The Implications of Declining Retiree Health Insurance

Courtney Monk
Alicia H. Munnell
Center for Retirement Research at Boston College

11th Annual Joint Conference of the Retirement Research Consortium

August 10-11, 2009
Washington, D.C.

This research was supported by a grant from the U.S. Social Security Administration (SSA) as part of the Retirement Research Consortium (RRC). The findings and conclusions expressed are solely those of the authors and do not represent the views of SSA, any agency of the Federal Government, or Boston College.
Introduction

Once relatively common in the United States, employer-sponsored retiree health insurance (RHI) is now on the decline. Rising health costs, higher life expectancies, and changes in accounting rules have all increased the pressure on companies like General Motors, Ford, Caterpillar, and IBM, as well as state and local governments. As the health care liability for current and future retirees grows too big to manage, public and private employers alike are cutting these benefits. Using data from the 1998 to 2006 waves of the Health and Retirement Study (HRS), this paper seeks to determine the potential impact of a full withdrawal of RHI for both those under and over 65.

Results

Because of the importance of Medicare, the analysis focuses on two groups of retirees: those 55 to 64, young retirees for whom RHI may be their only health insurance, and those 65 and over, Medicare-eligible individuals who use RHI as a supplement to their basic Medicare benefits. Our analysis for people between ages 55 and 64 focuses primarily on how the elimination of RHI would change the retirement decision. For Medicare beneficiaries age 65 and over, we first determine what type of supplemental coverage, if any, RHI holders would buy if RHI were no longer available, and then consider the secondary impacts on spending, utilization, and health outcomes of this change in supplemental insurance.

A. RHI and the Retirement Decision

For individuals aged 55 to 64, we are interested in the effect of RHI on the retirement decision, controlling for observable characteristics, in order to predict what retirement choices these people might make without RHI, ceteris paribus. Because having access to RHI is only one of many reasons that people choose to retire, a multivariate analysis is required to find the conditional probability of retirement.¹ The sample is comprised of those observed to be working in the current wave of the survey,

¹ These retirement regressions assume that the offer of RHI through one’s own or a spouse’s employer is exogenous. This may be wrong if those with RHI consider it in their job choice, or if employers that offer RHI also encourage early retirement, for example through offering a defined benefit (DB) pension or higher quality pension benefits (Gruber and Madrian 2002). Unobserved job conditions can also create endogeneity issues. We have tried to assuage these criticisms by including control variables for job history and pension type, though we acknowledge that bias may still remain.
and the dependent variable is a binary indicator of whether someone is retired or working in the next wave of the survey (two years later), where “retired” is defined as being partly or fully retired. The regressions control for several factors that affect the decision to retire, such as gender, wealth, health, pension coverage, and self-assessed life expectancy. The focus is on having access to an RHI plan from a current or former employer, or a spouse’s current or former employer, that covers the respondent up to age 65; we use dummy variables for having the RHI offer at different ages.

We find a strong positive effect of the availability of RHI on retirement hazard. Figure 1 shows the marginal effects, evaluated at the means of the other variables, of the RHI offer at each age for married individuals. RHI has the greatest impact at ages 57 to 62. The findings imply that the average marginal effect of the RHI offers at each age is between 6 and 7 percentage points, for both single and married individuals. In other words, if we use just one dummy for the RHI offer, rather than the RHI offer at each age, the coefficient is about .07 for singles and .06 for married individuals.

Figure 1: Marginal Effect of the RHI Offer on the Probability of Retirement, Married Individuals Aged 55-64, 1998-2006

Source: Authors’ calculations from the HRS, using cross section sample weights.

The simulation shows that among those with the RHI offer, an elimination of RHI would lower the conditional retirement rate from an average of 26 percent to 18 percent.
Given the proportion of workers with an RHI offer at each age, the total number of people who are working at the ages of 55 to 64 would increase by about 7 percent. In short, an RHI withdrawal could cause a shift in labor force participation among older workers. But a sizable number of individuals would still decide to retire in spite of the elimination of the RHI offer, and they would need to find some source of protection. Just over a quarter of them could go on their spouse’s employer-provided plan, but the rest would need to find a non-employer source of health coverage. Thus the elimination of RHI would have the biggest impact on those who would still retire even without RHI but then have to turn to COBRA or private non-group insurance upon retiring, or risk going without health insurance.

