



HEALTH INSURANCE ON THE WAY TO MEDICARE: IS SPECIAL GOVERNMENT ASSISTANCE WARRANTED?

Pamela Farley Short, Dennis G. Shea, and M. Paige Powell
The Pennsylvania State University

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EXECUTIVE SUMMARY

The survey analyses described in this report are intended to help policymakers understand better the health insurance problems that confront Americans who are approaching age 65 and Medicare eligibility. A clear understanding of these problems is crucial to deciding whether or not to proceed with incremental coverage reforms for older, “pre-Medicare” adults. We had four specific research objectives:

1. To learn about the transitions in health insurance coverage experienced by older adults prior to age 65, especially as they relate to changes in employment and health;
2. To look at how well a policy allowing people to “buy in” to the Medicare program at age 62 (as proposed by former President Clinton and others) would compensate for the loss of employer-based insurance;
3. To see if there are compelling arguments, in addition to early retirement and the loss of employer coverage, to target older Americans in particular for coverage expansions;
4. To explore the empirical justification for targeting people age 62 and older, rather than setting eligibility for a buy-in at some other age.

More generally, we wanted to produce a compendium of relevant statistics that would be useful to policy analysts and others who are considering coverage reforms for older Americans.

To accomplish these objectives, we made detailed estimates of change over time using revised data from the first two waves of the Health and Retirement Study (HRS), a nationwide longitudinal data collection sponsored by the National Institute on Aging that has been providing a wealth of information about preretirement-age Americans since its inception in 1992. We looked specifically at transitions in health coverage among members of the over-55 and over-62 age groups that are targeted in Medicare buy-in proposals. We also analyzed Current Population Survey (CPS) data for a recent period (1998) in order to complement the HRS data, which are from the early 1990s and focus on changes over time.

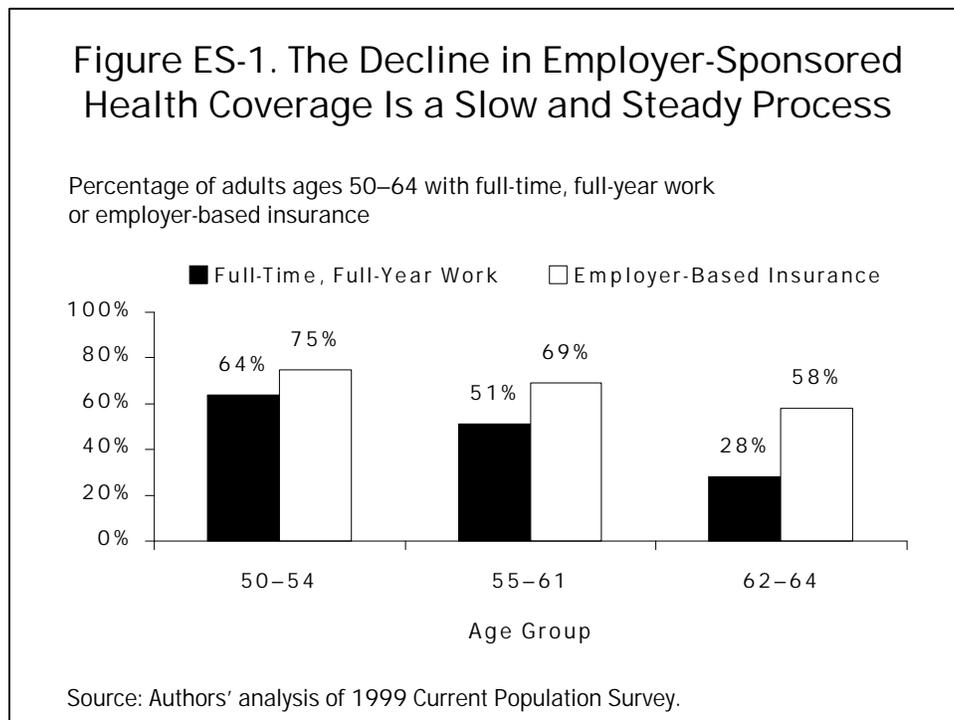
KEY FINDINGS

Our analysis of the data presented here leads us to conclude that legislators and policy analysts should not use the loss of employer insurance as the primary justification for

implementing Medicare buy-in or other age-related reforms. Instead, we propose that the better justification for such reforms is the poorer average health status of those nearing age 65. We show that it is possible to make a strong empirical case for proceeding on this basis.

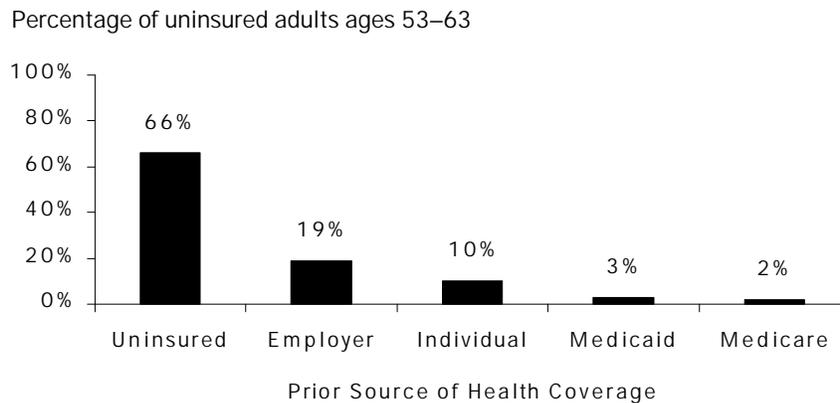
Reasons Not to Target the Loss of Employer Insurance

The transition out of employer-sponsored insurance begins when adults enter their fifties and seems to be a slow, steady process. The HRS shows that fewer than 10 percent of adults age 50 or older lose their employer coverage over a two-year period. Although retirement rates peak at age 62, when people first become eligible for Social Security, the rate of disenrollment from employer insurance is essentially the same for people in their early fifties as for those age 62. Cross-sectional comparisons of employment patterns and employer insurance by age in the current CPS also suggest that the decline in employer-sponsored health coverage starts well before age 62, and that employer coverage does not decline as sharply as does full-time employment (Figure ES-1).



Short-term eligibility for Medicare or continuation of employer insurance will not effectively bridge the long gaps in coverage that occur during this slow transition. Two-thirds of the uninsured who are older than age 50 have been uninsured for at least two years, and only one of five uninsured people who are older than age 53 has a recent connection to an employer-based health plan (Figure ES-2). More than 60 percent of the uninsured older than age 62 were uninsured when they turned 62. Another 19 percent were covered by nongroup insurance. Employers covered only 15 percent before they turned 62.

Figure ES-2. Only One of Five Uninsured Older Adults Was Recently Enrolled in an Employer Health Plan



Source: Authors' analysis of Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Policies that focus government assistance on the loss of employer insurance also run a considerable risk of displacing other, private arrangements. Most older Americans successfully negotiate employment transitions with their insurance intact: 82 percent of employer policyholders who stopped working in 1992 or 1993 were still covered by employers in 1994. Only 11 percent were uninsured. Many more people leave employer plans than become uninsured. Only 3 percent of those who were employer policyholders in 1992 were uninsured in 1994; about 9 percent of those who were insured in 1994 were covered by a new employer or a spouse's employer.

Government policies that target the loss of employer insurance are regressive, because people who lose employer insurance have higher incomes than those who never had it at all. Only 10 percent of those who were uninsured in 1994 and who had lost employer insurance in 1992 or 1993 were poor. By contrast, 27 percent of those who were uninsured in both 1992 and 1994 were poor.

The Connection Between Increasing Age and Declining Health

Proposed expansions of Medicare (and other reforms that focus on people who are just under the age of Medicare eligibility) also have the important effect of targeting a population subgroup that is particularly vulnerable to declining health. One of five people in the 62-to-64-year-old age group has health problems that limit his or her ability to work (nearly twice the percentage in the 51-to-54-year-old group). More than a quarter of those in the 62-to-64 age group are in fair or poor health—also nearly twice the percentage in the 51-to-54 group.

Although enrollment in Medicare disability coverage increases significantly as people get closer to age 65, the current patchwork of insurance for those approaching 65 leaves serious gaps in the coverage of older people with serious health problems. Medicare enrollment increases from about 4 percent of 51-to-54-year-olds to 15 percent of 62-to-64-year-olds. This fills about two-thirds of the gap created by declining enrollment in employer insurance. Medicaid coverage of disabled adults ages 50 to 64 remains at around 3 percent. Nevertheless, nearly a third of the uninsured older than age 62 are in fair or poor health. Given the current 29-month waiting period for Medicare disability benefits for those younger than age 65, Medicare does not even provide complete protection for people who are unable to work. Almost one-third of new beneficiaries are uninsured during the waiting period.

