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Editorial

Health insurance and the American public sector labor market☆

Most active state and local government employees are covered by health plans, and these plans extend into retirement as well.[1] The generosity of these plans help governments recruit and retain quality workers, but the plans raise significant issues for the public sector and the economy as a whole. Fiscal issues are one obvious concern: like health costs nationally, the cost of coverage for state and local governments has been increasing more rapidly than the economy. Only a few state or local governments have created reserve funds to support the promise of health insurance to retired employees. This leads to a number of incidence questions: do workers or taxpayers pay for these benefits? How do recessions affect this balance?

In addition, the presence of generous retiree coverage creates significant incentives for individuals to stay in public sector jobs through middle age, and then retire at relatively young ages. Consistent with these incentives, public employees tend to have lower quit rates than comparable workers in the private sector and typically retire at younger ages, often in their 50s. Savings may also be affected, without the need to finance health benefits in retirement.

Public sector workers considering retirement must forecast whether these promises will be honored or whether their employers might change the rules in the future so that actual benefits in retirement will be less valuable than those promised. In the private sector, the Employee Retirement Income Security Act (ERISA) provides certain safeguards for retirement plans, but ERISA does not apply to public plans.

Recent events highlighting large unfunded liabilities and rising annual expenditures associated with public sector health plans have resulted in considerable changes. The economic difficulties of Detroit and other cities and states (New York City and the state of Wisconsin, to name two) have exacerbated the concern of public and governmental planners over the cost of health coverage and how they affect state and local government budgets. And the widespread reporting of these economic difficulties may well have increased the concern of public employees that the promise of health care in retirement will be reduced or eliminated.

The importance of understanding the issues associated with these plans is evident when one considers that state and local governments employ almost 18 million workers or 13.2% of the national, nonfarm work force. Benefit costs for state and local employees represent 35.5% of total compensation,[2] and this calculation excludes any deferred costs associated with underfunded retiree benefits, both health care and pensions.

The articles in this special issue examine five important labor market and public finance questions associated with public sector health plans. First, what is the incidence of the cost of the health insurance for public sector workers and retirees? Is it on workers in the form of lower wages or citizens in the form of higher taxes and/or reductions in other public goods? Second, does retiree health insurance coverage induce public sector workers to retire at earlier ages than private sector workers and if so, is this an important concern to public agencies? Third, does the promise of subsidized health insurance in retirement reduce individual saving and wealth accumulation and if so, does lower saving impact well-being in retirement? Fourth, to what degree can employers influence the choice of health plans by retirees so that they select lower cost plans and reduce public expenditures? Fifth, what is the impact of retiree health insurance plans on the budgets of state and local governments and how will this change in the coming decades? In addition to these papers, the special issue also includes a review of data sets available for research in this area. Each of the papers is briefly described below.

Clemens and Cutler

Clemens and Cutler analyze rising costs of employee health benefits on budgets of school districts across the country. They created a panel of data on school district finances from 1998 to 2007 using files made available through the National Center for Education Statistics. Using school district financial information, they assess the effects of benefits on the total compensation for teachers and other school personnel, the total spending by the district, and the student dropout rate. Their estimates indicate that each dollar

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[1] The BLS (2013) reported that 83% of state employees and 66% of local employees had access to retiree health insurance plans and 92% of state and 89% of local government workers had access to a retirement plan. The incidence of retirement and health plans is also very high at institutions of higher education whether they are public or private. http://www.bls.gov/opub/perspectives/program_perspectives_vol3_issue1.pdf.

[2] See, http://www.bls.gov/web/empsit/ceseeb1b.htm and http://www.bls.gov/news.release/ecec.t04.htm.

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increase allocated to employee benefits is associated with an 85% increase in total compensation. Thus, the rising cost of higher benefits is not borne in the form of lower wages by employees. If not employees, who pays for benefit increases? Clemens and Cutler find that increased cost of health and pension benefits were financed primarily by monetary transfers from higher levels of government – either state or federal governmental agencies. These revenue transfers come from sources subject to significant discretionary reporting and revenue responses tend to vary by union strength in the district. As districts modify budgets and organizations to attain and utilize these discretionary funds, student dropout rates decreased.

Qin and Chernew

Qin and Chernew also examine the relationship between insurance coverage and its cost and the level of wages and hours for state and local government workers. Related analysis assesses the variation in state contributions for health insurance premiums and their impact on the wages and hours of public sector employees. They link person records from the 1992–2011 March Current Population Surveys (CPS) with those from the Merged Outgoing Rotation Groups (MORG) for their research. In addition, they use reports of monthly premiums tabulated by The National Conference of State Legislators (NCSL) for years 1999–2006, 2009 and 2011. Qin and Chernew find evidence of small cost shifting of increasing employer spending on health insurance in the form of lower wages, a finding that is reasonably consistent with that of Clemens and Cutler. Further analysis suggests that the tradeoff is larger among non-unionized workers and was larger during the Great Recession.

