are assumed to have retiree coverage if they reported that they are "retired" or if they are receiving a pension and are working less than 35 hours per week.

c/ Based on Lewin Group analysis of the pooled Survey of Income and Program Participation (SIPP) data.

Source: The Lewin Group analysis of the pooled March Current Population Survey (CPS) for 2005 through 2007corrected for under-reporting of Medicaid coverage.

Figure 2
Average Total Spending for Personal Health Care by Age in 2008 [a/]

	Average Spending
Under Age 19	**$2,154**
19-24	$2,526
25-34	$3,778
35-44	$4,953
45-54	$6,067
All under age 55	**$3,710**
55-64	$9,441
All under age 65	**$4,480**
Age 65+	$13,019
All People	**$5,499**

a/ Includes spending for all health services except long-term care including the amounts paid by public and private payers and the amounts paid out-of-pocket for care. Excludes long term care, insurance administration, public health, research and construction.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 3
Premium and Out-of-Pocket Health Spending for Families Headed by Someone Age 55 to 64: 2008

Average Spending	All Age 55-64	Insured	Uninsured [a/]
Average Spending per Family	$5,060	$5,926	$3,747
Families by Health Spending as a Percent of Income			
Less than 5%	44.8%	43.8%	49.7%
5.0% - 7.5%	13.6%	13.5%	13.7%
7.5% - 10.0%	9.6%	10.0%	7.5%
10.0% - 15.0%	11.8%	12.3%	9.5%
15% or more	20.3%	20.4%	19.7%
Total	100%	100%	100%

a/ Includes all families headed by someone age 55 to 64 with one or more family member that is uninsured.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 4
Distribution of People Age 55 - 64 by Family Income

	All Age 55-64	Uninsured 55-64
Total Family Income		
Less than $10,000	7.0%	14.3%
$10,000 - $19,000	8.8%	16.7%
$20,000 - $29,999	9.8%	17.0%
$30,000 - $39,999	9.9%	13.2%
$40,000 - $49,999	9.1%	8.1%
$50,000 - $74,999	19.3%	13.4%
$75,000 - $99,999	12.7%	7.5%
$100,000 or more	23.5%	9.8%
All Families	100.0%	100.0%
Income as a Percentage of the Federal Poverty Level (FPL)		
Below FPL	9.3%	19.0%
100% - 150% of FPL	6.1%	11.8%
150% - 200% of FPL	6.9%	12.1%
200% - 300% of FPL	13.6%	19.8%
300% - 400% of FPL	13.1%	12.0%
400% - 500% of FPL	11.3%	7.3%
500% or more of FPL	39.9%	17.9%
All Families	100.0%	100.0%

Source: Lewin Group analysis of the pooled March Current Population Survey (CPS) for 2005 - 2007.

Figure 5
Distribution of People Age 55 - 64 by Self-Reported Health Status and Primary Source of Coverage

Self-Reported Health Status	All People	Medicare	Medicaid	Employer Coverage	CHAMPUS	Non-Group Insurance	Uninsured
Excellent	18.6%	3.1%	6.1%	22.2%	12.9%	23.7%	15.0%
Very Good	30.4%	8.7%	12.1%	35.3%	24.0%	32.6%	27.8%
Good	30.5%	22.0%	25.9%	30.8%	28.8%	30.3%	34.9%
Fair	13.5%	33.8%	31.0%	9.0%	22.0%	10.2%	16.0%
Poor	7.0%	32.4%	24.9%	2.7%	12.3%	3.2%	6.4%
Total	100%	100%	100%	100%	100%	100%	100%
Number of People (millions)	31.5	2.6	1.4	20.0	0.8	1.6	5.1

Source: Lewin Group analysis of the pooled March Current Population Survey (CPS) for 2005 - 2007.

Figure 6
Estimated Monthly Premiums for the Federal Workers BC/BS Standard Option Health Plan for a Typical Population by Age and Gender of the Policy Holder [a/]

	Single	Family
Under 25 Males	$161.47	$583.32
25 - 34 Males	$197.38	$850.34
35 - 44 Males	$261.01	$1,015.23
45 - 54 Males	$438.18	$1,141.72
55 - 64 Males	$744.59	$1,363.86
Under 25 Females	$288.53	$621.39
25 - 34 Females	$363.14	$877.25
35 -44 Females	$422.48	$972.39
45 - 54 Females	$556.95	$1,149.37
55 - 64 Females	$801.36	$1,411.24
Average Across all Policy Holders	$357.47	$892.34
Per Member Per Month (PMPM) [b/]		$326.85

a/ Estimates are for the privately insured population. We assumed the Blue Cross / Blue Shield Standard Option PPO plan offered through the Federal Workers Health Benefits Program (FEHBP).
b/ Average across all covered people including policy holders and dependents.
Source: Lewin Group estimates using actuarial analyses prepared by NovaRest Consulting.

Senator WYDEN. Mr. Sheils, thank you, for all of your collaboration and assistance. We are very, very appreciative. Let me just ask a few questions of each of you and feel free, the three of you, because you are so renowned in this field, to chime in at any point. This is not some kind of Star Chamber kind of grilling thing, but a chance to really get an education on these critical questions.

Mr. Fronstin, what do you make of this situation described by Mr. Roach and others. How are these trends going to actually hurt the economy? They are saying that some older persons who are 56, 57 years old, would like to go out and set up their own business. In today's health care system, there are many challenges you have in front of you like pre-existing illness problems. They are claiming that not only is this an issue and others going to effect people getting health care coverage, but they assert that this situation is going to be harmful to the economy.

Forty-five minutes ago Ms. Fitzpatrick just sat where you are now and said her first choice would be to be able to go out and set up her own business—hire people, help our economy during these kind of troubled times—but she cannot do it. What do you make of that?

Mr. FRONSTIN. Well, I thought her comments were very interesting because towards the end of the Q&A she had mentioned that her husband gets coverage from his own job now, and while they are concerned about his ability to continue working because of his health status, I presume she does have the ability to go onto his policy and start her own business, and she did not talk about that.

