



A WORKABLE SOLUTION FOR THE PRE-MEDICARE POPULATION

Pamela Farley Short, Dennis G. Shea, and M. Paige Powell
The Pennsylvania State University

December 2000

Strategies to Expand Health Insurance for Working Americans

A Report Series from The Commonwealth Fund Task Force on the Future of Health Insurance

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff, or to members of the Task Force.

Copies of this report are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering publication number 420. The report is also available on the Fund's website at www.cmwf.org.

CONTENTS

Executive Summary	v
Uninsured and Age 55 or Older: Background on the Population at Risk.....	1
A Strategy to Make Coverage Affordable: Medicare as an Option	3
Other Proposals for the Pre-Medicare Population	5
Clinton Administration's Proposal.....	5
Loprest and Moon Proposal	6
A Workable Solution for the Pre-Medicare Population	7
Overview	7
Medicare Buy-in Premium	8
Subsidized Voucher	8
Pre-Medicare Savings Program	9
Pre-Medicare Insurance Options	11
Preventing or Compensating for Adverse Selection.....	11
Interactions with Existing Programs	12
Political Considerations.....	14
Summary	16
Notes.....	19
References.....	21

EXECUTIVE SUMMARY

Fifteen percent of Americans between the ages of 55 and 64 were uninsured in 1998. Although the proportion of uninsured younger people tends to be higher, the number of uninsured older people is actually rising faster.

Improving access to Medicare for those from 62 to 65 would help many uninsured older Americans. One way to achieve this would be to provide vouchers for people with low lifetime earnings, and to establish tax-favored IRAs for people with higher incomes, so that everyone could buy into Medicare at age 62. People in both the savings and voucher programs would not be required to sign up for Medicare, but would be offered a range of health insurance choices. They could buy into a Medicare+Choice plan, or purchase employer-sponsored group, retiree, or COBRA benefits if they wished. They might even purchase non-group insurance, although few would be expected to do so, because such plans tend to have the highest premiums and the narrowest benefits. In order to be eligible for funding from the savings or voucher programs, all plans would have to provide coverage that was at least equivalent to traditional Medicare.

Allowing 62–64-year-olds to buy into Medicare would not only help those currently without insurance, but could also spare those who are currently covered the disruption of changing HMOs and perhaps even doctors, when they become eligible for Medicare at age 65.

The Medicare buy-in premium for those ages 62–64 would be community rated, and the value of the voucher would be set to cover this premium. Vouchers would be available to those with lifetime earnings below 200 percent of the poverty line. The Social Security Administration would determine eligibility by comparing average earnings over the last 40 years to the average value of the poverty line during that time. The voucher system would be funded from the budget surplus, through general tax revenues, or through a small increase in Medicare or FICA taxes, and would probably be easier to administer than one that involved subsidies or tax credits.

Beginning at age 50, everyone would be able to contribute to a tax-favored savings account, similar to a “Roth” IRA. At age 62, the account holder could then use the money to buy into Medicare or into a private insurance plan. If any of the balance were unused by the time the account holder reached age 65, he would be able to use the money for any purpose. For those who are not familiar enough with investing and financial planning to establish IRAs, the government could establish an alternative savings

account. Contributions to the government accounts could be made voluntarily through the tax system, when participants pay their income taxes.

People would be encouraged to contribute early to the savings plan. The limit on contributions would be as much as \$2,000 per year and interest would be tax-free. These measures should reduce adverse selection, by encouraging more healthy people to enlist in the savings program in order to buy insurance for their older years, and by discouraging people from first waiting to see whether they became ill before buying into Medicare.

Vouchers and distributions from savings accounts could be used to purchase many types of insurance, but in order to avoid adverse selection against Medicare, the voucher would be worth less if it were used to purchase insurance other than Medicare. This provision is based on the assumption that voucher recipients who opt out of Medicare would be healthier on average, and that they will make fewer claims.

Another measure to limit adverse selection would be to restrict Medicare enrollment to specific periods, either once a year, or once only at age 62. If adverse selection is a problem for the expanded Medicare program, the federal government might need to contribute funds to maintain the community-rated premium.

During the 1990s, the number of employers offering retiree health benefits declined. COBRA laws permit some retirees to remain in their employers' groups, but only for 18 months, and only if the retiree pays the premiums herself. Medicare or Medicaid is available for some disabled people under 65, but income and asset limits, prior work requirements, disability tests, and waiting periods exclude many people from these public insurance programs. If the proposal described here were implemented, more employers might offer benefits to early retirees, if they knew that money from savings or vouchers would be available to pay for it. Other employers may wish to make contributions to pre-Medicare IRAs, rather than provide retiree health benefits.

It is likely that many 62–64-year-olds would leave the non-group market, if they were able to buy into Medicare or some other group plan. Insurers would lose some business from the non-group market, but these same individuals, and many more currently without insurance, would buy into group plans. To the extent the non-group market lost many older participants, this shift in age mix could help to bring premiums down in states that limit the variation in premiums by age.

A WORKABLE SOLUTION FOR THE PRE-MEDICARE POPULATION

Uninsured and Age 55 or Older: Background on the Population at Risk

Fifteen percent of Americans between the ages of 55 and 64 were uninsured in 1998 (Short, Shea, and Powell 2000). This statistic is sobering, since the risk of serious and costly illness is greatest among the oldest people under 65, the usual age of Medicare eligibility. Nevertheless, a smaller percentage of people between 55 and 64 are uninsured than the average for the entire population under age 65 (15% compared with 18%; Fronstin 2000). However, the percentage of uninsured people has been increasing faster for 55–64-year-olds than for other adults (EBRI 1996; Fronstin 2000), and these statistics about the uninsured do not tell the whole story about the health insurance of older Americans. Such statistics hide the high cost of individual private insurance that older Americans purchase more often than other age groups, because they would rather pay the high premiums than go without insurance. Statistics also hide the fact that access to employer-paid health insurance decreases as older Americans begin to retire. Statistics about the uninsured hide the vulnerability of older Americans to unanticipated and unwelcome changes in their health, health insurance, jobs, and employment status that may leave them poorly positioned for old age.

