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ABSTRACT

This paper begins by noting that at the time that Medicare was enacted in 1965, the plans for funding Medicare through a mix of public and private financing mechanisms seemed quite adequate. It goes on to explain how, 20 years later, the situation is changing enough to create a need to examine whether there is a fairer or more efficient way to maintain current levels of health insurance for the elderly. Of particular interest in this report is the role that employers can or should be expected to play. Data from national surveys and other sources are assembled to provide a description of the employer-sponsored insurance of Medicare beneficiaries currently and to speculate on the future direction of retiree health benefits. The 1977 National Medical Care Expenditure Survey (NMCES) and the more recent Survey of Income and Program Participation are used to examine patterns and trends in enrollment. NMCES provides additional data concerning the payment of premiums by employers and retirees and the provisions of the insurance. Sections of the report focus on current retiree benefits, uneven access to employer-sponsored insurance, and looking to the future. A technical note gives further information on data sources and definitions. (NB)

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Employers and Medicare as Partners in Financing Health Care for the Elderly

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EMPLOYERS AND MEDICARE AS PARTNERS IN FINANCING HEALTH CARE FOR THE ELDERLY

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Employers and Medicare as Partners in Financing Health Care for the Elderly

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I. INTRODUCTION

Medicare, Title XVIII of the Social Security Act, was enacted in 1965 to protect the elderly from major health expenses by providing insurance for hospital and physician care. The program was adopted during a period of sweeping economic and social change accomplished through federal legislation. At the time, when continued economic growth was expected, when budget deficits were less than 1 percent of the gross national product, when the cost of medical care was increasing by only 2.5 percent a year and the elderly were less than 10 percent of the population, the plans for funding Medicare through a mix of public and private financing mechanisms seemed quite adequate. Payroll taxes would go into a Hospital Insurance Trust Fund (Part A, covering hospital, skilled nursing facility, and home health care); premiums paid by beneficiaries and general tax revenues would finance Supplementary Medical Insurance (Part B, covering physician and other ambulatory services); and beneficiaries would also pay for their care directly, through deductibles and other cost-sharing provisions.

Twenty years later, the situation is changing. Sluggish economic growth has slowed the expansion of payroll and income tax revenues, the bulwarks of Medicare financing, at the same time that new medical technologies and more resource-intensive modes of treatment have expanded health care costs. In addition, there are increasingly fewer active workers paying into the system compared with beneficiaries drawing out of it. Demographic projections indicate that the elderly will comprise 12 percent of the U.S. population in the year 2000 and 19 percent in 2030 (Davis and Rowland, 1986). These trends, together with a political realignment that favors reduced public involvement in health care financing and a reduced role for the federal government more generally, are calling into question the assumptions of Medicare's current financing.

Is there a fairer or more efficient way, in the context of these changes, to maintain current levels of health insurance for the elderly? Of particular interest in this paper is the role that employers can or should be expected to play. In 1965 the assumption was that health care for the elderly could not be financed satisfactorily through the employer-sponsored groups that insured most of the nonelderly population. Many fewer elderly persons were employed than nonelderly, and employers were generally unwilling to accept the liability of such a potentially sickly group of enrollees based on past

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employment affiliations. At the time, about 9 out of 10 employees could expect to lose their group health insurance when they retired, although most could convert to a nongroup plan (Skolnik, 1976). This, too, has changed since the advent of Medicare. According to the Bureau of Labor Statistics (1986), currently only 34 percent of full-time employees of medium and large firms have group plans that will not continue after retirement from the firm at age 65. Over two-fifths of elderly beneficiaries with private insurance to supplement Medicare, a third of the elderly Medicare population overall, are now insured by current or former employers. An important difference, however, is the fact that health insurance groups are now responsible only for the expenses of elderly retirees that Medicare does not pay.

The federal government has already taken steps to expand the financing responsibilitites of employers. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) required employers to offer the same insurance as they offer to younger employees to working beneficiaries aged 65 to 69 and made Medicare the secondary payer. This reduced Medicare's liability to covered expenses not reimbursed by the employer's plan. In the Deficit Reduction Act of 1984 (DEFRA), the same rules were extended to the insurance of workers under 65 covering a spouse on Medicare. Federal policy also permits employees to retire on Social Security when they are 62, but does not include them in Medicare until they are 65. This gap is commonly filled by employers, with continuation of health benefits for early retirees. Even without any conscious public policy changes, as new Medicare enrollees with retiree benefits replace the old cohorts who stopped working before such benefits were common, the percentage of the Medicare population that is insured by employers will increase substantially over time.

Nevertheless, there are significant difficulties with the hope of a new partnership between employers and Medicare to preserve the health benefits of the elderly. Most importantly, employer health plans are in much the same situation as Medicare. Like Medicare, they operate on a pay-as-you-go basis, financing the health care of both active and retired employees from the current production of the active workforce. As employees retire earlier and the elderly population grows and lives longer, the higher ratio of retirees to workers raises the cost of retiree health benefits in relation to a firm's output and the wages of active workers (U.S. Senate Special Committee on Aging, 1985). In addition, the sluggish performance of the economy means that employers and workers are not doing that well financially, and they, too, have felt the pinch of health care inflation. Health insurance premiums paid by employers increased as a percentage of total labor compensation at a rate of 5 percent a year between 1970 and 1982 (Chollet, 1984).