Her employer offered coverage to keep her employed at his company. He was making a business case for that as well. Listening to that exchange and the comment that came up from the other witness, I just found it interesting, because the middle witness—I forget the name—was agreeing with you and agreeing with Lee Anne. Yet, if we made coverage more portable he would potentially lose a valued employee, someone who he added a benefit for his entire company to keep this one person. At least that is what I heard in the testimony. I just found that interesting.

That is not to minimize the fact that there are some real issues here with the impact on the economy. I think health care costs in general are having a huge impact on the economy. They are having a huge impact on wage growth, and portability in general is an issue whether you are 55 to 64 or even younger. It does not matter what your age is if you have a pre-existing condition and you try and go out on your own. Chances are if you have not met the HIPAA rules that pre-existing condition is going to be excluded, and even if it is not, you may not be able to afford the premiums.

Senator WYDEN. Dr. Lambrew.

Ms. LAMBREW. Just a quick comment: This issue of job lock, I think, is interesting because it cuts in both directions. On one hand, it means that people continue to work longer or in types of jobs that they do not want to be in because of the health insurance situation, and vice versa, so that people may, when there is a choice, decide to retire earlier. That might be a choice that people want, although some people say it would depress economic activity.

But all the trends you see are in the opposite direction, which is given since health care costs are fairly high. People want dif-

ferent types of jobs. There is this whole literature on what are called bridge jobs to retirement meaning that people want a new second career or to go into self-employment or work part time as a way to work their way through a retirement that is now lasting longer than it used to.

So, having the freedom of having health insurance independent of jobs will potentially prevent some people from being locked into working longer than they would like, but also could free up some people to go into these part time self-employed bridge jobs to retirement.

Senator WYDEN. Do you want to respond to that?

Mr. SHEILS. Well, anything that restricts one's ability to innovate or be an entrepreneur, to develop some new ideas in the economy, anything that does that is really a drag on the economy, and you have me wondering whether I should start my own business all of a sudden.

But it is a complicated issue, and I know, knowing people who have started their own business in this age group, that it is baffling when you try and work through the different options available on insurance coverage. It is very difficult to figure out what these health plans really do and what they do not do, and I am talking people who are health experts who have gone out in their own business and they are totally lost when it comes to the insurance for their small group.

So anything that limits one's ability to innovate, like the fear or the concern about how difficult it is to arrange insurance, anything like that, has the potential to really be a drag on the economy.

Senator WYDEN. I think this is particularly important for people like yourselves who are the scholars to get us more information. I think this is going to be a big deal because we are clearly faced with huge economic challenges, even beyond what we have seen with the subprime, mortgage mess and Wall Street and credit card debt.

I will tell you, Mr. Fronstin, I do not get the sense that it is going to be real easy for somebody to go off and set up a business, find coverage and coordinate with a spouse who has existing coverage. I think it is going to be a huge challenge, and I would like to see the three of you take a further look at this because I think it is going to be hugely important as we figure out what to do for this group between 55 and 64.

Mr. FRONSTIN. I did not mean to imply that in my comments. I was just trying to bring up the fact that it seemed like there was a constraint that was being talked about that did not really exist in the example that we heard about during the testimony.

Senator WYDEN. Well, I have heard it so many times from so many people, I think it would be helpful if the three of you could look at that further.

Ms. Lambrew, you make a number of points that are very helpful. I especially like your conclusion—that as you look at the incremental, options, it really does push you down the road to examining comprehensive reform, which is essentially the conclusion I came to.

But I am curious about the costs of those four incremental options, and how one would raise, the revenue for it. When we start-

ed the Healthy Americans Act, the first thing we came up with was, well, we are spending $2.3 trillion today. There are 300 million of us. You divide 300 million into $2.3 trillion, and you could go out and hire a doctor for every seven families in the United States, pay the doctor $200,000 for the year, and say, "Doctor, that is going to be your job, taking care of seven families."

Whenever you bring it up with the physicians, they always says, "Where do you go to get your seven families?" Because they like the idea of being doctors again and using the dollars in the system more efficiently. But if we are going to look at these incremental options that you have described, clearly, that will cost additional money. What are your thoughts about how much these various four options would cost, and what are the options for generating the revenue?

Ms. LAMBREW. Well, I will just say that my task as I understood it, my mission as I understood it, was to look at incremental reform, and I would define that as being relatively low cost and at the margin. When we used to do the Medicare buy-in policies, the cost was $5 billion, $10 billion over a five year period, although John could answer this question as well as I can.

Senator WYDEN. That is Medicare buy-in, would be $5 billion to $10 billion?

Ms. LAMBREW. The way that these policies are designed, there is an upfront cost that gets paid back later by the premiums that get paid after you turn 65. So it is a timing issue. So you seed the pool, get people in, and then, over time, they pay back the excess cost of their risk during this period.

But I wanted to say that there are public costs and private costs, and we are not ever very good at talking about this. You are absolutely right. We have a $2.2 trillion health care system of which about 45 percent is public and 55 percent is private, and when you talk about federal budget costs, you take that 45 percent slice and go down further because this includes state and local spending too.

We oftentimes try to jam into our federal spending slice the subsidies for the entire system and try to figure out how we spread that, and it is very difficult. Almost all the policies I outlined would try to do that by using implicit private-sector subsidies, either by, in the individual market, using rate bands, which causes the lower cost people in that market to pay more to cross subsidize. If you are talking about group purchasing pools, the federal employees cross-subsidize the people who come in. If you are talking about COBRA, the active workers are going to be cross-subsidizing the older workers who are retired.

At the end of the day, it is all this kind of cost shifting that goes on short of a comprehensive system where we think through as a society how much we want to raise, how do we want to spend, do we want to target some of the options like John mentioned, to poor people or high-risk people, or do we want to cross-subsidize in different ways.

