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Notes

EXECUTIVE SUMMARY

The Impact of PPACA on Employment-Based Health Coverage of Adult Children to Age 26

MANDATE FOR COVERING ADULT CHILDREN: The Patient Protection and Affordable Care Act (PPACA) enacted March 23, 2010, requires that group health plans and insurers make dependent coverage available for children until they attain the age of 26, regardless of tax or student status, or dependent status as it relates to financial support. The mandate to offer coverage to adult children ages 19–25 took effect for policy years that begin on or after Sept. 23, 2010, but since January is the beginning of the plan year for most employment-based health plans, many insurers adopted the requirements of the law before the effective date.

AVAILABLE DATA: This report reviews the evidence as to whether the mandate to extend coverage to adult children had an effect on the percentage of young adults with coverage in late 2010 and early 2011. Data from the Census Bureau's Current Population Survey (CPS) and Survey of Income and Program Participation (SIPP) are examined, as well as data from the Center for Disease Control's National Health Interview Survey (NHIS).

PPACA HAS INCREASED COVERAGE: The data from these three surveys suggest that the PPACA's coverage mandate has resulted in an increase in the percentage of young adults with employment-based health coverage as a dependent.

Spending Adjustments Made By Older Americans to Save Money

INVOLUNTARY SPENDING ADJUSTMENTS: Data from the 2009 Internet Survey of the Health and Retirement Study (HRS) show that more than 1 in 5 (21.5 percent) of those aged 50 or above made prescription drug changes such as switching to cheaper generic drugs, getting free samples, stopping pills or reducing dosages, and nearly as many (19.4 percent) skipped or postponed doctor appointments to save money.

LESS HEALTHY DO MORE ADJUSTMENTS: Among those in (self-reported) poor health, 29.9 percent made prescription drug changes and 36.5 percent skipped or postponed doctor appointments to save money. For those in excellent health, the comparable numbers were 15.3 percent and 9.5 percent, respectively.

SINGLE WOMEN AND BLACKS ADJUST MOST: Among different demographic groups, single women and blacks had the highest involuntary spending adjustments: 22.8 percent and 24.8 percent of single women made prescription drug changes and skipped or postponed doctor appointments to save money. Similar numbers for blacks were 25.9 percent and 27.3 percent, respectively.

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The Impact of PPACA on Employment-Based Health Coverage of Adult Children to Age 26

By Paul Fronstin, Employee Benefit Research Institute

Introduction

The Patient Protection and Affordable Care Act (PPACA) of 2010, requires that group health plans and insurers make dependent coverage available for children until they attain the age of 26, regardless of tax or student status, or dependent status as it relates to financial support. Group plans and insurers also may not limit dependent coverage based on whether the child is married, although the law does not extend the mandate for access to coverage to the married child's spouse and/or children. Group health plans that were "grandfathered" under the law are not required to offer coverage to adult children if they currently have their own employment-based coverage or if they are eligible for such coverage.

The mandate to offer coverage to adult children ages 19–25 took effect for policy years that begin on or after September 23, 2010. Given that January is the beginning of the plan year for most employment-based health plans, many parents would not have been able to cover their adult children until January 2011. Many insurers adopted the provisions of the law before its effective date,[1] but it was up to employers to decide whether to offer the coverage early.

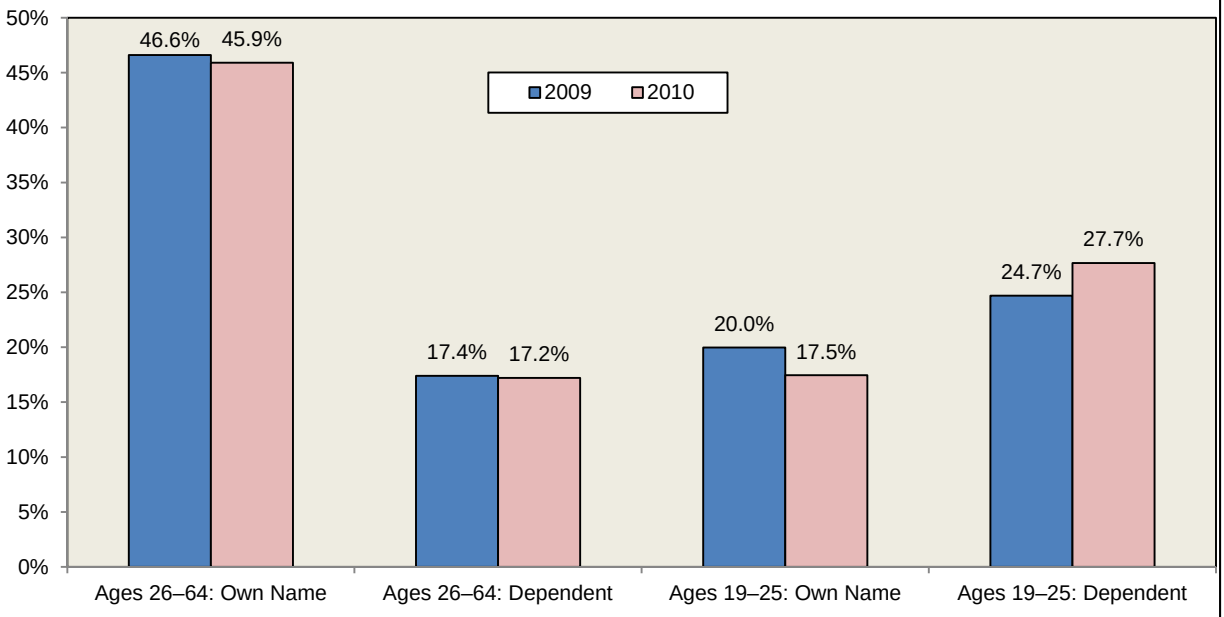
This report reviews the evidence as to whether the mandate to extend coverage to adult children had an effect on the percentage of young adults with coverage in late 2010 and the first half of 2011. Data from the Census Bureau's Current Population Survey (CPS) and Survey of Income and Program Participation (SIPP) are examined, as well as data from the Center for Disease Control's National Health Interview Survey (NHIS). The data from these three surveys suggest that the PPACA's coverage mandate has resulted in an increase in the percentage of young adults with employment-based health coverage as a dependent.

Findings from the Current Population Survey (CPS)

In mid-September 2011, the Census Bureau reported that the percentage of individuals ages 18–24 who were uninsured fell from 29.3 percent in 2009 to 27.2 percent in 2010.[2] The finding was touted[3] as an indication that "health reform is working," but it is natural to be skeptical about the real impact of a policy that was only in effect for three months in 2010, and even then only in situations when employers chose to voluntarily expand their current coverage to include the provision, since most plan years start January 1.