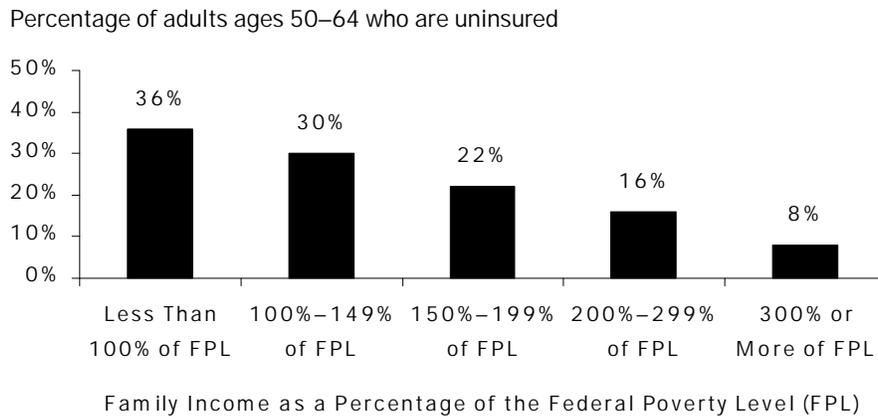
Other Considerations in Targeting Coverage by Age

Older Americans in particular would benefit from being able to buy insurance that is more affordable than that offered in the individual health insurance market. More people in the 62-to-64-year-old age group are uninsured because they drop out of the individual market than because they lose employer insurance. Older buyers generally pay the high cost of individual insurance over longer periods than younger buyers in the same market do. Nearly three of five individual enrollees older than age 62 have been covered for two years or more, according to our estimates from the HRS data. Even though individual premiums increase with age, people older than 62 buy insurance in this market at almost twice the rate of people in their early fifties.

Glaring disparities in health insurance coverage among older Americans are related to income. The uninsured rate for the poor is nearly five times higher than the rate for people with incomes above 300 percent of the poverty level (Figure ES-3). Reforms that provide subsidized coverage to the poor who are older than age 62 could benefit as many as 36 percent of the poor who are uninsured, plus another 9 percent who are currently paying for nongroup insurance. Of enrollees who are older than 62, more than half of the uninsured and a third of nongroup enrollees have incomes below 200 percent of the poverty level.

There is no empirical reason to choose age 62 as the eligibility age for incremental reforms aimed at older Americans. As noted above, the relationship between age and disenrollment from employer insurance is essentially flat. Employer insurance coverage begins to decline, slowly, well before age 62. Mainly because Medicare and individual insurance coverage expand to fill the gap left by the slow decline in employer insurance, similar percentages of 51-to-54-year-olds, 55-to-61-year-olds, and 62-to-64-year-olds are uninsured.

Figure ES-3. Among Adults Ages 50 to 64,
Sharp Disparities in Uninsured Rates
Are Related to Income



Source: Authors' analysis of 1999 Current Population Survey.

CONCLUSION

We believe that the connection between health and age provides a strong justification for age-related reforms. People who are uninsured at older ages face particularly acute financial and health risks that current public policies do not address. Older Americans have poorer access to coverage because they must rely more on the individual insurance market, where they pay higher premiums and are affected more than younger adults by preexisting-condition clauses and other coverage limitations. There are even good reasons for making uninsured poor adults in this age group a higher priority for incremental reforms than younger uninsured poor adults. Given their increased health risks and health care needs, along with higher costs for insurance, older adults who have limited economic resources are even more disadvantaged than younger adults with the same resources.

A Medicare buy-in fits very well into the framework of incremental reforms. It would be easy to start small with a coverage expansion limited to older Americans, with the eligibility age initially as high as 64, or with stringent income-related or health-related restrictions on eligibility. Then, as budgetary or political considerations permit, these restrictions could be gradually relaxed to allow an increasing number of Americans to join Medicare before they reach age 65.

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INTRODUCTION

In the wake of the Clinton administration's failed attempt to bring about universal coverage and comprehensive health care reform, the United States embarked on a series of incremental health insurance reforms in the 1990s. Congress enacted federal insurance market reforms with the Health Insurance Portability and Accountability Act of 1996. The State Children's Health Insurance Program was included in the Balanced Budget Act of 1997, along with a variety of changes to Medicare and Medicaid. Now policymakers are turning their attention to other areas in which small interventions by government might yield important social benefits.

One idea frequently discussed in this context is to provide older Americans with more assistance in obtaining health insurance coverage before they are eligible for Medicare benefits. Health insurance is especially vital to people who are approaching age 65 because the risk of major, costly health problems increases with age. However, access to employer-sponsored insurance diminishes in the years leading up to the Medicare age threshold. People who retire early—that is, before they qualify for full Social Security benefits and Medicare at age 65—must often buy health insurance in the individual market, with its limited coverage for pre-existing conditions and premiums that increase markedly with age (to cover the increased likelihood of significant claims).¹ Improving coverage during the years leading up to the Medicare eligibility threshold is also an important part of broader policy discussions about raising the age for Medicare eligibility to 67. This change would reduce the burden of baby boomers on Medicare expenditures and match the change in eligibility for full Social Security benefits that will be fully effective in 2027 (Jones 1999).

No other age group relies so heavily on so many different arrangements for health insurance as does the population that is nearing Medicare eligibility. Many older Americans are still active workers who obtain health insurance from their employers. Some who are no longer working have retiree health insurance from former employers. Others rely on the current or former employers of their spouses for coverage. Early retirees are especially likely to exercise their right to continued coverage from former employers under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) (Flynn 1994). This law requires employers with 20 or more employees to offer continuing coverage for 18 months after both voluntary and involuntary terminations. Former employees must pay up to 102 percent of the total group premium (the sum of

employer and employee shares for active workers). Additionally, because of the higher rates of disease and disability at older ages, a disproportionate share of older Americans qualify for Medicare and Medicaid disability benefits that are available to people who are unable to work. Disabled workers are also able to extend COBRA for an additional 11 months beyond the initial 18-month extension, and employers may charge as much as 150 percent of the usual premium. Finally, despite the high cost, older Americans are also more likely than others to buy health insurance on an individual basis.

The analyses described in this report are intended to give policymakers a better understanding of the insurance problems that confront older Americans. Such an understanding is important for deciding whether or not to proceed with reforms for older Americans and, if the decision is to proceed, for designing appropriate solutions to the problems.

Our first objective was to learn more about the likelihood and timing of changes in health insurance coverage, especially as they relate to the changes in employment and health that occur as people approach the age of Medicare eligibility. We wanted to corroborate and extend earlier research findings based on data from the Health and Retirement Survey (HRS) suggesting that employer insurance is surprisingly stable during this transitional stage of life (Sloan and Conover 1998). (The HRS, a nationwide longitudinal data collection sponsored by the National Institute on Aging, has been providing a wealth of information about preretirement-age Americans since its inception in 1992.)

Our second objective was to look at how well a Medicare buy-in at age 62 (when older Americans first become eligible for Social Security) would protect against the loss of employer insurance. Reforms proposed by former President Clinton (Sheils and Chen 2001; The White House 2000) and others (Loprest and Moon 1999) would allow people to buy into Medicare at that age.

Our third objective was to see if there are other compelling arguments for specifically targeting reforms by age: we looked at gaps and coverage issues (other than early retirement and the loss of employer insurance) that would be addressed by extending Medicare to people older than age 62.

Our fourth objective was to explore the empirical justification for targeting the over-62 age group, as opposed to basing eligibility on some other age.

More generally, we wanted to produce a compendium of relevant statistics that would be of use to policy analysts and others considering or evaluating coverage reforms for older Americans.

To these ends, we used revised data from the first two waves of the HRS to make our own detailed estimates of coverage changes. Our analysis of the HRS focuses specifically on insurance transitions in groups with members who are 55 and older and 62 and older—the targets of Medicare buy-in proposals. We also analyzed Current Population Survey (CPS) data for a recent period (1998) to complement the HRS data, which focus on changes over time and come from the early 1990s.

The next section of this report explains our approach to analyzing the HRS and CPS, including the conceptual underpinnings of our analytic strategy. Then we present the key estimates from the two surveys. Because the 1999 CPS best describes the current context for health insurance reforms, we begin with the CPS estimates and follow with estimates from the HRS. The report ends with a discussion of the policy conclusions that we draw from these data. Additional methodological details and statistical tables are provided in an appendix. While we believe the data make a good case for providing special assistance to older Americans before they reach age 65, we conclude that the *primary* goal of such reforms should not be to help early retirees bridge the gap between employer insurance and Medicare.

METHODS

This study focuses on age-related differences and transitions in health status, employment, and health insurance. It is based on the analysis of cross-sectional data from the 1999 CPS and longitudinal data from Waves 1 and 2 of the HRS.

Data

The CPS is a nationally representative survey of approximately 50,000 households conducted monthly by the Bureau of the Census for the Bureau of Labor Statistics (U.S. Census Bureau and Bureau of Labor Statistics 2000). The sample is randomly selected to represent the civilian noninstitutionalized population of the United States. The Annual Demographic Survey, or March Supplement, is the source for annual income, employment, and health insurance data for the preceding calendar year. The data that we present here are from the 1999 March Supplement and refer to calendar year 1998. (See Swartz 1997 for a current and historical review of CPS methods related to the measurement of health insurance.)

The HRS is a nationally representative longitudinal study that examines health and retirement patterns in the United States. The original sample cohort consisted of noninstitutionalized adults born from 1931 to 1941, and their spouses (regardless of the spouse's age). The first wave of interviewing was conducted in 1992, with follow-up waves every two years.

We limited our analyses to people born from 1931 to 1941. These people were 51 to 61 years old in HRS Wave 1 and 53 to 63 in Wave 2. Thus, our analyses were limited to the population younger than 62 in 1992 and younger than 64 in 1994.

Analytic Approach

The ideal data set for studying the nature and timing of coverage gaps in the years leading up to Medicare would follow a cohort of individuals from middle age (say, 50 years old) to age 65 or older. In fact, this is the general design of the HRS. The problem with such cohort studies is that one must wait a very long time for the results. Even then, as times change, the life experiences of the particular cohort that one studies may no longer describe the experiences of later cohorts at the same age.