B. RHI and Supplemental Insurance Coverage for Retirees

For Medicare beneficiaries, an elimination of RHI would affect first and foremost choices about supplemental coverage. To determine what type of supplemental coverage RHI holders would choose if RHI were not available, a multinomial logit for insurance choice is used. The regression creates a sorting mechanism which, based on observable characteristics, predicts the probability of choosing each type of supplemental coverage. The supplemental insurance options, which exclude RHI, are: 1) basic Medicare (no supplemental); 2) Medicare HMO; and 3) Medigap.

The control variables include demographics, job characteristics, risk aversion, and financial planning horizon. The results show that in general, those who are white, educated, wealthier, and non-smoking are more likely to choose Medigap in preference to basic Medicare. Interestingly, the results also reveal evidence of adverse selection into both Medicare HMOs and Medigap. The implication is that those who are sick carry more insurance coverage. In addition, the regression results show that being risk-averse is associated with a greater likelihood of buying Medigap coverage.

These multinomial results make it possible to determine, based on observables, the relative likelihood of the RHI holders choosing one of the alternative insurance

---

2 29 percent of those who retire and have an RHI offer have a spouse with his/her own employer-based coverage that is not RHI. Our calculation assumes that this figure would be the same for those who do not choose to keep working in response to the RHI withdrawal. However, the worker’s retirement decision may be altered if the spouse has his/her own coverage, though this variable is insignificant when added to the retirement regressions.
categories if they did not have RHI. This computation predicts that about one quarter of RHI holders would go into basic Medicare, one quarter would choose a Medicare HMO, and about half would go into a Medigap plan.

Figure 2: Mean 2-Year Spending For RHI Holders Before and After Switching, 2006 (2006 Dollars)

With the sorting knowledge from the multinomial logit, we can make some informed predictions about what might happen to spending and utilization after switching insurance. Figure 2 shows that total spending would fall for those who take up basic Medicare and a Medicare HMO. Conversely, the Medigap group would see a rise in total spending. Most of the change in spending would come from a change in premiums: downward for basic Medicare and HMOs, but upward for Medigap. OOP spending would rise for everyone except those in a Medicare HMO. We also estimate the long-term impact of the change in spending, projected over the expected lifetimes of the participants, assuming that health care spending increases in line with projected increases in Medicare costs, and find that the projected effect on spending would be small.

3 In our analysis, we ignore any general equilibrium effects by which an increase in demand could affect the price, and thereby the demand, for the various products. We also assume that RHI holders age 65 and over are not unobservably different, in a non-random way, from other Medicare beneficiaries.
The next question is what impact the shift in coverage would have on utilization. The results show that, in general, RHI holders would use less medical care once they switched to a different insurance category. Although the number of doctor visits would mostly stay the same, the use of most other kinds of services would drop. The sizes of the declines are largest for those who choose basic Medicare.

The last question of interest is how the elimination of RHI could affect health outcomes. The difficulty in answering this query is that various measures of health, both self-assessed health and illness indicators, are functions of a multitude of observable and unobservable factors. Instead, we argue that a change in supplemental insurance should not affect health for two key reasons. First, health is a persistent, auto-regressive process. Prior health is the most important driver of current health and dwarfs most other factors. So health today is more a function of health yesterday than of type of insurance, especially when Medicare acts as a safety net for the elderly. Second, existing research shows that although going from no insurance coverage to some can affect health (Card, Dobkin and Maestas 2007; Lichtenberg 2002; and Decker 2005), a change from one type of insurance to another does not. The most convincing evidence of this is the RAND Health Insurance Experiment, the only randomized experiment with health insurance, which found no significant effects on health of different types of insurance coverage, even though utilization varied (Newhouse, 1993).

**Conclusion**

Our findings have implications for policymakers who are concerned with the ramifications of the decline of RHI. First, if individuals work longer, this could produce improvements in retirement security in general (see Munnell and Sass, 2008). Second, if the employer-sponsored model of health insurance persists, as it is very likely to do, then a continued decline in RHI would create a large pool of early retirees with a substantial, untapped demand for health insurance. At some point, it would seem logical for insurers to step in to provide more affordable plans for these early pre-Medicare retirees. Policymakers may want to consider encouraging insurers to do so.