

ISSUE BRIEF

Examining the Links between Retirement and Health Insurance: Implications for Medicare Eligibility

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A discussion featuring

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Links between Retirement and Health Insurance

Beginning in 2011, America's giant baby-boom generation will begin turning age 65—the age at which most Americans now become entitled to receive full Social Security and Medicare benefits. Several policymakers have begun to question the validity of this eligibility age during a time when many older Americans are living longer and healthier lives.

Indeed, the 1983 Social Security program amendments raised the normal retirement age from 65 to 67—a change that is being phased in beginning in 2003 and will be complete in 2027. The early retirement age of 62—at which beneficiaries can claim reduced benefits—will remain under the changes adopted in 1983, but the benefits available at that age will decline as the full retirement age increases.

Social Security reform proposals under consideration by Congress would raise the normal retirement age even higher. Bipartisan legislation (S. 2313, H.R. 4256) introduced last year by Sens. John Breaux (D-La.) and Judd Gregg (R-N.H.) and Reps. Jim Kolbe (R-Ariz.) and Charles Stenholm (D-Texas) would provide for a phased-in increase in the normal and early retirement ages, up to a normal retirement age of 70 in the year 2037 for individuals attaining early retirement age in the year 2029. After 2029, further increases would be indexed to changes in life expectancy to maintain expected years in retirement at a constant level. The bill was based on recommendations developed by the National Commission on Retirement Policy. A bill (S. 21) introduced early this year by Sens. Daniel Patrick Moynihan (D-N.Y.) and Robert Kerrey (D-Neb.) would also tie benefit levels to projected increases in life expectancy. Thus, if life expectancy increases, the level of monthly benefits payable at age 65 decreases. Both proposals would almost certainly guarantee that the age at which beneficiaries could receive full benefits would keep going up.

Several Medicare reform proposals have also called for increasing the eligibility age. In 1995, the Senate considered but quickly dropped a provision that would have raised the Medicare eligibility age from 65 to 67 in the year 2000. In 1997, the Senate passed a similar proposal as part of its budget reconciliation package, which would have begun implementation in 2002, but the provision was removed before the legislation went to the president. In 1999, as a starting point for the

Bipartisan Commission on the Future of Medicare, Statutory Chairman John Breaux presented a comprehensive proposal that contains a provision to increase the Medicare eligibility age from 65 to 67 over a 24-year period. Rep. Bill Thomas (R-Calif.), administrative chairman of the Medicare Commission, has suggested linking Medicare eligibility to health or disability status rather than age.

On the other side of the spectrum, some policymakers would provide access to Medicare for individuals under age 65. President Clinton's budget for fiscal year 2000 includes the proposal (S. 202) introduced by Sens. Tom Daschle (D-S.D.), Moynihan, and Edward M. Kennedy (D-Mass.) that would allow Americans between age 62 and 65 to buy Medicare coverage. In addition, the proposal would offer the Medicare buy-in option to workers between the ages of 55 and 62 who have lost employer-sponsored health insurance coverage because their hours were scaled back or their employer relocated or stopped operations. Moreover, retirees between the ages of 55 to 65 whose employer-sponsored retiree health benefits have been canceled would be guaranteed the option to "buy in" to the employer-sponsored plan at a "fair price."

Proposals to increase the retirement age are implicitly based on the assumption that elderly persons are increasingly able to continue working beyond age 65.

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This assumption is not consistently supported by past trend data, although it may be true of tomorrow's elderly. In any case, physical ability to work is clearly only part of the equation. The elderly person's ability to maintain his or her lifestyle through pensions and other retirement income sources and avoid erosion of retirement income with adequate and affordable health insurance protection are equally, if not more, important.

To assess the impact of these proposals on future work and retirement patterns, it is important to understand recent trends in retirement and health insurance status for older Americans. Working in collaboration with the Employee Benefit Research Institute (EBRI), NHPF is expanding distribution of an EBRI issue brief, "Retirement Patterns and Bridge Jobs in the 1990s," written by Joseph F. Quinn of Boston College, that describes post-World War II labor force participation trends for older Americans. The issue brief also discusses the correlation of retirement decisions with the individual's health, age, health insurance, and pension status.

This Forum session will examine trends in labor force participation and health care coverage for early retirees, as well as the relationship between health insurance and retirement. In particular, the discussion will focus on the extent to which policy changes that impact the availability of health insurance for older workers and retirees affect their labor force participation as well.

