

Findings Brief

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CHANGES IN HEALTH CARE
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Availability of Retiree Health Insurance Important Factor as Near-elderly Consider Leaving Work Force

In the U.S. health care system, the quality of an individual's health insurance coverage can have a significant impact on that person's security, in terms of both health and finances. This is particularly true later in life, because as age increases, so does the likelihood of serious illness, often with a corresponding increase in health care costs. Unlike the elderly age 65 or older, who receive health benefits through Medicare, many of those younger than 65 leave guaranteed health insurance behind when they leave the labor market because they are no longer eligible for the employer-sponsored insurance (ESI) they relied on while working. The availability and comprehensiveness of health insurance coverage is therefore a critical issue for the near-elderly, especially those considering early retirement, and has gained the attention of the Clinton administration. Among the major questions being asked are: What effects do policies to address coverage gaps experienced by the near-elderly have on the labor market? and How might such policies affect retirement decisions by the near-elderly population?

Researchers at the Urban Institute in Washington, D.C., recently completed a study examining how the availability and cost of health insurance affect older workers' decisions to retire. The first phase of the project, led by Sheila Zedlewski, Ph.D., and Pamela Loprest, Ph.D., described the work and health insurance transitions of older persons, while the second phase of the project, led by Richard Johnson, Ph.D., and Amy Davidoff, estimated how changes in premium costs due to COBRA availability or Medicare reforms affect older workers' decisions to retire before age 65. According to Johnson, "The results of this study have implications not only for Medicare reform, but for retirement policies as well, especially those regarding Social Security reform."

During phase one of the study Zedlewski and Loprest found a declining trend in the provision of employer-provided retiree health insurance (RHI) coverage — defined as coverage partially or wholly paid for by one's employer post-retirement, but prior to Medicare eligibility. The first phase of the project found that one-quarter of older Americans leaving the labor force for retirement experienced a change in their insurance coverage, and the percentage who were uninsured increased from 7 to 13 percent. Fully one-third of those who became uninsured when they retired had ESI when they were working.

The researchers hypothesized that the presence or absence of RHI might play an important role in the retirement decision, given the increased utilization of health resources that generally occurs with age. At least two factors converge to make the decision to retire one that rests heavily on the availability of affordable insurance coverage: 1) the perceived importance of health coverage for the near-elderly; and 2) the unfamiliarity with and unaffordability of the non-group market faced by workers who were enrolled in employer-sponsored plans, either through their own employer or a spouse. Dependence on one's employer for coverage may make those considering retirement before they become eligible for Medicare unable to do so without paying a high penalty in lost coverage benefits. Furthermore, even those individuals who are able to receive RHI benefits find that they are required to share more of the premium cost and often receive fewer benefits than they did while employed.

Background

Using data from the Health and Retirement Study (a longitudinal survey fielded by the Institute for Social Research at the University of Michigan), the researchers constructed a nationally representative sample of full-time workers age 55 to 61 in 1992, who were then re-interviewed in 1994. About 88 percent of the full-time workers in the sample were covered through ESI, either through their own employment or their spouse's employment, and about 60 percent of full-time workers had RHI benefits. Approximately one-in-four (25 percent) full-time workers who received ESI reported that they would not be provided with RHI. Approximately 5 percent of full-time workers in the sample purchased insurance through non-group policies, and about 7 percent were uninsured.

To understand the effects of health insurance on retirement, Johnson and Davidoff first used multivariate models of retirement to measure the impact of premium costs associated with retirement on labor force withdrawals. Controlling for health status, pension wealth, other financial assets, and demographic characteristics, researchers found that workers who faced steep increases in premiums upon retirement were significantly less likely to retire early than workers who faced more modest increases. For example, preliminary estimates suggested that a 50 percent increase in insurance costs would reduce retirement rates by roughly

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7 percent for men and 10 percent for women. According to Johnson, "The somewhat larger effects for women are consistent with findings from other studies that women's work behavior tends to be more responsive to economic incentives, such as wage and tax rates, than does men's."

As noted above, the issue of how insurance coverage affects retirement decisions goes beyond the presence or absence of coverage; it also has a great deal to do with the affordability of post-retirement coverage, whether it be through COBRA or through a non-group policy. Indicating that even COBRA coverage may not be ideal for near-elderly retirees, the researchers found that even for those who received RHI coverage, the average cost of this coverage compared to the cost while employed increased substantially. For example, the average cost of a male retiree's share of health benefits (expressed in 1994 dollars) increased by approximately \$100 per month after retirement to a total out-of-pocket monthly cost of \$160 per month. Not surprisingly, the increase in insurance premiums for those who had ESI but not RHI was even higher. Compared to costs immediately following retirement, when these men could continue receiving coverage through COBRA, the monthly out-of-pocket insurance costs rose by almost \$200 to approximately \$250 a month after 18 months when COBRA benefits expired. The finite period of COBRA eligibility forced retirees to enter the individual market, where their average monthly premium costs rose to approximately \$300 for relatively healthy men and to more than \$400 for men with health problems. Based in part on these significant cost increases, the researchers found that retirement rates for male workers with ESI but not RHI were substantively lower than those for male workers who did receive RHI from their employers.

The Medicare Buy-In Policy Option

Many workers who are forced to retire before age 65 because of health problems lack sufficient financial resources to purchase coverage, which raises the question of how to make coverage accessible to the near-elderly before they become eligible for Medicare benefits. The Clinton administration put forth a proposal designed to address this issue without increasing the financial strain on Medicare by allowing retirees younger than 65 to buy into Medicare after COBRA benefits expire. While the proposed \$310 monthly premium (in 1999 dollars) seems high compared to the premium

costs of RHI or COBRA, it is generally less costly than other options for many retirees who, in many cases, would pay higher-than-average premiums in the individual market due to poor health status.

In order to inform the debate on this controversial Medicare reform proposal, the researchers simulated the impact of the Medicare buy-in proposal outlined above on retirement behavior. The results of the simulation models indicate that the impact of a Medicare buy-in program on early retirement decisions depends critically on the premium cost to participate. If premiums were set high enough so that the buy-in program was cost-neutral and did not require subsidies from the rest of the Medicare program, the effects on early retirement would be quite small, increasing retirement rates for full-time workers with ESI but not RHI by no more than 6 percent. Retirement rates would increase more substantially, however, if premiums for the buy-in program were means tested. Under a pricing scheme where premiums were fully subsidized for workers in the bottom 20 percent of the income distribution, the researchers estimated that a buy-in program would increase overall retirement rates among those age 55-61 with ESI but not RHI by 17 percent for men and 18 percent for women.

Questions for Future Research

The Urban Institute researchers note that proposals such as the Medicare buy-in program are well-intentioned, aiming to slow erosion in health insurance coverage for the near-elderly. Johnson argues, however, that the commendable intentions of the buy-in proposal must be weighed against the consequences of promoting early retirement, which he says is undesirable because of mounting concerns over who will support the growing numbers of retirees in the future.

"Do we want to encourage people to work longer?" is the question that Johnson says must be considered when evaluating changes to both Medicare and Social Security reforms. Another question is whether funds that would be put toward paying for the Medicare Buy-In program should be used to pay for prescription drug benefits for Medicare beneficiaries. These questions and others will continue to be addressed in this upcoming election year. Although the grant period has ended, the Urban Institute researchers are continuing to work on the project and are refining their estimates of the effect of health insurance costs on early retirement in preparation for publication. ■

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