So the short answer is these are all low-budget items in the federal budget, but that is only looking at the federal budget perspective, and these are largely costs that have to be spread somewhere.

Senator WYDEN. I think it would be very helpful—because I read your testimony and I thought it was very good—if you could give

us for the record and for the staff in the days ahead some sense of what those options would cost and—to the extent you can—on the public and private side. That would be very helpful.

One other question I had for you just as we look at this whole question of funding. I think you and the panel know that I feel very strongly about the tax code. The group working on the Healthy American Act have had some briefings. There is a $200 billion expenditure—or, I guess, it would be more accurate to say $200 billion in revenue forgone. It is more likely to be $300 billion in revenue foregone. It would be the biggest single item in terms of revenue foregone in this whole debate, and I feel very strongly that this is regressive in terms of its very nature.

I mean, if you are a high flyer in this country today and you want to get a designer smile put on your face and your company has a plan, you can go off and get a designer smile put on your face, and the federal taxpayer, picks it up. If you are a hard-working woman in the local furniture store, your company does not have a plan, you do not get anything other than really getting your federal tax payment out there to subsidize the high flyer.

It seems to me most economists agree on this, and I want to just ask you, Ms. Lambrew. Here is what Bob Greenstein who heads the Center of Budget and Policy Priorities, somebody I respect very much, said. Mr. Greenstein said, "I do not think there is much disagreement that the current tax treatment of health care is regressive." Would you by and large share Bob Greenstein's view?

Ms. LAMBREW. Yes.

Senator WYDEN. Great. Very good.

Let me turn to Mr. Sheils, and for you Mr. Fronstin and you Ms. Lambrew, feel free to just chime in at any point.

What I want to see, Mr. Sheils, is how the Healthy Americans Act addressees what I think are the big issues that people between 55 and 64 care about. They care about affordability, they care about portability, availability, loss of insurance. So could you just answer a few questions with respect to that?

Under the Healthy Americans Act, could a person in this age group move to another job if it did not offer health insurance?

Mr. SHEILS. Yes.

Senator WYDEN. Could they get employer health benefits if they worked less than full time?

Mr. SHEILS. Yes.

Senator WYDEN. Since they have health problems in my example, would it be possible to purchase or afford to buy health insurance on the individual and non-group market?

Mr. SHEILS. I think that much is done in the plan to try and address the question of affordability. Community rating is a key part of that. It gets the premium to a level that is more affordable for everyone, rather than unaffordable for some and pretty affordable for others, and then it provides subsidies through a mechanism which we think will be fairly easy to use through the tax code to help people pay for that coverage and to essentially have that assistance at the point when they actually need it. So the premium subsidies are a key feature of what will assure that sort of availability.

Senator WYDEN. If we were to take somebody who was 62, say a woman who was 62, and her husband was retiring at 65 and is going to sign up for Medicare, but they would no longer have health insurance through his employer. What would happen in the next three years to that person until they were Medicare eligible?

Mr. SHEILS. Well, really nothing. The way the program works is that your employment is really independent of where you work. You can get any insurance policy that is offered in your area. You can move from one job to another and never change your plan. You could move in and out of the labor force and never change your source of health coverage, and if you decided to change coverage, you became unhappy with your plan and you want to move on, you would still be able to do that. You would be able to do that as freely as would a person who has employer coverage available at work.

Senator WYDEN. Now we are going to have to be very sensitive to the financial situation of small businesses. That is where most of the jobs are in our country. That is where certainly most of the jobs are in our state. I would be interested in knowing your view under the Healthy Americans Act. How would Mike Roach's responsibility change in paying for health insurance coverage for his employees?

Mr. SHEILS. Well, the change would come first in the form of a cashout. He would just figure out what he is spending on health benefits. There will be a weighted procedure for that. Then they will take that amount and give it to the workers in the form of a wage increase. Individuals would then be responsible for buying the insurance.

If their employer is offering coverage and they want to use the employer's plan, they would be permitted to do that. If they would prefer to go to a health plan available in their area through—they are called health help agencies—if they want to go to a plan in the area that—you will be able to make those changes.

After two years, the employer is going to have to start paying an amount equal to up to 25 percent of the premium. For the very smallest firms, it is around 2 percent of the premium, which is a fairly small amount. As you work your way up, you know, the discounts off of the 25 percent requirement are pretty substantial. So the small firms in particular are going to find themselves contributing at least after the second year, and that contribution will for a lot of them be fairly small, but for no one it will be greater than 25 percent of the premium.

Senator WYDEN. I have just a couple of other questions, and then we have been joined by my friend from Delaware who has a great interest in these issues. So I will just ask a couple of additional questions. Then we will recognize the senator from Delaware.

Some of the health insurance problems, Mr. Sheils, that people in late middle age face are essentially these various locks. There is a job lock, where they cannot leave or move to another job for fear of losing insurance. There is an insurance lock—they cannot change insurance companies. That was essentially the situation Mr. Lindner described. Or they cannot get individual non-group insurance or they cannot afford to pay for it.

So how would the Healthy Americans Act, in effect, unlock some of these precarious economic circumstances that our citizens face?

Mr. SHEILS. Well, they make it possible for you to make changes without hurting yourself, without disadvantaging yourself. As I said, the premiums that you pay under the plan are community rated. They are the same regardless of your age or health status. So you are in the labor force, you know. In that respect, in terms of your health insurance premium, you are as healthy as anyone else is.

That does not create any kind of a barrier to your moving. The arrangement is such that there will be an open enrollment period at the end of every year, and individuals would be able to acquire a change in their coverage without going through any sort of extraordinary steps. It will be irrelevant whether you are working, who you are working for, how much you make. All those things would be irrelevant in the process of selecting a health plan, retaining that health plan, or moving to another health plan when you decide you would prefer a different source of insurance.

Senator Wyden. The last question I had for you, Mr. Sheils, deals with an issue that is getting a lot of discussion in our country. That is, how much is health reform going to cost? Certainly, there is no consensus in the United States about this. There are people saying it will cost hundreds of billions of dollars more but then there are a wide variety of projections.