If the burden of Medicare on taxpayers is the issue, shifting the burden to employer-sponsored plans that rely on largely the same financing sources--namely, the wages of active workers and corporate profits--is not a solution. Moreover, the future burden on employer plans of paying for promised retiree health benefits is already substantial. As of 1983, unfunded employer liabilities associated with retiree health benefits were estimated by the Department of Labor to be $100 billion (U.S. Department of Labor, 1986).In addition to the already significant burden on employment-related health insurance groups in the future, there is an important difference between them and Medicare that is likely to make employers extremely cautious about accepting a larger role in insuring retirees. Unlike Medicare, according to

recent court decisions, employers are not permitted to modify health benefits that they have either explicitly or implicitly promised to retirees (EBRI, 1985; U.S. Senate Special Committee on Aging, 1985; U.S. Department of Labor, 1986). Thus, to offer benefits to a retiring employee is to risk a 20- or 30-year commitment in the face of an uncertain economic future and the uncertainties of medical inflation and future demand. Also, employers cannot control the future of Medicare itself, and cutbacks in Medicare could greatly increase the financial burden on their own plans.

Another problem is the uneven access to employer-sponsored plans among Medicare beneficiaries, which raises questions of fairness about the burdens distributed among the elderly themselves. Because the availability of retiree health benefits has expanded over time, the oldest beneficiaries (who are in the poorest health on average) are least often enrolled in group plans. Because of their historically lower rate of labor force participation, females are also less likely to be insured by employers. In the future these differences will even out, as today's retirees with employer benefits grow older and the upward shift in female labor force participation is translated into an increase in female retirement benefits. However, there are also marked discrepancies in group enrollment between elderly whites and blacks, and the tight relationship between the lack of retirement income from prior employment (whether private pensions or Social Security) and poverty among the elderly means that the poor as a rule also lack health benefits from a former employer.

Despite emerging interest in the involvement of employers in insuring the elderly, there is not much factual information widely available. In this paper, data from national surveys and other sources are assembled to provide a description of the employer-sponsored insurance of Medicare beneficiaries currently and to speculate on the future direction of retiree health benefits. In particular, the 1977 National Medical Care Expenditure Survey (NMCES) and the more recent Survey of Income and Program Participation (SIPP) are used to examine patterns and trends in enrollment. NMCES provides additional data concerning the payment of premiums by employers and retirees and the provisions of the insurance. (See the Technical Note for more information about the data sources.) The estimates distinguish working Medicare beneficiaries from retirees who are covered by employer plans, as well as beneficiaries insured through their own employers from those insured through their spouses' employers. The former distinction has been important in recent legislation, and both are important in projecting the effects of changing demographics and labor force participation on enrollment in the future.

II. CURRENT RETIREE BENEFITS

Of the roughly 25 million persons aged 65 and over enrolled in Medicare in 1983, about 7.9 million or 31 percent also had employer-sponsored insurance (Table 1). In comparison, only a quarter of the 22 million Medicare elderly in 1977 (5.5 million) had employer-sponsored insurance 6 years before. This amounts to an increase in enrollment of about 6 percent per year. Retirees and their dependents (in contrast to workers and their dependents) accounted for roughly the same proportion of enrollment in 1977 and 1983 among those 65 and older. However, among those aged 62 to 64 there was a substantial shift

in enrollment from active workers to retirees, reflecting the trend toward early retirement.

In 1977, in both age cohorts displayed in Table 1, employers insured about 1 dependent for every 3 retirees or employees. By 1983, this ratio was closer to 1 dependent for every 2 retirees or employees. In both years, employers insured roughly 1 dependent for every 3 retirees 65 and older compared with the higher ratio of 1 to 2 for younger retirees 62 to 64. The latter probably reflects the higher proportion of retirees aged 62 to 64 with a surviving spouse.

As noted earlier, the recent legislative trend is to declare Medicare the secondary payer for claims covered by the insurance of active employees. However, of the Medicare beneficiaries who were covered by employer plans in 1983, only 21 percent were either working themselves or were dependents of active workers. Most were either retirees or their dependents. Thus, even if this policy were carried out to its maximum extent, Medicare's liability for little more than a fifth of its beneficiaries would be affected. Indeed, if the decline in labor force participation of persons 65 and older over the last decade continues as expected, from 16.3 to 13.3 percent of males and from 7.5 to 7.0 percent of females between 1984 and 1995 (U.S. Bureau of the Census, 1985, p. 392), the relative effectiveness of this policy may be diminished somewhat. Further, the policy itself is likely to encourage the trend toward earlier retirement, since firms can reduce their insurance costs by retiring employees who have Medicare.