AGING OF THE POPULATION

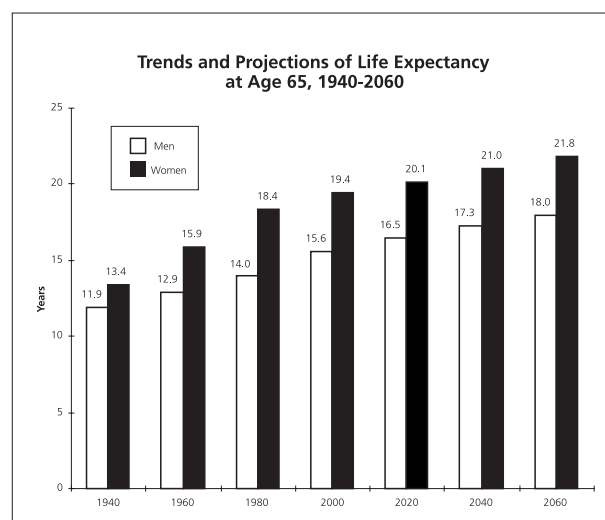
The composition of the U.S. population is changing dramatically as the baby boom generation (born between 1946 and 1964) ages. Individuals aged 65 and older will make up a rising share of the population, increasing most rapidly between the years of 2010 and 2030 when the baby boom generation reaches age 65. The Bureau of the Census projects that by 2030 there will be about 70 million older Americans, more than twice the number in 1995.

Americans continue to live longer and life expectancy trends are likely to continue upward. In 1940, the life expectancy of persons at age 65 was 12 years for men and 13 years for women.¹ By 1995, life expectancy at age 65 improved to 15 years for men and 19 for women, and by 2040, it is projected to be 17 years and 21 years, respectively, according to the Social Security Administration's (SSA's) intermediate actuarial assumptions (Figure 1).

The number of young and middle-aged people available to support a growing number of elderly people

will be relatively fewer. Between now and 2030, the retirement age population (aged 65 and older) will double, while the working-age population (ages 20 to 64) is expected to grow by only about 15 percent. Under most plausible assumptions about the future course of births, deaths, and immigration, old age dependency ratios—that is, the number of older people divided by the number of working-age people—are expected to be much higher than they are today. In 1990, the old age dependency ratio was 0.21—or one older person for every five working-age people. By 2035, when all the baby boomers reach age 65+, the ratio is projected to nearly double to 0.40—a two-to-five ratio.²

Figure 1



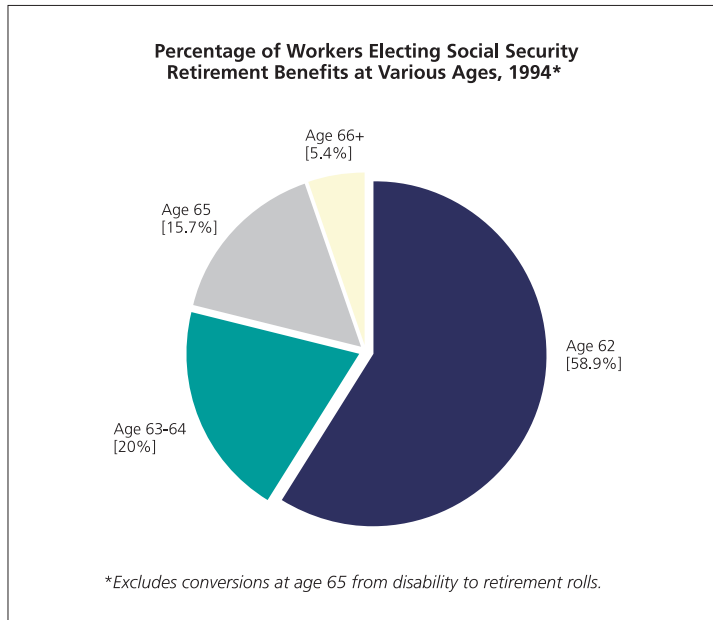
Note: Projections for 2000-2060 are based on the trustees' intermediate actuarial assumptions.

Source: 1996 Annual Report of the Board of Trustees of the Federal Old Age and Survivors Insurance and Disability Insurance Trust Funds.