Life transitions can also be inferred from the differences between age groups in cross-sectional data pertaining to a single point in time. Age differences can provide an accurate representation of the changes that individuals experience over time, but only if there are no important differences from cohort to cohort.

Our analyses of the HRS and CPS make use of both analytic approaches. The first two waves of the HRS provide information about individual transitions over the two-year interval from 1992 to 1994. HRS data following the same person over the long time-path leading up to Medicare are not yet available, but we make age-specific estimates of the probability of transitions between the first two waves to approximate the time-paths that individuals will follow. We also use the more recent CPS data to make cross-sectional estimates for three different age groups. These CPS estimates are useful in estimating how many people older than 62 would be eligible for a Medicare buy-in at a given point in time, for example. They also shed light on disenrollment from employer insurance and other life transitions.

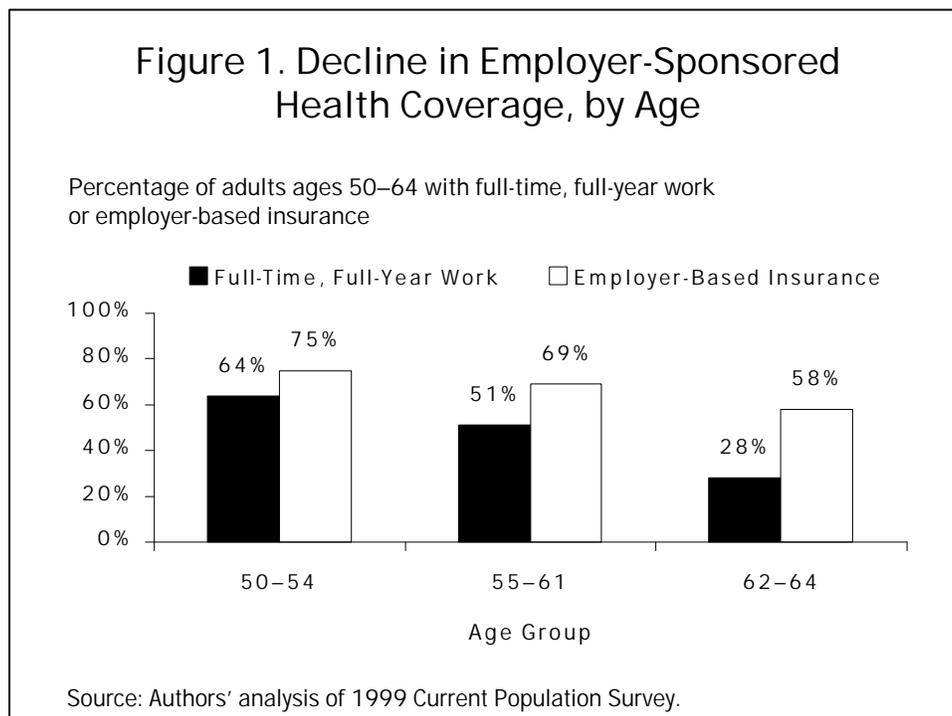
Estimates from the Current Population Survey

Employment and Health Insurance

Estimates for calendar year 1998, the time period covered by the March 1999 CPS interview, confirm that many older workers leave the labor force before they qualify for

full Social Security benefits and Medicare at age 65 (Table 1). Just half of those in the 62-to-64-year-old age group and 70.5 percent of those in the 55-to-61-year-old age group worked at all during 1998, compared with more than 80 percent of those in the 50-to-54-year-old age group. Nearly a third of people older than 62 described themselves as retired, as did 11 percent of 55-to-61-year-olds. By contrast, only 2.9 percent of people in their early fifties were retired.

These differences in employment rates by age were mostly attributable to lower rates of full-time work at older ages. The percentage who work part time remained relatively steady across age cohorts, so part-time workers accounted for an increasing share of the shrinking labor force at older ages. In 1998, 63.9 percent of 50-to-54-year-olds were employed full-time for the entire year (Figure 1). However, the rate of full-time/full-year employment was less than 30 percent among 62-to-64-year-olds, the primary target group of incremental reform proposals. Four to seven percent of those in each age group older than 50 worked part time throughout the year. Although there is an especially marked decline in employment after age 62, the earliest age for receiving Social Security benefits, it is important to note that labor force participation begins to decline noticeably even before then. More than one of 10 people ages 55 to 61 were retired in 1998, and the level of full-time/full-year employment was 13 percentage points lower in this age group than in the 50-to-54-year-old group. As a result, barely half of all those in the 55-to-61-year-old age group were working full-time/full-year.



Withdrawal from full-time employment is particularly significant because stable full-time employment is more closely related to enrollment in employer insurance than is employment in general. More than 80 percent of full-time/full-year workers were insured by employers during the year (Table 2). Rates of enrollment in employer insurance were significantly lower for part-year workers (by about 10 percentage points) and part-time workers (by about 20 percentage points, whether full-year or part-year workers). Because part-time workers were more likely than full-time/part-year workers to enroll in individual insurance, the percentage of uninsured was similar among all workers with less than full-time/full-year employment.

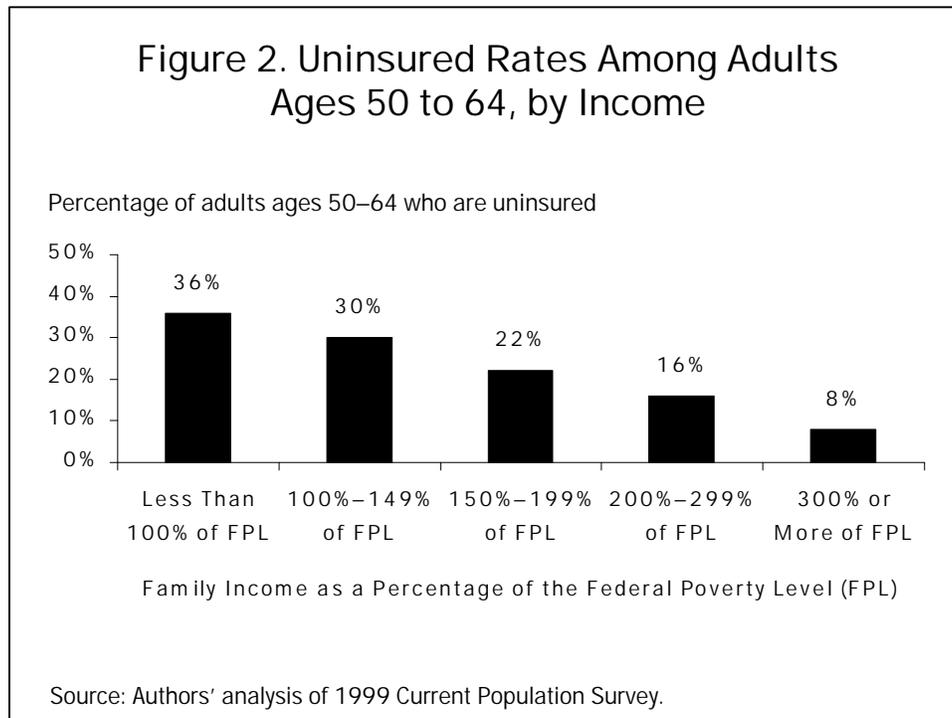
Although enrollment in employer insurance was even lower among retirees, more than half of retirees (and more than one-third of others older than 50 who did not work in 1998) had employer insurance. Rates of Medicare and Medicaid enrollment were much higher among nonworkers, partially offsetting lower rates of employer insurance. As a result, the percentage who were uninsured—around 20 percent overall and about 10 percentage points higher than the rate for full-time/full-year workers—was similar in all employment categories other than for full-time/full-year workers.

Income and Health Insurance

Because there are fewer full-time workers in older age groups, and relatively more people live on unearned income and assets in their retirement, annual incomes were somewhat lower for people older than 55 (Table 1). In 1998, more than 13 percent of 62-to-64-year-olds were poor compared with 9.2 percent of 50-to-54-year-olds. Fully a third of the population older than age 62 had family incomes below 200 percent of the poverty level, compared with about 20 percent of 50-to-54-year-olds.

Income is an imperfect measure of the ability to pay for insurance, especially when applied to retirees, who may have accumulated substantial assets during their working lives. Nonetheless, in the population age 50 and older in 1998, there were great differences in health insurance coverage related to income (Table 2). The percentage of those who were uninsured varied far more widely by income than by employment or health status because the availability of public insurance for members of this age group is targeted not at income, but at disability. Although 36 percent of the poor qualified for Medicare or Medicaid coverage for the disabled in 1998, an equal percentage of the poor were uninsured. The percentage of people with incomes below the poverty level who were uninsured was almost five times higher than the percentage of people with incomes above 300 percent of the poverty level who were uninsured (Figure 2). Employers covered only 20.5 percent of the poor, compared with 85 percent of people with incomes

above 300 percent of the poverty level. Surprisingly, given the high cost of nongroup insurance, the poor were enrolled in nongroup insurance at almost twice the rate of people with incomes above 300 percent of the poverty level.