Rates of full-time employment drop from about 70 percent of 51–54-year-olds to 60 percent of 55–61-year-olds to 35 percent of 62–64-year-olds (Short, Shea and Powell 2000). Early retirement, particularly withdrawal from full-time work, has important implications for the health insurance of older Americans under age 65. In contrast to individual health insurance that people buy on their own, group health insurance available through employers rarely limits coverage because of preexisting conditions, or requires higher premiums of older enrollees. Throughout the 1980s, the growth of retiree health benefits reduced the likelihood of losing employer insurance at retirement. However, the proportion of employers who offer health benefits for early retirees dropped from 88 percent in 1991 to 76 percent in 1998 (Hewitt Associates 1999). Fewer than half of full-time employees in medium and large private establishments have health plans that cover retirees under age 65 (Bureau of Labor Statistics 1999). Nearly three-quarters of current workers with retiree health benefits will be required to pay part, or all, of the premium when they retire.

Although fewer employers voluntarily offer retiree coverage, some retirees can take advantage of federal laws allowing them to continue group coverage from a former employer (COBRA) or convert from group to individual coverage (HIPAA). COBRA requires firms with 20 or more employees to offer continuing coverage for 18 months after both voluntary and involuntary terminations, with former employees paying up to

102 percent of the total group premium (the sum of employer and employee shares for active workers; Flynn 1994). HIPAA guarantees that group enrollees with at least 18 months of prior coverage, who have exhausted COBRA coverage, if available, can buy individual insurance without any restrictions due to preexisting conditions. However, HIPAA does not set any limits on the individual premium.

Some of the most vulnerable members of the population nearing age 65 can take advantage of Medicaid or Medicare for the disabled. However, income and asset limits, prior work requirements, disability tests, and waiting periods often exclude people from these programs. As a result, more than 15 percent of people over age 50 who are in poor health are uninsured (Short, Shea, and Powell 2000).

Eligibility for Medicare before age 65 is tied to receipt of Social Security Disability Income (SSDI), which is limited to people with at least 5 years of recent employment who are unable to engage in any “substantial gainful activity.” After waiting for 5 months to begin receiving SSDI benefits, the disabled must wait another 24 months before becoming eligible for Medicare. Nearly a third of new Medicare beneficiaries under age 65 are uninsured during this 29-month waiting period (Short, Shea, and Powell 2000).

Traditionally, Medicaid disability coverage was linked to receipt of Supplemental Security Income. The Balanced Budget Act of 1997 extended Medicaid coverage to the disabled who meet the SSDI criteria for disability and have family incomes below 250 percent of the poverty line (disregarding all earnings of the disabled person). However, anyone with countable assets in excess of \$2,000 for individuals or \$3,000 for married couples is generally disqualified from Medicaid coverage, although the Ticket to Work and Work Incentives Improvement Act recently gave states the option of eliminating or modifying the income and asset tests enacted in the BBA (Health Care Financing Administration 2000).

People just under 65 rely far more heavily than other adults on the individual insurance market, because their access to other sources of insurance is limited. Nine percent of people between the ages of 62 and 64 have individual insurance, twice the enrollment rate for people in their early fifties (Short, Shea, and Powell 2000). Because older Americans file more health insurance claims, state regulations that govern the individual market usually allow insurers to charge higher premiums to older policyholders, and to vary premiums with gender and health status (Chollet and Kirk 1998). Individual insurance is very expensive, because marketing and administrative expenses are not spread over groups of enrollees, and because insurers fear that only those at very high risk will want to buy it (Pauly and Percy 2000).

To make matters worse, a significant proportion of people between the ages of 62 and 64 may not be in a position to afford either individual insurance or make significant premium contributions for retiree health benefits. Nearly 15 percent of those 62–64 were poor in 1997, according to the official definition of poverty, which considers only current income and ignores any assets that retirees may be living on. (Short, Shea, and Powell 2000). Another 20 percent had incomes between 100 percent and 200 percent of the poverty line. More than half of the uninsured between the ages of 62 and 64 have incomes below 200 percent of the poverty line, and about a quarter are below the poverty line. Among those over 62, the poor buy individual insurance at a higher rate than those with incomes above 300 percent of the poverty line, even though it is very expensive (Short, Shea, and Powell 2000).

The risks associated with being uninsured at older ages are significant. More than a quarter of people 62 to 64 are in fair or poor health, compared with 15 percent of those 51 to 54 (Short, Shea, and Powell 2000). The incidence of new work-limiting disabilities over age 50 is about 10 percent over two years. Medical expenditures (paid by all sources) for 55–64-year-olds averaged about \$3,500 in 1996, according to unpublished data from the Medical Expenditure Panel Survey, more than twice the average for the age group from 35 to 44.

Furthermore, poverty and poor health often go together. Of those 62–64, 42 percent of the uninsured with incomes below the poverty line also rate their health as fair or poor (Sheils and Chen, 2000), as do more than a third of those with incomes between 100 and 150 percent of the poverty line. In contrast, just 17 percent of 62–64-year-olds with incomes above 300 percent of the poverty level are in fair or poor health. In short, while some people retire early because they can afford to, others face retirement with the triple threat of declining health and rising health care expenses, little income, and no health insurance.

A Strategy to Make Coverage Affordable: Medicare as an Option

Our approach to reforming health insurance for those 55–64 emphasizes the need to view health insurance, ability to pay, and the increased health risks of people who are nearing age 65 in a lifetime perspective. We also stress that reforms should be appropriate for people whose assets are becoming as important for their economic well-being as their incomes, and for whom government, rather than employers, will soon be the primary source of insurance.