TRENDS IN RETIREMENT

While Americans are living longer than ever before, paradoxically they are working less. Today, approximately 80 percent of Social Security beneficiaries claim retirement benefits before the age of 65, electing reduced benefits.³ This is a significant increase since 1965, when only about 40 percent took early benefits. Over half of American workers start receiving Social Security retirement benefits at age 62, when they first become eligible (Figure 2).

Labor force participation rates for older males have been declining rapidly over the last three decades. In

Figure 2

Source: Committee on Ways and Means, U.S. House of Representatives, 1996 Green Book, Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means (Washington, D.C.: U.S. Government Printing Office, November 14, 1996), Table 1-9.

1950, nearly 50 percent of American men aged 65 and older were still in the workforce; by the 1990s, fewer than 20 percent of men continued working past age 65.⁴ Labor force participation rates of workers under age 65 also declined between the mid-1960s and mid-1980s. According to SSA researchers, during this time period there was a 30 percent decline in participation rates among men aged 60 to 64, a 14 percent decline among men 55 to 59, and a 7 percent decline among men aged 50 to 54. However, as the EBRI issue brief points out, this trend came to a halt in the mid-1980s. Since 1985, male labor force participation rates have been flat and have actually increased over the past several years (Figure 3).

Older women's participation rates did not mirror those of men because of the offsetting phenomenon of increasing numbers of married women entering the labor force during the post-war period. As a result, older women's labor force participation rates were relatively steady, rising or falling very slowly between 1964 and 1985. Since the mid-1980s, EBRI's issue brief notes, older women's labor participation rates have increased significantly.⁵ Labor force participation rates of both older men and women since 1985 are much higher than the pre-1986 trends predicted.

Surveys of baby boomers indicate that most plan to continue working—at least part time—past age 65. A recent survey of 2,000 baby boomers ages 34 to 52 by the American Association of Retired Persons (AARP) found that 80 percent expect to keep working at least on a part-time basis after retirement.⁶ But these figures contrast sharply with the current labor force participation rate of 22 percent for Americans ages 65 to 69 (28 percent for men; 18 percent for women), raising doubts about the future scenario predicted by these boomers.

Current retirees have reported that they retired earlier than they had planned. The 1997 EBRI Retirement Confidence Survey found that 44 percent of current retirees had retired earlier than expected, often for reasons beyond their control.⁷ Sixty-five percent cited changes at their company such as downsizing or closure, and 41 percent cited health reasons. On the other hand, 62 percent reported that they retired earlier than planned because they could afford to do so.

