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THE IMPLICATIONS OF DECLINING RETIREE HEALTH INSURANCE

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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.

Because of the importance of Medicare, the analysis focuses on two groups of retirees: 1) those 55 to 64, young retirees (not yet eligible for Medicare) for whom RHI may be their only health insurance; and 2) 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.

For individuals aged 55 to 64, we are interested in the effect of RHI on the retirement decision, controlling for observable characteristics, which is used to predict what retirement choices these people might make without RHI, *ceteris paribus*. Using a multivariate analysis, we find a strong positive effect of the availability of RHI on retirement hazard. The findings imply that the average marginal effect of the RHI offer at each age is between 6 and 7 percentage points, for both single and married individuals. These results are then used to estimate the effect of an RHI withdrawal on the number of people working. Given the proportion of workers with an RHI offer at each age, we calculate that 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.

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 supplemental insurance options, which exclude RHI, are: 1) basic Medicare (no supplemental); 2) Medicare HMO; and 3) Medigap. From the multinomial results, we calculate, based on observables, the relative likelihood of the RHI holders choosing one of the alternative insurance 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.

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. We find 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. We also estimate the long-term impact of the change in spending, projected over the expected lifetimes of the participants, and find that the projected effect on spending would be small.

In terms of 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 last question of interest is how the elimination of RHI could affect health outcomes for Medicare beneficiaries. 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. 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 insurance coverage can affect health (Card, Dobkin and Maestas 2007; Lichtenberg 2002; and Decker 2005), a change from one type of insurance to another should not (Newhouse, 1993).

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.

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