In this context, any new policy initiative to expand health insurance for Americans near age 65 should be judged by six criteria. Such a policy should:

1. provide insurance efficiently, exploiting the economies that can be achieved through large insurance groups;
2. pool all insurable risks, including the risk of becoming “uninsurable”;
3. minimally distort decisions about work and retirement;
4. minimally distort decisions about saving for retirement;
5. require anyone who can afford insurance to pay for it, while making insurance affordable for those who cannot pay; and
6. preserve and offer health insurance choices.

The last of these criteria is related less directly to the special circumstances of the near elderly, but it acknowledges a strongly held preference of the American public.

Our “workable solution” is designed to provide everyone 62 or over with guaranteed access to Medicare 3 years before the current age of eligibility. A pre-Medicare subsidized voucher for people with lifelong low income and a pre-Medicare savings program to fund the health insurance of older Americans with higher incomes would increase access to insurance for everyone.

The program would provide meaningful choices, and would also protect Medicare from the threat of adverse selection. People in both the savings and voucher programs would be able to buy into the traditional Medicare program, choose a Medicare+Choice plan, and purchase employer-sponsored group, retiree, or COBRA/HIPAA health insurance coverage. This program would protect the Medicare pool from adverse selection because the healthy would be encouraged to buy insurance with subsidies for the poor and tax breaks for the non-poor. In addition, the program would offer an actuarial adjustment to the subsidies for people who opt out of Medicare, and would encourage people to buy insurance before they need it.

Our approach to insuring the population near Medicare age advances the debate on this subject in several ways. First, we call attention to the need to offer choices to people in this transitional stage of life, to accommodate a variety of circumstances. Second, our approach integrates planning for health insurance with other aspects of retirement planning. Finally, given that this group is already eligible (at age 62) for Social Security

and in a few years (at age 65) will be eligible for Medicare, we argue for a program with broad eligibility that will smooth the transition into these universal retirement programs.

To put our proposal in perspective, in the next section, we describe other recent proposals for improving the health insurance coverage of people nearing Medicare eligibility. Then we discuss alternative options for structuring eligibility, financing, and other aspects of incremental reforms for older Americans in detail, and develop a new proposal for expanding options for this vulnerable age group. Next we consider the interaction of our proposal with other public and private insurance programs, and political issues that might aid or impede passage and implementation. Our paper concludes with a summary of the strengths and weaknesses of our proposal.

Other Proposals for the Pre-Medicare Population

Clinton Administration's Proposal

In each of his administration's last three State of the Union messages, President Clinton proposed to allow some older Americans to buy into Medicare at their own expense or to continue their employer-sponsored insurance through an expansion of COBRA. Under the Clinton plan (Sheils and Chen, 2000), anyone between the ages of 62 and 64 would be able to buy into Medicare for a premium of approximately \$300 a month. This premium would not cover the full actuarial cost of this coverage, so early enrollees would pay an additional \$10 premium per month after reaching Medicare eligibility for every year that they participated in the buy-in.

"Displaced workers" would be eligible for the buy-in after age 55 and after exhausting any available COBRA coverage. This part of the President's plan would cover people who lose their jobs because of plant closings or company relocations, slack work, or elimination of their positions. For displaced workers under age 62, the premium would be \$400 per month during enrollment, and there would not be any increase in the Medicare premium after age 65.

The last component of the President's proposal applies to retirees between the ages of 55 and 64 whose former employers stop providing retiree health benefits. These retirees would not buy into Medicare, but would be able to continue COBRA coverage for as long as ten years, long enough to reach Medicare eligibility at age 65. Their premium would be limited to 125 percent of the premium for active employees, with employers bearing any remaining costs. More recently, the President modified his plan to include a 25 percent tax credit to offset the cost of the Medicare buy-in and a 25 percent tax credit to offset the cost of COBRA continuation coverage (The White House, 2000).

Under the President's original plan, nearly a million uninsured people between the ages of 62 and 64 would be eligible for the general buy-in (Sheils and Chen, 2000). However, the Administration projected that participation in the entire program was projected to be less than 300,000 (Loprest and Moon 1999), and some estimates were as low as 39,000 (Sheils and Chen, 2000). Furthermore, because those choosing to participate would be likely to have more health problems, adverse selection was likely to raise the average cost of providing Medicare insurance to buy-in participants to a level well above \$300–\$400 per month. A 25 percent tax credit would not be likely to induce many more people to participate, especially those with low incomes, so this aspect of the President's proposal would be unlikely to expand coverage, or combat adverse selection.

Loprest and Moon Proposal

Under the President's proposal, the buy-in premium would be set at an actuarially fair level, requiring participants to pay for their own higher-than-average claims. In contrast, Loprest and Moon (1999) have suggested setting the buy-in premium at the community rate that would prevail if all 62–64-year-olds participated. General tax revenues would be used to make up part of the shortfall if people opting into the program actually incurred more claims than the community average. Private insurance plans participating in the program would make up the rest.

The Loprest and Moon proposal, which is directed only at those 62 to 64, would also subsidize the community-rated premium for low-income participants. The subsidies would be based on a sliding scale, with those under 100 percent of the poverty level receiving a full subsidy, and those above 200 percent of the poverty level receiving no subsidy.

Loprest and Moon estimate the cost of subsidizing the community-rated premium for low-income participants would be between \$528 million and \$677 million, with 448,000 to 570,000 people participating. This is based on their estimate that the community-rated premium would be approximately \$3,200 per year.

The President's proposal would assist relatively few people between ages 62 and 64, because it does relatively little to make a Medicare buy-in affordable. The Loprest and Moon proposal, while subsidizing the participation of those in need, fails to consider lifetime ability to pay, offers relatively little to those with incomes above 200 percent of poverty (many of whom live on quite modest incomes), and provides few choices of insurance coverage. By addressing these issues, our proposal provides a more complete program to aid the pre-Medicare population.