Closer examination of the Census data shows that the percentage of persons ages 19–25 with employment-based coverage as a dependent increased from 24.7 percent in 2009 to 27.7 percent in 2010 (Figure 1). The number of persons ages 19–25 with employment-based coverage as a dependent increased from 7.3 million to 8.2 million. It should be noted, however, that the increase in employment-based coverage as a dependent could be the result of individuals losing coverage through work and thus moving from employment-based coverage in their own name to employment-based coverage as a dependent, which was observed for persons ages 19–25.[4] The percentage of individuals ages 19–25 with coverage through their own job fell from 20 percent in 2009 to 17.5 percent in 2010. However, such a notable effect was not observed for adults ages 26–64. The percentage of adults 26–64 with employment-based health coverage in their own name fell from 46.6 percent in 2009 to 45.9 percent in 2010, while the percentage with coverage as a dependent slipped from 17.4 percent to 17.2 percent.

Figure 1
Percentage of Individuals Ages 19–64 With Employment-Based Health Benefits, by Source of Coverage, 2009 and 2010



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2010 and March 2011 supplement.

Findings From the Survey of Income and Program Participation (SIPP)

SIPP, conducted by the Census Bureau, is useful for examining the impact of PPACA on health insurance coverage of adult children because coverage can be examined monthly. Data are currently available on a monthly basis through November 2010. Examination of the SIPP data shows an increase in dependent coverage in October and November 2010.

Figure 2 contains monthly data for 2010 on the percentage of individuals ages 19–25 and 26–64 with employment-based health coverage in their own name, while Figure 3 shows the average for January–September and October–November. The percentage of individuals with employment-based health coverage in their own name was lower in October and November 2010 for both age cohorts as compared with January–September (Figure 2). The percentage of individuals ages 19–25 with employment-based health coverage in their own name averaged 20.1 percent during January–September 2010, and fell to an average 19.3 percent during October and November (Figure 3). Similarly, among 26–64-year-olds, it averaged 44.9 percent during January–September 2010, and fell to an average 44.4 percent during October and November.

In contrast to the findings for employment-based health coverage in one's own name, the percentage of individuals with dependent coverage decreased among those ages 26–64, but increased among those ages 19–25. The percentage of individuals ages 19–25 with employment-based health coverage as a dependent averaged 26.9 percent during January-September 2010, and increased to an average 27.1 percent during October and November, while among 26–64-year-olds, it averaged 18.5 percent during January–September 2010, and fell to an average 18.2 percent during October and November. Figure 4 contains the monthly data for 2010 on the percentage of individuals ages 19–25 and 26–64 with employment-based health coverage as a dependent.

It should be noted that because of the rolling nature of interviews, data are currently available for only three-quarters of the sample in September 2010, one-half of the sample in October 2010, and one-quarter of the sample in November 2010. Future data releases will contain data for the entire sample for these months. It is possible that when data for the full sample are available, the estimates presented in this paper may be revised.

Findings from the National Health Interview Survey (NHIS)

NHIS is the only survey that has data on health insurance coverage for 2011. This allows examination of the impact of PPACA on young adult health coverage after January 1, 2011, when most employers were required to comply with the adult dependent mandate. Full-year data on the percentage of the population with any private insurance and the percentage uninsured are available for 2010. Data for the first three months for 2011 were made available in September 2011 and data for the first half of 2011 were made available in December 2011. Data on the percentage of the population with employment-based coverage as a dependent were not published. Similarly, data for 26–64-year-olds were not published, and thus data for 19–25-year-olds are compared with the entire 18–64-year-old population.

The NHIS shows that the percentage of the population ages 18–64 with private health insurance increased slightly, from 64.1 percent to 64.2 percent between 2010 and the first half of 2011 (Figure 5). There was also a decline in the percentage uninsured, falling from 22.3 percent to 21.3 percent. The uninsured declined because the percentage with public coverage (mostly Medicaid) increased from 15 percent to 15.7 percent. Among those ages 19–25, the percentage with private insurance increased from 51 percent to 55.8 percent, and the percentage uninsured fell from 33.9 percent during 2010 to 28.8 percent during the first half of 2011.

Conclusion

This report reviewed evidence as to whether the mandate to extend coverage to adult children had an effect on the percentage of young adults with coverage in late 2010 and early 2011. According to data from the CPS, the percentage of persons ages 19–25 with employment-based coverage as a dependent increased from 24.7 percent in 2009 to 27.7 percent in 2010. SIPP shows that the percentage of individuals ages 19–25 with employment-based health coverage as a dependent averaged 26.9 percent during January–September 2010, and increased to an average 27.1 percent during October and November. According to data from the NHIS, the percentage with private insurance increased from 51 percent to 55.8 percent, and the percentage uninsured fell from 33.9 percent during 2010 to 28.8 percent during the first half of 2011 among those ages 19–25. Data from these three surveys show that PPACA has had a positive effect on the percentage of young adults with employment-based coverage as a dependent.

Endnotes

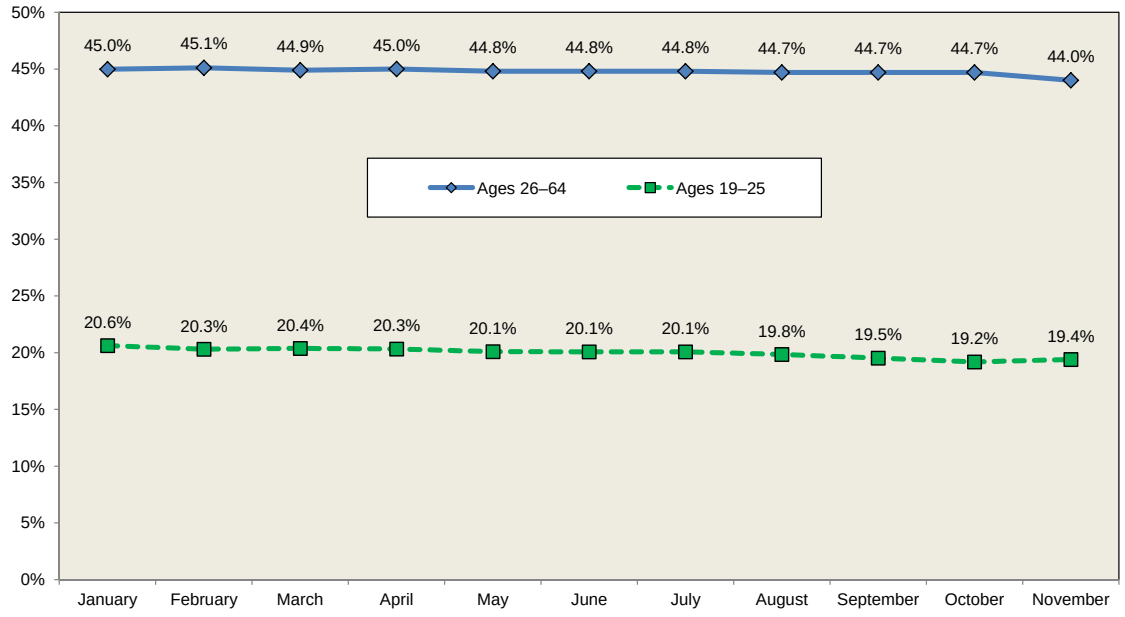
[1] A main reason for adopting this provision early was to avoid de-enrolling college graduates only to re-enroll them (www.bizjournals.com/phoenix/stories/2010/04/26/daily31.html). See www.dol.gov/ebsa/faqs/faq-dependentcoverage.html for a list of early adopters.