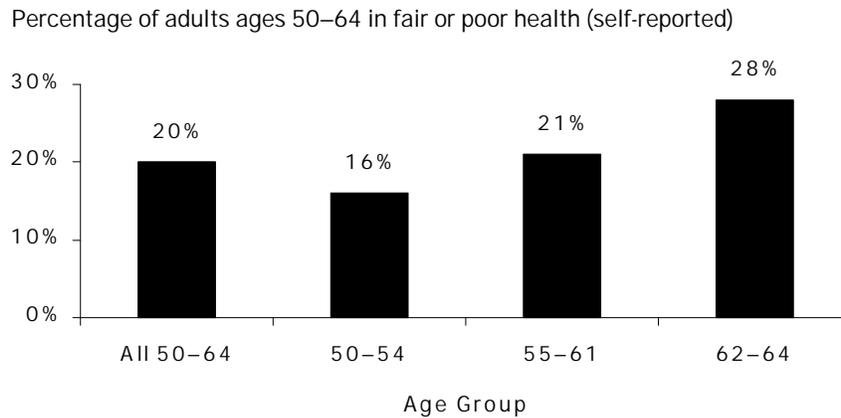


Health and Health Insurance

Both disability rates and poor health status increase with age (Table 1). There was a difference of 10 percentage points in the share of people who reported excellent or very good health after age 62 compared with people in their early fifties. The rate of work disability was also about 10 percentage points higher after age 62. Yet only about 3 percent of the members of each age group over 50 were disabled and working. Given the higher rates of disability at older ages, the constant percentage of working disabled across age groups implies that the disabled were increasingly less likely to work at older ages.

Two other aspects of health differences by age should be noted. First, nearly eight of 10 Americans in the 62-to-64-year-old age group reported no work limitations, and more than 43 percent said that they were in excellent or very good health. This means that there are good prospects for pooling the elevated health risks associated with age within the population that is near 65, without necessarily shifting those risks to other age groups. Second, the statistics relating to disability and health status for 55-to-61-year-olds fall about halfway between those of the younger and older age groups. This pattern implies that health problems begin to increase well before age 62, so that there is an accumulating percentage of people with health problems as a cohort ages (Figure 3).

Figure 3. Fair or Poor Health Status, by Age



Source: Authors' analysis of 1999 Current Population Survey.

The relationship between health and health insurance after age 50 is U-shaped, with higher percentages of people who are in good or fair health or partially disabled lacking insurance than people at either end of the health spectrum (Table 2). Medicare and Medicaid make up for the extremely low rates of employer insurance and somewhat lower rates of individual insurance among people who are in poor health or who are disabled and not working. However, because public insurance is not available to older people with more moderate health problems (who are also less likely to have employer insurance), the uninsured percentage is highest in the middle ranges of health status and disability.

Health Insurance by Age

The overall effect of employment, income, and health differences related to age are reflected in health insurance differences by age (Table 1). With half as many full-time/full-year workers in the group of people older than 62 compared with the group composed of people in their early fifties, enrollment in employer-sponsored insurance was noticeably lower among 62-to-64-year-olds in 1998 (57.8% vs. 75.4%) (Figure 1, above). However, the difference in rates of employer insurance was relatively smaller than the difference in employment and was largely offset by higher rates of enrollment in Medicare and individual insurance at older ages. The rate of individual enrollment for people older than 62 was nearly double the rate for people in their early fifties (9.1% vs. 4.7%). Medicare covered almost 15 percent of the population older than age 62. As a consequence of the coverage drawn from these sources, the uninsured percentages for the two over-55 age

groups were similar (about 15%) and only slightly higher than the uninsured percentage for the 50-to-54-year-old age group (13.4%).² Medicaid enrollment did not vary by age.

Because of age-related differences in employment, health, and income, the characteristics of older Americans who lacked access to employer insurance or public insurance (the uninsured and individually insured who are the main focus of policy concerns) also varied somewhat by age (Table 3). For example, compared with the 50-to-54-year-old group, fewer of those in the 62-to-64-year-old age group who were uninsured or individually insured were full-time workers. More of the uninsured and individually insured were disabled or in poor health at older ages. Nevertheless, even in the oldest group, almost half of the uninsured and the individually insured were working—nearly a quarter worked full-time all year. While 30 percent of the uninsured and about 21 percent of the individually insured in the age group older than age 62 were in fair or poor health, about 40 percent of the uninsured and half of the individually insured were in excellent or very good health.

At the same time, the incomes of the uninsured and individually insured were quite similar across age groups. The poor and those with low incomes accounted for a large proportion of the uninsured in each group with members older than 50 (as is also true among uninsured adults generally) (Campbell 1998). About half the uninsured in each age group whose members were older than 50 had incomes of less than 200 percent of the poverty level, and more than a quarter were poor. The group composed of those with incomes above 300 percent of the poverty level was large—it included nearly two-thirds of the entire population older than 50 (Table 1). Therefore, the small percentage of people with incomes above 300 percent of the poverty level who were uninsured also accounted for 30 to 35 percent of the uninsured in every age group (Table 3). About half of the individual enrollees in each age group had incomes above 300 percent of the poverty level; about a third had incomes that were below 200 percent of the poverty level.

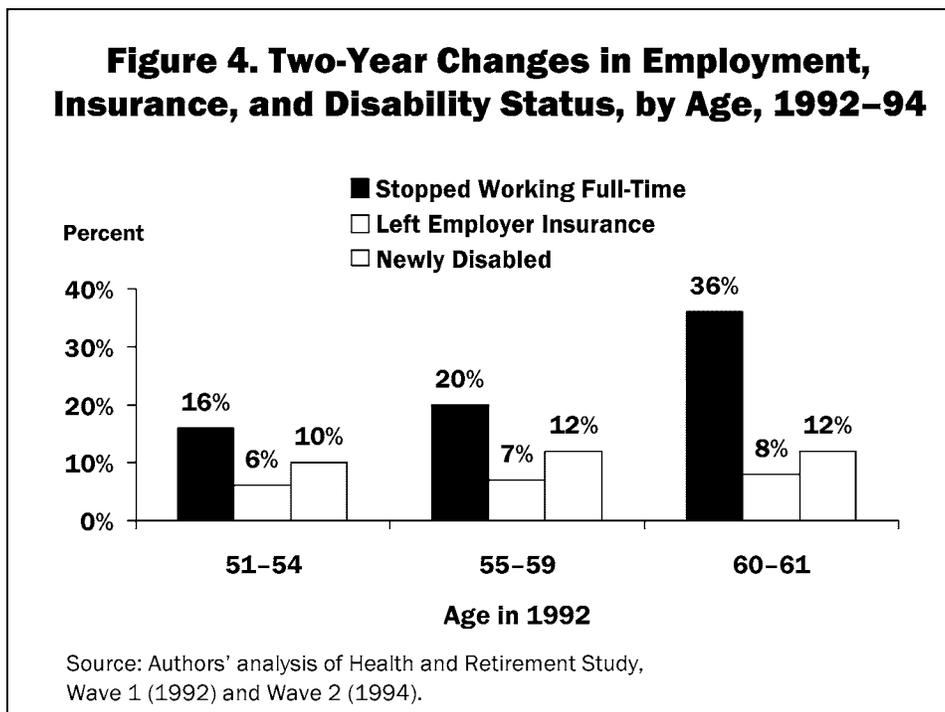
Estimates from the Health and Retirement Study

Although these CPS estimates provide some clues about the changes that individuals experience as they approach the age of Medicare eligibility, longitudinal HRS data are a more authoritative source for information about such life transitions as early retirement, disenrollment from employer insurance, and the onset of disability. Generally, the longitudinal data in the HRS confirm the impressions about the nature and timing of these transitions that are suggested by the cross-sectional differences among age groups in the CPS.

Employment Transitions

Both data sources offer a similar picture of early retirement. Like the CPS, the HRS shows that there are dramatic reductions in full-time work as people age. The likelihood of working part-time remains relatively constant, mainly because part-time workers who retire are replaced by full-time workers who cut back to part-time. Finally, although people are particularly likely to leave full-time jobs when they turn 62, many people leave full-time work long before then.

Specifically, the HRS shows that approximately 36 percent of those ages 60 to 61 who worked full time in 1992 no longer worked full time in 1994 (Figure 4). This includes 20.5 percent who retired and 11.2 percent who changed to part-time jobs (Table 4). Transitions out of full-time work occurred at about half that rate in each of the two younger cohorts (20% for 55-to-59-year-olds and 16% for 51-to-54-year-olds). As everyone aged by two years, the overall percentage of full-time workers (which reflects both transitions in and out of full-time work during the two-year period) dropped significantly in each age cohort, with the largest reduction (-14.5%) in the cohort that turned 62.



Health Transitions

The HRS data that pertain to the nature and timing of health status changes in the 50-to-64 group are also generally consistent with the moderate cross-sectional differences by age in the CPS (Table 5). Relatively few people experience a sharp decline in their

health before they turn 65, although average health status does decline. Furthermore, the risk of a major change in health status is roughly the same across age cohorts. The rate of new work disability was only 10 to 12 percent in each of the three age cohorts, and two-thirds of the newly disabled were able to work. Sixteen to 19 percent of the people in each cohort reported that their health status worsened from 1992 to 1994.

The latter measure of health decline is more sensitive than the one that measures transitions from one category of health status to another (for example, transition from excellent or very good health to fair or poor). Also, it is not biased against finding health status declines among people whose health is already fair or poor. The latter point turns out to be important, because the HRS data suggest that health decline in the period leading up to age 65 is often a downward progression, rather than a matter of sudden major change. Indeed, the percentage of people who reported that their health worsened from 1992 to 1994 increased markedly with increasingly worse health status in 1992. Similarly, while only about 4 percent of people without disabilities in 1992 were unable to work in 1994, 18 percent of those who were already limited in ability to work in 1992 were completely unable to work in 1994 (Table 15).