A Workable Solution for the Pre-Medicare Population

Overview

Our workable solution for making health insurance more affordable and nearly universal among the pre-Medicare population comprises two main parts. One is directed at providing access to a less expensive source of coverage than the individual insurance market. Toward that end, we propose to allow everyone over the age of 62 to purchase coverage through Medicare at a community-rated premium. The second part of the solution is directed at providing older Americans with more resources to purchase insurance, through Medicare or other sources. We distinguish between those with low lifetime earnings, who cannot reasonably be expected to pay the full cost of a health insurance plan at any age, and those who earned enough over their lifetimes to pay for their own insurance coverage.

For individuals and couples with low lifetime earnings, we propose a subsidized voucher that could be used either to buy into Medicare or pay for private health insurance. We prefer the voucher to a tax credit for administrative reasons, and will continue to describe the subsidy program as a voucher in the rest of our discussion. However, the subsidy could be operationalized simply as the opportunity to buy into Medicare at reduced rates or could also take the form of a refundable tax credit if the credit were sufficient to cover the higher costs for this age group.

For the middle class, we propose a special savings program to help pay for health insurance in the pre-Medicare years. In keeping with our philosophy of offering public and private choices in insurance, we propose both public and private options as part of this savings program. The private option is a slightly modified “Roth” IRA. The current income-tax rules for Roth IRAs already allow participants to earn tax-free interest on taxed contributions to an Individual Retirement Account. They then receive the proceeds beginning at age 59½ or at an earlier age if the participant becomes disabled or uses the proceeds to purchase health insurance while unemployed. The public option would allow people over 50 to earn a guaranteed rate of tax-free interest on taxed contributions, simply by supplementing the payments that they already make to the federal government through the income-tax system.

Everyone 62 or older would be eligible to buy into Medicare, using the subsidized voucher, distributions from either savings option, or other resources. In addition, to encourage early and wide participation in the pre-Medicare savings program, participants in either savings option who became disabled (and eligible for SSDI) before age 62 would be allowed to “buy down” the 24-month Medicare waiting period at an actuarially fair

rate with distributions from the savings program. Further details on each component of the workable solution are provided below.

Medicare Buy-in Premium

The premium for buying into Medicare at age 62 would be community rated for a representative cross-section of 62–64-year-olds who enrolled in traditional Medicare.¹ That is, just as in the Loprest-Moon proposal, the buy-in premium would not be adjusted for adverse selection. Recipients of Social Security Disability Income and Medicaid would be excluded from this calculation. Because Medicare is virtually universal in the population over 65, it should be possible to establish the community-rated premium initially by applying an age adjustment to current Medicare costs. Later, if there is broad participation in the program among 62–64-year-olds, then actual program costs could also be used to set the community-rated premium. Applying an age adjustment to current Medicare claims costs suggests that the community-rated premium would be about \$3,500 in 2001.²

It might be possible to allow participants who are not eligible for a voucher and did not participate in the savings program to “borrow” all or part of the premium with an actuarially fair reduction in future Social Security benefits. This system would be similar to the adjustment that is already made when someone begins receiving Social Security at age 62. Alternatively, as in the President’s proposal, the buy-in premium could be added to regular Medicare premiums at age 65. However, we do not recommend this approach, because it might encourage adverse selection against Medicare. It allows people to “wait and see” if they need insurance, and poorer health risks will have the greatest incentive to buy into Medicare by borrowing on future benefits.

Subsidized Voucher

The pre-Medicare voucher would be available at age 62 to all individuals and couples with lifetime earnings below 200 percent of the poverty line. Those eligible for Medicaid or Medicare under provisions for the disabled would remain covered, and would not be eligible for the pre-Medicare voucher. Eligibility for the voucher would be calculated by comparing the lifetime average earnings of single individuals and married couples over the prior 40 years, measured by Social Security earnings history data, to the average value of the poverty line during the same 40-year period. Thus, the Social Security Administration would make a one-time determination of lifetime earnings from its records and then provide the Health Care Financing Administration with this information for individuals and couples. As noted above, in this age group where many people have chosen to retire on reduced incomes, any true measure of ability to pay must look beyond current income. While many current programs use an asset test to identify people with significant resources

beyond current income, we believe that the lifetime earnings test is simpler to administer. Also, our approach cannot be undermined by asset planning, as currently occurs in response to the asset limits on Medicaid coverage of nursing home care.

Those meeting the lifetime earnings test would receive a voucher (or premium reduction) equal in value to all or part of the Medicare buy-in premium. Like the subsidies proposed by Loprest and Moon (1999), the voucher in our proposal would cover the full cost of the Medicare buy-in for those with lifetime earnings below the poverty line. The value of the voucher would be phased out for people with lifetime earnings between 100 and 200 percent of the poverty line, with the phase-out proportional to the difference between lifetime earnings and the poverty line. In other words, individuals and couples with lifetime earnings equal to 125 percent of the poverty line would receive 75 percent of the base amount, people at 150 percent of the poverty line would receive 50 percent of the base amount, and so on. The pre-Medicare vouchers would be funded through the budget surplus, general (mostly income tax) revenues, or through a small increase in Medicare or FICA taxes.

To give everyone choices beyond Medicare, the voucher could be used to purchase insurance directly from an insurance company or to participate in an employer-sponsored plan. However, in order to account for adverse selection against Medicare, the base amount of the voucher would be reduced if it were used to purchase insurance other than Medicare.³

The value of the voucher would be reduced for those who opt out of community-rated Medicare, because it is assumed that those who do so will be healthier than average, with claims below the community average. When healthier individuals opt out of Medicare, the claims saved by the Medicare funding pool will be less than the community average, so the funding pool should not pay the community average to another insurer to cover healthier enrollees. Furthermore, healthy individuals should be able to find insurance through an employer or private insurer that reflects their lower expected claims. If they cannot do better than a community-rated premium, then they can fall back on Medicare.