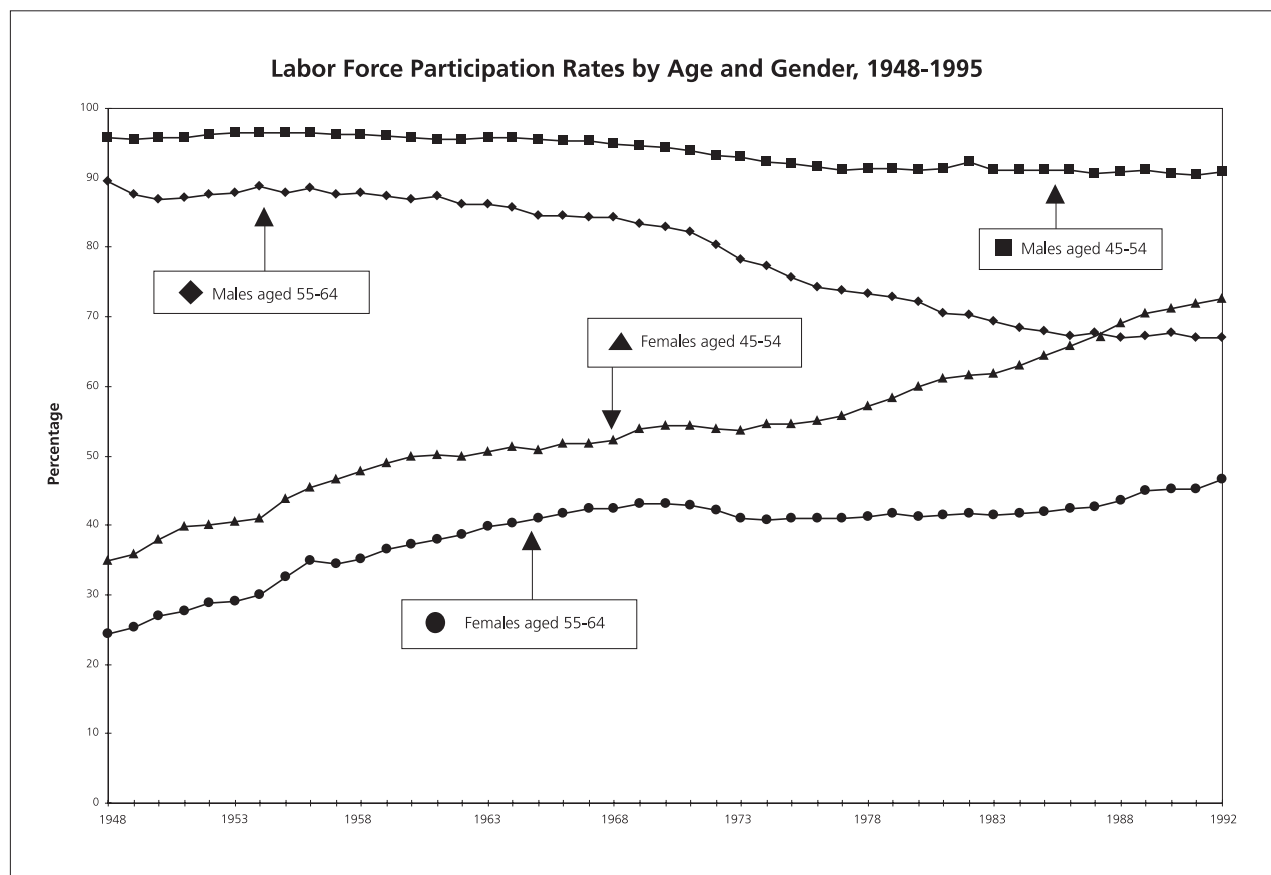
SSA researchers⁸ have identified three main reasons that older Americans choose to retire early:

- They can financially afford retirement.
- Poor health forces them to withdraw from the workforce.
- Suitable jobs may not be available to them.

Poor health was considered a primary cause of retirement in the 1970s. However, later work by SSA researchers suggests that the decision to retire is based primarily on financial considerations. According to SSA, four main variables influence a retiree's financial situation and play a role in the decision to retire early: (a) the level of personal savings and investment, (b) the availability of employer-sponsored pensions, (c) Social Security policy, and (d) access to employer-sponsored health insurance in retirement.

Many analysts have attempted to predict how the baby boomers will fare in retirement. While some studies say boomers are not saving enough to maintain their lifestyles in retirement, most conclude that baby boomers are likely to enjoy higher real incomes in retirement than their parents do. On average, incomes of boomers today exceed, and in retirement are expected to significantly exceed, those of their parents at a similar age. Projections of future incomes using

Figure 3



Source: U.S. Department of Labor, Bureau of Labor Statistics.

middle-of-the-road assumptions about economic growth suggest that married couples will do significantly better than single persons and that single men will have higher incomes than single women.⁹

A recent report by AARP's Public Policy Institute divides the baby boomers into three groups.¹⁰ The first group, comprising roughly the top fifth of boomers, appear to have a secure future with high incomes (more than \$75,000) and are likely to have retirement savings, employer-sponsored pensions, own their own homes, and be protected from high health costs. The second group, comprising more than half of boomers (earning between \$25,000 and \$75,000) generally have less pension coverage, more modest retirement savings, and higher health insurance costs. The bottom quarter or so in the third group have incomes under \$25,000, are more likely to be single-earner households, have more intermittent work histories, lack pension coverage and much savings, and rent rather than own their homes.

The AARP report notes that "the single greatest threat to boomers' economic security in retirement will be whether health costs continue to outpace incomes." According to the Health Care Financing Administration, health costs have far outstripped wages in the last 30 years. And health expenditures are an increasing part of household budgets, especially during retirement.

THE RELATIONSHIP BETWEEN RETIREMENT AND HEALTH INSURANCE

Several studies have shown that there is a strong link between individual retirement decisions and the availability of health insurance coverage.¹¹ More recently, the development of the Health and Retirement Study, sponsored by the National Institute on Aging, has enabled researchers to study the role of a variety of economic incentives on retirement patterns. This is a

national longitudinal study that focuses on individuals born between 1931 and 1941. The first wave of the study in 1992 interviewed more than 9,000 age-eligible respondents; respondents and their spouses are re-interviewed every other year to track retirement patterns. The first survey collected data on demographics, health, housing, family structure, current and past employment, expectations, retirement plans, income, and insurance.