National data are available only for 1977 with respect to the cost of the insurance provided by employers (Table 2). At that time, employers paid over $1.3 billion, 64 percent of the premiums, for coverage supplementing the Medicare benefits of employees and retirees. Projecting the average premium at the same rate of growth as private health insurance premiums per enrollee overall (13 percent a year between 1977 and 1983; HIAA, 1985), while taking into account the growth in enrollment, yields an estimate of roughly $4 billion in 1983. Most employers offer the same insurance plan to retirees as to active workers (BLS, 1986). However, the average total premium for retirees on Medicare ($498) was about $350 less than the average total premium for workers aged 62-64 in 1977, and the average difference in employer-paid premiums was nearly $300. In short, the cost of retiree health insurance was substantially less than the insurance of active workers under age 65.

This difference is a function of several factors. The main difference, and presumably a major consideration in the willingness of employers to offer retiree health benefits since the introduction of Medicare, is the fact that Medicare and not the employer-sponsored plan is the primary payer for the claims of retired beneficiaries. These savings are reflected in the lower premium that is set for each Medicare beneficiary in the employer's plan. Because employee health benefits have improved over time, the lower average premium for all elderly retirees also reflects the lower premiums of older cohorts who retired some time ago with plans less generous than those currently offered. The increasing breadth of retiree health benefits over time is evident from Table 3, where the inclusion of selected services under the plans of primary insured persons in 1977 is compared by age. For example, only 62 percent of those 75 and older were insured for prescription drugs, an expense not covered by Medicare, compared with 68 percent of those aged 70-74,

and 74 percent of those aged 65-69. Employees and retirees between the ages of 62 and 64 most often had drug benefits (83 percent). Also, fewer elderly retirees have family coverage to insure their spouses, as noted earlier.

Although Medicare is the primary payer for all elderly retirees, there are several ways of specifying the supplementary benefits to be paid under an employer's plan. The beneficiary's out-of-pocket costs and the amount saved by the employer's plan depend on the method specified. A "carve out" provision is apparently the most common (EBRI, 1985). Under this arrangement, benefits under the employer's plan are first calculated without regard to Medicare and are then reduced by the amount that Medicare pays. For example, suppose the employer has a major medical plan with a $50 deductible and 20 percent coinsurance. For a $500 physician bill, Medicare would pay $340 (80 percent of the amount in excess of the $75 Part B deductible) and the employer's plan would pay $360 ignoring Medicare (80 percent of the amount in excess of $50). The employer's benefit is reduced by the $340 paid by Medicare to $20, leaving the beneficiary to pay $140. In effect, the beneficiary is open to whatever cost-sharing is specified by the employer's plan.

Under "coordination of benefits (COB)," the benefits under the employer's plan are again calculated without regard to Medicare, but are available to offset any covered costs not reimbursed by Medicare. In the example above, $160 from the employer defrays all of the cost-sharing left by Medicare, and the beneficiary pays nothing. Thus, in contrast to a carve-out, the beneficiary's out-of-pocket payments are reduced to zero at the private plan's expense. An "exclusion plan" falls somewhere in between, both with respect to the plan's savings and the beneficiary's out-of-pocket expenses. Here the deductible and coinsurance provisions of the employer's plan are applied to the out-of-pocket expenses remaining after Medicare. The employer's plan would pay $88 in this example, 80 percent of the difference between the Medicare cost-sharing of $160 and the plan deductible of $50. Finally, some employers offer reduced benefits to retirees (about 15 percent in medium and large firms; BLS, 1986) compared with active workers, often along the same lines as the "Medigap" plans marketed directly to the Medicare population that specifically cover the program's various deductibles and copayments.

An indirect effect of increasing Medicare's cost-sharing requirements would be to shift more of the financial burden to the employer plans that cover beneficiaries. Under all of the arrangements described above except for the exclusion plan, the employer's plan would probably pick up the entire difference.[1] But who would end up paying the increase in premiums that would result from the increase in benefit payments? If the present shares were maintained, Medicare beneficiaries would pay about a third and employers or active workers would pay the rest. However, conceivably any distribution of the burden of payment among benficiaries, younger workers, and employers could result.[2]

Similarly, the Medicare program could probably also be cut back at the expense of employer-sponsored plans by postponing the age of Medicare eligibility, with the expectation that employers would continue to provide insurance to young retirees. As noted earlier, continued group coverage is already offered by many employers of medium and large firms to early retirees--those between 62 and 65 years of age who are eligible for Social Security but are not eligible for Medicare (BLS, 1986). In fact, more employers offer continued coverage to early retirees than to employees who retire at age 65 when they

are eligible for Medicare. Employers insured 1.7 million early retirees and their dependents in 1983 and 1.2 million in 1977 (Table 1). Employers also paid 72 percent of the premiums in 1977, the same share as for active workers, at a cost of $0.6 billion (Table 2). One could argue that employers expect to insure employees until they are 65, and consequently are willing to do so even if the employee retires. However, to insure all employees for several additional years beyond age 65 is a somewhat different proposition, perhaps unacceptable to employers without a reduction in plan benefits or the employer's share of the premiums. Here, too, especially in the short-run, the issue is how much elderly beneficiaries, active workers, and employers would each end up paying.