Pre-Medicare Savings Program

The pre-Medicare savings program would be optional, and available for those 50 to 62. At age 62, the savings accumulated through this program could be used to purchase either private health insurance or to buy into Medicare. Any balances not used to purchase insurance between ages 62 to 65 could be used thereafter for any purpose. The present value of the expected premium for three years of Medicare is approximately \$10,000, or a

little less than \$1,000 per year if contributions start at age 50, so total deposits into the savings program would be capped at \$10,000. This would be adjusted over time for inflation of the buy-in premium.

In order to encourage early contributions, as a hedge against unexpected economic reversals before age 62, the maximum allowed contribution would be set at \$2,000 per year. As a further inducement to set aside the cost of pre-Medicare coverage at an early age, all interest earned on contributions to the savings program would be exempt from income taxes. Another inducement to participate in the savings program would be to allow anyone who became disabled and qualified for SSDI before age 65 to use a pre-Medicare savings account to buy into Medicare at an actuarially fair rate before the end of the 24-month waiting period. Anyone who contributed to a pre-Medicare savings account, but qualified at age 62 for the pre-Medicare voucher, would be allowed to keep the voucher regardless of the account balance.

The pre-Medicare savings program would be fully funded from individual contributions. While there would be some reduction in tax revenues as a result of the favorable tax treatment of interest earnings, the impact on the federal budget would be relatively small.

The private savings option would be modeled on the current provisions for Roth IRAs. Contributions to Roth IRAs are not exempt from income taxes, a feature we favor because exempting IRA contributions from taxation is regressive. (Deductions from income provide more tax savings to higher-income taxpayers with higher tax rates.) However, as with a regular Roth IRA, none of the interest accumulated on contributions to a pre-Medicare IRA would be taxed in our proposal.⁴ Although the interest exemption is also regressive, we believe that it is necessary so that pre-Medicare IRAs can compete with other tax-preferred investment options available to middle- and upper-income taxpayers.

All people over age 50 would be allowed to contribute to a pre-Medicare IRA regardless of whether they already contribute to standard Roth IRAs or other tax-favored savings and pension arrangements. Except for the special case of SSDI eligibility, penalty-free distributions from the pre-Medicare IRA would not be allowed until age 62 (in contrast to distributions from a regular Roth IRA at age 59½). Nor would there be any special provision for paying for health insurance for the unemployed before age 62, since distributions from a regular Roth IRA could be used to defray that expense.

In contrast to the private savings option, the government option would guarantee a minimum rate of return on contributions to the savings program (until the participant reached age 65). Interest earned through the government savings option, like the private option, would be exempt from federal income tax.

For people who might be intimidated by the idea of establishing a private IRA, the government option would provide a convenient and relatively familiar way of setting aside money to purchase health insurance for early retirement. The Internal Revenue Service would modify the W4 form to invite individuals over 50 to supplement their regular income-tax withholding with contributions to the pre-Medicare savings program (up to a maximum of \$2,000 per year). These contributions would be reported on the W2 form that is sent from employer to employees at the end of each tax year. The 1040 form would be modified to allow taxpayers to indicate contributions to a pre-Medicare savings account (subject to the limit of \$2,000 per person over 50 per year), and then adjust their tax refunds or payments to the IRS accordingly. Because the self-employed already pay their Medicare and Social Security taxes in this fashion, administrative mechanisms are already in place that are similar to those that would receive these payments and post them to individual accounts.

Pre-Medicare Insurance Options

Anyone over 62 would be able to use the subsidized voucher, distributions from the savings program, or their own resources to purchase the basic Medicare package, any of the Medicare+Choice plans, any employer-sponsored insurance plan for which they were eligible (including COBRA/HIPAA), or individual health insurance.

Medicare+Choice plans that covered elderly Medicare enrollees would also be required to participate in the buy-in program. Plans would have to provide coverage at least equivalent to traditional Medicare in order to be eligible for funding from the voucher or the savings program. Many buy-in enrollees would have access to comprehensive benefits through Medicare+Choice plans, and there would be no subsidies for Medigap plans (supplemental insurance, sold by private insurers to fill in the gaps not covered by Medicare) for elderly Medicare enrollees. Therefore, the use of pre-Medicare vouchers and distributions from pre-Medicare savings accounts to purchase Medigap plans would be prohibited.

Preventing or Compensating for Adverse Selection

Adverse selection against Medicare could undermine the affordability and financing of the Medicare buy-in, especially since it would have a community-rated premium, and since participants in the savings or voucher programs would have a choice between Medicare

and private alternatives. In order to limit adverse selection, premiums and administrative structures must be established so that many relatively healthy individuals would be better off in the Medicare pool than elsewhere. Several features of the program, as well as other options, should encourage healthy people to participate in the Medicare buy-in.

As described above, the first defense against adverse selection is the reduced value of the voucher for people who opt out of Medicare. This will make participation in Medicare relatively more attractive. In addition, when healthier people do opt out of the Medicare pool, the funds removed will be less than the community average for claims.

Siphoning off many of the most costly cases to Medicaid or the Medicare disability program will also help to protect the buy-in pool.

Administrative mechanisms can also help limit adverse selection. We recommend an annual open enrollment for the Medicare buy-in, like the system of annual open enrollment that has been legislated for Medicare in the future. Alternatively, if adverse selection turns out to be a more serious problem than expected, pre-Medicare participants could possibly be held to a one-time enrollment decision at age 62 (with some flexibility for those with later changes in employment or family circumstances).

If these lines of defense are not effective, then additional federal funds may be necessary to support the community-rated Medicare premium. Similar to the Loprest and Moon proposal, funds would seek to make up the shortfall above community rates.

The pre-Medicare savings program should not contribute noticeably to adverse selection against Medicare or private insurers. The design features that encourage early participation beginning at age 50 should limit self-selection of less healthy people into the savings program. At 50, relatively few people will be able to predict their health status at age 62. Also, if the savings programs succeed in encouraging most people to buy insurance at age 62, then adverse selection will necessarily be reduced.

