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

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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.

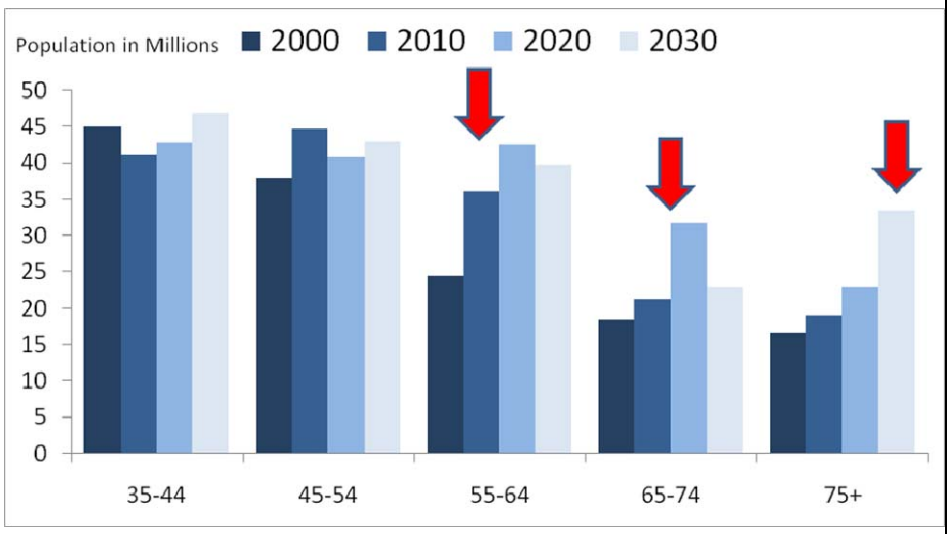
Of the incremental options discussed here, I'd argue that the Medicare buy-in is the most viable, for one reason: it does require other populations to pay for this high-risk group. It gives participants the choice of getting coverage now and paying later. It requires no new infrastructure to run, and 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

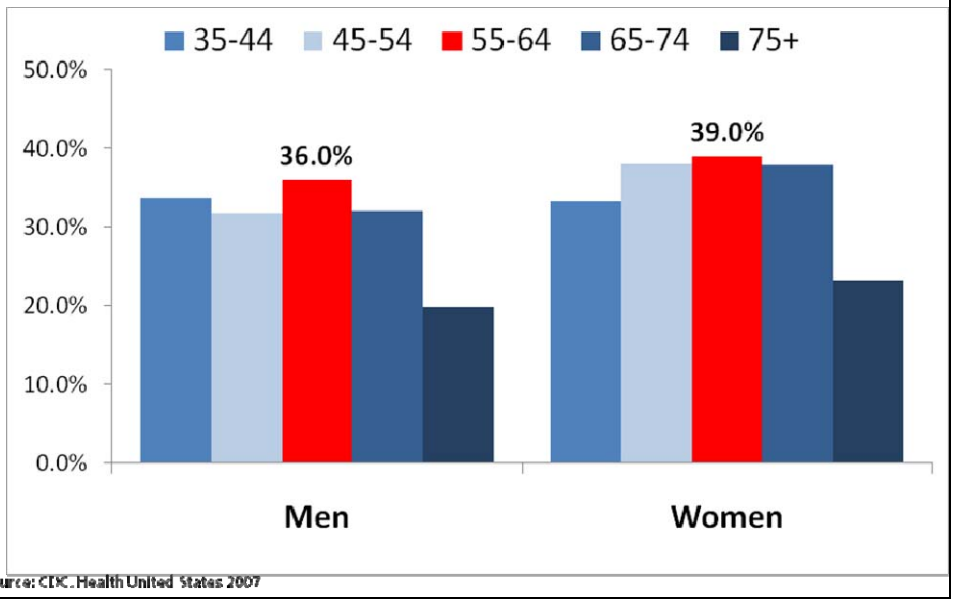
Baby Boomers Moving through 55 to 64 Year-Old Age Bracket



Source: U.S. Census Bureau, Interim projections (http://www.census.gov/ipc/www/usinterimproj/)