Health Insurance Transitions

Transitions out of employer-sponsored insurance (Table 6) were much less likely than transitions out of full-time work, which is consistent with the narrower differences in enrollment rates by age compared with differences in employment rates in the CPS. Unlike employment transitions, rates of disenrollment from employer insurance were remarkably similar in each of the age cohorts. Transitions out of employer insurance were similar to health losses in this respect. Of those with employer insurance in 1992, only 6 to 8 percent no longer had employer insurance in 1994. Furthermore, because of transitions into individual private insurance and Medicare, only 2.0 to 3.5 percent of those with employer insurance in 1992 were uninsured after two years. The only statistically significant difference between enrollees who turned 62 and younger enrollees was the slightly higher probability of the older group moving into Medicare.

When transitions both in and out of employer insurance are taken into account, there were small reductions in the enrollment rate for employer insurance in the cohorts older than age 55 during the two years between HRS interviews. However, these changes were not significantly different from zero, given that the changes measured over two years were small, and the impossibility of measuring these changes very precisely when the HRS sample is broken into age cohorts. The small changes in the HRS are qualitatively consistent with the moderate cross-sectional differences in employer insurance by age in

the CPS (and two-year changes of 2 to 4 percent a year, which would be more quantitatively consistent with the CPS, are within the 95 percent confidence intervals for the HRS).

It is important to note that the HRS shows that more people changed employer plans over two years than left employer insurance entirely. Therefore, enrollment in employer insurance was not quite as stable in the population older than 50 as the preceding discussion would suggest. For example, among all policyholders older than 50 in 1992, 7.6 percent held policies from different employers in 1994 (Table 12). Another 1.6 percent of policyholders changed to a spouse's employer-sponsored plan. All together, 84 percent of policyholders remained with the same plan over two years; 9.2 percent changed to another employer plan; and 3.3 percent changed to another type of coverage.

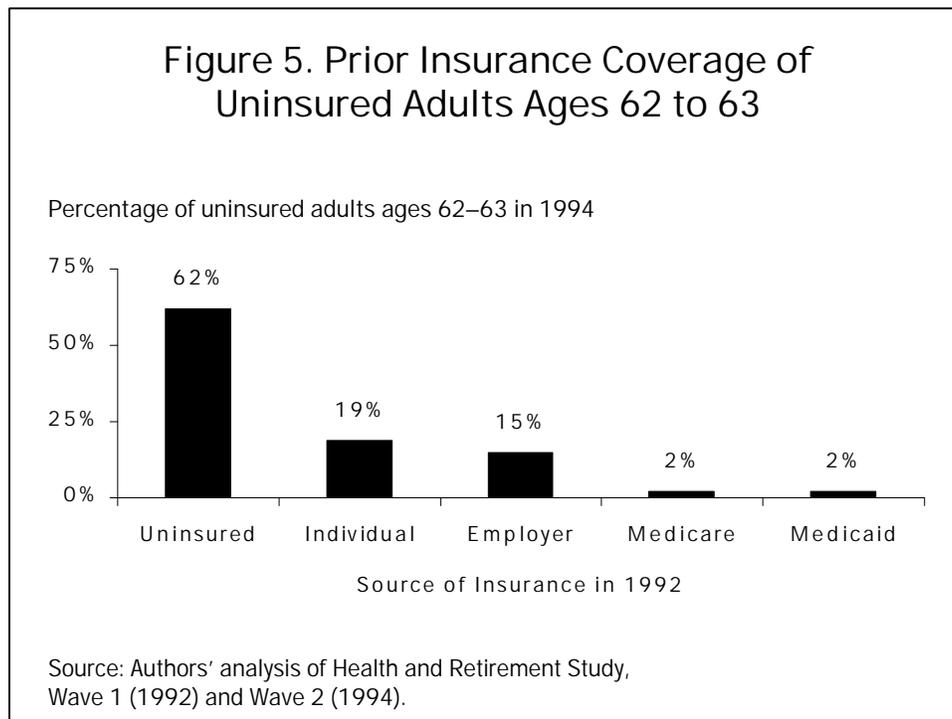
Given the differences in the likelihood and timing of transitions out of the labor force and out of employer insurance, it should not be a surprise that the two were not closely connected in the individual experiences portrayed in the HRS. Among policyholders with employer insurance in 1992, 82.1 percent of those who stopped working in 1992 or 1993 were still covered by an employer in 1994 (Table 7). About 5 percent bought individual insurance and 10.6 percent became uninsured. Among the newly uninsured, 20.9 percent still had the full-time jobs they held in 1992, and 33.1 percent worked full-time in both years (Table 8). Although a third of the newly uninsured were not in the labor force in 1994 and 8.7 percent were unemployed, the majority of the newly uninsured were working in 1994.

There was not a close connection between the loss of employer insurance and health decline. Nearly 90 percent of policyholders who became newly limited in their ability to work in the years 1992 to 1994 retained employer coverage (Table 7). Among people who were newly uninsured between 1992 and 1994, 68.2 percent were not limited in their ability to work in 1994 and 17.6 percent were already limited in 1992 (Table 9). Only 14.2 percent had recently experienced a change in their ability to work.

Insurance History

The preceding estimates describe transitions in employment, health, and health insurance as the people in the HRS sample moved forward in time from 1992 to 1994. Looking backward from 1994 to 1992, we can also make a number of important observations about the insurance history of the three key coverage groups that are not insured by employers: the uninsured, people with individual insurance, and the disabled who are covered by Medicare.

In keeping with the small probability of transitions from employer insurance to being uninsured, the HRS shows that relatively few of the people who were uninsured at any age from 53 to 63 (about one of five) had a recent connection to employer-sponsored insurance (Table 10). After age 62, more of the uninsured were recently disenrollees from individual insurance (19%) than from employer insurance (15%) (Figure 5). Most of the uninsured (about two-thirds at every age) had been uninsured for two years or more.



The two-thirds of the uninsured who were without coverage for at least two years had noticeably lower incomes than people who became uninsured or individually insured because of losing employer insurance (Table 11). Fewer than a third of the long-term uninsured had incomes above 300 percent of the poverty level compared with nearly 60 percent of the uninsured or individually insured who lost employer insurance.

Distinguishing among the individually insured in 1994 according to insurance history shows that the individual insurance market drew more enrollees from the ranks of the uninsured than from employer insurance at every age (Table 10). After age 55, the majority of people with individual insurance had been enrolled in that market for at least two years. Before age 55, enrollment in individual insurance seemed to be more short-term; fewer than half of enrollees had been enrolled for two years.

Roughly half of the Medicare beneficiaries in each age group enrolled between 1992 and 1994, so their insurance status during the Medicare waiting period is indicated

by their status in 1992. Looking back at the insurance status of new beneficiaries in 1992 shows that from 27.4 percent to 38.9 percent of new Medicare beneficiaries were uninsured during the Medicare waiting period, with some variation by age group.

POLICY CONCLUSIONS

These analyses are intended to clarify the nature of health insurance problems that confront older Americans in the years before they become eligible for Medicare. We wanted to examine the gaps in coverage caused by early retirement and the loss of employer insurance, as well as problems such as the increased risk of disability and illness at older ages, and the increased reliance of older Americans on nongroup insurance. Our analysis of the data presented here leads us to conclude that legislators and policy analysts should not focus on the loss of employer insurance as the primary rationale for instituting a Medicare buy-in or other age-related reforms. Instead, we propose that the better justification for age-related reforms is the poorer average health status of the population as it nears age 65. The data we have presented make a strong case for proceeding on this basis.

Our interpretation of the small changes in employer insurance that Sloan and Conover uncovered in the HRS indicates that the transition out of employer-sponsored insurance begins when a cohort is in its early fifties and is a slow, steady process. We show here that more than 90 percent of employees over age 50 retain employer coverage over a two-year period in the HRS, confirming the Sloan–Conover findings, and we also show that the disenrollment rate is constant across successively older cohorts. These transition rates imply that gaps between employer-sponsored insurance and Medicare (where they exist) are often of long duration—five to 10 years or more. Although fewer employers offer retiree health benefits now than in the early 1990s (Loprest 1998), cross-sectional differences in enrollment rates for employer insurance in the current CPS (which drop from 75 percent among 50-to-54-year-olds to 69 percent among 55-to-61-year-olds to 58 percent among 62-to-64-year-olds) suggest that this view of disenrollment from employer insurance is still essentially accurate.

Trying to bridge such long gaps presents a very difficult policy challenge. Lowering the Medicare eligibility age to one that is young enough to cover most of these gaps (e.g., 50) would go way beyond the usual bounds of an “incremental reform.” Nor is it likely that employers could be induced or compelled to provide coverage to former employees for such long periods. Short-term extensions of employer insurance like COBRA will not take care of the many people (four of five of the uninsured over age 50, according to our estimate from HRS) who no longer have a recent connection to an employer plan.

Furthermore, because transitions out of employer insurance do not cluster around age 62 like retirements, there is no large group of people with gaps in employer insurance starting at age 62 who will be helped by aligning the eligibility ages for Medicare and Social Security (Figure 4). Eighty percent of the uninsured over age 62 are uninsured or covered by nongroup insurance when they turn 62, according to our estimates from the HRS. Employers cover only 15 percent.³ As a consequence, the main effect of opening Medicare at age 62 would be to shorten the time that some older Americans are uninsured (or forced to buy into the individual health insurance market). Only for a few would it actually bridge the gap between employer insurance and Medicare.