Interactions with Existing Programs

Any new program to provide health insurance for older Americans must fit into the existing web of public and private programs that cover people nearing the age of Medicare eligibility. The web includes Medicare itself, Medicaid, health insurance regulations such as COBRA and HIPAA that provide for continuation of coverage, employer-sponsored benefits for active workers and retirees, and nongroup insurance purchased directly from insurers.

In considering the new program's interaction with Medicare, our main goal is to make the universal transition to Medicare at age 65 as seamless as possible. One of the main arguments for allowing 62–64-year-olds to buy into Medicare, instead of some other source of group coverage, is to avoid further disruption of their insurance at age 65 when they join Medicare. The prevalence of managed care makes such continuity all the more important, because changing from one managed care plan to another is likely to disrupt enrollees' relationships with their physicians.

With the goal of a seamless transition in mind, we propose to extend all existing Medicare rules to new "buy-in" enrollees under age 65. Like elderly enrollees, they would have access to all Medicare+Choice plans, including traditional Medicare. If they selected traditional Medicare, they would probably have to purchase supplemental coverage at their own expense to cover prescription drugs and other gaps in the Medicare benefit package. Medicare would serve as the secondary payer if working enrollees with employer-sponsored insurance were to buy into the program, just as it does for elderly workers. The special Medicare eligibility of the disabled under age 65 would also continue as before, and would serve as a separate "high-risk pool" that would help to keep the buy-in premium at an affordable level. Medicaid would continue for the severely disabled, and would also protect the Medicare buy-in from the high costs associated with Medicaid enrollees. Medicare might need new administrative procedures to divert the Medicare disabled and Medicaid eligibles from the buy-in program, especially those with low enough lifetime earnings to qualify for a pre-Medicare voucher. However, because of the greater generosity of Medicaid benefits compared with Medicare, especially for the disabled who require a broad range of supportive services, it is likely that those who are eligible for Medicaid would voluntarily apply for it as a matter of self-interest.

To avoid perverse incentives that favor retirement over work, we propose to offer the option of enrolling in Medicare or buying health insurance with money from a pre-Medicare savings account to everyone in the eligible age group, regardless of employment status. Employers and employees might choose to take advantage of the new program to increase coverage for early retirees and active workers in a number of ways.

Although our proposal will not necessarily reverse the erosion of employer-sponsored health insurance for retirees, it should help to keep employers somewhat involved. First, some employers who are reluctant to pay for health insurance for early retirees might at least offer access to health insurance through the employer group, knowing that early retirees will be able to pay the premium from their pre-Medicare savings accounts or vouchers. Even if employers do not explicitly offer retiree benefits, the savings account or voucher could be used to finance the mandatory continuation benefits

already available to former employees under COBRA. Second, employers may choose to contribute to the pre-Medicare IRAs of their active workers, instead of promising to provide retiree health benefits in the future and showing the liability on their balance sheets, as the Federal Accounting Standards Board now requires.⁵

Employers would also continue to cover workers between 62 and 65. Participation in employer-sponsored plans might actually increase in this age group, because workers would be able to use their pre-Medicare savings accounts or vouchers to pay the employee share of the premiums. If employers were involved in administering pre-Medicare IRAs, it would be especially easy for employees to transfer funds from the IRA to pay the employee premium. If their employers did not offer insurance, or Medicare+Choice offered more for the money, then workers could buy into Medicare. Because Medicare would be the secondary payer for workers with employer-sponsored insurance, there would be little incentive for them to purchase both types of coverage.

Pre-Medicare savings accounts and vouchers could also be used to purchase health insurance in the individual market, including the conversion of group to individual insurance guaranteed by HIPAA. However, if our recommended measures successfully protect the Medicare pool against adverse selection, then the insurance available from Medicare or employer-sponsored groups should be cheaper than insurance purchased directly from an insurer. The Medicare buy-in would cause insurers to lose some 62–64-year-olds from the individual market, but premiums for those who remain might fall, after this high-cost age group was removed.⁶

The web of public and private programs that currently covers older Americans is very complicated and leaves plenty of opportunity for people to fall through the net when their circumstances change. Some could lose health insurance if they lose their jobs or become unable to work, if they have to change to jobs that do not offer health insurance, or if their employers stop offering health insurance. The vulnerability of older Americans to unexpected changes in the availability and affordability of health insurance would be considerably reduced if they had money set aside in a pre-Medicare savings account or voucher, and a guaranteed place to buy insurance at reasonable rates.

Political Considerations

Three basic elements are fundamental to our proposal for covering older Americans in the transitional years leading to Medicare eligibility: (1) providing access to a cheaper source of insurance than the individual market, through Medicare; (2) health insurance subsidies for those with low lifetime earnings; and (3) prepayment (or saving) for health insurance in advance of the pre-Medicare period. Although we operationalize these ideas in terms of

a Medicare buy-in, with pre-Medicare savings accounts and vouchers financed from general revenues, there are different ways to package these elements to appeal to different political perspectives or insurance concerns.

For example, for those who embrace the universality and broad risk-pooling of social insurance, our proposal could be implemented as an earmarked increase in Social Security or Medicare taxes that would provide everyone with a tax credit or voucher to purchase health insurance at age 62. Like the pre-Medicare savings accounts that we propose, this credit could be exchanged for cash (or an increase in Social Security benefits) at age 65, so that people who did not need the credit to buy health insurance at age 62 would still benefit from participating. Most people would pay for their own health insurance in small advance installments, through the tax on earnings. Furthermore, financing the subsidies with a tax on earnings would also subsidize the lifelong poor.

Social insurance involves mandatory participation in a public program. An alternative way to formulate our proposal, which would stop short of mandatory social insurance, is to offer everyone the option of signing up for a pre-Medicare tax credit or voucher at age 50, which would be financed by a small, voluntary increase in the Medicare tax. This approach is very similar to the government savings option that we propose, except it would provide a defined benefit instead of a defined premium contribution at age 62.