III. UNEVEN ACCESS TO EMPLOYER-SPONSORED INSURANCE

The other reason for not hoping for too much from employers is the uneven access of beneficiaries to employer-sponsored plans. Most Medicare beneficiaries lack employment-related insurance (Table 4 and Table 5), despite an increase in the proportion of covered beneficiaries from 25 percent in 1977 to 31 percent in 1983. About 40 percent of elderly Medicare beneficiaries purchased private supplementary insurance directly from insurance companies in 1983, down slightly from 43 percent in 1977, and about 30 percent had no private insurance at all. Some of those without private insurance are covered by Medicaid, but 20 percent of the Medicare population have no supplementary insurance (Cafferata, 1984). They would bear the full brunt of either a cutback in Medicare benefits or a postponement of eligibility in terms of higher out-of-pocket expenses, as would nongroup enrollees in terms of higher premiums (Taylor, Farley, and Horgan, 1984).

Coverage of the elderly Medicare population by employment-related health insurance varies systematically with a number of demographic and economic variables. The extent of employer-sponsored coverage is inversely related to age, with 42 percent of persons 65-69 having coverage in 1983, compared with only 31 percent of those 70 to 74 and about 22 percent of those 75 and older. The oldest age groups are somewhat more likely to purchase other private insurance, but this only partly compensates for their lack of employee coverage. About 27 percent of persons 75 and older and about 31 percent of those 70 to 74 lacked private supplementary insurance in 1983 compared to less than a quarter of the 65-69 age group.

Disparities between males and females reflect historical differences in labor force participation and employment experience. Twenty-seven percent of elderly females on Medicare had employer-sponsored insurance in 1983, about 12 percent as the dependent of an active worker or retiree. About 37 percent of elderly males on Medicare had employer-sponsored insurance in 1983, 26 percent as a result of their own employment. By the same token, married females were almost twice as often insured by employers as females who were not married (including the widowed and divorced). The rise in the proportion of beneficiaries obtaining employment-related coverage since 1977 is evenly distributed by sex, with both groups experiencing an increase of 6 percentage points.

Racial differences in the employment-related insurance of the elderly, as well as in supplementary private insurance more generally, are quite pronounced but have narrowed somewhat since 1977. In that year roughly twice the proportion

of whites had employment-related insurance as blacks (28 percent compared with 15 percent). In 1983, 32 percent of whites had employment-related coverage compared to 21 percent of blacks. As of 1983, whites and blacks had almost the same probability of obtaining employment-related insurance as a retiree (19 percent of whites, 14 percent of blacks), while in 1977 white retirees were almost four times as likely to receive such benefits. Just 17 percent of blacks purchased other private insurance compared with 43 percent of whites, leaving almost two-thirds of elderly blacks without private insurance to supplement Medicare.[3]

Among the elderly, as among the younger working population (Farley, 1986), income and employment-related insurance are tied closely together. Social Security benefits, as well as pension benefits, are important income sources that reflect prior employment experience. Prior employment, in turn, is a necessary prerequisite for enrollment in an employer-sponsored plan. As a consequence, those best able to supplement Medicare out of their own pocket are the most likely to have comprehensive, employer-subsidized insurance, and those least able to pay for uncovered expenses have the least employment-related insurance. Over 50 percent of the Medicare elderly with high family incomes in 1983 were insured through employers, compared with about 20 percent of those with low incomes and just 5 percent of the poor. The connection created by the dual role of employment as a source of income and as a source of insurance is evident in the 57 percent of Medicare beneficaries with employment-related insurance in families with pension income, almost three times the rate as families without a pension. This proportion has increased markedly since 1977 in families with pension income (47 percent receiving health insurance benefits in 1983 compared with only 28 percent in 1977), reflecting the increased growth in retirement benefits since that time.

Note that the situation is made even more favorable for the wealthy by the exclusion of non-cash benefits from taxable employee income, an implicit subsidy that increases in value as income increases. The retirement benefits of highly paid workers are consequently the most highly subsidized. There is also an incentive to substitute health insurance benefits from a former employer for taxable pension income.

Finally, there appear to have been substantial increases in the employment-related insurance of the elderly in the South and West between 1977 and 1983 that were reflected in a decline in the percentage of Medicare beneficiaries without supplementary insurance. The latter figure stayed roughly the same in the Northeast and North Central regions, but there was a shift to employment-related plans from other private insurance.

IV. LOOKING INTO THE FUTURE

Continued enrollment in an employer-sponsored health insurance plan is an attractive retirement benefit. Such plans generally supplement Medicare far more generously than a plan purchased directly from an insurance company at about the same cost (Cafferata, 1984). Not only do employers pay a substantial share of the premiums, but group insurance also offers marketing and administrative economies and safeguards against adverse risk selection that result in lower rates. Furthermore, retiree health benefits receive favorable

tax treatment in comparison to nongroup premiums that have to be paid out of taxable retirement income.