[2] See Table C-3 in www.census.gov\\prod\\2011pubs\\p60-239.pdf

[3] See www.healthcare.gov/blog/2011/09/fewer_uninsured091311.html

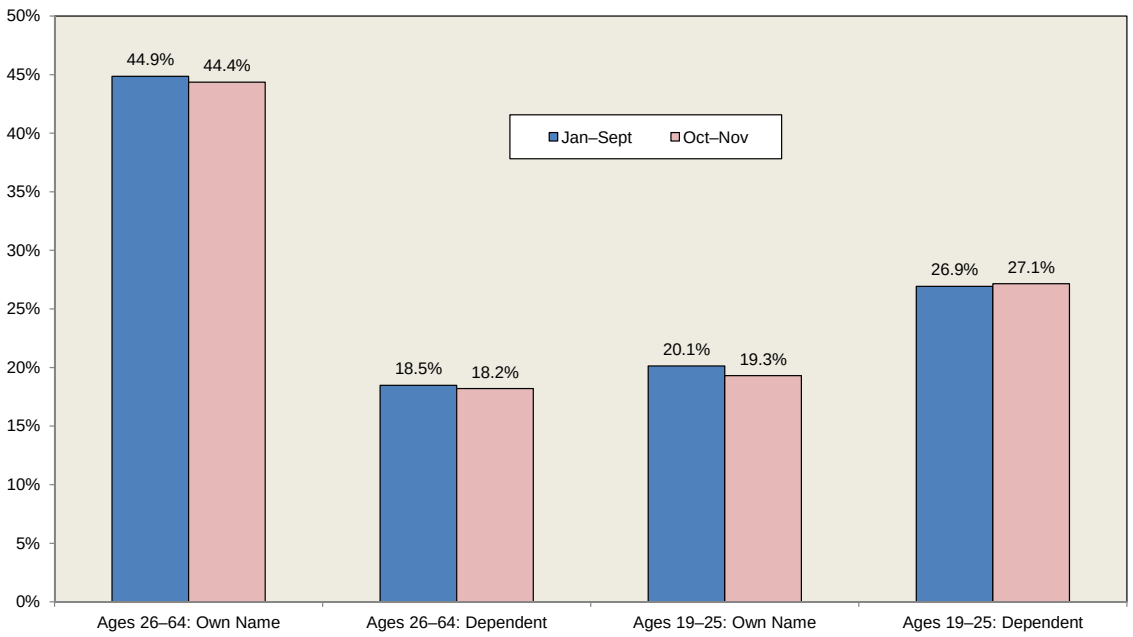
[4] Switching from coverage from one's own job to parent's coverage may also be due to the way health coverage is usually priced. For parents with family coverage, there is often no additional cost when adding another person to a family plan.

Figure 2
Percentage of Individuals Ages 19–64 With Employment-Based Health Benefits in their Own Name, by Month, 2010



Source: Employee Benefit Research Institute estimates from the Survey of Income and Program Participation, 2008 Panel.

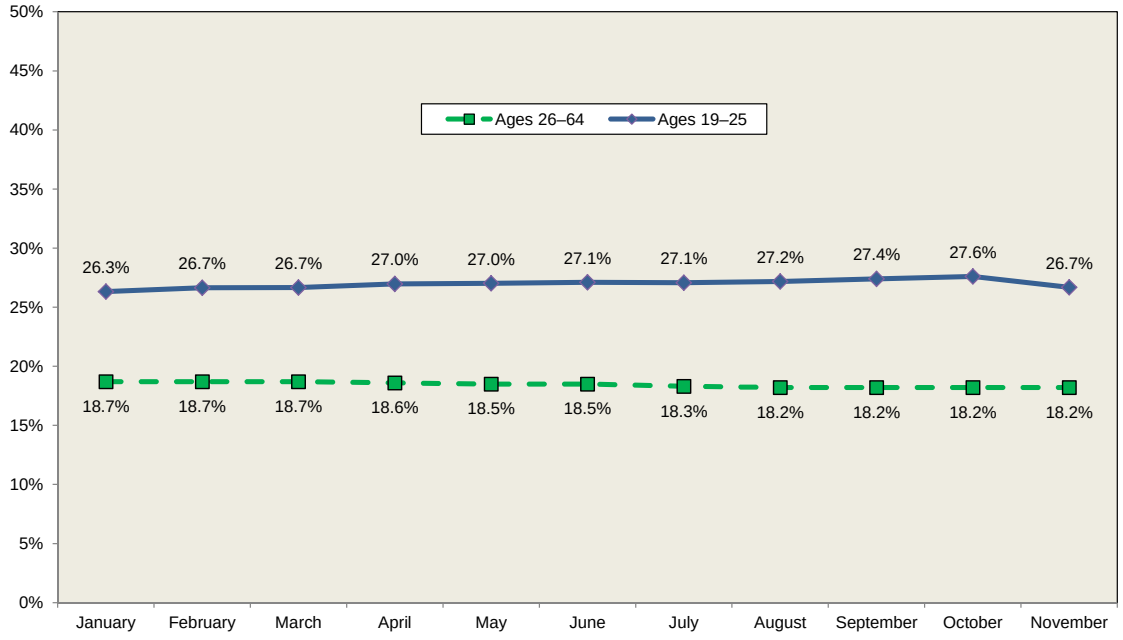
Figure 3
Percentage of Individuals Ages 19–64 With Employment-Based Health Benefits, by Source of Coverage, Monthly Average, Pre- and Post-PPACA, 2010



Source: Employee Benefit Research Institute estimates from the Survey of Income and Program Participation, 2008 Panel.