Quinn's analysis of the Health and Retirement Study in the EBRI issue brief shows a strong correlation between health insurance coverage and job transitions late in one's career. As might be expected, individuals who were most likely to lose health coverage if they left their career job were the least likely to leave. Those with health insurance on the job who would maintain coverage even if they left the job (through retiree health insurance, a spouse's policy, private insurance that they were already purchasing, or Medicare) were the most likely to move out of employment. Those with no coverage at all were the most likely to move to another job.

In a 1998 EBRI Health Confidence Survey, 74 percent of workers said they would not retire before becoming eligible for Medicare if their employer did not provide retiree health benefits. Interestingly, the same survey found that 45 percent of respondents planned to retire before age 65, with the mean planned retirement age before age 61. A large number of respondents (82 percent) believed they would need additional health insurance coverage beyond what is provided by Medicare, and 47 percent expected their former employer to provide retiree health insurance.

These expectations are not likely to be met, given that employers continue to drop retiree health coverage. In 1998, the percentage of large employers (500+ employees) providing coverage to retirees not yet eligible for Medicare fell to 36 percent, down from 38 percent in 1997¹² (Figure 4). Those employers providing coverage to Medicare-eligible retirees fell from 31 percent to 30 percent.

The likelihood of an employer's offering retiree medical coverage increases as the size of the employee population increases. Although large employers have been dropping retiree health coverage, the largest—those with 10,000 or more employees—are bucking this trend; since 1996, the percentage of employers this size offering coverage has remained relatively stable. William M. Mercer survey analysts say employers continue to provide retiree medical coverage because of the need to attract and retain employees. In their latest survey, 3 percent of retiree medical plan sponsors actually offered the coverage for the first time in 1998,

and another 9 percent are increasing the covered services they provide retirees.

But those employers that provide retiree health coverage are also asking retirees to pay an increasingly large share of the cost. For pre-Medicare coverage, 36 percent of employers required retirees to pay the full cost of coverage in 1998, up from 31 percent in 1997 and 28 percent five years ago, according to Mercer/Foster Higgins data. When both the employee and retiree share in the cost, the average retiree contribution is 30 percent of premium for both pre-Medicare and Medicare-eligible retirees.

The need for health insurance increases with age. Older individuals are more likely to report that they are in fair or poor health, that they have been diagnosed with a serious health condition, and that they spend a greater proportion of their family income on medical expenses.¹³ EBRI's 1997 Retirement Confidence Survey found that 30 percent of retirees reported that their health had been worse than expected, with 16 percent saying they were not prepared to cover their medical expenses.¹⁴

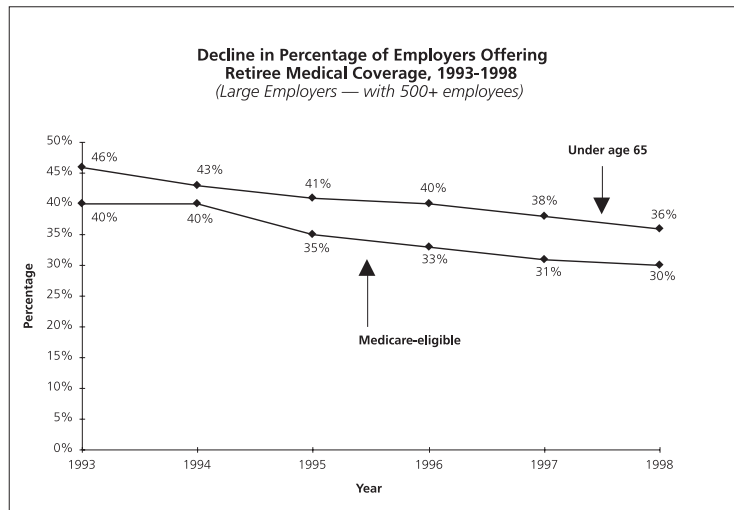
The cost of health insurance also rises rapidly with age. According to Watson Wyatt, in 1994, the average annual health premium cost for fee-for-service policies was \$1,741 for persons aged 40 to 44, \$2,513 for those aged 45 to 49, \$3,362 for those aged 50 to 54, \$4,445 for those aged 55 to 59, and \$5,698 for those aged 60 to 64.¹⁵ Out-of-pocket health costs can also be expected to increase with age, reaching one-fifth of income for those over age 65, according to AARP.