Figure 2

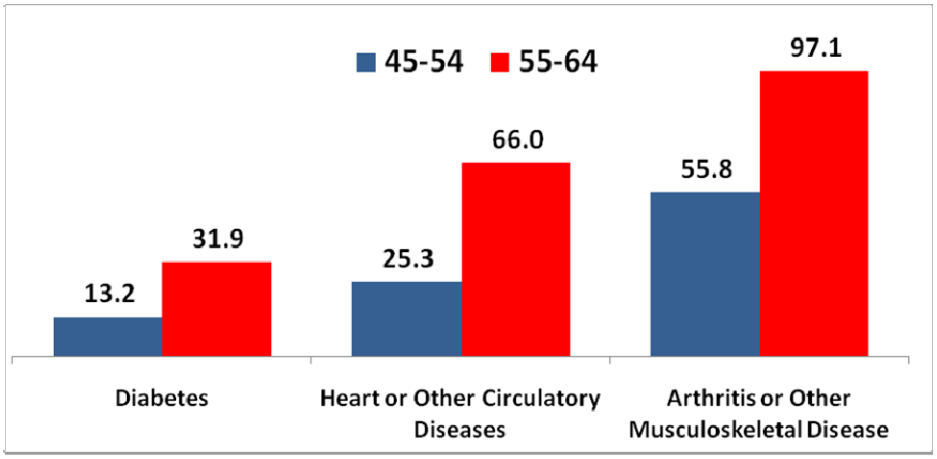
Rates of Obesity by Age, 2001-04



Source: CDC, Health United States 2007

Figure 3

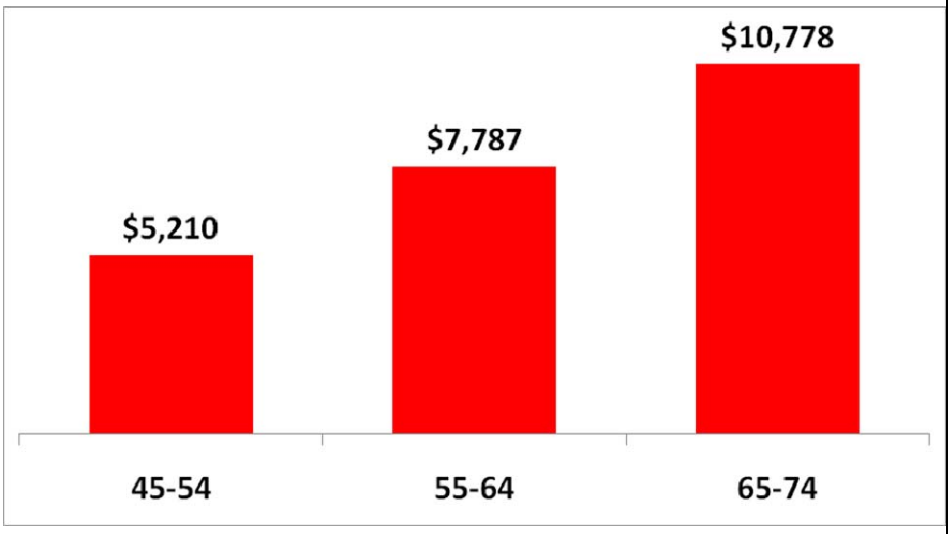
Functional Limitations per 1,000 People by Disease and Age, 2004-05