To address concerns of over-reliance on Medicare, the proposal seeks to preserve private health insurance and investment choices. In addition, the Medicare program itself offers many private alternatives through Medicare+Choice.

Additional options for early retirees are likely to appeal to employers. Employers may get more involved in funding or offering retiree health insurance if they can do so on a limited basis (with employees having access to other sources of funds and to group insurance through Medicare).

Insurers are likely to lose most of their business with 62–64-year-olds in the individual market, but the increase in group health insurance purchases through employers and Medicare should offset this. In other words, pre-Medicare IRAs and vouchers should stimulate demand so that a larger number of 62–64-year-olds would buy health insurance.

There are few implications or obligations for the states, except in their role as large employers. Given their primary role in regulating other types of health insurance, the

states would probably regulate and certify private plans that could be purchased with pre-Medicare savings accounts or vouchers.

The federal government will play the primary role in implementing this proposal, since it can minimize costs by building on existing administrative structures. The Social Security Administration will pass information about lifetime earnings, already used in determining Social Security benefits, to the Health Care Financing Administration. The Social Security Administration will also track contributions to individual government savings accounts and distribute funds from the accounts, just as it currently does for Social Security contributions and benefits. The Treasury Department will manage the government savings fund, and the Internal Revenue Service (housed within the Treasury Department) will administer the IRAs. The major new activities for the Health Care Financing Administration, which will administer the voucher program and the Medicare buy-in, would be to issue the vouchers (or subsidized rates) and enroll participants in the buy-in program. HCFA would contract with private health plans to cover buy-in participants, just as it does for other Medicare enrollees, or it will negotiate rates and pay claims under traditional Medicare.

Summary

In our introduction, we suggested six criteria for developing a workable solution to the high cost, insecurity, and gaps in coverage that characterize the current web of public and private insurance programs for older Americans near age 65. Our two-part proposal for pre-Medicare savings accounts and vouchers, combined with a Medicare buy-in, goes a long way towards satisfying each of these criteria.

Our workable solution would provide insurance more efficiently. Currently, non-group insurance is more prevalent among the pre-Medicare population than any other age group. With administrative and marketing costs amounting to as much as 35–40 percent of premiums, nongroup insurance is very costly. We propose to give all 62–64-year-olds access to a source of insurance that achieves some of the scale economies of large employer plans. For this age group, we favor Medicare over other new sources of insurance, because this age group is only three years away from enrolling in Medicare anyway.

Guaranteed access to Medicare at a community-rated premium will protect older Americans against the risk of becoming uninsurable, or that the cost of health insurance will be out of reach. Pre-Medicare savings accounts will allow individuals to insure themselves against the possibility of economic reversals at a late stage in their working lives, which might otherwise leave them without the means to purchase insurance.

Allowing SSDI recipients to use the funds in their pre-Medicare savings accounts to shorten the waiting period for Medicare disability benefits will eliminate an important gap in the disability insurance provided by Social Security and Medicare.

Our proposal does not particularly favor either work or retirement for people in the early retirement years. Both workers and early retirees would be eligible for pre-Medicare vouchers and savings accounts. Because eligibility for the subsidized vouchers would be based on earnings prior to age 62, work and retirement decisions made after age 62 would not affect the determination of subsidies. Nevertheless, by providing all older Americans with access to group insurance, and by basing subsidies on lifetime earnings, our proposal may encourage some people to choose leisure or retirement over work.

By designing a proposal that is explicitly part of financial planning for retirement, we have also minimized the distortion of savings and consumption decisions. People who make different decisions about saving for retirement will receive the same vouchers, because the subsidies represented by the vouchers are based on past earnings. Assets and unearned income from investments and savings are not considered. Our proposal rewards savers with a tax exemption for interest and dividends, but does not favor people who consume all of their earnings and fail to save for their retirement years.

By encouraging people to save for health insurance in their early retirement years, our proposal will make pre-Medicare insurance more affordable without a big increase in government spending. At the same time, subsidies will be available to the lifelong poor who have earned too little during their lives to pay for health insurance.

Finally, this proposal expands the range of affordable health insurance choices for older Americans, by enabling them to use pre-Medicare vouchers and savings accounts to buy private health insurance, as well as to buy into Medicare. Unfortunately, providing choice may create adverse selection, and participation in Medicare (the insurer of last resort) may not support a community-rated premium. However, a number of strategies, including a reduction in the value of the voucher for people who opt out of Medicare, could form a workable solution that would preserve choice while protecting a Medicare buy-in against adverse selection.

NOTES

¹ Given current program rules, the same premium would finance enrollment in a Medicare+Choice plan, after the usual adjustment of the benefit package to equal the cost of traditional Medicare.

² We are grateful to Jim Mays, of Actuarial Research Corporation, for suggesting this approach to setting the community-rated premium and for providing the premium estimate.

³ A variable risk-adjustment that was more refined than a flat reduction in the voucher could be implemented for people who opt out of Medicare.

⁴ In contrast to a Roth IRA, contributions to a traditional IRA are not taxed before they go into the account. Nor is tax paid on the interest as it is earned. However, both the initial contributions and the accumulated interest are taxed when taken out of the account.

⁵ If employer contributions to pre-Medicare IRAs were allowed, there would be an issue of whether to exclude such contributions from the taxable income of employees (in the same way that employer premium contributions are excluded). Excluding employer premiums from taxation would subsidize the IRA more generously.

⁶ Premiums for those remaining in the individual market would only be reduced in states where insurers are not able to freely vary premiums by age.