What we felt very strongly about in the Healthy Americans Act was right at the center of the reform effort. That is, the key issue of showing that this is not going to dramatically increase health spending. When The Lewin Group looked at the legislation, the judgment was that in the short term that it would essentially be revenue neutral. It was possible to do that for the short term. For the longer term, after 10 years, the plan generates a substantial amount of savings, close to $1.48 trillion.

What are some of the critical elements in the legislation that you found helped to hold the costs down?

Mr. SHEILS. Well, I think that, you know, typically if you were to just talk about covering the uninsured under today's system, we would get an increase in health spending of about $50 billion. But that is because you are using the existing system and you are continuing to rely upon a system that does is really very expensive to administer. It also has some poor incentive structures for individuals and for physicians that actually cause us to use more health care.

Under your proposal, you included provisions which are first designed to reduce administrative costs. Those uninsured people, yes, they may go out and start using more health care, but you are going to adopt a system which makes it simpler and easier to administer the system. So you have some savings there. You also change incentives in the system by really replacing the existing tax exclusion for employer-provided benefits with a fixed tax credit. I am sorry. In your case, it is a deduction.

The idea here is that in today's system the system actually rewards you if you spend more on health care. Right now, the premium that your employer spends for your health benefits is not taxable. Any contribution you make for your health benefits generally is not taxable. Some people have flexible spending accounts, which allow them to take, say, $3,000, put it in an account, use it

to pay for their out-of-pocket expenses. All of that is in pretax dollars. So there is quite a tax benefit there.

Under your system, you give people a standard deduction for health care that is uniform. You get on average roughly the same tax benefit you are already getting from a tax exclusion, but it is set up so that you are not going to lose any tax benefits because you decided to go to a less costly plan, and the idea here is to make the tax code as neutral as possible when it comes to consuming health care.

A lot of economists believe that this tax exclusion is really distorting the way people see their health care expenses. A lot of people do not even know what the premiums are for the benefits they have. I had a meeting—a brown bag lunch—at our work, and I asked people what they thought the health benefits costs were for our firm, and I actually offered $100 to whoever got it right.

Virtually, no one knew the answer. I did not know the answer until I had checked a couple of days before. This is a firm filled with health care experts, half of whom are economists. We have no idea what we are spending on the health benefits we get.

Under a system like this, you are going to see that. You are going to write the check for the full amount, and if you can find a lower-cost source of insurance, the check you write can be smaller. You can save some of that money for other purposes. This is a change in incentives. This is intended to fuel competition. It is intended to get people more cost conscious about their utilization of health care.

It is a controversial ideal. But it is one of the few ideas out there, outside of regulating what providers are paid, outside of regulating payments for providers. There is really very little else out there right now in terms of a comprehensive cost-containment initiative, and I think this would have that feature.

You are not alone. There are other plans with this in it. So your leadership has certainly been noticed, but it is certainly a feature in your plan.

Senator WYDEN. Well, thank you very much.

In fact, thank all three of you. We have a very strong advocate for older people here with Senator Carper, and let me recognize him for whatever questions he may have.

Do not feel constrained by the 5-minute rule.

Senator CARPER. Thank you.

Senator WYDEN. I want you to be able to ask what you choose.

OPENING STATEMENT OF SENATOR THOMAS CARPER

Senator CARPER. Thank you. Thank you, Mr. Chairman. Thanks for pulling this together today.

This is the second panel. I have four Committees that are meeting today, and we are working on housing legislation on the floor which I am keenly interested in, so I apologize for arriving here at the tail end. I would like to say we saved the best for last, that being me, but that is not at all the case.

Senator Wyden indicated that I have a real concern for older Americans, and I used talk a lot about my mom. She died about two years ago, and I would always talk about my care for her and

for her generation. Now I guess I am getting to be an older American, I am 61 years old, and I try to take pretty good care of myself.

I am going to ask you really two questions.

One of the questions I want to ask is I presume some of you are pretty familiar—is it Mr. Sheils?

Mr. SHEILS. Yes.

Senator CARPER. Mr. Sheils, I presume that you are pretty familiar with the Healthy Americans Act which Senator Wyden has worked on for years and which I am pleased to co-sponsor with him, and you may have already had some discussion about the aspects of the legislation that you like, particularly within the context of the age 55 to 64 group.

But let me just ask if when you look at this legislation, our legislation, what are some areas that you all think we can do better?

Mr. SHEILS. Well, I have been working with Senator Wyden on it.

Senator CARPER. I say that knowing everything I do, I can do better.

Mr. SHEILS. Yes. I am sure everything I do can be done better, too. So it is probably a better question for my colleagues here. But, occasionally, we see features of it that we want to tailor. It comes up time and time again, and I know that during the year we added in the ability for employers to continue to provide health insurance, if they want, and that has been a very important improvement in the bill. So we have made those changes.

We have added some cost-containment provisions, things having to do with clinical trials research, health information technology—a lot of people have come up with these ideas—all in an effort to strengthen the cost containment package. The incentives plus the clinical trials research so that you know what works and what does not, all those things together, we are hoping, is going to have a long-term cost-containment effect.

Senator CARPER. All right. Let me ask our other witnesses. If I am asking an unfair question, I do not know how familiar you are with the legislation, but are there some aspects to it that you would like to see improved? Mr. Sheils has just mentioned a couple of changes that have been made in the past year.

Ms. LAMBREW. Sure. I will say this in the context of giving you all credit for what you have done so far. It is a universal coverage bill with access that really matters, as we talked about previously. Accessibility for this particular age group is particularly important because their ability to access quality coverage is limited given their risk. I think access is, as John Sheils has mentioned before, pretty well dealt with.