Figure 4

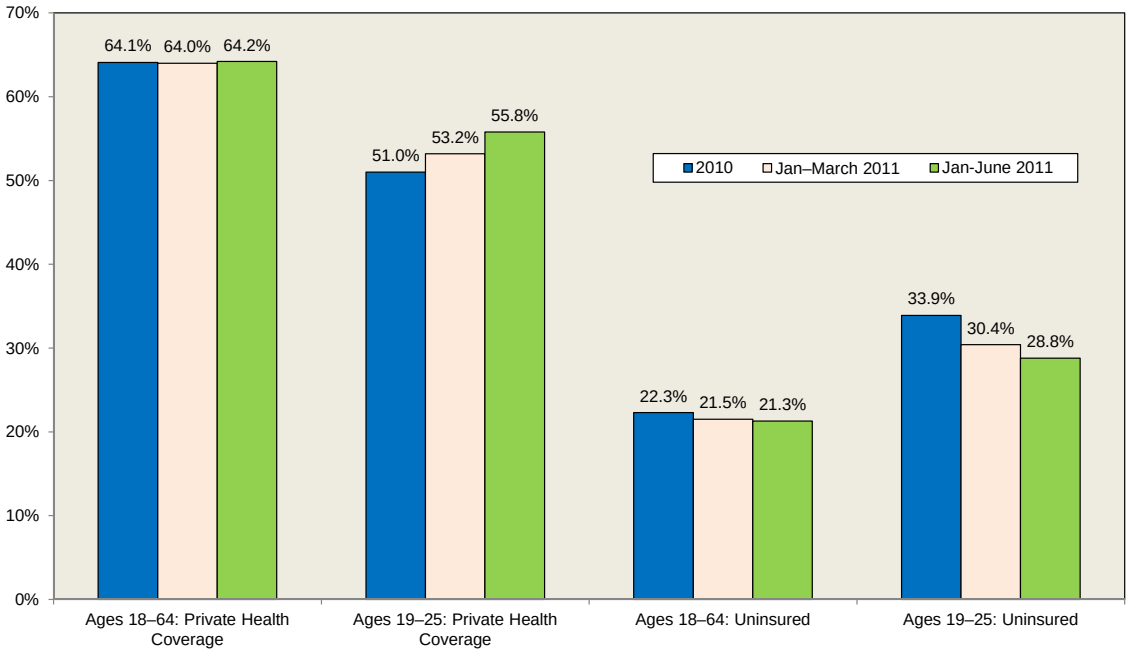
Percentage of Individuals Ages 19–64 With Employment-Based Health Benefits as a Dependent, by Month, 2010



Source: Employee Benefit Research Institute estimates from the Survey of Income and Program Participation, 2008 Panel.

Figure 5

Percentage of Individuals Ages 18–64 With Any Private Health Insurance and Percentage Uninsured, 2010-2011



Source: www.cdc.gov/nchs/data/nhis/earlyrelease/insur201109.pdf and http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201112.pdf

Spending Adjustments Made By Older Americans to Save Money

By Sudipto Banerjee, Employee Benefit Research Institute

Introduction

Studies (Banerjee, 2012) have documented that consumption falls with age, and Hurd and Rohwedder (2011) use this falling consumption pattern to show that 7 out of 10 people between ages 66 and 69 will be able to support their consumption needs in retirement. Using old-age consumption data to calculate required retirement income is better than calculating ad hoc income replacement rates. However, one problem with relying on consumption data for such a study is that falling consumption may be involuntary, reflecting an inability to spend due to lack of funds rather than optimal spending behavior.

Therefore, it is important to determine if falling consumption at older ages is involuntary, and, if so, to what extent. This study presents evidence suggesting that a large part of the older population may be making involuntary spending adjustments.

The data used for this analysis come from the 2009 Internet Survey of the Health and Retirement Study (HRS), the most comprehensive national survey of older Americans. HRS is sponsored by the National Institute on Aging (NIA) and Social Security Administration (SSA) and is administered by the Institute for Social Research (ISR) at the University of Michigan. A subsample of the HRS 2008 Core Survey (of persons who reported having Internet access) and respondents from earlier HRS Internet Surveys were selected for the 2009 Internet Survey. The field period for the survey was from March 2009 to August 2009, and it received 4,433 complete responses.

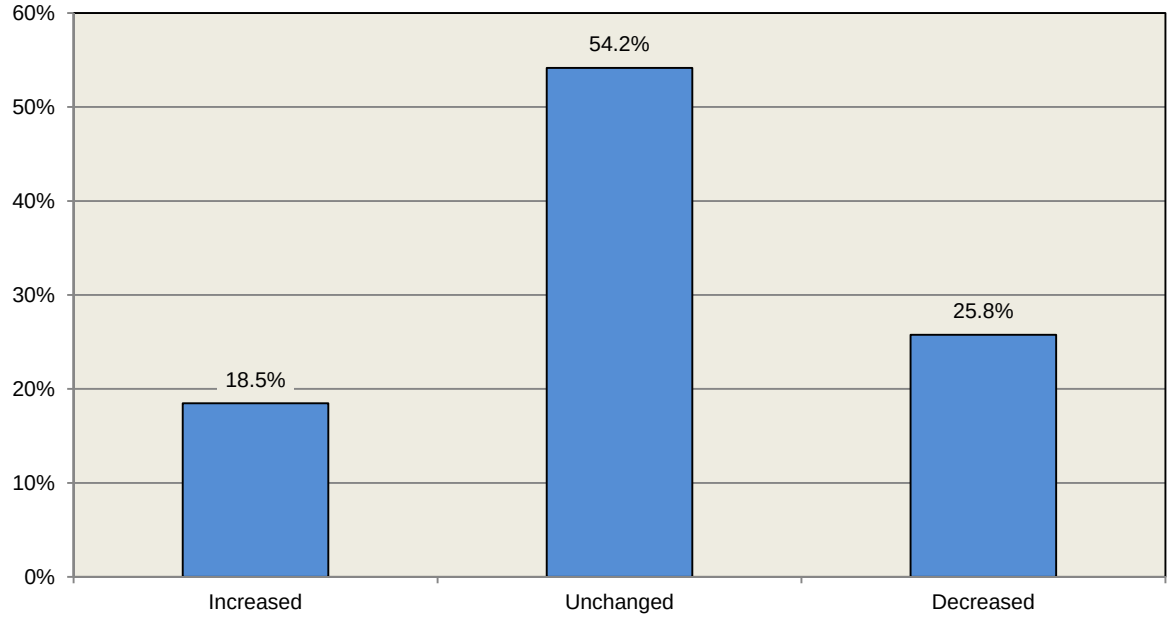
This survey asked respondents if they have made changes in prescription drugs to save money, skipped or postponed doctor appointments to save money, or found it difficult to pay their monthly bills. All these questions are used to examine the percentage of the population that is making such spending cuts. The study also examines how such behavior relates to key demographic characteristics such as race and marital status, and also examines the correlation of such involuntary spending cuts with self-reported health status.

Changing Household Spending and Its Reasons

Figure 1 shows the percentage of households, age 50 or over, who reported that their household spending increased, decreased, or remained unchanged compared with a year ago. For the majority (54.2 percent), spending remained unchanged. But 1 in 4 (25.8 percent) reported decreased spending, while 18.5 percent reported increased spending in the last year.