REFERENCES

- Bureau of Labor Statistics. "Employee Benefits in Medium and Large Private Establishments, 1997." Bulletin 2517. Washington, D.C.: U.S. Department of Labor, 1999.
- Chollet, D. J., and A. M. Kirk. *Understanding Individual Health Insurance Markets*. The Henry J. Kaiser Family Foundation, March 1998.
- Employee Benefits Research Institute (EBRI). *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1996 Current Population Survey*. EBRI Issue Brief Number 179. Washington, D.C.: Employee Benefits Research Institute, November 1996.
- Flynn, Patrice, "COBRA Qualifying Events and Elections, 1987–1991," *Inquiry* 31 (Summer 1994): 215–220.
- Fronstin, Paul. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey*. EBRI Issue Brief Number 217. Washington, D.C.: Employee Benefits Research Institute, January 2000.
- Health Care Financing Administration. Informational website on "Ticket to Work and Work Incentives Improvement Act of 1999." Accessed at <http://www.hcfa.gov/medicaid/twwiia/twwiiahp.htm> on July 25, 2000.
- Hewitt Associates. *Retiree Health Coverage: Recent Trends and Employer Perspective on Future Benefits*. Washington, D.C.: The Henry J. Kaiser Family Foundation, October 1999.
- Loprest, P., and M. Moon. *Medicare Buy-in Proposal*. The Kaiser Project on Incremental Health Reform, October 1999.
- Pauly, M. V., and A. M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics, Policy & Law* 25 (February 2000): 9–26.
- Sheils, J., and Y. J. Chen. *Medicare Buy-In Options: Estimating Coverage and Costs*. The Commonwealth Fund, December 2000.
- Short, P. F., D. G. Shea, and M. P. Powell, "Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?" 2000. [Draft]
- The White House. *The Clinton-Gore Administration FY2001 Budget: Maintaining Fiscal Discipline While Making Key Investments, Summary Documents*. Accessed at <http://www.pub.whitehouse.gov/uri-res/l2R/urn:pdi:/oma.eop.gov.us/2000/2/7/11.text.1> on July 20, 2000.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering by number. These items can also be found on the Fund's website at www.cmwf.org. Other items are available from the authors and/or publishers.

#415 Challenges and Options for Increasing the Number of Americans with Health Insurance (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series *Strategies to Expand Health Insurance for Working Americans*.

#442 Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance (January 2001). Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication #415, presents a detailed side-by-side look at all the option papers in the series *Strategies to Expand Health Insurance for Working Americans*.

#423 A Health Insurance Tax Credit for Uninsured Workers (December 2000). Larry Zelenak, University of North Carolina at Chapel Hill School of Law. A key issue for uninsured adult workers is the cost of insurance. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes using a tax credit to help workers afford the cost of coverage. It assumes age-/sex-adjusted credits averaging \$2,000 per adult or \$4,000 per family, with a full refundable "credit" for those with incomes at or below 200% percent of poverty. The paper analyzes administrative and other issues related to the use of such tax credits.

#422 Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs (December 2000). Alan Weil, The Urban Institute. Medicaid and CHIP offer administrative structures and plan arrangements with the capacity to enroll individuals and families. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes permitting, but not requiring, tax-credit recipients to use their credits to buy into Medicaid or CHIP.

#421 Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance? (December 2000). Katherine Swartz, Harvard School of Public Health. Efforts to improve the functioning of individual insurance markets require policy makers to trade off access for the highest-risk groups against keeping access for the lowest risk-groups. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, discusses how individual insurance markets might best be designed in view of this trade-off.

#419 Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so.

#418 *A Federal Tax Credit to Encourage Employers to Offer Health Coverage* (December 2000). Jack A. Meyer and Elliot K. Wicks, Economic and Social Research Institute. Employers who do not currently offer health benefits to their employees cite costs as the primary concern. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, examines the potential of offering tax credits (or other financial incentives) to employers of low-wage workers to induce them to offer coverage.

#417 *Public Subsidies for Required Employee Contributions Toward Employer-Sponsored Insurance* (December 2000). Mark Merlis, Institute for Health Policy Solutions. Some uninsured workers have access to employer group coverage but find the cost of their premium shares unaffordable. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, examines the potential for using a tax credit or other incentive to help employees pay their share of premium costs in employer-sponsored plans. The paper analyzes how such premium assistance might work as an accompaniment to a tax credit for those without access to employer plans.

#416 *Transitional Subsidies for Health Insurance Coverage* (December 2000). Jonathan Gruber, Massachusetts Institute of Technology and The National Bureau of Economic Research, Inc. The unemployed and those switching jobs often lose coverage due to an inability to pay premiums. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, suggests ways that the existing COBRA program could be enhanced to help avoid these uninsured spells.

#414 *Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program* (December 2000). Beth C. Fuchs, Health Policy Alternatives, Inc. The FEHBP has often been proposed as a possible base to build on for group coverage. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes an extension of FEHBP (E-FEHBP) that would operate in parallel with the existing program. The proposal would require anyone qualifying for a tax credit to obtain it through E-FEHBP and would also permit employees of small firms (<10 workers) to purchase health insurance through the program. The proposal would also provide public reinsurance for E-FEHBP, further lowering the premium costs faced by those eligible for the program.

#413 *Private Purchasing Pools to Harness Individual Tax Credits for Consumers* (December 2000). Richard E. Curtis, Edward Neuschler, and Rafe Forland, Institute for Health Policy Solutions. Combining small employers into groups offers the potential of improved benefits, plan choice, and/or reduced premium costs. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes the establishment of private purchasing pools that would be open to workers (and their families) without an offer of employer-sponsored insurance or in firms with up to 50 employees. All tax-credit recipients would be required to use their premium credits in these pools.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70*, reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons why nine of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#363 *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance* (January 2000). Cathy Schoen, Erin Strumpf, and Karen Davis. This issue brief based on findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance reports that most Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#262 *Working Families at Risk: Coverage, Access, Costs, and Worries—The Kaiser/Commonwealth 1997 National Survey of Health Insurance* (April 1998). This survey of more than 4,000 adults age 18 and older, conducted by Louis Harris and Associates, Inc., found that affordability was the most frequent reason given for not having health insurance, and that lack of insurance undermined access to health care and exposed families to financial burdens.