A couple open questions about affordability. This issue is something that is difficult to define. We are learning that as Massachusetts is unfolding its health reform plan. Whether the premiums are considered affordable for middle-income, low-income families is an open question weall have to look at, as is the issue of cost sharing. We know that right now people are underinsured in greater extents, so will there be sufficient and adequate protections on the cost-sharing front? I think this comes up especially important in this bill in the context of eliminating Medicaid and having Medicaid play a supplemental role. Will that be sufficient to make the

cost of services affordable for low-income people and people with disabilities who rely on the key protections in that program?

I will also throw in a concern that I have about health savings account, which is, I think, what we are seeing in the Medicare medical savings account demonstration. When you have medical savings account, i.e., health savings account, next door to a comprehensive plan, people will fit themselves into where they are going to be most benefited, and if, like in the Medicare plan, the people can join them when they are healthy, get that account build-up and then switch to a comprehensive plan when they are sick, there are some concerns about whether or not that is a viable long-run model.

But these are some of the things that I am happy to talk to your staff about.

Senator CARPER. Sure. Thank you, ma'am.

Is it Fronstin?

Mr. FRONSTIN. Fronstin.

Senator CARPER. Fronstin. Mr. Fronstin.

Mr. FRONSTIN. Clearly, a lot of thought has been put into this bill, and a lot of work behind it. As far as recommendations go for improvement, that is not what we do at EBRI. We stay away from recommending changes. So I am going to pass on the rest of the question.

Senator WYDEN. You have the best deal in town.

Senator CARPER. All right. One last question I would like to ask you. There are some folks around the country, employers around the country in an employer-based health insurance system who have done a pretty good job of not only providing coverage for their employees, but also finding ways to rein in the growth of their health costs and premiums, hopefully not at the expense of their employees' health. Starbucks is one that comes to mind.

But there are a lot of other companies that are trying to figure out how to incentivize healthier behaviors, healthier lifestyles for their employees, and I think must be succeeding to some extent because they are demonstrating maybe some growth in health care cost premiums, but not double-digit growth, not the kind that some others are incurring.

What might we do to help incentivize, to encourage more of that behavior to emulate those that are doing well, doing well by their employees and doing well by their bottom lines?

Mr. SHEILS. Well, I think I spent too many years as an economist, I guess, but I think that incentives are the key thing for Congress to work on at every turn of the corner.

Providers have to have an incentive to do it right, but to do it without waste. Individuals have to have an incentive to seek out those sources of coverage that are going to help them reduce costs.

We need to be open to ideas. The bill, for example, is open to HSAs, for example. These are hot issues. Some people do not like them. We need to basically do as much as possible to set up these incentives.

When employer insurance works, it works really well, and if a firm wants to continue providing coverage, they would be able to do that, and I know a lot of the larger firms are already working

on wellness programs. So they have this financial incentive to help people more. So I tend to think in terms of these incentives.

Senator CARPER. All right. Thanks.

Anyone else on that?

Ms. LAMBREW. Just quickly two points. I actually want to underscore this because I think that in the absence of seeing a revised bill, in addition to giving people a choice of joining HSA, giving firms that self-insure that are doing a good job the option of continuing to offer that coverage is something that is right now, without that being changed in your bill, a major concern among some people who think that they have been doing a good job and people should have the choice of that type of insurance option.

But the second thing I will say is that I have been spending a lot of time thinking about this issue of prevention and wellness because, with our chronic disease epidemic, it has to be a priority, and this bill clearly does take this on at some level.

But sometimes we rely on insurance for too much. There is a point at which insurance is not supposed to be doing prevention per se. Why would they want to invest now in a benefit that is going to accrue to people in society 10, 20, 50 years out?

So I have been working on a proposal called the Wellness Trust where we pull the prevention money out of the system, consolidate it, and figure out pay-for-performance and other incentive mechanisms to pay for it ubiquitously, get it out into supermarkets and schools and workplaces to really move prevention to a new model that is not an insurance model. That is something I would recommend you think about.

Senator CARPER. All right. Thanks.

Ms. LAMBREW. Thank you.

Senator CARPER. Mr. Fronstin, anything you want to add?

Mr. FRONSTIN. In the work that we have done in the past year, employers want a number of things. They want provider accountability, they want more price and quality transparency, they want more information technology, and they specifically told us that they viewed government as a partner. So they are certainly willing to partner with you to work at this, because they are concerned about health care costs as much as anyone else. Even those that are having success would like to continue to manage those costs in the future.

Senator CARPER. All right.

Mr. Chairman, I am sorry I got here so late, and I am glad I got here at all.

Thank you to this excellent panel, and we appreciate very much your being here and your responding to my questions, I know to all of our questions. Thank you for your testimony.

Thank you, Mr. Chairman, again for your leadership.

Senator WYDEN. Well, I thank my friend for all his interest and involvement, and we are just thrilled to have you part of the group of 14. Thank you.

A couple of points—I want to give you a chance—one on this question of prevention, Dr. Lambrew, is that I think you are absolutely right about the nature of what happens to prevention in today's insurance market, no question about it. One of the reasons I feel so strongly about reforming the private insurance market as

it stands today is that I think in the future when individuals stay with companies with private insurance because they like it, because they get better treated, that creates new incentives for the private insurers to offer prevention.

So we envision under our legislation that, when private insurance companies can no longer cherry pick and focus just on taking healthy people and sending sick people over to government programs more fragile than they are, they compete on the basis of price, benefit, and quality. You will see private insurers use as a draw for their particular package during the open enrollment season, "We have the best prevention programs around," "We have the best programs for dealing with early incidence of diabetes," that kind of thing.

In fact, I will keep the record open for all three of you on this issue for prevention because I think it is an area where there is widespread interest in incentives. We try to do that with the Medicare portion of the bill where there would be reductions for seniors' premiums if they lower their blood pressure and cholesterol. We try to do that for parents with young children where if the parents take the kids to preventive programs, the parents are eligible for reductions in their premiums. As far as I am concerned, we cannot do enough to create incentives for prevention, and we will just keep the record open for the three of you on that point.

