HEALTH CARE, HEALTH INSURANCE, AND THE RELATIVE INCOME OF THE ELDERLY AND NONELDERLY

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In 1960 medical spending accounted for less than 7 percent of total U.S. personal consumption. By 2007 this fraction had risen to almost 21 percent. Strikingly, however, relatively little of the increase in health spending was financed directly out of household budgets. The actual fraction of health care costs paid as out-of-pocket payments by households fell by approximately one-third between 1960 and 2007. Even though employer contributions for health insurance and government health insurance benefits now pay for more than one out of every seven dollars consumed by U.S. households, none of this spending is included in standard measures of income or household well-being. This measurement problem was small when employer premiums and government health benefits accounted for less than 3 percent of total consumption, as was the case in 1960. It is much more important when these funding sources pay for more than 15 percent of personal consumption, as is the case today. Because aged Americans consume a disproportionate share of health care goods and services, and because they receive generously subsidized insurance under public programs, their cash incomes provide a particularly misleading picture of their claims on real resources.

This paper develops alternative measures of income that combine estimates of households' annual cash income and the health care consumption they obtain that is not financed out of current cash income. The Census Bureau has developed comprehensive income measures that include the insurance value of major kinds of government and employer-provided health insurance. However, these measures have rarely if ever been used to assess the relative well-being of the young and the old. We extend the earlier Census analysis by examining the actual distribution of health care consumption and health care financing across U.S. households using information collected in the 1996-2005 Medical Expenditure Panel Survey (MEPS).

Our analysis of the MEPS household files shows that total health spending is very unequal across individuals and households. Most of the variation at the individual level is due to differences in health rather than to differences in household income. Poor health is more common among people in low-income families and among the aged than it is among the affluent and the nonaged. The great majority of consumers with large annual medical bills receive insurance reimbursement that covers most of the cost of their care. In the aggregate, annual insurance premiums are much lower than the reimbursement payments that consumers receive from insurers. For Americans in all age groups, the MEPS household survey indicates that the excess of reimbursement payments over health insurance premiums added 7.6 percent to average gross money income between 2001 and 2005. The additions to income represented a much higher

percentage of money income for the aged than for the nonaged. For an average American between 30 and 34, the excess of reimbursement payments over insurance premiums was 4.6 percent of gross money income; for an average person between 75 and 79, the excess was 26.9 percent of income.

Within each age group, the additions to income from health insurance are larger for people with lower incomes. Among Americans 65 and older who are in the bottom tenth of the old-age income distribution, the excess of insurance reimbursement over premium payments represents 130 percent of their average gross money income. Among aged Americans in the middle one-fifth of the old-age income distribution, the excess reimbursement payments represent only about a quarter of gross money income. The comparable estimates for Americans younger than 65 show much smaller excess insurance reimbursement payments. Younger Americans are less likely to be seriously ill, and a smaller percentage of them receive generously subsidized health insurance. Even among Americans under 65, however, the excess insurance reimbursement payments are proportionately much larger for members of households which have low incomes.

The MEPS household survey provides data that shed light on the generosity of health insurance before and after retirement. These data can be used to calculate a replacement rate that includes the value of health insurance. We use synthetic cohort analysis to obtain an estimate of the change in unearned income, including health insurance, that occurs when a cohort's labor earnings fall as a result of retirement. The results of the analysis suggest that labor earnings of a cohort will decline 70 percent between ages 50 and 71. The total money income of the cohort, including earnings, Social Security, occupational pensions, public assistance, and capital income, falls only about 30 percent. If we use a more comprehensive measure of income, one that includes the excess of insurance reimbursement payments over insurance premiums, the fall in income is just 14 percent. These estimates indicate that the increased value of health insurance protection as a cohort ages is an important source of income protection for the retired elderly.

A comprehensive income definition substantially improves the relative income position of the aged. Under the standard money income definition, both the median and average incomes of aged households are considerably lower than the corresponding incomes for nonaged households. The standard income statistics show that median gross money income in aged households is 28 percent lower than the median income of the general population. In contrast, under income definitions that include the Census Bureau's estimate of fungible insurance value or our estimates of excess insurance reimbursement payments, the median incomes of people in aged households are higher than the population average. In fact, the income distribution of people in aged households is uniformly higher than that of people in households headed by someone under 55.

An important goal of U.S. health policy is to improve access to good health insurance among the elderly and low income populations. Although this goal has not been fully achieved, especially for the nonelderly poor, a large percentage of the poor and elderly are now covered by generously subsidized insurance. Under the broadest definitions of income we consider here, the economic status of America's aged households appears to be approximately the same if not better than that of nonaged households.