Figure 2 examines reason(s) the respondent cited as important (or not so important) for the decline in household spending. The reasons cited as very important by almost half of the sample (for whom spending dropped) were reduced income, a worrying economic future, and the need to reduce debt. Thirty-seven percent cited decrease in stock values as a very important factor for their spending cuts. Approximately 30 percent cited a change in employment and depreciating home value as very important factors in their reduced spending. Figure 3 shows the important (or not so important) factors for increased household spending among those who did so: Most (72 percent) reported increased household spending needs as the most important cause of rising expenses, including increased spending on medication, food, gas, utilities, etc. Sixteen percent reported an increase in income or wealth to be the most important factor for their increased spending, while 9 percent reported that better employment as the primary reason. Thus, it is clear that most of the older households that spent more did so in response to a higher cost of living.

Figure 1
Percentage of 50+ Households Whose Spending Increased, Decreased or Remained Unchanged Compared to a Year Ago



Source : Employee Benefit Research Institute estimates from the HRS 2009 Internet Survey.

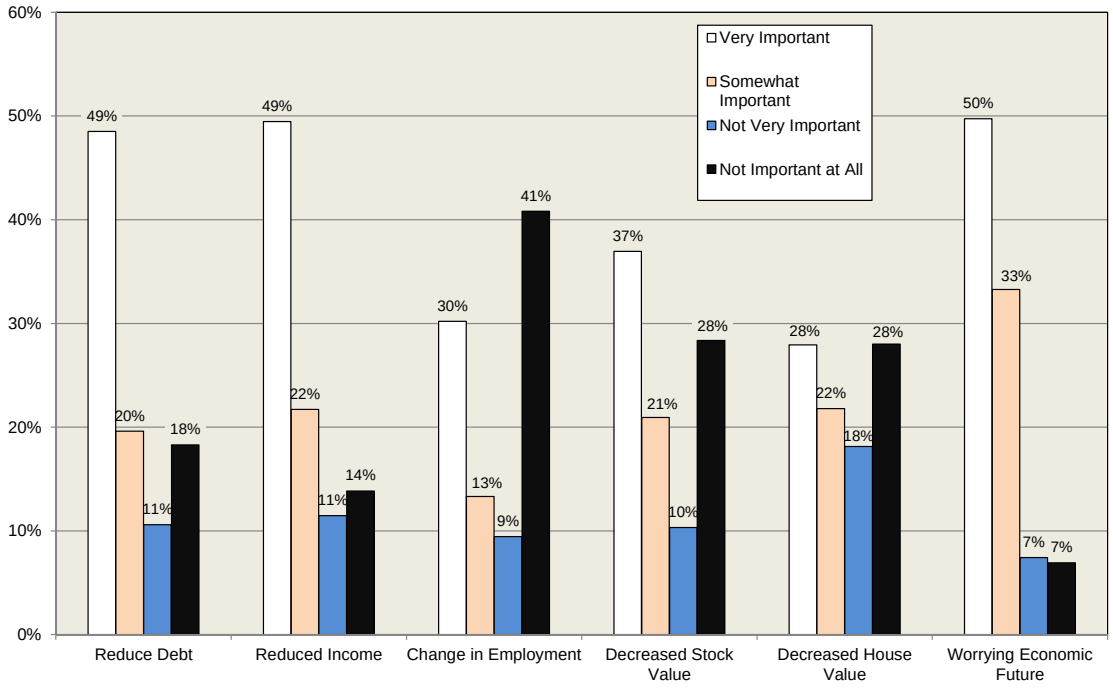
Involuntary Saving Behavior

Figure 4 reports the percentage of households that either made prescription drug changes or skipped/ postponed doctor appointments to save money. More than 1 in 5 (21.5 percent) households reported that they have made some changes in their prescription drugs to save money, and nearly as many report that they have either skipped or postponed doctor appointments to do so. Figure 4 also shows that 27.5 percent of households reported difficulty in paying their monthly bills.

Figure 5 shows that involuntary saving of this kind is almost equally prevalent among households that report increasing or decreasing annual spending. The size of the sample that made prescription drug changes to save money for those who reported reduced and increased spending was 28.3 percent and 27.7 percent, respectively. For skipped or postponed doctor visits, the numbers are 31.9 percent and 25.6 percent for reduced and increased spending, respectively. Even for those who reported that their spending was unchanged, 16.5 percent reported making prescription drug changes, while 11.7 percent reported skipping or postponing doctor visits to save money.

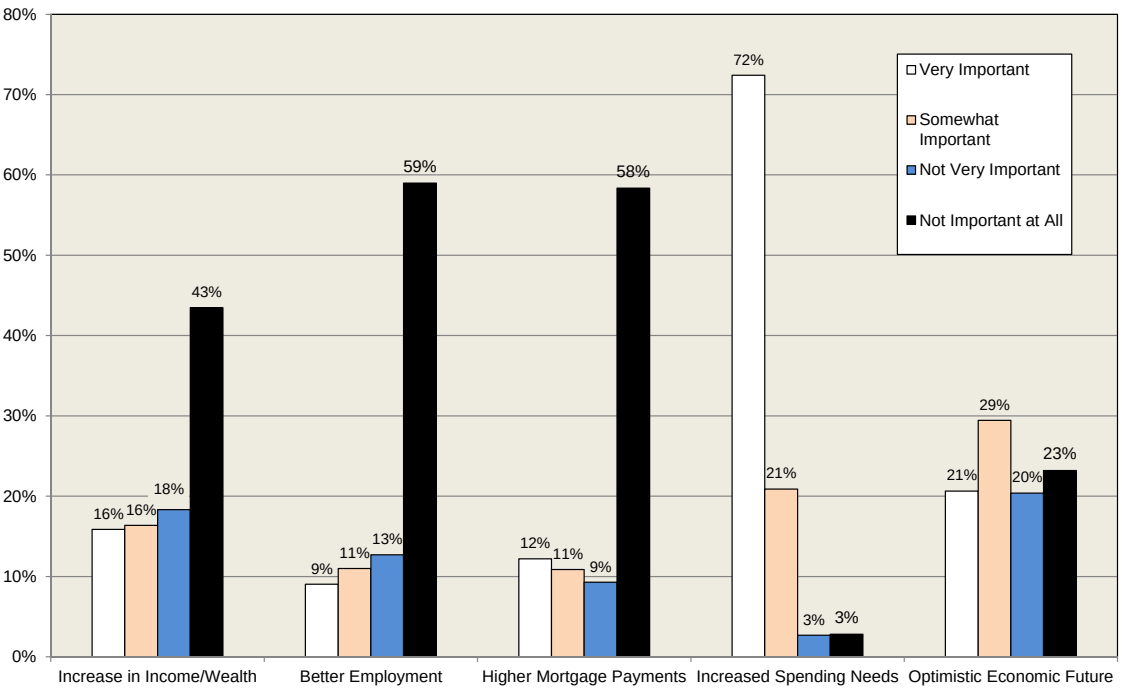
Figure 6 shows the different methods people adopted to make prescription drug changes to save money. Among the 21.5 percent of the entire sample who reported making such changes, the most frequently cited way (82.1 percent) to reduce prescription drug costs was to shift to cheaper generic drugs, and the next most-frequently cited method (40.3 percent) was getting free samples. More than a quarter (27.1 percent) of this group (making prescription drug changes), or 6 percent of the entire sample, reported that they stopped taking one or more pills. Also, 23 percent in this group—5 percent of the entire sample—reported splitting pills and taking a reduced dosage of their medication.