I want to give you three, actually, the last word. I am particularly glad we had a chance with Senator Carper's question to get into what we have accepted in terms of a change in the bill from its original version to provide this role for the employer. It was our judgment that once you have allowed the worker to really see what their compensation is all about, because that is what health benefits are, it is kind of a myth that it is the employer's money. It is really part of the compensation package for the worker, and as Mr. Sheils said, a lot of the most knowledgeable people in the country do not even know what is being spent.

Once you have made that change people will see what is being spent and that it is their money, I think it is very wise to say that if the worker wants to choose between the various private-sector offerings—we offer that in the Healthy Americans Act—and the employer wants to offer coverage we feel very strongly about preserving that option. I think all three of you have today and in the past made statements indicating that you were interested in that sort of thing.

So the last word to you three for being so patient and all the good work you have done. Mr. Fronstin, Ms. Lambrew, Mr. Sheils, last word for you three.

Mr. Fronstin. Real quickly I would just say, in response to your comment about worker compensation and choice, there are some employers, large employers, very concerned about—even though they are cutting back on retiree health benefits—the implications of that, and they are trying to create markets for retirees to give retirees choices and accessibility that they do not have, and I just want to recognize two examples out there.

One is a consortium of about 50 colleges and universities that is known as Emeriti Retirement Health Services that has created this coalition, is partnering with an insurance company to offer benefits

right now to Medicare-eligible retirees, but eventually they plan on extending that to early retirees, and a sizeable number of the 50 never offered retiree health benefits to begin with. So they have been brought into this group.

Then there is a group of large, private-sector employers organized by the Human Resources Policy Association that has created their retiree health access program that is, providing guaranteed issue benefits without, exclusions for health status to early retirees that are associated with those organizations. So they are very concerned about choice, and it is voluntary. It is a very small step in terms of the number of people that are covered, but I think it is very significant that this is where they are thinking.

Senator WYDEN. I agree with you.

Dr. Lambrew.

Ms. LAMBREW. I will give you unsolicited advice;—which is, given the jurisdiction of this Committee, I think it would be useful in your future hearings and study to look at why it is important to Medicare for us to solve the health system crises, and I say that from the narrow perspective of today's hearings.

What we know is uninsured people, when they join Medicare, are sicker and more expensive. You find that after five years of being on Medicare, you can reduce some of that sickness gap by about 50 percent, but there is still a cost to the program of being uninsured prior to Medicare. We know that the chronic disease epidemic cannot be stemmed after the age of 65. We have to each back into the younger populations to do it, and, more importantly, a lot of the cost drivers of Medicare are systemic.

There is the lack of a high-quality, high-value system. It is a lack of prevention that we talked about. So, as a potential topic for future hearings, we hear a lot of "Medicare is the problem," but I would argue that the health system is the problem, and if you call could focus on that as well, that would be greatly appreciated.

Senator WYDEN. Spot on. Absolutely agree.

Mr. Sheils.

Mr. SHEILS. Thank you. I think we are very fortunate right now that we have—I think there are a dozen health reform bills in Congress right now—three presidential candidates who have plans that would greatly expand coverage in the United States. We are very, very fortunate, and I think that one of the things that you have clearly explored in your work here is a bipartisan approach to making some choices and making some decisions, and I am very encouraged by your leadership in that regard.

I guess my one word of advice—and this is very easy to say, very difficult to figure out how to actualize on—is incentives, incentives, incentives. We need to change the incentives in the system. People have been saying this for 14 years. We need to change the incentives in the system as much as possible so that we have incentives for people to be efficient, for people to stress wellness, and for people to moderate their use of health care, frankly, in cases when it is of little or no benefit.

Very difficult issues, but I think that focusing on incentives in those regards, continuing to be clever, continuing to try and change incentives for everybody in the system in any way that you can is going to be the key to the cost problem. I do not see how any pro-

gram would be sustainable if we have costs growing as they are now for the indefinite future.

Senator WYDEN. Good one to quit on. It is very obvious that if you can make it attractive for people to do something, rather than taking yet another government approach where people feel like they are beaten over the head with a stick, it is much more attractive. So we have a lot of work to do in the days ahead, and I think this time there is a real sense that this is doable. One of the reasons it is doable is because we have good people like you three out there helping and offering good counsel and good suggestions.

So thank all three of you for the work you do and your patience this morning.

With that, the Committee is adjourned. [Whereupon, at 12:23 p.m., the Committee was adjourned.]

APPENDIX

MIKE ROACH RESPONSES TO SENATOR SMITH'S QUESTIONS

Question. As an owner of a small business trying to provide health insurance, what do you think of this type of assistance? Would you support this type of assistance at the federal level (i.e. a federal tax credit to small businesses who employ low-income workers)?

Follow Up: Mr. Roach, what are your thoughts on this program?

Answer. The Oklahoma program would improve the status quo but still leaves our business with the significant burden of being responsible for our employees' health insurance. I am very interested getting out of the health insurance business and just running our clothing store. I am prepared to contribute toward a health insurance pool but prefer not to be involved with making health insurance decisions for our employees.

Young or Old: Sick Individuals Pay Higher Costs

We understand older workers tend to be sicker. However, whether young or old it's clear even one sick employee or dependent can drive up an employee's health care costs.

Question. Are there situations in which younger workers at your firm have had an illness that impacted your company's overall health care costs? In your experience, have you seen a difference in cost impact to your company depending on the employee's age?

Answer. As far as I know, employee age drives the cost of health insurance more than individual experience. Our older employees definitely increase our premiums substantially.

LEE ANNE FITZPATRICK RESPONSES TO SENATOR SMITH'S QUESTIONS

Question. The issue of health reform is gaining increased attention both in the media and in Congress. Over the next year, my colleagues and I will devote time through hearings like these, and on the Senate floor, to this critical issue. It's important for Congress to hear directly from the men and women who are struggling to afford health insurance coverage.

Would you rather we make changes to the current system to make health insurance more accessible and affordable—so you could pick your health care plan and providers? Or would you like the government to provide your health care coverage?