In short, trying to bridge from employer insurance to Medicare makes the policy problem less tractable. Thinking in these terms also encourages policies that focus specifically on people who lose employer insurance (e.g., Clinton's proposal to open Medicare to displaced workers after age 55, proposed new tax credits for former employees who extend their coverage under COBRA, or the current extension of COBRA for people younger than 65 who are waiting to qualify for Medicare disability benefits). Such policies unfairly ignore the problems of people who have no employer insurance to lose—that is, those who are uninsured or buy individual insurance over the long term. Policies that focus government assistance on the loss of employer insurance also run a considerable risk of displacing other, private arrangements according to the data shown here. Most older Americans successfully negotiate employment transitions with their insurance intact, and many more leave employer plans than become uninsured. Finally, government policies that target the loss of employer insurance are regressive, because people who have employer insurance to lose are more economically secure than those who never had it at all.

For all of these reasons, it seems unwise to think of incremental reforms for older Americans as bridging the gap between employer insurance and Medicare. However, proposed expansions of Medicare (and other reforms that focus on people who are just under the age of Medicare eligibility) also have the effect of targeting a population subgroup that is particularly disadvantaged by health status. Conceptually speaking, we believe that the connection between health and age provides a strong justification for age-related reforms. People who are uninsured at older ages face particularly great financial risks (and may lose the assets that they have accumulated for retirement). Older Americans who buy individual insurance pay higher premiums and are more affected by pre-existing condition clauses and other coverage limitations in that market. There are even good reasons to target government subsidies for low-income adults based on age: given their increased health risks and health care needs, along with higher costs for insurance, older

adults who have limited economic resources are at a greater disadvantage than younger adults with the same resources.

The data presented here support this line of argument. Health does indeed deteriorate with age. One of five people in the 62-to-64-year-old age group has health problems that limit his or her ability to work (nearly twice the percentage as in the 51-to-54-year-old age group). More than a quarter of those in the 62-to-64-year-old group are in fair or poor health—again nearly twice the percentage as in the 51-to-54-year-old group.

The current patchwork of coverage also leaves serious gaps in the coverage of older people with serious health problems, even though Medicare and Medicaid currently cover a significant percentage. Nearly a third of the uninsured over age 62 are in fair or poor health. Because Medicare and Medicaid focus on work disability, federal insurance programs do not really address the problems of people who have chronic illnesses, which may require a lot of health care or add to the cost of individual insurance but do not prevent them from working. Furthermore, Medicare does not even provide complete protection for people who are unable to work, given the current 29-month waiting period for Medicare disability benefits for those younger than 65. Almost one-third of new beneficiaries are uninsured during the waiting period.

It is also evident that older Americans in particular would benefit if they could buy insurance that is more affordable than what is offered in the individual health insurance market. Not only do older Americans pay more for individual insurance because of their greater health risks, but individual insurance is considerably more costly than group insurance obtained through employers and unions for buyers of all ages. Adverse selection adds to the cost of individual insurance, because insurers charge higher premiums to account for the likelihood that people who are willing to pay for such expensive insurance are bad risks who will file more claims. Marketing and administrative costs—an estimated one-third to one-half of individual premiums, compared with as little as 5 percent of the premium for large groups—also add significantly to costs (Pauly and Percy 2000).

As it is now, more people in the 62-to-64-year-old age group are uninsured because they drop out of the individual market than because they lose employer insurance. Even though individual premiums increase with age, people over 62 enroll at almost twice the rate as people in their early fifties. And older buyers generally pay the high cost of individual insurance over longer periods than younger buyers in the individual market. Nearly two-thirds of individual enrollees over age 62 have been covered for two years or more, according to our estimates from the HRS.

Another aspect of the affordability problem for older American is evident in the glaring disparities in health insurance that are related to income. These disparities provide further justification for government intervention that would help pay the especially high cost of insurance at older ages. Our estimates from the CPS show that among people over 50, low income is more closely associated with being uninsured than age, employment, or health status. The uninsured rate for the poor is five times higher than for people with incomes above 300 percent of the poverty level. Reforms that would provide subsidized coverage to the poor who are over age 62 could benefit as many as 35 percent of the poor who are uninsured, plus another 9 percent who are currently paying for nongroup insurance. In the age group over 62, more than half of the uninsured and a third of nongroup enrollees have incomes below 200 percent of the poverty level.

Finally, focusing on health status instead of early retirement puts an entirely different perspective on one of the key issues that surround age-related reforms—that is, at what age should older Americans qualify for special assistance? We find that except for its association with early retirement, there is no particular reason to choose 62 as the eligibility age. After age 51, the relationship between age and changes in either employer insurance or in health is essentially flat (Figure 7).

There are two major arguments for starting a coverage expansion with the oldest people who are not currently eligible for Medicare. First, on average, the oldest people are in the poorest health. Second, it is relatively easy to extend Medicare to people who will soon be covered by Medicare anyway. Although policymakers will have to choose a specific eligibility age if they do enact a Medicare expansion, they should feel free to base their decision on political considerations related to the desired size and cost of the program. Negotiation over the eligibility age is likely to be particularly important in garnering political support for the government subsidies that will be needed to make coverage affordable for older Americans. Health care costs do indeed increase with age and subsidies for this age group will be particularly expensive.

Furthermore, when viewed in the way we suggest, a Medicare buy-in fits perfectly within the framework of incremental reform. It would be easy to start small, setting the eligibility age as high as 64, and expanding the program over time by lowering the age threshold.

TABLES

Table 1
Percent Distribution of Persons 50–64 Years of Age by Employment, Income,
Health Status, Disability, and Insurance, 1998^a

Characteristics	All	Age		
	50–64	50–54	55–61	62–64
Employment Status				
Employed	72.1	82.2	70.5	49.7
Full time/full year	52.8	63.9	50.9	28.4
Part time/full year	6.1	5.8	6.2	6.5
Full time/part year	8.4	8.8	8.2	8.0
Part time/part year	4.8	3.7	5.2	6.8
Not employed	28.0	17.9	29.6	50.4
Retired	11.0	2.9	11.0	32.6
Other	17.0	15.0	18.6	17.8
Annual Income				
<100% of poverty	11.6	9.2	13.1	13.6
100%–150% of poverty	6.5	5.1	6.8	9.7
150%–200% of poverty	6.6	5.5	6.5	10.0
200%–300% of poverty	13.3	12.0	13.1	17.2
>300% of poverty	62.1	68.3	60.6	49.5
Self-Reported Health Status				
Excellent	21.4	25.0	19.9	15.9
Very good	31.0	33.2	30.2	27.6
Good	27.8	26.3	28.9	29.0
Fair	13.0	10.4	13.8	17.5
Poor	6.8	5.2	7.2	10.1
Work Disability				
Limited	14.9	11.4	16.2	20.4
Not working	12.1	8.6	13.4	17.6
Working	2.8	2.8	2.8	2.8
Not limited	85.2	88.6	83.8	79.6
Health Insurance^b				
Medicare	6.6	3.5	6.8	14.6
Employer insurance	69.7	75.4	68.6	57.8
Individual insurance	6.3	4.7	6.7	9.1
Medicaid	3.1	3.0	3.1	3.3
Uninsured	14.3	13.4	14.9	15.2

^a Subgroup percentages may not sum to 100% due to rounding.

^b Persons with more than one type of insurance are assigned to the first applicable category shown.

Source: Current Population Survey, March 1999.

Table 2
Percent Distribution of Persons 50–64 Years of Age by Insurance Type,
According to Employment, Income, Health Status, and Disability, 1998^{a,b}

Characteristics	Population (thousands)	Medicare	Employer Insurance	Individual Insurance	Medicaid	Uninsured
Total	38,880	6.6	69.7	6.3	3.1	14.3
Employment Status						
Full time/full year	20,528	0.2	84.3	4.9	0.3	10.3
Part time/full year	2,357	2.5	64.2	11.7	2.1	19.6
Full time/part year	3,272	1.5	74.5	5.3	1.4	17.3
Part time/part year	1,871	2.6	63.9	11.9	2.7	18.9
Retired	4,257	14.7	55.1	10.0	2.5	17.8
Other	6,596	26.5	35.2	5.1	13.2	20.0
Annual Income						
<100% of poverty	4,491	18.6	20.5	8.6	16.9	35.5
100%–150% of poverty	2,538	19.5	34.5	8.2	7.7	30.1
150%–200% of poverty	2,571	12.9	51.9	9.1	3.8	22.2
200%–300% of poverty	5,153	6.6	67.7	8.3	1.3	16.1
>300% of poverty	24,128	2.4	85.0	4.9	0.3	7.5
Self-Reported Health Status						
Excellent	8,309	1.0	81.3	7.2	0.6	10.0
Very good	12,060	1.7	78.8	6.2	0.7	12.6
Good	10,821	4.4	70.1	6.0	1.9	17.6
Fair	5,042	17.6	49.8	6.4	8.3	17.9
Poor	2,648	35.1	28.7	4.1	16.6	15.5
Work Disability						
Limited and not working	4,687	40.5	25.8	4.3	16.5	13.0
Limited and working	1,088	5.5	64.1	7.1	5.5	17.8
Not limited	33,105	1.9	76.2	6.5	1.1	14.4

^a Subgroup percentages may not sum to 100% due to rounding.

^b Persons with more than one type of insurance are assigned to the first applicable category shown.

Source: Current Population Survey, March 1999.