Figure 2
Relative Importance of Reasons for Drop in Household Spending



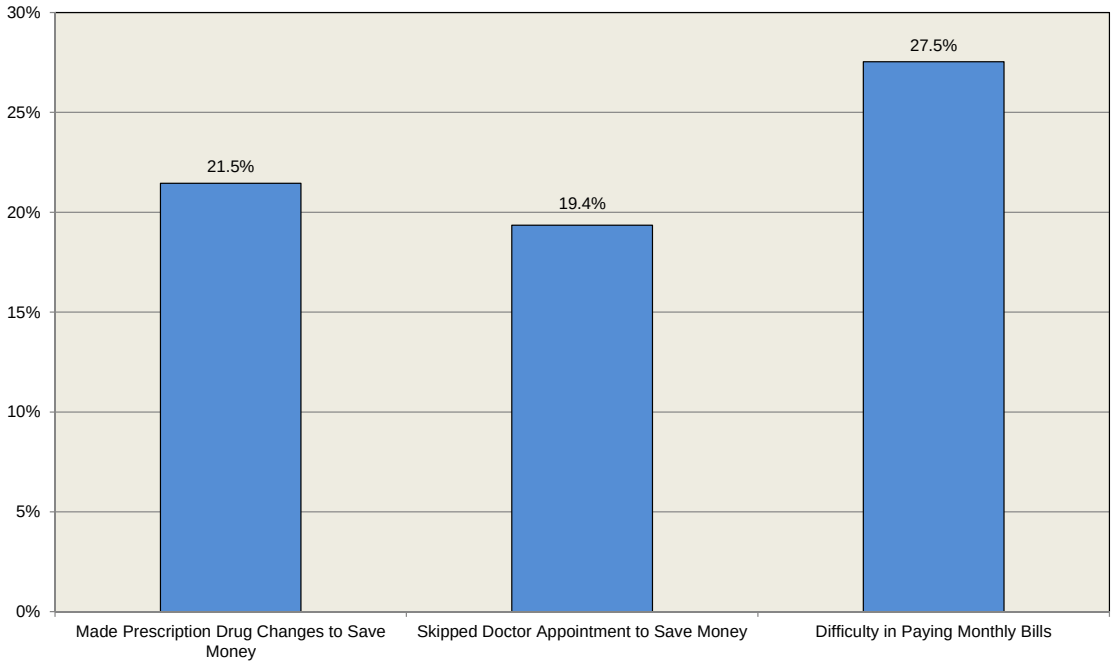
Source : Employee Benefit Research Institute estimates from the HRS 2009 Internet Survey.

Figure 3
Relative Importance of Reasons for Increase in Household Spending



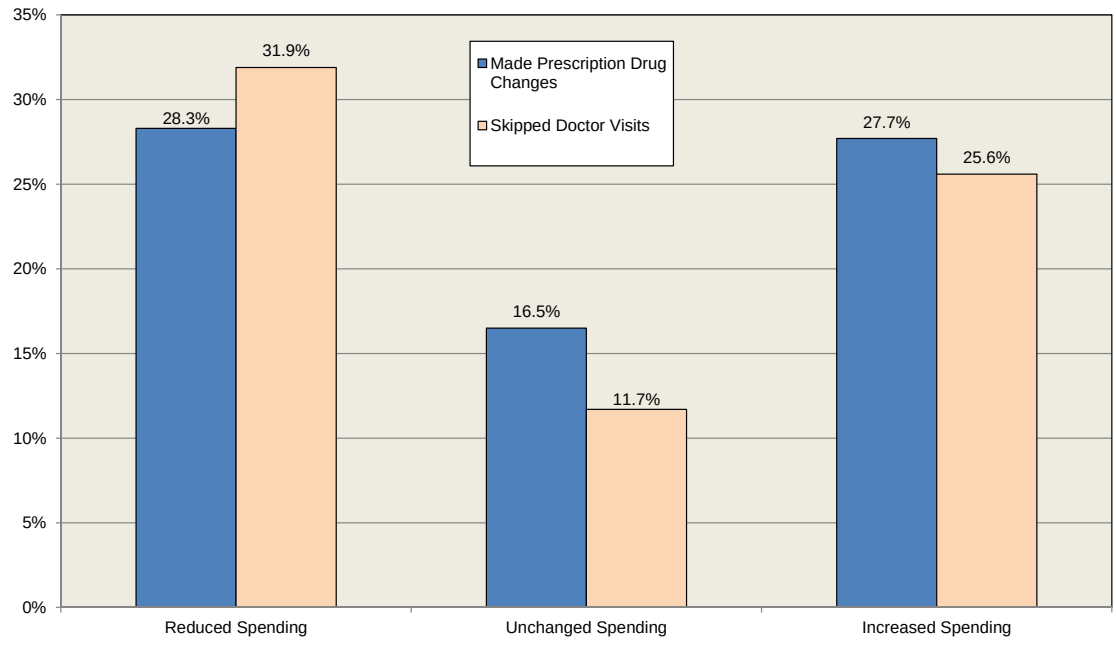
Source : Employee Benefit Research Institute estimates from the HRS 2009 Internet Survey.

Figure 4
Percentage of 50+ Households Which Made Different Involuntary Saving Decisions and Faced Difficulty in Paying Monthly Bills



Source : Employee Benefit Research Institute estimates from the HRS 2009 Internet Survey.

Figure 5
Involuntary Saving Behavior Among Households Whose Annual Spending Increased, Decreased or Remained Unchanged



Source : Employee Benefit Research Institute estimates from the HRS 2009 Internet Survey.

Involuntary Saving Behavior and Self-Reported Health

Skipping a pill or a doctor's appointment might not affect one's health significantly if he or she is in good health, but the data present a completely opposite correlation. Figure 7 shows that the percentage of those who made prescription changes or skipped/postponed doctor visits to save money increased directly with a worsening self-reported health condition. Among those claiming to be in excellent health, 15.3 percent reported making prescription drug changes to save money, a finding that almost doubled to 29.9 percent for those in poor health. Only 9.5 percent of those in excellent health reported skipping or postponing doctor appointments to save money, while nearly four times as many (36.5 percent) of those in poor health reported doing so.