HEALTH STATUS AND RETIREMENT

As indicated earlier, the link between health status and retirement behavior has become less significant over time, as other considerations play a larger role. Many researchers have concluded that most early retirements are voluntary and are based primarily on economic factors. A recent study found that most men and women who claim Social Security retirement benefits at age 62 are in good health.¹⁶ The SSA's Office of Research, Evaluation, and Statistics suggests that health problems may actually provide an incentive for individuals to continue working so that they can retain employer-provided health benefits (if available) until they qualify for Medicare benefits.

However, the Health and Retirement Study found that blue-collar workers are disproportionately affected by health problems and are 80 percent more likely than white-collar workers to experience pain that affects their

Figure 4



Source: William M. Mercer, 1999.

ability to work. As a result, blue-collar workers are more likely to take early retirement than white-collar workers.

Moreover, data have consistently shown that the need for personal assistance with everyday activities increases with age (Figure 5). In his analysis of the

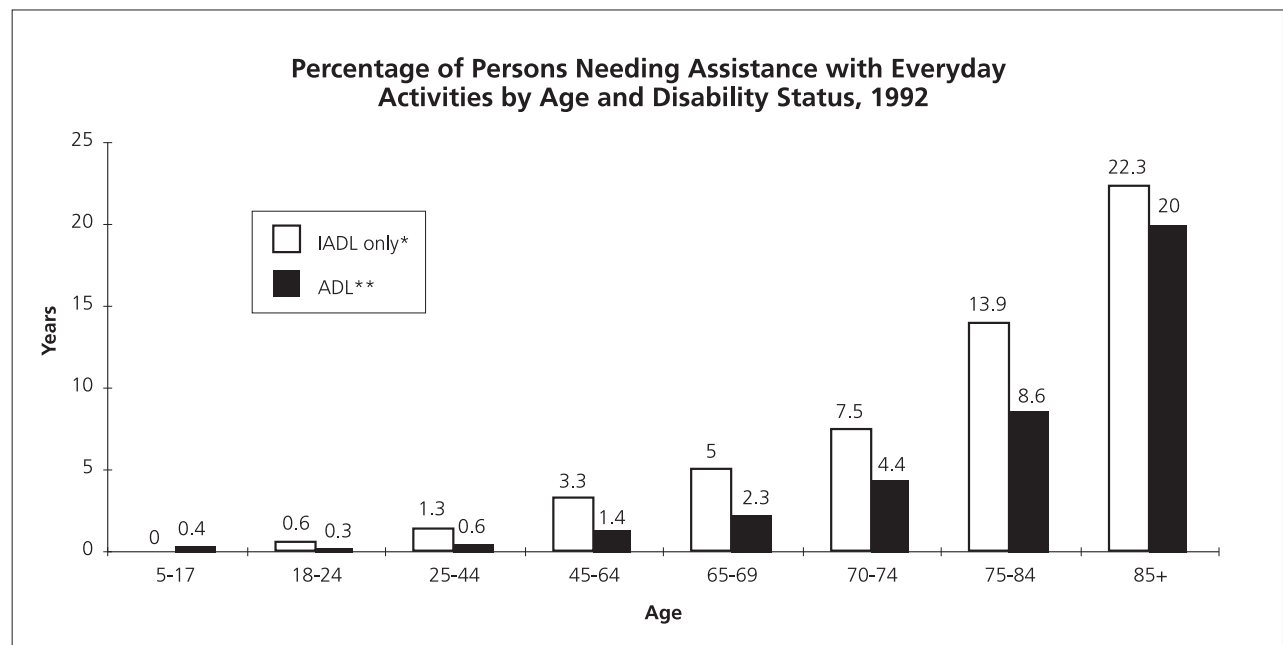
Health and Retirement Study, Quinn notes that the higher the number of activities of daily living with which the respondents reported “a lot of difficulty,” the higher the probability that they had left the workforce.¹⁷

On the other hand, today’s elderly are healthier than their predecessors, and advances in public health and medicine may lead to lower mortality and disability rates in the future. Mortality rates for cancer and heart disease—the leading cause of death for the elderly in the United States today—have been declining.¹⁸

There are indications that the disability rates of the elderly are declining as well. Research at Duke University found that 1.2 million fewer people were disabled in 1994 than would have been expected if the age-specific chronic disability rates of 1982 had prevailed¹⁹ (Figure 6).