Table 3
Percent Distribution of Uninsured and Individually Insured Persons 50–64 Years of Age
by Income, Employment, Health Status, and Disability, 1998^a

Characteristics	Uninsured			Individual Insurance		
	50–54	Age 55–61	62–64	50–54	Age 55–61	62–64
Employment Status						
Employed	72.4	59.9	47.6	83.0	68.0	50.3
Full time/full year	44.7	36.9	24.7	55.3	40.0	23.5
Part time/full year	8.1	8.9	6.9	10.2	11.5	12.5
Full time/part year	14.0	7.8	7.7	8.2	7.7	4.4
Part time/part year	5.6	6.3	8.3	9.3	8.8	9.9
Not employed	27.7	40.1	52.4	17.0	32.1	49.9
Retired	4.3	15.1	31.4	5.3	16.6	36.3
Other	23.4	25.0	21.0	11.7	15.5	13.6
Income						
<100% of poverty	26.7	31.2	25.6	14.2	18.4	12.5
100%–150% of poverty	13.7	13.3	15.1	6.7	9.1	10.1
150%–200% of poverty	9.7	9.7	13.3	8.9	8.7	12.6
200%–300% of poverty	14.6	15.3	14.7	18.1	16.4	19.2
>300% of poverty	35.4	30.6	31.3	52.1	47.5	45.7
Self-Reported Health Status						
Excellent	16.5	13.9	13.9	32.2	21.3	21.3
Very good	29.2	26.2	26.2	31.4	31.1	29.7
Good	35.0	34.9	30.2	23.0	28.7	28.0
Fair	13.3	16.5	22.4	9.7	15.0	14.6
Poor	6.0	8.5	7.4	3.8	3.9	6.5
Work Disability						
Limited	10.6	16.0	18.8	9.0	11.7	14.6
Not working	7.0	12.8	14.8	5.1	8.9	11.5
Working	3.6	3.2	4.0	3.9	2.8	3.1
Not limited	89.5	83.9	81.3	91.0	88.3	85.4

^a Subgroup percentages may not sum to 100% due to rounding.

Source: Current Population Survey, March 1999.

Table 4
Transitions Out of Full-Time Work Among Persons 51–61 Years of Age, 1992–94

	Age in 1992		
	51–54	55–59	60–61
Percent Distribution of Full-Time Workers in 1992 by 1994 Employment ^a			
Full-time same job	73.5	72.6	59.3
Full-time different job	10.4	6.7	3.1
Part-time	4.9	6.8	11.2
Unemployed	3.0	2.2	1.5
Retired	3.0	7.5	20.5
Others not in labor force	4.7	3.3	2.9
Percent Working Full-Time			
1994	58.0	47.4	32.2
1992	62.7	53.8	46.7
Change	-4.7	-6.4	-14.5

^a Subgroup percentages may not sum to 100% because of rounding and missing values for 1994 employment.

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 5
Changes in Work Disability and Health Among Persons 51–61 Years of Age, 1992–94

	Age in 1992		
	51–54	55–59	60–61
Percent Distribution of Persons Without Disability in 1992 by Disability in 1994			
Not limited	90.2	88.3	88.2
Limited in kind or amount	6.4	8.0	7.7
Unable to work	3.4	3.8	4.0
Percent with Worse Health in 1994 by 1992 Health Status			
Total	16.4	17.1	19.0
Excellent	5.8	5.5	7.2
Very good	10.1	10.2	13.7
Good	19.5	15.2	18.8
Fair	33.8	32.6	35.6
Poor	52.0	55.0	50.8

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 6
Transitions Out of Employer Insurance Among Persons 51–61 Years of Age, 1992–94

	Age in 1992		
	51–54	55–59	60–61
Percent Distribution of Those with Employer Insurance in 1992 by 1994 Insurance ^a			
Medicare	1.0	2.1	3.4
Employer	93.8	92.9	92.7
Individual insurance	1.6	1.8	2.0
Medicaid	0.1	0.2	0.0
Uninsured	3.5	3.0	2.0
Percent with Employer Insurance			
1994	75.4	70.7	69.5
1992	75.4	72.1	71.5
Change	0.0	-1.4	-2.0

^a Persons with more than one type of insurance are assigned to the first applicable category shown.

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 7
Health Insurance in 1994 of 1992 Employer Policyholders Who Stopped Working or Were Newly Disabled (Persons 51–61 Years of Age)^a

Employer Policyholders in 1992	Stopped Working	Newly Disabled
Percent on Medicare in 1994	1.6	0.9
Percent on Medicaid in 1994	0.8	0.8
Percent with Employer in 1994	82.1	88.5
Percent with Individual in 1994	4.9	2.2
Percent Uninsured in 1994	10.6	7.7

^a Persons with more than one type of insurance are assigned to the first applicable category shown.

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 8
Percent Distribution of the Newly Uninsured in 1994 by Current
and Prior Employment (Persons 51–61 Years of Age)^a

	Newly Uninsured
Full-Time in 1994	36.2
Same job in 1992	20.9
Different job in 1992	12.2
Did not previously work	3.1
Part-Time in 1994	17.3
Same job in 1992	5.2
Different job in 1992	7.4
Did not previously work	4.7
Unemployed in 1994	8.7
Not in Labor Force in 1994	33.2

^a Subgroup percentages may not sum to 100% because of rounding and missing values for 1994 employment.

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 9
Percent Distribution of the Newly Uninsured in 1994 by Current
and Prior Work Limitations (Persons 51–61 Years of Age)

Work Limitations	Newly Uninsured
Not Limited	68.2
Ongoing Limitation	17.6
Currently limited, previously limited	5.9
Currently unable to work, previously limited	11.7
New Work Limitation	14.2
Currently limited, previously not limited	8.3
Currently unable to work, previously not limited	5.9

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 10
Percent Distribution of the Uninsured, Individually Insured, and Medicare Enrollees
in 1994 by 1992 Insurance (Persons 51–61 Years of Age)^{a,b}

1992 Insurance	Age in 1992		
	51–54	55–59	60–61
Uninsured in 1994			
Medicare	2.0	1.6	1.9
Employer	21.8	17.9	14.6
Individual	6.3	11.9	18.9
Medicaid	1.6	3.5	2.4
Uninsured	68.2	65.1	62.2
Individual Insurance in 1994			
Medicare	0.7	0.4	1.0
Employer	22.5	18.3	15.6
Individual	48.0	61.2	59.1
Medicaid	0.8	0.9	1.6
Uninsured	28.0	19.3	22.7
Medicare in 1994			
Medicare	46.8	55.5	40.3
Employer	17.5	23.2	29.4
Individual	3.9	2.7	1.6
Medicaid	11.0	6.4	9.4
Uninsured	20.7	12.2	19.4

^a Subgroup percentages may not sum to 100% due to rounding.

^b Persons with more than one type of insurance are assigned to the first applicable category shown.

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 11
Percent Distribution of 1993 Income of the Previously Uninsured and Those Who
Lost Employer Insurance Between 1992 and 1994 (Persons 51–61 Years of Age)

1993 Income	Previously Uninsured ^a	Lost Employer Insurance ^b
<100% of Poverty	26.9	10.0
100%–150% of Poverty	12.8	9.1
150%–200% of Poverty	12.6	7.1
200%–300% of Poverty	16.2	12.5
>300% of Poverty	31.7	61.4

^a Uninsured in 1992 and 1994.

^b Employer insurance in 1992 and either uninsured or individually insured in 1994.

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 12
Comparison of 1992 and 1994 Health Insurance Status (Persons 51–61 Years of Age in 1992)

Source of 1992 Health Insurance	Population (thousands)	Source of 1994 Health Insurance (percent distribution)								
		Total	Employer*				Individual Insurance	Medicare	Medicaid	Uninsured
			Policyholder		Dependent					
			Same Group	Different Group	Same Group	Different Group				
Total	23,675	100.0	43.7	8.4	18.0	2.3	6.7	5.9	3.3	11.7
Employer* (policyholder)	12,272	100.0	84.0	7.6	0.2	1.4	1.6	1.6	0.1	3.4
Employer* (dependent)	5,089	100.0	NA	7.7	83.1	2.6	2.2	2.3	0.1	2.1
Individual Insurance	1,565	100.0	NA	15.5	NA	4.8	57.5	2.5	1.2	18.6
Medicare	922	100.0	4.1	1.5	1.5	0.3	1.0	75.2	11.1	5.5
Medicaid	628	100.0	NA	2.0	NA	0.3	2.5	18.6	65.1	11.5
Uninsured	3,200	100.0	NA	12.3	NA	5.0	11.3	7.1	7.3	57.1

* Includes CHAMPUS/CHAMPVA and other military insurance. People are assigned to the first applicable category shown. Subgroup percentages may not sum to 100% because of rounding.

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 13
Comparison of 1992 and 1994 Employment Status (Persons 51–61 Years of Age in 1992)

1992 Employment	Population (thousands)	1994 Employment (percent distribution)							
		Total	Employed Full-Time		Employed Part-Time		Unemployed	Not in Labor Force	
			Same Job	Different Job	Same Job	Different Job		Retired	Other
Total	23,675	100.0	40.4	9.0	8.9	4.3	2.6	14.5	19.1
Employed Full-Time	13,329	100.0	71.4	7.9	4.2	2.3	2.5	7.1	3.9
Employed Part-Time	2,986	100.0	NA	21.2	50.8	7.6	2.0	7.4	10.1
Unemployed	711	100.0	NA	30.7	NA	14.9	17.1	8.1	28.3
Retired	2,241	100.0	NA	3.5	NA	5.6	1.1	76.0	10.2
Other Not in Labor Force	4,279	100.0	NA	3.2	NA	5.5	1.6	11.7	75.6

Subgroup percentages will not sum to 100% because of rounding and missing values for 1994 employment.