Employers are playing an increasingly significant role in supplementing Medicare, a trend that will continue if present economic and demographic forces are allowed to have their effect. Although employers now insure just 31 percent of the entire elderly Medicare population, 36 percent of recent Medicare enrollees have employment-related insurance. Approximately two-thirds of today's full-time employees are promised private insurance to supplement Medicare, and an even larger number work for firms that offer continuing coverage until age 65 for employees who retire before they are eligible for the program. Enrollment of the Medicare population in employer-sponsored plans will also increase as a result of the dramatic increase in the labor force participation of women, who comprise 60 percent of the Medicare population and will qualify for retiree benefits in increasing numbers.[4] Despite recent court decisions that have limited the flexibility of employers in adjusting retiree benefits to reflect changing economic circumstances, there is no sign as yet of a retrenchment by employers (BLS, 1983; BLS, 1986).

The employment-related insurance of Medicare beneficiares is expanding in terms of the amount of coverage as well as enrollment Because most employers offer the same benefits to retirees as they offer to active workers, the continuing expansion of employee benefits over time is mirrored in the private insurance of retirees. For example, the proportion of 65-69-year-olds with insurance for prescribed medicines was 20 percent greater in 1977 than it was for persons 75 and older. As older retirees die and are replaced by new retirees with more generous insurance, the benefits paid by employer plans will increase.

"Employer-provided health benefits for retirees are a vital part of the developing three-legged stool in health coverage for older Americans--government, employers and individuals," observed Chairman John Heinz during hearings held in July 1985 by the Senate Finance Subcommittee on Savings, Pensions, and Investment Policy. "Instead of growing, though, the employer leg may be on the verge of collapsing. We need desperately to find a way to encourage employers to provide retiree health benefits before the tremendous burden of costs for older American is dumped entirely on the government and the elderly themselves" (Kosterlitz, 1985, p. 1746).

In other words, although a conscious policy decision to shift even more of Medicare's financial burden to employer sponsored plans is appealing at first glance, employers are already uneasy about their present level of commitment. There are also questions of equity and efficiency to be addressed before relying too heavily on this public-private partnership. The 50 percent increase in the ratio of retirees to active workers that is projected in the next 50 years creates the same problem for employers as it does for Medicare and raises the same questions about the burden on younger workers and taxpayers, since both employers and Medicare finance retiree health benefits on a pay-as-you-go basis. Furthermore, unlike the health insurance benefits of active workers, which can be modified from year to year, retiree benefits commit an employer to a specified plan for as many as 20 to 30 years into the future. Not only is this a significant long-term liability, but its actual amount depends uncertainly on future inflation, medical technology, and Medicare policies. Significantly, the Federal Accounting Standards Board now

requires the cost and funding of retiree benefits to be shown on each firm's annual financial statement and is considering disclosure of the unfunded obligations as a liability on corporate balance sheets. Finally, because of the limited and uneven work history of some elderly persons, no policy that operates through employers can reach the entire Medicare population. In this respect, the initial assumptions behind enactment of a public program to finance the health care of the elderly were correct.

The future of the partnership will undoubtedly be shaped by these considerations. In fairness to tomorrow's workers, tomorrow's elderly can probably count on having to pay for a larger share of their health care themselves. The issue is whether or not they and their employers will be encouraged by public subsidies to save now for that day. Although the Deficit Reduction Act of 1984 limited the use of tax-preferred voluntary employee beneficiary associations (VEBAs) to fund the future health benefits of current workers (EBRI, 1985),[5] several proposals make the shift from future, tax-supported Medicare benefits to current tax subsidies explicit. For example, the Health Care Savings Account Act of 1985 (H.R. 3505) would impose a higher Medicare deductible in retirement on employees who elect to participate in a tax-preferred, health IRA.[6] Alternatively, rather than specifically involving health care, the issue can be seen as involving public policies to encourage retirement savings more generally (that would be sufficient to cover the cost of health insurance and health care, as well as other things).

Complicating matters is the long and uncertain planning horizon for both employers and employees. One of the biggest uncertainties is the future of Medicare itself. If there are indeed to be substantial cutbacks in Medicare, either through postponement of eligibility or changes in cost-sharing, the announcement of this decision well in advance of its implementation would facilitate an efficient transfer of financing responsibility to employers and beneficiaries. In any event, in view of Medicare's uncertain future and the other uncertainties of inflation and changing medical practice, some employers are likely to move toward cash rather than in-kind retiree health benefits. Thus, instead of offering to pay whatever expenses Medicare does not cover, the employer would offer a specified cash amount to be used either to buy into the group plan or to pay medical expenses. Such an arrangement transfers the risk of inflation to retirees. However, because employers do not have the same flexibility as Medicare in terms of future adjustments, they may not be able to provide the same protection against such risks.