Fitzpatrick

Using data from the early 1980s when the state of Illinois introduced retiree health insurance for elementary and secondary school teachers, Fitzpatrick asks how the provision of retiree health insurance affects the teachers' retirement behavior, meaning they left what had been their career job. Prior to the introduction of retiree insurance, many teachers did not retire until age 65, presumptively because at that age they became eligible for Medicare and so continued to work to that age to maintain health insurance. Fitzpatrick finds that the introduction of retiree health insurance reduced the exit rate for teachers age 65 from 51 to 29%. Correspondingly, retirement at ages 55–64 increased; 55 is the age when teachers in Illinois become eligible for pensions. For example, retirement at age 55 jumped from 5.4 to 9.8%. Despite the additional budgetary cost of retiree health insurance, this increase in early retirement saved the state of Illinois money for two reasons: its pension costs were lower and the retiring teachers were replaced with lower salaried teachers.

Shoven and Slavov

Like Fitzpatrick, Shoven and Slavov study the impact of retiree health coverage on the labor supply of public sector workers between the ages of 55 and 64. While this topic has received some attention in the past, Shoven and Slavov use better data than other authors, focus on the public sector, and consider workers at different ages. Consistent with Fitzpatrick, they find that retiree health coverage raises the probability of stopping full time work by 4.3 percentage points over two years among public sector workers aged 55–69, and by 6.7 percentage points over two years among public sector workers aged 60–64. For the younger workers, the transition is largely to part-time work. Among older workers, individuals transition to full retirement. Shoven and Slavov note how these estimates may presage the impact of the Affordable Care Act, and how the ACA might have different effects.

Clark and Mitchell

Economic theory predicts that employer-provided retiree health insurance (RHI) benefits will crowd out savings. But empirical work has had a difficult time determining if this is empirically important. Clark and Mitchell examine this issue empirically using data on public sector workers reported in the Health and Retirement Study. They start by showing that retiree health coverage is significantly greater among public sector workers than among comparable private workers. Coincident with that, public sector workers have substantially fewer assets than comparable private sector workers. The difference is about $69,000, or 15% of net wealth. The difference in wealth accumulation is statistically significant for federal workers, but not for state and local government employees, perhaps because of sample size considerations.

Clark, Morrill, and Vanderweide

States can reduce their unfunded obligations for retiree health insurance by altering the terms of the insurance to induce retirees to join cheaper plans; these authors examine North Carolina's experience in attempting to do so over the period 2009–2012. During this four year period, North Carolina offered retirees two insurance options that differed in the coinsurance rate; the more generous option's coinsurance rate was 20%, the less generous option's was 30%. The more generous plan also had somewhat lower deductibles. Until 2011 retirees did not have to pay a premium for an individual retiree policy; thus, for that group the more generous plan dominated the less generous one. If, however, they wanted to cover both themselves and their dependent(s), they had to pay an additional premium. In 2010 and again in 2011 the state increased premiums for both the more and less generous options for retirees that wanted to cover dependents; in 2011 the state also began to charge a premium for the more generous individual plan, although the less generous plan remained free. In response to these changes, a substantial number of retirees changed plans; whereas in 2009 almost none of the non-Medicare eligible retirees were in the lower option plan, after the changes in 2010 and 2011 almost 40% were. Likewise, almost none of the Medicare eligible retirees were in the lower option plan until the higher option plan began to charge a premium for self-only coverage in 2011; thereafter there was a small increase in the share of retirees in the lower option plan. Although the state's policy changes clearly affected plan choice, especially for retirees not eligible for Medicare, the overall savings to the state were modest.

Lutz and Sheiner

Lutz and Sheiner make by far the most detailed effort to date to quantify the unfunded obligations of state and local governments for retiree health insurance. They use the annual actuarial reports of the public jurisdictions to estimate future annual cash flows for this insurance, thereby putting all jurisdictions on a common footing and allowing them to impose consistent assumptions on the discount rate, the rate of increase in medical expenditures, and mortality, as well as vary these assumptions systematically. Nationwide they find that these obligations are about a third of annual state and local revenue and about half the size of unfunded pension obligations, although individual states vary considerably. The average state's underfunding could be cured if it contributed

¾ of a percent more revenue each year to funding retiree health insurance.

Morrill

Understanding how health costs for active and retired public sector workers affects economic outcomes has historically been hampered by a lack of data. In recent years, however, the availability of high quality data has grown. Morrill presents a summary of the data that are available and how they have been used. The data include individual survey data, collections from state and local governments, and data calculated by researchers from government reports and other economic assumptions.

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