Answer. I feel that all Americans dependent of age, race and their economic situation should have equal availability and access to good health insurance. We should have good health options whether that be resources for well health or treatment for a serious illness or accident. I am more interested in a government program but I also feel it is our responsibility to help pay for this expense based on our incomes.

PAUL FRONSTIN RESPONSES TO SENATOR SMITH'S QUESTIONS

Employer Perspectives

According to EBRI, almost 60 percent of employers with three to 199 employees provide health care coverage to their employees.

Question. How do employers view the current employer-based health care system? What types of improvements do employers think should be made to the system?

Follow Up: What are the differences, if any, between how small and large employers view the existing employer-based health care system?

Answer. Employers offer health benefits voluntarily because they think there is a business reason for doing so. They think it affects the overall success of their business, in that it helps with recruitment and retention. They also think that offering

health benefits has a positive impact on worker health and therefore worker productivity. Both small and large employers share these opinions.

In terms of improvements, you can say that employers are all over the map on what they think should happen with the system. Large employers generally think that they should be getting more value for the money that they spend. They would also like to see the adoption of health information technology with an enhanced focus on wellness and prevention. They would like to see the measurement and publication of quality and price information. They would like to see the promotion of quality and efficiency. They would like a more competitive and accountable marketplace. Most medium and large employers, and employer associations, think that employer should continue to offer health benefits and continue to play an active role in the health care system, while other employers do not share this sentiment. Small employers are generally not as engaged on these issues as are large employers.

Tax Deduction To Purchase Health Insurance Outside The Workplace

During the budget debate last month, the Senate voted on an amendment offered by Senator DeMint that would have created an above-the-line federal income tax deduction for individuals purchasing health insurance outside the workplace. Although I voted for the amendment, it failed by a vote of 45 to 51. One of the arguments against the amendment was that if this change were to be enacted, it would mean the end to the current employer-based health care system.

Question. What are your thoughts with respect to this argument?

Answer. Any change to the way in which employment-based health benefits are taxed could mean the end of such a system of financing health insurance coverage in the United States. Presumably, young and/or healthy workers would be the first to leave employment-based health benefits for the individual market were a tax preference given to the individual market in its present form, where premiums charged generally vary by age and health status. This would be less true where an individual market is regulated to provide flat community rating so all would pay the same amount, with guaranteed issue to assure that even the sick can purchase coverage. To the degree that this happens in the present individual market environment, workers remaining in the employment-based system would be disproportionately old and unhealthy, which would drive up premiums in the employment-based system. The employment-based system would then be in a vicious cycle: As premiums increase, the youngest/healthiest workers would move to the nongroup market, leaving relatively older/less healthy workers in the employment-based system, which would continue to drive up premiums for employer coverage. This phenomenon is known as the "death spiral" because it means the death of employment-based health benefits as a result of continued and increased adverse selection. As workers leave the employment-based system, for the nongroup market and drive up premiums in the employment-based system, employers would find coverage less and less affordable, and would eventually drop that coverage. Furthermore, as fewer workers demand health benefits through work, employers could respond to this lack of demand by dropping benefits.

Retiree Coverage

Based on your testimony, surveys show there has been no erosion in health insurance coverage rates among retirees ages 55 to 64 from 1994 to 2006. However, I understand these retirees are more likely to get employment based coverage through another family member rather than through their former employer.

Question. Are you finding that retirees are getting coverage through a family member because it is less costly or more generous in terms of benefits?

Are you finding that employers are passing on a greater cost to early retirees?

Answer. Retirees may be getting coverage through a spouse as opposed to through a former employer for a number of reasons. First, fewer employers are offering those benefits. The Agency of Healthcare Research and Quality (AHRQ) reports that only about 13 percent of private-sector establishments offer health benefits to early retirees in 2005, down from nearly 22 percent in 1997. When the benefits are offered, employers have generally made it more difficult for retirees to qualify for health benefits and retirement, so not all of those who work for an employer that offers the benefit will qualify to receive it. They have been tightening eligibility requirements to control spending and reward longer-service employees. This might involve requiring workers to attain a certain age and/or tenure with a company before they qualify for health benefits in retirement. In addition to tightening eligibility for benefits, some employers have simply made the cost of participating in retiree health benefits more expense for retirees and some employers have gone so far as to eliminate their subsidy for retiree health benefits altogether for workers hired (or retiring) after a specific date.

Health Insurance Challenges for Workers Ages 55 to 64

Today's hearing focuses on some of the unique issues individuals 55 to 64 face to obtain and afford health insurance coverage, especially if they have pre-existing medical conditions.

Question. Do workers age 55 to 64 face any special problems if they lose their health insurance—and do they have any special options for obtaining new coverage?

Follow Up: If a worker age 55 to 64 loses coverage and has to obtain it on the individual market, what is the premium likely to be compared with the premium offered through an employer?

Answer. Individuals ages 55–64 have a limited number of options for obtaining health insurance coverage. If a person is working they may be able to obtain health insurance coverage through a new job. Some retirees may have to go back to work to obtain health insurance coverage. Some individuals can continue to be covered under COBRA though they will be required to pay 102 percent of the premium on an after-tax basis, which may not be affordable. Married persons may be able to maintain employment-based health benefits through a working spouse.

Individuals not eligible for employment-based benefits face a daunting situation when it comes to health insurance. Individuals seeking insurance on the individual market will be subject to medical underwriting and are likely to face preexisting condition exclusions or outright denials of coverage. Even when coverage is available, premiums are often unaffordable for an older person with health conditions with limited retirement income. Medicare is available for persons under age 65 with disabilities after a 29 month waiting period. Medicaid is available for certain low income people.

Premiums for persons 55–64 will depend heavily on an individuals state of residence, health status, and choice of health plan. Individuals may be able to choose less comprehensive coverage by either picking plans with high cost sharing requirements or plans that exclude certain benefits. Coverage is more affordable when an individual chooses a less comprehensive plan, though that usually means an individual will be responsible for higher out-of-pocket costs.