There will continue to be a substantial proportion of the Medicare population without access to employer-sponsored benefits, a fact with two important implications. First, a significant part of the cost of maintaining health benefits for an expanding elderly population cannot be financed through employers. Separate attention to elderly persons who purchase nongroup insurance or have no supplementary private insurance at all, who are disproportionately poor and disadvantaged anyway, will be a necessary part of any coherent policy. Second, if favorable tax treatment or other financial incentives are needed to encourage the involvement of employers, these inducements will discriminate against a large number of elderly persons who have no way to take advantage of them. As noted earlier, this bias is already inherent in the tax-free status of the health insurance premiums that employers pay for some retirees each year, in contrast to the premiums that other retirees pay directly to insurance companies out of their taxable

income. Subsidies, if offered, should be structured in a more neutral fashion than the targeting of employers alone permits. But this line of reasoning brings one full circle. Rather than fund a universal program of implicit or explicit subsidies for private insurance or private retirement savings, the same tax dollars might be used more fairly and efficiently to fund Medicare directly.

FOOTNOTES

1. Somewhat ironically, there would be no change in the beneficiary's out-of-pocket expenses under either a carve-out or coordination of benefits, although the level of out-of-pocket expense maintained under the two arrangements differs substantially. Since carve-out benefits are reduced dollar-for-dollar by the Medicare benefit, any reduction in Medicare would be fully reflected in the plan benefit. By the same token, the plan benefits that are available to offset out-of-pocket costs under coordination of benefits are generally more than enough to offset the current amount of Medicare cost-sharing. (Note: In the example given, the employer's plan pays only about half the regular benefit.) Consequently, additional cost-sharing requirements would also be fully covered in most situations.

2. The incidence of retiree benefits on active workers versus employers is an open issue. In the long run, one can argue (although perhaps with some difficulty, since the future value of health benefits at retirement is quite difficult to predict) that workers implicitly pay for their own future health benefits through a reduction in current wages. However, the issue here is the short-run adjustment to a cutback in the Medicare benefits of workers who have already retired.

3. A much higher proportion of nonwhites are enrolled in Medicaid, but about 30 percent have no supplementary coverage at all compared to about 20 percent of whites (Cafferata, 1984).

4. The Bureau of Labor Statistics projects that female labor force participation will increase from 53.6 percent in 1984 to 60.3 percent in 1995. Male labor force participation is projected to remain at just over 76 percent during this period (U.S. Bureau of the Census, 1985, p. 392).

5. Prior to DEFRA, tax law permitted employers to pre-fund retiree health benefits through Section 501(c)(9) trusts or voluntary employee benefit associations (VEBAs). DEFRA restricted the use of this funding mechanism by limiting the amount of qualified employer contributions to VEBAs, by requiring actuarial assumptions to be based on current medical care costs and plan experience, and by taxing investment earnings on reserves held in VEBAs. See EBRI (1985) and U.S. Department of Labor (1986).

6. See Bowen and Burke (1985) and the other proposals reviewed by EBRI (1986) as well.

TECHNICAL NOTE

Data Sources and Definitions

The data used in this study were obtained from the 1983 Survey of Income and Program Participation (SIPP) and the 1977 National Medical Care Expenditure Survey (NMCES). The following discussion briefly describes each data base as well as the definitions of employment and insurance status derived from each.

1983 SIPP

SIPP, conducted by the Bureau of the Census, is a longitudinal household survey designed to provide detailed information on the economic circumstances of households and persons representing the noninstitutionalized population of the United States. Sampled households are interviewed every 4 months over a period of 2 1/2 years, with the reference period the 4-month interval prior to the interview month. All persons 15 years and older who are household members at the initial interview are included for the entire length of the survey. The data concerning these adults includes data about their children, so the survey covers the entire population. Within a given yearly panel, sample households are divided into four subsamples or rotation groups of appoximately equal size, with one rotation group interviewed each month. One cycle of four interviews for an entire sample (i.e., one interview for each rotation group) is called a wave. Our estimates are derived from Wave 1 of the SIPP panel, where June was the first reference month of the first reference group. Age, family income, insurance, and employment status in our estimates are defined as of the last reference month for each person, covering the last third of 1983.

During each interview, respondents to SIPP are asked about their labor force activity, the types and amounts of income received, and their participation in various public programs. With regard to the specific interests of this paper, individuals are also asked about their labor force status and employment during each month of the reference period, whether they have ever retired from a job or business, and whether they were covered by private or public health insurance during the reference period. Details regarding private insurance include whether coverage is obtained through a current or former employer or union, whether a person has health insurance in his own name or is a dependent on a health insurance plan, and the months in which the person was covered.

For purposes of our analysis, persons are considered retired if they reported ever retiring from a job and displayed no evidence of employment during the fourth month of the reference period (i.e., no job held during the month regardless of whether they were looking or on layoff). Persons were considered employed if they reported having a job during the month (regardless of whether they were looking or on layoff). Persons who had retired from a previous job but were currently working were also considered to be employed. It was not possible to determine whether employment-related insurance held by such persons was obtained through the current or previous (retirement) job. Once employment status was established, data on type of health insurance and primary insured/dependent status was used to established employment and insurance classifications for persons 62 years of age and older.