Based on data from the 1982, 1984, 1989, and 1994 National Long-Term Care Surveys, they found that disability rates among persons 65 and older declined by 1.3 percent per year between 1982 and 1994. The cumulative effects of a decline at that rate, if borne out by other measures of disability, would be significant for

Figure 5



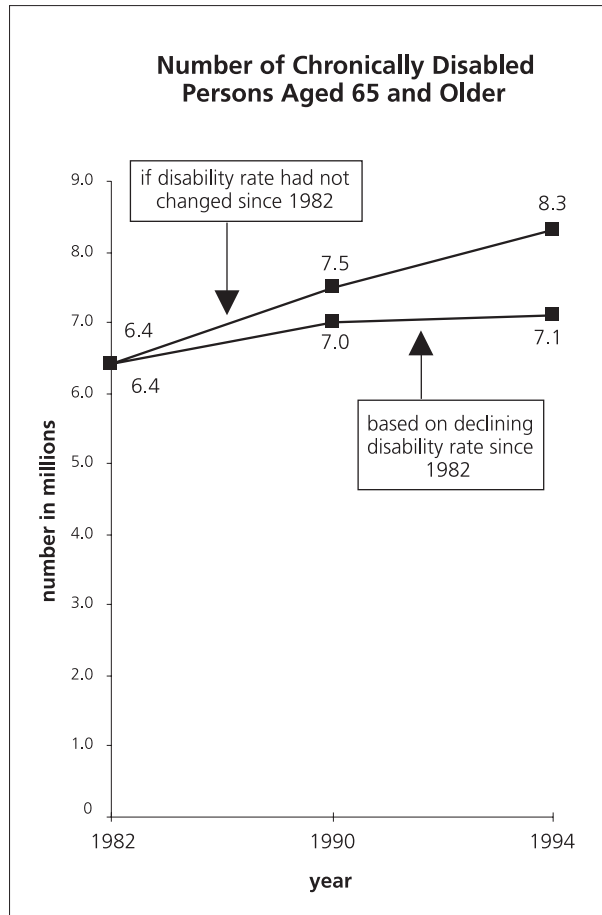
*Instrumental activities of daily living, such as preparing meals, using the telephone, shopping, managing money, and doing housework.

**Routine activities of daily living, such as eating, bathing, dressing, using the toilet, getting in and out of chairs or bed, walking, and getting outside.

Source: Lewis E. Krause, Susan Studdard, and David Gilmartin, *InfoUse*, Chartbook on Disability in the United States, 1996, H133D50017 (Washington, D.C.: U.S. Department of Education, National Institute on Disability and Rehabilitation Research, 1996), 31.

the health, activity levels, health care utilization and spending, and independence of millions of aged individuals.

Figure 6



Source: Population Reference Bureau, *Aging Trends and Forecasts, Issue No. 3, prepared for the National Institute on Aging, National Institutes of Health, May 1997.*

THE FORUM SESSION

This Forum session will examine the recent trends in retirement patterns and health insurance coverage for retirees and their implications for proposals to change the Medicare eligibility age. **Joseph Quinn, Ph.D.**, a professor of economics at Boston College, will describe and discuss labor force participation trends for older Americans and what can be expected in the future. In his presentation, Professor Quinn will also utilize the Health and Retirement Study to show the correlations between labor supply decisions late in life with the individual's health, (measured in several ways), age, and pension and health insurance status. Over the past

20 years, Professor Quinn has researched the economics of aging, with emphasis on the economic status of the elderly, the determinants of the individual retirement decision, and the trends and patterns of labor force withdrawal among older Americans.

Paul Fronstin, Ph.D., senior research associate at the Employee Benefit Research Institute, will discuss the latest data on health insurance coverage of the near elderly (persons aged 55 to 64). He will examine public and private sources of coverage, including trends in the provision of employer-sponsored retiree health coverage. Dr. Fronstin's research interests include trends in health insurance coverage and the uninsured, the effectiveness of managed care, retiree health benefits, retirement transition, employee benefits and taxation, and public opinion about health care.