Involuntary Saving Behavior Across Different Demographic Groups

Next, the study tries to identify how prevalent these practices are among different demographic groups. Figure 8 shows the percentage of married and single (male and female separately) individuals who report such involuntary saving behavior. The data clearly show that these practices are most prevalent among single women across all the marital status groups: 22.8 percent of single women reported that they made such prescription drug changes, 24.8 percent of single women reported skipping/postponing doctor appointments, and 38 percent of single women reported of having difficulty in paying their monthly bills, compared with single men where the responses were 16.2 percent, 20.7 percent and 27.1 percent, respectively. Married individuals were least likely to skip doctor visits or face difficulty in paying monthly bills, but they were more likely (21.6 percent) to make prescription drug changes than single men.

Finally, Figure 9 examines these behaviors across different racial groups. Among blacks, 25.9 percent reported making prescription drug changes, 27.3 percent reported skipping/postponing doctor appointments, and 42.3 percent reported facing difficulty in paying their monthly bills. In contrast, the comparable numbers for whites were 21.1 percent, 18.6 percent, and 26.1 percent, respectively.

Conclusion

This study presents some evidence suggesting that not all declining spending at older ages is voluntary. Changes made in medical care, such as moving to cheaper generic drugs, skipping pills, reducing dosage, etc., and skipping or postponing doctor appointments to save money can be indicators of involuntary saving. The study finds that 1 in 5 (20 percent) adults over age 50 has adopted such involuntary saving behavior, and that such behavior is more prevalent among those who are in poor health. Among different demographic groups, African Americans and single women were most likely to use these methods of involuntary savings.

The study suggests that the consumption behavior of a large section of the older population may be "optimal" only when viewed within the limits of the inadequate resources they have available. Retirement income adequacy studies that use such consumption data will benefit if such involuntary spending adjustments can be separated from "optimal" spending adjustments. Better data and more research are needed to improve knowledge in this area.

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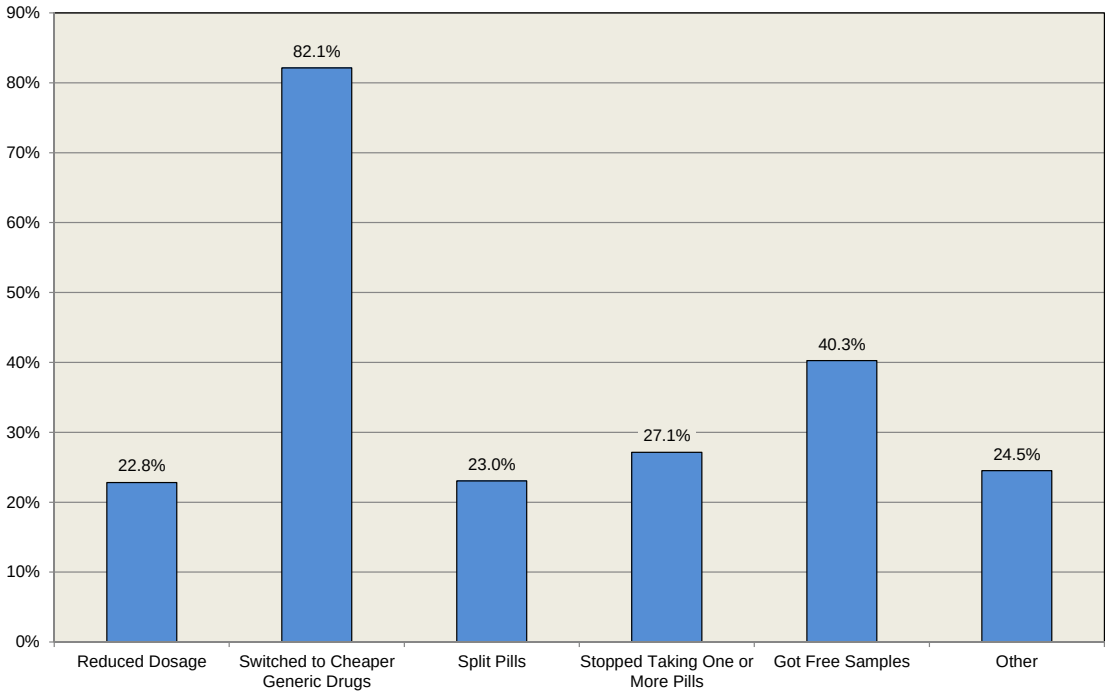
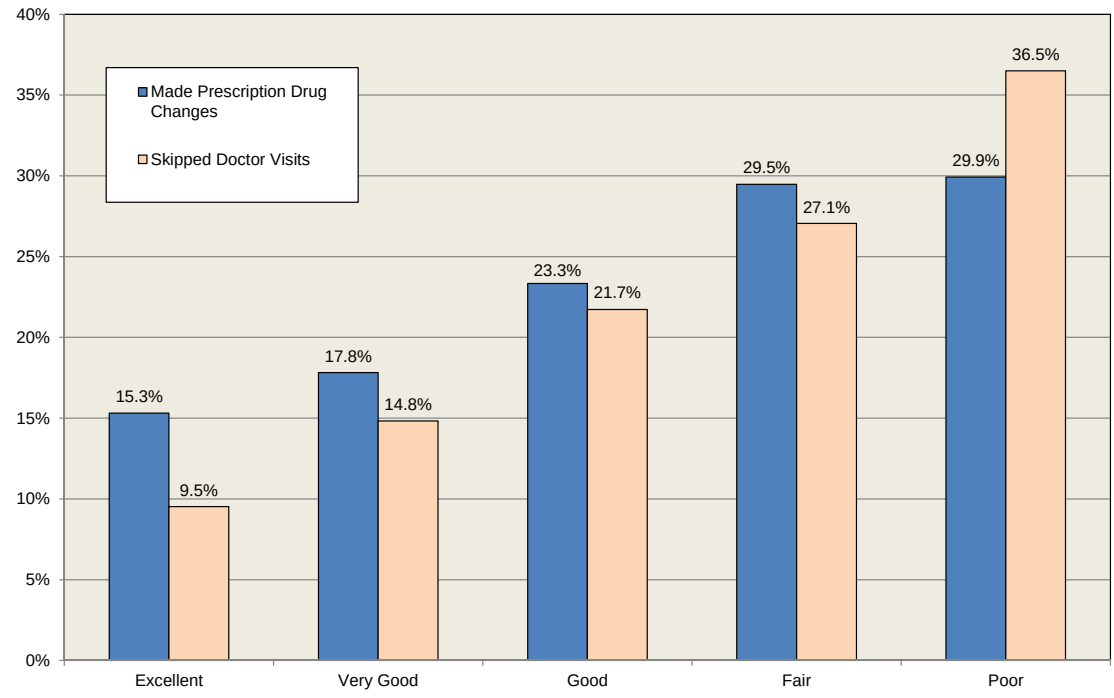
Figure 6
Different Types of Prescription Drug Changes Used to Save Money