1977 NMCES

The 1977 National Medical Care Expenditure Survey (NMCES) is a survey of the health insurance and medical care utilization and expenditures of 14,000 randomly selected households representative of the civilian noninstitutionalized population. The survey was undertaken to provide data for a major research effort in the National Center for Health Services Research and was cosponsored by the National Center for Health Statistics.

Respondents to the survey were asked about their health insurance and expenditures for medical care in 1977 during five interviews conducted over an 18-month period from 1977 to early 1978. A variety of other sociodemographic and economic data were collected, including information on employment status and type of health insurance held by household members throughout the year.

Information regarding private health insurance from the household survey was verified and supplemented by the NMCES Health Insurance/Employer Survey (HIES). By surveying insurance companies, employers, unions, and other organizations named as the source of each household's coverage, HIES provided a detailed description of benefit provisions and premiums, and the distribution of premiums among employers, employees, and other sources.

For purposes of our analysis, individuals 62 years of age and older were considered retired if they were without a job or out of the labor force at the last (Round 5) NMCES household interview. Individuals were considered employed if they held a job for pay during the week preceding the Round 5 interview date. This distinction provides definitions of "retired" and "working" that are comparable to those developed using SIPP and yields estimates of labor force status for December 1977. These definitions have been combined with information on health insurance status during 1977 from both the household and HIES surveys to yield the employment and insurance classes presented in our analyses of NMCES data.

Table 1. Enrollment in employment-related plans by the elderly.

Enrolled in employment-related plans	1977[a]		1983[b]	
	Thousands	Percent Distribution	Thousands	Percent Distribution
Age 65+, with Medicare	5,469	100.0	7,865	100.0
Working primary insured	1,182	21.6	1,644	20.9
Primary insured	701	12.8	935	11.9
Dependent only	481	8.8	709	9.0
Retired primary insured	4,287	78.4	6,221	79.1
Primary insured	3,305	60.4	4,666	59.3
Dependent only	982	18.0	1,555	19.8
Age 62-64	3,313	100.0	3,777	100.0
Working primary insured	2,083	62.9	2,045	54.2
Primary insured	1,573	47.5	1,430	37.9
Dependent only	509	15.4	615	16.3
Retired primary insured	1,230	37.1	1,732	45.9
Primary insured	856	25.8	1,099	29.1
Dependent only	375	11.3	632	16.7

[a]NMCES, Health Insurance/Employer Survey. [b]Survey of Income and Program Participation, Wave 1.

SOURCE: National Center for Health Services Research and Health Care Technology Assessment.

Table 2. Financing of employment-related plans of the elderly (NMCES, Health Insurance/Employer Survey: 1977).

Primary insured persons	Number of primary insured	Mean Annual premium	Source of payment		
			Family	Employer	Other
	Thousands	Dollars	Percent distribution		
Age 65+, with Medicare	4,006	516	31.0	64.3	4.7
Working	701	601	36.9	60.5	2.6
Retired	3,305	498	29.5	65.3	5.3
Age 62-64	2,429	811	26.3	72.0	1.7
Working	1,573	852	26.4	72.0	1.6
Retired	856	736	26.0	72.0	2.0

SOURCE: National Center for Health Services Research and Health Care Technology Assessment.

Table 3. Breadth of employment related benefits by age of primary insured (NMCES, Health Insurance/Employer Survey: 1977).

Primary insured persons	Outpatient physician	Outpatient psychiatric	Prescribed medicines	Dental
	Percent covered for service			
Total	78.1	64.4	74.5	14.4
Age				
62-64	84.1	73.3	82.8	18.9
65-69	73.4	60.7	74.3	12.7
70-74	75.2	60.1	68.0	13.6
75 and older	76.0	54.8	61.7	7.9

SOURCE: National Center for Health Services Research and Health Care Technology Assessment.

Table 4. Private health insurance of the Medicare elderly (SIPP: Wave 1, 1983).

All medicare elderly	Number of persons	With employment-related insurance					Other private	No private
		Total	Active worker	Dependent of active worker	Retiree	Dependent of retiree		
	Thousands				Percent distribution			
Total[b]	25,329	31.1	3.7	2.8	18.4	6.2	39.6	29.2
Age								
65-69	8,461	42.0	6.6	5.3	21.1	9.1	34.1	23.8
70-74	7,051	30.7	3.5	2.2	18.3	6.7	42.8	26.5
75 and older	9,818	21.9	1.4	1.1	16.2	3.2	42.1	35.9
Sex and marital status								
Male	10,306	36.9	6.1	2.4	25.7	2.7	35.5	27.6
Not Married	2,403	20.6	3.1	*0.2	17.1	*0.2	32.9	46.3
Married	7,903	41.8	7.0	3.1	28.3	3.4	36.3	21.9
Female	15,023	27.1	2.0	3.1	13.4	8.5	42.5	30.4
Not Married	9,221	20.3	2.5	*0.5	17.3	*0.1	44.3	35.3
Married	5,803	37.7	1.3	7.2	7.3	21.9	39.5	22.7
Race								
White	22,489	32.4	3.7	2.9	19.2	6.5	42.5	25.1
Black	1,974	20.7	3.1	*0.9	14.2	2.5	17.4	61.7
Family income, adjusted for family size								
Poor	3,080	4.7	*0.8	*0.1	3.7	*0.1	29.7	65.6
Near Poor	2,358	8.9	*0.8	*0.4	6.7	*0.9	41.3	49.8
Low	5,621	19.8	*1.0	*0.6	15.3	2.9	48.0	32.2
Middle	9,504	41.7	4.0	3.1	24.9	9.7	39.9	18.1
High	4,765	51.0	9.6	7.7	24.3	9.4	34.8	14.2
Family pension benefits								
Yes	7,739	56.9	4.2	1.7	46.5	4.5	28.5	14.5
No	17,590	19.7	3.5	3.3	6.1	6.9	44.5	35.7
Region								
North	5,747	33.1	4.1	3.8	19.0	6.3	38.6	28.1
North Central	6,202	36.2	3.6	2.8	22.4	7.4	40.7	23.2
South	8,948	26.5	3.5	2.2	15.5	5.4	39.9	33.6
West	4,435	30.4	3.5	2.8	18.0	6.1	39.1	30.3