Finally, under the current system, employees generally pay only a small portion of the total premium, while they would pay all of it in the individual market. This approach allows the employer to keep all workers in the pool, rather than driving out the young and the healthy.

Health Promotion & Worker Productivity

As you stated in your testimony, employers have a motivation to provide health insurance and additional benefits as a means of protecting their investment in their workers. Health promotion programs have shown to decrease health care costs due to diet-related chronic disease and obesity, and to increase employee productivity through lower rates of absenteeism. Studies have reported a proven rate of return within 12 to 18 months, ranging from $2 to $10 for each dollar invested.

Question. Based on your experience with employers, if they no longer offer health care coverage, would these wellness programs go away? Would employees have access to wellness programs on the individual market?

Are employees less likely to enroll in these programs if they are not offered on-site?

Answer. Employers offer health benefits because they think there is a business case for offering benefits. The availability of health benefits helps employers be competitive in the labor market and to the degree that health coverage improves worker health, it also improves worker productivity. If employers stop offering traditional health benefits they may or may not continue to offer wellness programs. If employers think that there is a business case for offering a wellness programs then they will offer such a program.

Insurers already offer wellness programs to employers and may continue to do so to the individual market. If insurers find that offering such programs help them manage population health and controls health care use and costs, they are very likely to offer these programs. Whether insurers offer these programs depends on whether they expect individuals who would benefit from these program will stay with the insurer 12–18 months so that they reap some reward.

Insurers and employers have found that most workers do not take advantage or wellness and prevention programs. This has led them to try many methods of increasing the use of such programs ranging from paying all costs to provision of dollar incentives and/or penalties. None of these experiments to date have led a majority of workers to participate. Were the employer to no longer provide health insurance these financial tools that have served to increase use at least somewhat would be less available. Employer interest in health employees would be no lower, but the capacity to affect health status would decline.

JEANNE LAMBREW RESPONSES TO SENATOR SMITH'S QUESTIONS

Medicare Buy-in

In your testimony, you mention health care reform proposals that would expand Medicare eligibility to Americans under age 65 and would allow Medicare to "compete" with private health plans.

Question. As we are aware, individuals in the commercial market experience higher costs or cost-shifting because of uncompensated care and underpayments in public health programs. I am curious if you or any of the second panel witnesses have done any research to determine whether expanding Medicare to early retirees, or everyone under age 65, would exacerbate the cost-shifting phenomenon?

Answer. I have not conducted research on this topic. However, most research suggests that the premiums of insurance in the commercial market are higher than larger, self-insured plans due to greater administrative costs and less ability to bargain for lower provider payment rates. Uncompensated care does contribute to higher costs, but the shift due to an unpaid bill for an uninsured person is greater than that of a low payment from public programs. To the extent that a policy like a Medicare buy-in insures the uninsured and better manages the chronic illnesses and risks of people in this age group, it should lower uncompensated care and costs, not raise them.

Could this type of proposal push health insurance coverage further out of reach of small businesses?

If a Medicare buy-in was a viable option for people in this age groups, who tend to have higher health risks and thus premiums, it could lower the premiums for small businesses since the workers left in their insurance plans would be younger and less expensive.

Should Reforms Target the Uninsured or the Employer Market?

Question. As we have heard today, nearly 162 million individuals under age 65, or 62 percent, are covered by an employment-based health plan, while 18 percent of this population is uninsured. According to an EBRI survey, we also understand that most employees are satisfied with their employer-sponsored coverage. There are several reform proposals being considered, including those which would convert the employer system into an individual market.

What is your opinion? Should reforms target the 18 percent of the uninsured population or make large-scale changes for the 62 percent of the population who already have coverage?

Answer. In my opinion, policy makers cannot solve the problem of the uninsured without making health coverage more affordable for all Americans. The uninsured is not a single, static group. Over the course of two years, 85 million Americans have some gap in coverage. The problem is increasing affecting middle-income workers, people with higher education, and young adults. Policy makers could target subsets of the uninsured, but until systemic reforms are implemented to promote high-value care, coordinated care, continuous coverage, and prevention, people will continue to fall from the employer system into the widening cracks in our health insurance system.

Question. What are your thoughts on this disparate tax treatment—and what are the pros and cons to moving to a tax system that treats people who get their health care through their jobs the same as those who do not?

Follow Up: Jeanne or Paul, do you have thoughts on this?

Answer. I believe that public financing—both when it is provided as direct premium assistance or indirect tax breaks for insurance—can and should be used to leverage value-oriented, accessible, and affordable health insurance. The tax breaks for employer coverage support coverage that: (a) guarantees access to all workers and their dependents; (b) charges enrollees the same premiums regardless of age or health risk; (c) sets benefits based on employer and employee, not insurer, preferences; and (d) has lower administrative costs than policies sold in the individual market. These tax breaks could be improved; for example, they could be linked to benefit packages that promote high-value services and calibrated to provide greater assistance to low-income than high-income workers to make the premiums for such coverage more affordable.

I do not believe that the goal of using public financing to leverage value-oriented, accessible, and affordable health insurance would be achieved by extending the current tax break for employer coverage to individual coverage. Currently, in most states, individual insurers can: (a) deny applicants coverage; (b) charge enrollees higher rates if they are older, have greater risks, or have had a health problem in their past; (c) set benefits to exclude coverage for preexisting conditions or high-cost services like maternity coverage; and (d) pass along underwriting and marketing

costs to enrollees through higher premiums. In short, this idea would use good money for bad coverage.

That said, policy makers must develop viable accessible, and affordable insurance options for the large and growing number of people who lack access to employer-sponsored insurance. Numerous solid ideas would achieve this, from building on group purchasing pools to using regulation to make individual-market insurance function more like group health insurance. People without access to employer coverage should receive a comparable tax subsidy, but only for coverage that shared the positive features of employer-sponsored insurance.