In Brief

Increasing Health Insurance Coverage for High-Cost Older Adults in the 50-to-64 Age Group

"Increasing Health Insurance Coverage for High-Cost Older Adults," a report funded by AARP's Public Policy Institute, discusses public policy options for insuring older adults too young for Medicare. The report concludes that there are compelling reasons to cover this population but serious efforts to expand access to affordable coverage will require significant changes in health care financing.

A well-known truth about health care expenditures is that a small fraction of individuals accounts for a large share of total health spending. A subset of such individuals includes persons aged 50 to 64, or "prime age" adults. Although not yet eligible for Medicare coverage, prime age adults have reached a time when many chronic diseases, which require regular medical attention and can lead to catastrophic spending, begin to develop.

Private insurers have an incentive to avoid covering individuals in this population, reducing opportunities for affordable coverage in the private small-group and non-group insurance markets.

The implications of this problem for public spending are clear: studies show that Medicare spending is significantly higher for those without continuous insurance coverage after age 50.

In seeking improved coverage options for the 50-64 population, however, policy makers face a number of challenges. Not least is the difficulty of containing costs over time. Another involves dealing with the consequences of making coverage mandatory.

Policy Options for the High-Cost, High-Risk Population

Certain public policy options focus on the prime age population's vulnerability to exclusion from the health insurance market. If implemented, some would involve substantial government subsidization, while others would increase the pooling of risk through premium and market regulation.

Government-financed reinsurance would remove a portion of the financing burden of large claims from insurers (and, by extension, individuals and employers), with that portion of reinsured medical spending financed by taxpayers. Public reinsurance could increase the stability of small-group and nongroup markets by reducing variation in health spending. But, alone, it would not appreciably lower the number of uninsured, decrease medical underwriting, or curb the incentive for insurers to avoid high-cost individuals.

Public program buy-in proposals would allow otherwise ineligible individuals to purchase Medicare or Medicaid coverage. This approach has the advantage of broad risk pools and

pre-existing plan infrastructure. Subsidies for low-income individuals would likely be necessary, and the establishment of actuarially fair premiums would depend on whether participation was mandatory or voluntary.

Assigning risk to private insurance carriers is an approach under which high-cost individuals could apply for random assignment to a private carrier operating in their area. Carriers would be assigned high-cost individuals in proportion to their share of the group and nongroup markets. The enrollees themselves would pay income-related premiums, with the government paying the difference between the individual's portion and the full standard risk premium. Creating incentives for carriers to effectively manage high-cost assignees, even with government subsidization, would be a critical design feature.

Federal financing of state high-risk pools —to include expanded benefits, income-related premiums, and elimination of pre-existing condition exclusions—could improve the ability of existing high-risk pools to serve people with high-cost medical needs. However, using this option alone to expand coverage to the high-need population would swell the public dollars necessary to finance coverage for this population.

Purchasing pools (also known as exchanges, connectors, and cooperatives) could provide a structured marketplace through which at least a segment of consumers (e.g., individual purchasers and small employers) are guaranteed insurance coverage with a defined set of benefits, coupled with income-related subsidies. Important design details for the pool and the market outside the pool would affect whether coverage for high-risk individuals was accessible and affordable.

Expanding COBRA coverage through extending periods of eligibility or subsidizing premium costs is another option for covering prime age individuals. On the plus side, this approach could reduce the premium costs for high-risk individuals, as they would be pooled with lower-risk employees. On the minus side, premiums of current and former employers could rise substantially and coverage would be limited to the recently unemployed with prior employer-based insurance—a relatively small portion of the high-risk population.

Conclusions

Private insurance options under the current health care system are deteriorating. Comprehensive health reform, if enacted, is likely to address many of the shortcomings of the current system for the high-cost population. However, in the absence of such reforms, there continues to be a compelling public interest in increasing access to coverage for this at-risk population.

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