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 14
Comparison of 1992 and 1994 Health Status (Persons 51–61 Years of Age in 1992)

1992 Health	1994 Health	
	Fair/Poor	Worse Than 1992 (self-perceived)
Total	21.8%	17.1%
Excellent	2.8	5.9
Very Good	6.0	10.7
Good	19.1	17.4
Fair	63.6	33.5
Poor	88.3	53.4

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

Table 15
Comparison of 1992 and 1994 Work Limitations (Persons 51–61 Years of Age in 1992)

1992 Work Limitation	Population (thousands)	1994 Work Limitation (percent distribution)			
		Total	Not Limited	Limited in Kind or Amount of Work	Unable to Work
Total	23,489	100.0	75.0	11.4	13.6
Not Limited	18,611	100.0	89.1	7.3	3.6
Limited in Kind or Amount of Work	2,190	100.0	39.2	43.0	17.8
Never Worked Regularly	462	100.0	18.7	16.6	64.7
Unable to Work	2,226	100.0	4.3	13.8	81.9

Subgroup percentages may not sum to 100% because of rounding.

Source: Health and Retirement Study, Wave 1 (1992) and Wave 2 (1994).

APPENDIX: DESCRIPTION OF DATA SOURCES AND ESTIMATION METHODS

We used population weights in all of our survey analyses and adjusted for survey design effects in estimating standard errors. Unless otherwise noted, all differences discussed in the text are statistically significant at the 0.05 level for a two-tailed test.

Current Population Survey

The Current Population Survey (CPS) is a nationally representative survey of approximately 50,000 households conducted monthly by the Bureau of the Census for the Bureau of Labor Statistics (U.S. Census Bureau and Bureau of Labor Statistics 2000). The sample is randomly selected to represent the civilian noninstitutionalized population of the United States. Sampling occurs within 2,007 primary sampling units that are grouped into strata within each state. Usually a single household respondent provides information for everyone in the household. The Annual Demographic Survey, or March Supplement, is the source of annual income, employment, and health insurance data for the preceding calendar year. The data that we present here are from the 1999 March Supplement and refer to calendar year 1998. (See Swartz 1997 for a current and historical review of CPS methods related to the measurement of health insurance.)

For each person aged 15 or older, the CPS questionnaire asks about coverage under employer- or union-sponsored insurance, Medicare, Medicaid, CHAMPUS/CHAMPVA/military insurance, or individual private insurance in the preceding calendar year. People who give negative responses to all of these probes are counted as uninsured, with the implication being that they were without coverage for the entire year. However, because estimates from the CPS of the all-year uninsured are high in relation to all-year estimates derived from longitudinal surveys that track coverage over a year, many analysts believe that CPS respondents have a tendency to report the coverage in place at the time of the interview (Lewis, Ellwood, and Czajka 1998).

In our analysis of the CPS data, we assigned respondents with more than one type of insurance to mutually exclusive categories according to the following hierarchy: all respondents with Medicare were assigned to that category, followed by employer insurance, private individual insurance, Medicaid, and uninsured. Coverage through CHAMPUS/VA for military retirees and dependents was treated as employer insurance.

We used the official definitions in categorizing the family incomes of respondents in the CPS as a percentage of the poverty level. (The March Supplement of the CPS is the

source of official estimates of the poverty rate in the U.S.) The official methodology defines poverty by comparing the combined income of all related persons living in the same household to a poverty threshold that is adjusted for family size.

Health and Retirement Study

The Health and Retirement Study is a nationally representative longitudinal study sponsored by the National Institute on Aging that is examining health and retirement patterns in the United States. The original sample cohort consisted of noninstitutionalized adults born from 1931 to 1941, and their spouses (regardless of the spouse's age). A multistage area probability sampling procedure was used to select participants, with household financial units (including at least one age-eligible member and, if applicable, that person's spouse) as the observational unit. If more than one unrelated age-eligible person resided in a housing unit, then one person was randomly selected within the housing unit to participate in the study. Blacks, Hispanics, and residents of Florida were oversampled to increase their representation in the study.

The first wave of interviewing took place in 1992, with follow-up waves every two years. (Respondents are not necessarily interviewed in the same calendar month every wave, so the time interval between individual interviews often is not exactly two years.) Most Wave 1 interviews were conducted in person; Wave 2 interviews conducted in 1994 were mainly by telephone.

Unlike Sloan and Conover, we limited our analyses to people in the 1931–41 birth cohort, who were age 51 to age 61 in Wave 1 and 53 to 63 in Wave 2. This means that our HRS analyses were limited to the population younger than 62 in 1992 and younger than 64 in 1994. We believe that it is inappropriate to try to represent the entire population younger than age 65 in either of these waves by including spouses who were interviewed, because unmarried people who were born before 1931 are not represented.

In addition, by limiting our analysis to the HRS birth cohort, we were able to use the population weights that were developed for the survey. These weights correct for differential nonresponse and unequal probabilities of selection (including the oversampling of married individuals). Because the survey was designed to be nationally representative only of the 1931–41 cohort, positive weights were assigned only to respondents in this cohort.

In Wave 1, the HRS collected data for 12,652 people (including age-eligible respondents and their spouses) in 7,702 households (HRS 1995). Approximately 82

percent of eligible respondents participated in Wave 1 (HRS 1999). Only 9,825 of these people were age-eligible and were assigned positive weights for Wave 1 (HRS 1998). Because of our interest in health insurance transitions, we included only people with non-missing insurance data in both Wave 1 and Wave 2 in our analyses. After excluding Wave 1 respondents who did not participate in Wave 2 (891 with positive Wave 1 weights) and others with missing insurance data in either wave (173 with positive Wave 1 weights), there were 8,761 people in our final analysis sample.⁴ We inflated the Wave 2 weights of this smaller sample to match the weighted population counts and demographic distributions of the full Wave 2 sample (persons with positive Wave 2 weights in the public use file). We made these adjustments within the same weighting classes (involving race/ethnicity, census region, age, and gender) that were used in the post-stratification of the original HRS weights.

Unlike the estimates from the CPS, estimates of health insurance status (and employment status) from the HRS refer to a person's status at the time of the interview. We used the same hierarchy that we used in the CPS in assigning people to mutually exclusive insurance categories in the HRS. In distinguishing between policyholder and dependents with employer insurance in our analysis of the HRS, we assigned anyone with coverage through his or her own employer to the policyholder category. Two features of the HRS questionnaires that could affect estimates of changes in coverage between waves should be noted. First, employer insurance in Wave 2 was primarily determined by asking respondents if they were still covered by the employer plans reported in Wave 1. All other sources of coverage were determined independently, without referring to the Wave 1 data in Wave 2. Second, although the knowledgeable financial respondent provided insurance data for both spouses in Wave 1, each spouse was asked about his/her own coverage in Wave 2.

Questions about employment status, self-reported health status, and work limitations in Wave 1 and Wave 2 were asked independently. However, respondents who reported that they were working in both waves were asked if they had changed jobs between waves. Also, respondents were asked in Wave 2 if their health had changed over the two years ("Compared with your health two years ago, would you say that your health is much better now, somewhat better now, about the same, somewhat worse, or much worse than it was then?")

Finally, we departed from the official definition of poverty in categorizing the family incomes of respondents in Wave 1 and Wave 2 as a percentage of the poverty level. We added the individual incomes of couples and considered only the individual income of

unmarried persons (regardless of the presence of other relatives in the household). We used the total income for each person that was constructed for the Wave 1 public use file and aggregated components of each person's income on the Wave 2 file according to the procedure used in constructing the total income variable on the Wave 1 public use file.

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#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

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#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

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#207 *Uninsured Older Adults: Implications for Changing Medicare Eligibility* (April 1998). Pamela Loprest and Cori Uccello, The Urban Institute. The authors examine the growing number of uninsured Americans between ages 58 and 63 who are not yet eligible for Medicare and may not have access to group or private health insurance. They also assess proposals that could increase this age group's accessibility to health care.

NOTES

¹ State regulations that govern the individual market usually allow insurers to charge higher premiums to older policyholders (and to vary premiums with gender and health status), so that young, healthy buyers will not be driven out of the market (Chollet and Kirk 1998).

² This estimate for 55-to-64-year-olds matches the estimate from the 1999 CPS that was released by the Employee Benefits Research Institute (Fronstin 2000). According to the EBRI estimates for all age groups, the uninsured rate for 35-to-44-year-olds is slightly higher (17.3%) and the uninsured rate for 45-to-54-year-olds is slightly lower (13.7%). From earlier CPS estimates released by EBRI, it appears that the uninsured rate for 55-to-64-year-olds increased from 13 percent in 1995 (EBRI 1996) to 15 percent in 1998. During the same time period, the rate for 35-to-44-year-olds remained essentially unchanged and the rate for 45-to-54-year-olds increased by about 1 percent.

³ The small percentage of recent disenrollees from employer insurance reflects the presence of a “hard core” of uninsured and nongroup enrollees who do not have employer insurance in their early fifties, as well as the timing of disenrollment after age 50. Thirteen percent of people in the age group from 50 to 54 were uninsured in 1998, according to the CPS, and 5 percent were covered by nongroup plans. Our estimates from the HRS suggest that more than two-thirds of the uninsured in their early fifties had been without coverage for at least two years.

⁴ Out of the 9,825 person records with positive Wave 1 weights, 248 did not link to the data file with the Wave 1 insurance data. This group included 106 people who dropped out of HRS between Wave 1 and Wave 2, because they were reassigned to a different component of the study (the AHEAD Survey). There were 142 individuals in married-couple households where the Wave 1 insurance data were not collected, because the spouse with the best knowledge of the couple’s finances refused to be interviewed.