

### Concerns about health insurance and retirement

*Health Insurance Coverage in Retirement: the Erosion of Retiree Income Security.* By Christian E. Weller, Jeffrey Wenger, and Elise Gould, Economic Policy Institute, Washington, DC, 2004, 64 pp., \$11.50/paperback.

In *Health Insurance Coverage in Retirement: The Erosion of Retiree Income Security*, authors Christian E. Weller, Jeffrey Wenger, and Elise Gould examine health insurance coverage for two age groups in the year 2002: the near elderly (between ages 55 and 64) and the elderly (those 65 and older). The writers attempt to provide a picture of the health insurance coverage of retired Americans by comparing their coverage with that of the population at large and that of the near elderly who remain employed. The authors' premise is that both income security for retirees and the percentage of retirees with employer-sponsored insurance (ESI) have fallen over the years. If this premise is correct, it will be particularly disconcerting for a large number of "baby boomers" (defined as those born between 1946 and 1964) who are already retired or who will retire in the next two decades.

One might be tempted to dismiss this 8-year-old book because of recent reforms in the health insurance industry—in particular, two landmark laws: the Medicare Modernization Act, signed into law by President George W. Bush on December 8, 2003, and the Patient Protection and Affordable Care Act, signed into law by President Barack Obama on March 23, 2010. But that

would be a mistake. This one convenient book contains an extensive set of tabulations that provides a historical perspective of the health insurance status of Americans retirees. Anyone studying trends in health insurance coverage will find the book useful.

The book is well organized. It steps the reader through previous literature on the topic and guides the authors' choice of tabulations found throughout the pages of the volume. The literature presented exhibits links between health status and demographics such as educational attainment, income, and race. To set the stage, Weller, Wenger, and Gould summarize the rapid rise in healthcare spending from 1980 to 2002. They cite data which show that nominal per-capita healthcare spending quadrupled in those 22 years, from \$1,067 in 1980 to \$5,427 in 2002. To temper optimism about the improvement in the overall health status of those 55 and older during this same period—which would presumably aid in slowing expenditure growth—the writers cite information from the Centers for Medicare and Medicaid Services which project that national per-capita healthcare expenditures will likely continue to increase by 5 percent to 6 percent annually, a rate that is much more rapid than the average annual increase in national income.

The authors argue that a number of factors have led to rising health care spending, not least "changing demographics, availability of health care services and improved technology." Of course, easier access to improved healthcare for a growing and aging population is, in and of itself, important for society, but Weller, Wenger, and Gould contend

that external factors have accelerated medical costs at the same time that health insurance coverage has declined among retirees. Added to these factors is medical-care price inflation: the authors show that medical care prices have increased much faster than overall prices—276 percent, compared with 110 percent, over the same 22-year period.

Given these stark statistics, Weller, Wenger, and Gould draw the broad-brush conclusion that both those retired in the near elderly (55 to 64) age group and those retired in the elderly (65 and above) age group have declining retirement income security. The evidence they present is not conclusive, however, resting principally on the declining incidence of private insurance coverage. That is indeed an important metric to use in assessing retiree income security, but there should have been more to their story. Because most retired persons 65 and older have guaranteed public health coverage through Medicare, evaluating only the incidence of private insurance coverage leaves the story wanting.

To be fair, Medicare does not cover all health expenditures of the elderly; therefore, many retirees insure against large health-expense episodes by acquiring supplemental insurance. The authors' tabulations show that insurance sponsored by previous employers has been an important source of this supplemental coverage. Tracking the trends in ESI coverage for the retired in part assesses that group's income security. However, the authors' tabulations also show that ESI coverage among the elderly retired declined by less than 1 percent from 1996 to 2002, a percentage that is too little to make a case for an erosion of income

security. This assessment is not to suggest that the elderly are not increasingly at risk, but the incidence statistics alone fail to shed much light on the premise. For instance, even though the incidence of ESI coverage for the Medicare-eligible retired has remained largely unchanged, little is known about what might be happening to plan provisions (products and services covered by insurance plans) and cost-sharing parameters such as deductibles, co-pays, coinsurance, and premiums. If there has been a contraction in provision coverage or a rise in retirees' share of costs, then, arguably, retiree incomes are less secure.

For the near-elderly retired, the authors' incidence statistics provide a much clearer picture of eroding income security. Since retirees younger than 65 are ineligible for Medicare, some sort of coverage would seem essential to insure against large, unexpected health-related costs. For near-elderly retirees, private coverage comes mainly from either ESI or nongroup insurance. (Only 10 percent of the near-elderly retired had nongroup coverage, and that rate has remained stable over the years, a fact barely mentioned by the authors.) Using the Current Population Survey, Weller, Wenger, and Gould show that 78 percent of the near-elderly *employed* had coverage provided by their own employer or were covered as a dependent in 2002. That rate was markedly higher than the 54-percent ESI coverage of the near-elderly retired. The authors further show that ESI coverage among early retirees has trended

downward, from 57 percent in 1996 to 54 percent in 2002. The downward trend certainly supports the authors' premise.

What is most disconcerting is the large increase in the number of uninsured among the near-elderly retired. One-third more were uninsured, compared with those in the same age group who continued to work. (The percentages are 21 percent and 14 percent, respectively.) The much higher rate of uninsured among the early retirees puts these individuals and their families at greater financial risk than the insured, a fact that also supports the premise of the book. The large numbers of discouraged workers currently leaving the workforce because they believe that there are no jobs for them is likely to exacerbate the situation, in this reviewer's opinion.

The incidence of public insurance in 2002 was much higher among retirees (12 percent) than the employed (2 percent). Public insurance for those too young to qualify for Medicare typically is administered through joint federal-state Medicaid programs. As the literature presented in the book suggests and the tabulations support, those in poor health are least likely to have ESI and more likely to have public coverage, as are those who have the least number of years of education or fall into the lowest income stratum. These relationships hold whether the individual is employed or retired. However, the near-elderly retired who are in poor health are 3 times more likely to be covered by public insurance than their working

counterparts (33 percent versus 11 percent).

Similar comparative statistics between retirees and workers hold for the least educated and lowest income groups as well. No cross-tabulations were made among poor health status, educational attainment, and income, but it is reasonable to presume that these classifications are also strongly correlated. What the tabulations in the book clearly show is that, were it not for public health coverage in the absence of ESI, some of the early retirees who are among the least healthy would be in severe financial stress today.

Although the book provides a wealth of health-insurance statistics, the authors' premise that retiree income security has been eroding remains unproven. The evidence presented that Medicare-eligible retirees have had their income security erode over the years is simply inconclusive. Only among early retirees—especially the growing percentage of these individuals without any health insurance coverage—do the authors offer strong evidence that their income security has been eroding.

I recommend this book to anyone with an interest in health insurance statistics and retirement income security. □

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