[a]Includes persons of Hispanic and other ethnic origin or unknown race, and unknown pension status not shown separately. *Relative standard error exceeds 30 percent of estimate.

SOURCE: National Center for Health Services Research and Health Care Technology Assessment

Table 5. Private health insurance of the Medicare elderly (NMCES, Health Insurance/Employer Survey: 1977).

All Medicare elderly	Number of persons	With employment-related insurance					Other private	No private
		Total	Active worker	Dependent of active worker	Retiree	Dependent of retiree		
	Thousands	Percent distribution						
Total[b]	21,766	25.1	3.2	2.2	15.2	4.5	43.1	31.8
Age								
65-69	7,276	35.9	6.5	3.2	20.4	5.9	38.7	25.4
70-74	6,075	25.0	3.0	2.4	14.0	5.6	44.2	30.8
75 and older	8,415	15.8	*0.5	*1.3	11.5	2.5	46.1	38.1
Sex and marital status								
Male	8,897	31.0	5.5	1.8	21.6	2.1	38.9	30.1
Not Married	2,044	19.8	4.3	*1.2	13.9	*0.4	29.3	50.9
Married	6,853	34.4	5.9	2.0	23.9	2.6	41.8	23.9
Female	12,869	21.0	1.6	2.5	10.8	6.2	46.0	33.0
Not Married	8,260	14.8	1.7	*1.5	11.1	*0.4	49.2	36.0
Married	4,608	32.3	*1.4	4.2	10.1	16.6	40.3	27.5
Race								
White	16,933	27.8	3.3	2.1	17.5	5.0	47.9	24.4
Black	1,632	15.3	5.1	4.8	4.6	*0.7	19.8	65.0
Family income, adjusted for family size								
Poor	3,476	6.9	*0.4	*0.2	5.5	*0.8	37.4	55.7
Near Poor	2,052	10.2	*0.8	*0.2	8.0	*1.2	41.3	48.5
Low	5,025	19.9	*1.7	*0.3	13.6	4.3	46.2	33.8
Middle	6,670	32.1	4.0	3.4	18.5	6.2	46.1	21.8
High	4,543	41.3	7.0	5.0	22.7	6.6	40.3	18.4
Family pension benefits								
Yes	5,175	44.2	3.5	2.5	27.9	10.2	42.6	13.2
No	13,999	19.7	3.3	2.2	11.7	2.5	45.4	34.9
Region								
North	5,021	24.7	4.0	3.8	14.0	2.9	47.8	27.5
North Central	5,789	28.6	4.0	2.5	15.9	6.1	47.8	23.7
South	6,639	20.8	2.5	*1.3	13.3	3.6	39.6	39.7
West	4,316	27.8	2.2	*1.4	18.6	5.7	36.8	35.5

[a]Includes persons of Hispanic and other ethnic origin or unknown race, and unknown pension status not shown separately. *Relative standard error exceeds 30 percent of estimate.

SOURCE: National Center for Health Services Research and Health Care Technology Assessment

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16. Abstract (Limit: 200 words)

This NCHSR staff paper is one of the first to look, from a population-based perspective, at employers and Medicare as partners in financing health care for the elderly and the prospects of employers relieving some of the financial difficulties facing Medicare. The study is based on data from sources including the Census Bureau's 1983 Survey of Income and Program Participation and NCHSR's 1977 National Medical Care Expenditure Survey. Results showed that the growing elderly population and the trend toward early retirement are increasing the ratio of retirees to active workers--the ultimate source of funding for both employee health plans and Medicare. The result is significant potential unfunded liability for both employee-sponsored plans and Medicare. Changing Medicare's cost-sharing requirements would shift some of those costs to employers, as would other measures designed to potentially reduce the Medicare budget. Given the similarity of circumstances facing both employers and Medicare, tomorrow's elderly will probably pay a much larger share of their health costs through some combination of private insurance premiums, taxes, and out-of-pocket expenditures.

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