Brigitte Madrian, Ph.D., an assistant professor at the Graduate School of Business at the University of Chicago, will then discuss her research on the relationship between health insurance and retirement. Dr. Madrian has done extensive research on the effect of health insurance on the employment decisions of individuals, including its effects on job turnover, retirement, unemployment, and self employment.

Following these presentations, several invited discussants will provide commentary on the research and discuss the implications for policy proposals to raise or lower the Medicare eligibility age. Invited discussants include **Marilyn Moon, Ph.D.**, senior fellow at the Urban Institute, who will argue that the Medicare eligibility age should not be raised. Dr. Moon also serves as public trustee for both the Medicare and Social Security trust funds. She has written extensively on health policy, both for the elderly and the population in general, and on social insurance issues. Recent articles include: "Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform" and "Is Managed Care for the Elderly a Threat or a Promise?"

Neil Howe, M.A., M.Phil., senior advisor for the Concord Coalition, will present a case for raising the eligibility age. Dr. Howe has written extensively on budget policy and aging, on attitudes toward economic growth and social progress, and on how generations succeed or fail in creating endowments for their heirs. In addition to his role at the Concord Coalition, Mr. Howe serves as senior advisor on public policy to the Blackstone Group and chief economist for the National Taxpayers Union Foundation.

Joseph R. Antos, Ph.D., assistant director for health and human services at the Congressional Budget Office

(CBO), will discuss the budget implications of proposals currently under consideration to raise or lower the eligibility age. Before joining CBO in 1994, Dr. Antos held senior positions at the U.S. Department of Health and Human Services, including director of the Office of Research and Demonstrations in the Health Care Financing Administration, as well as deputy chief of staff and principal deputy assistant secretary for management and budget for the department. He also held high-level positions at the President's Council of Economic Advisers, the Office of Management and Budget, and the Department of Labor. Dr. Antos has been a member of the National Health Policy Forum's Steering Committee since 1992.

Dale Yamamoto, F.S.A., a principal and actuary for Hewitt Associates, will discuss how employers would likely respond to proposed changes in the Medicare eligibility age. Mr. Yamamoto serves as the national practice leader for the group actuarial practice and for retiree health care consulting at Hewitt Associates, a global management consulting firm. Prior to joining Hewitt in 1991, he had 16 years of professional actuarial experience, emphasizing all phases of actuarial services and employee benefits. He has testified before Congress and published several articles on retiree health benefits, including a report he coauthored, *Retiree Health Trends and Implications for Possible Medicare Reforms*, prepared for the Kaiser Medicare Policy Project.

KEY QUESTIONS

- Are new attitudes developing about work late in life? Can we expect individuals to work longer? Can we expect employers to change economic incentives to encourage individuals to work longer?
- Will technological innovation continue to replace labor, making employment of older workers less attractive? Or, conversely, will technology create new jobs that do not impose physical demands, thereby increasing the likelihood that older individuals will remain in the labor force? Will the economy need more workers because an aging America will have a smaller labor pool?
- If workers ease out of the workforce through "bridge jobs" as Quinn's analysis suggests, are these jobs likely to provide health insurance?
- To what extent does the availability of health insurance affect a person's decision of when to leave the workforce? How does this compare to research regarding the availability of pension benefits?
- How strong a role does health status play in retirement decisions? Do health factors weigh more heavily for certain types of workers or as workers age?
- If the Medicare eligibility age were increased, would workers remain in the labor force longer? Would the number of uninsured increase? If so, by how much? What would be the impact on Medicare program costs? On employer costs? On individual out-of-pocket expenses? What would be the impact if premiums were income-related?
- If individuals under age 65 were allowed to buy in to the Medicare program, would workers be less likely to remain in the labor force? How many individuals would likely take advantage of such a proposal? What would be the impact on Medicare program costs? On employer costs? On individual out-of-pocket expenses?

ENDNOTES

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5. Joseph F. Quinn, "Retirement Patterns and Bridge Jobs in the 1990s," *EBRI Issue Brief*, no. 206, February 1999, 6.
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7. Paul Yakoboski and Jennifer Dickemper, "Increased Saving but Little Planning: Results of the 1997 Retirement Confidence Survey," *EBRI Issue Brief*, no. 191, November 1997, 12.
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