Source: CDC, Health United States 2007

Figure 4

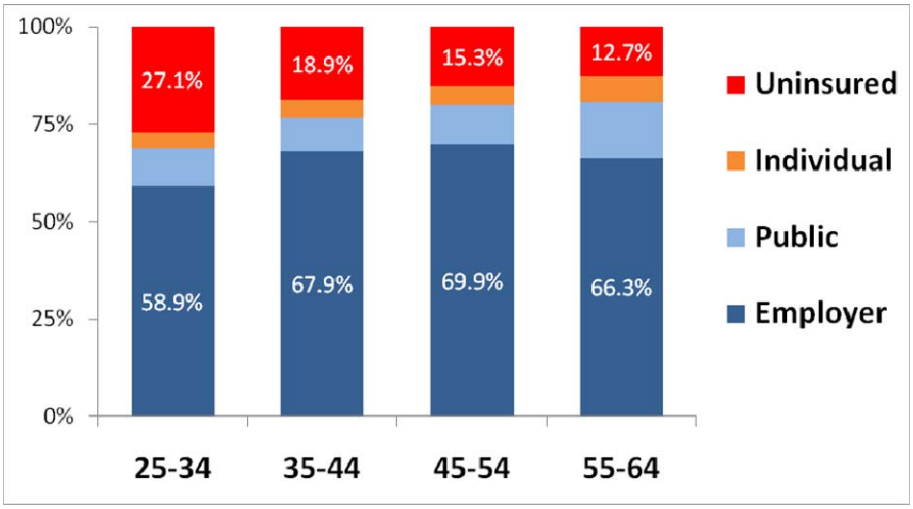
Health Spending Per Capita by Age, 2004



Source: CMS, National Health Expenditures by Age

Figure 5

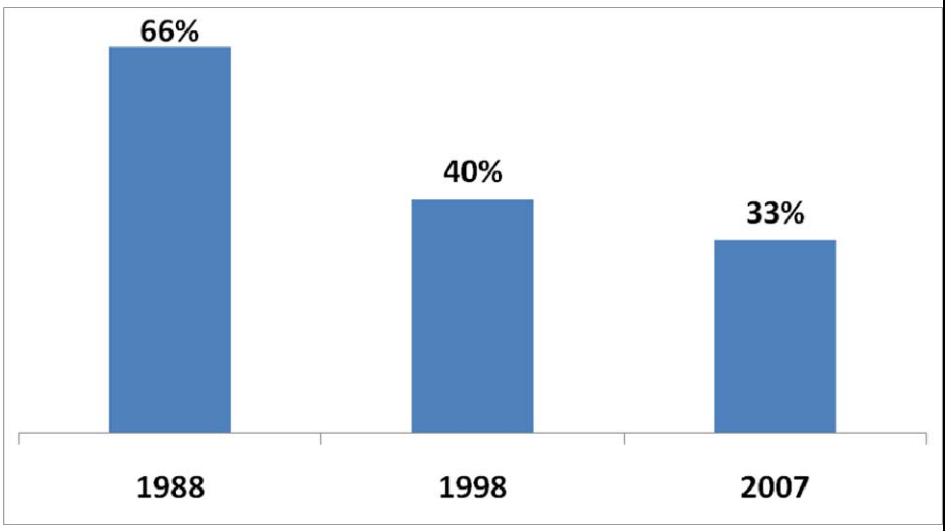
Health Coverage by Age, 2006



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

Figure 6

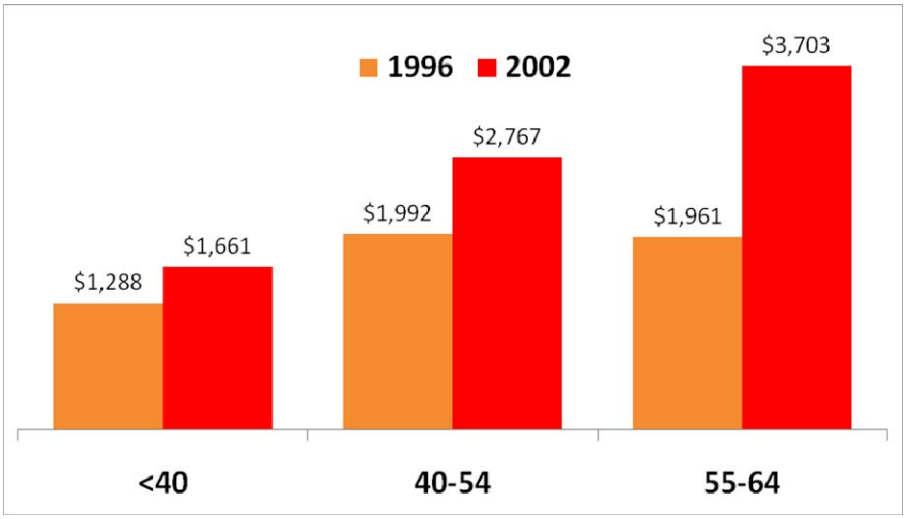
Large Firms Offering Retiree Health Benefits



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

Figure 7

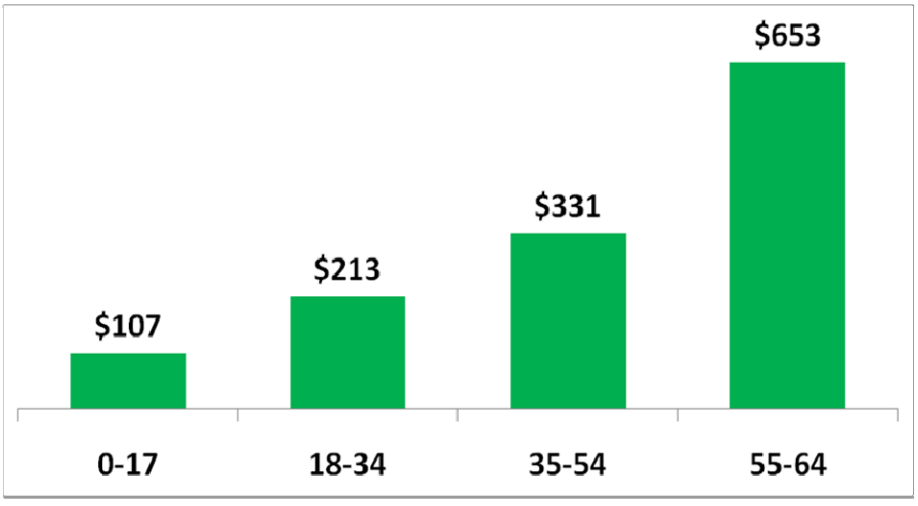
Individual Market Premiums by Age



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:

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