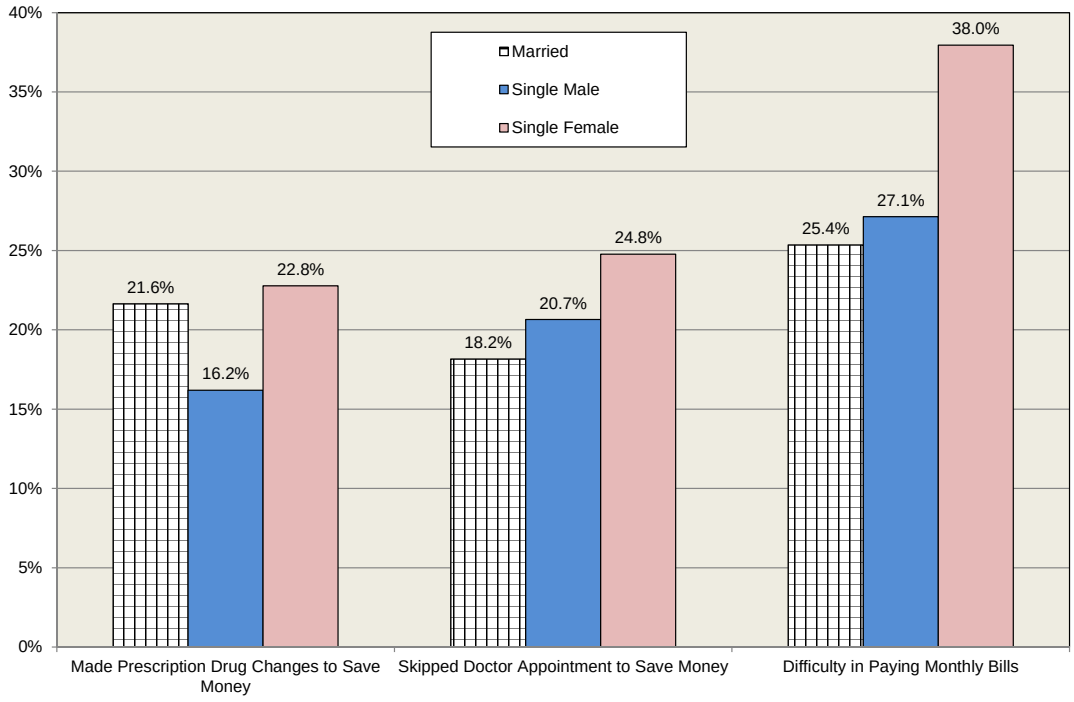
Source : Employee Benefit Research Institute estimates from the HRS 2009 Internet Survey.

Figure 7
Involuntary Saving Practices and Self-Reported Health Status



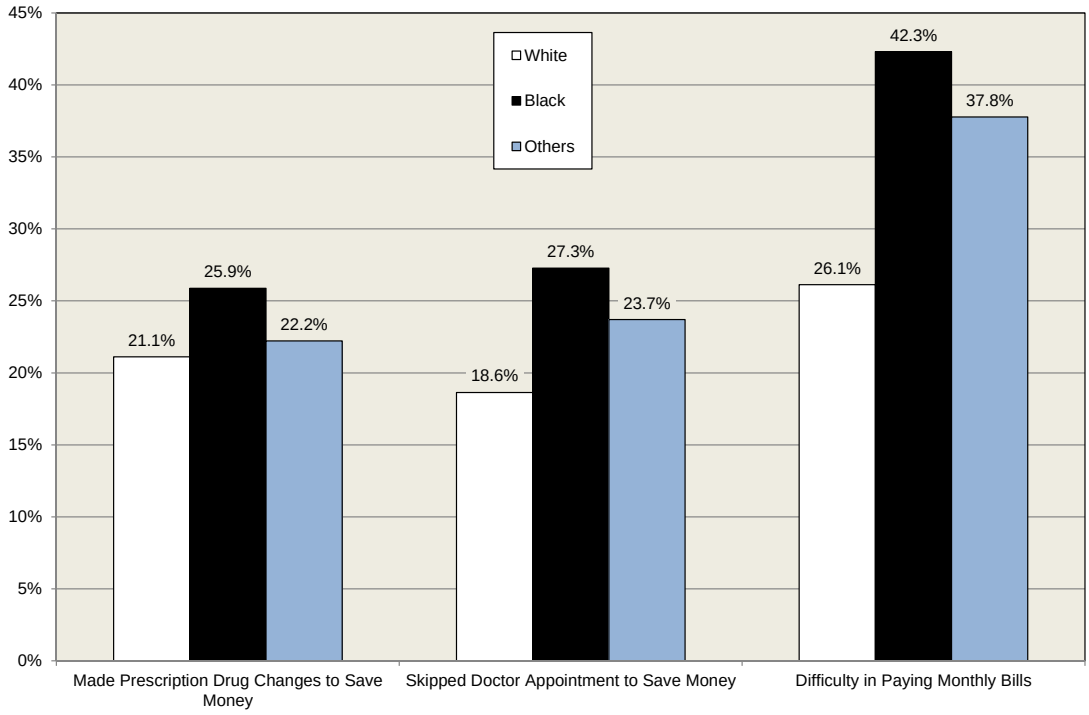
Source : Employee Benefit Research Institute estimates from the HRS 2009 Internet Survey.

Figure 8
Involuntary Saving Practices Among Different Marital Status Groups



Source : Employee Benefit Research Institute estimates from the HRS 2009 Internet Survey.

Figure 9
Involuntary Saving Practices Across Different Racial Groups



Source : Employee Benefit Research Institute estimates from the HRS 2009 Internet Survey.

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Employee Benefits

Rosenbloom, Jerry S. *The Handbook of Employee Benefits: Health and Group Benefits*. Seventh Edition. $135. The McGraw-Hill Companies, Order Services, P.O. Box 182604, Columbus, OH 43272-3031, (877) 833-5524, fax: (614) 759-3749, e-mail: pbg.ecommerce_custserv@mcgraw-hill.com, www.mcgraw-hill.com

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Investment Company Institute: *The Role of IRAs in U.S. Households' Saving for Retirement, 2011* http://ici.org/pdf/per17-08.pdf

Appendix: Additional Data on IRA Ownership in 2011 www.ici.org/pdf/per17-08_appendix.pdf

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