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Notes

AT A GLANCE

Characteristics of the Population With Consumer-Driven and High-Deductible Health Plans, 2005–2011, *by Paul Fronstin, Ph.D., EBRI*

- Generally, the population of adults within high-deductible health plans (HDHPs) and traditional health plans is split 50–50 by gender. In contrast, consumer-driven health plan (CDHP) enrollees were more likely to be female in 2010 and 2011.
- CDHP enrollees were roughly twice as likely as individuals with traditional coverage to have a college or post-graduate education. HDHP enrollees were also more likely than traditional-plan enrollees to have a college or graduate degree.
- CDHP enrollees have consistently reported better health status than traditional-plan enrollees.
- During the survey period, HDHP enrollees have been consistently less likely than those with traditional coverage to report that they smoke, but no recent differences were found in exercise rates, and differences were not found in obesity rates.

Time Trends in Poverty for Older Americans Between 2001–2009, *by Sudipto Banerjee, Ph.D., EBRI*

- Generally, poverty rates fell from 2001–2005 for almost all age groups, and then started rising. This correlates to the two economic recessions that occurred during the last decade.
- During this period, poverty rates rose among seniors, as did the number of new entrants into poverty.
- Blacks, Hispanics, and single women face a higher poverty rate than other seniors.
- Poverty rates for women are nearly double of that of men for almost all survey years. For example, in 2009, the poverty rates were 7 percent and 13 percent, respectively, for men and women.
- The chance of suffering a health condition (acute or otherwise) rose 45–55 percent for those below the poverty line.

Characteristics of the Population With Consumer-Driven and High-Deductible Health Plans, 2005–2011

By Paul Fronstin, Ph.D., Employee Benefit Research Institute

Introduction

In 2001, a handful of employers started offering health reimbursement arrangements (HRAs)—a then-new type of health plan. The most prevalent HRA plan design had a deductible of at least $1,000 for employee-only coverage and a tax-preferred account that could be tapped by workers and their families to pay their out-of-pocket health care expenses. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act included a provision to allow individuals with certain high-deductible health plans to contribute to a health savings account (HSA).[1] HRAs and HSA-eligible plans are collectively known as consumer-driven health plans (CDHPs).

Initially, projections for growth of CDHPs were strong. In reality, growth has been slow, but steady. By the end of 2010, 16 percent of employers with 10–499 workers and 23 percent of employers with 500 or more workers offered either an HRA or HSA-eligible plan.[2] As a result, about 21 million individuals with private insurance, representing about 12 percent of the market, were either in a CDHP or an HSA-eligible plan. (Fronstin 2011).

This article examines the population with a CDHP and how it differs from the population with traditional health coverage. Data from the 2005−2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey and the 2008−2011 EBRI/MGA Consumer Engagement in Health Care Survey are used for the analysis. Differences between the population with traditional coverage and high-deductible health plan (HDHP) enrollees are also examined.

Demographic Differences

Gender—Generally, the population of adults, both within HDHPs and traditional health plans, is split 50−50 between men and women. Throughout 2005−2011, about 50 percent of traditional-plan enrollees were male and 50 percent were female (Figure 1). HDHP enrollees have also been mostly split 50−50 between men and women. When it has not been an even 50−50 split, the differences between HDHP enrollees and the population with traditional coverage was not statistically significant (such as in 2011, when 47 percent of the HDHP population was male and 53 percent was female). In contrast, differences in gender have been found between CDHP enrollees and those with traditional coverage. In 2005, 2006, and 2009, there were no statistically significant differences between CDHP enrollees and those with traditional coverage. However, in 2007 and 2008 CDHP enrollees were more likely than those with traditional coverage to be male, and in 2010 and 2011 CDHP enrollees were more likely than those with traditional coverage to be female. Specifically, 44 percent of CDHP enrollees were male and 56 percent were female in 2011.

Marital Status and Children—In 2006−2009 and 2011, HDHP enrollees were less likely to be married than those with traditional coverage. Similarly, in 2006−2007 and 2009, CDHP enrollees were less likely to be married than those with traditional coverage.

HDHP enrollees were less likely than traditional-plan enrollees to have children in 2006, 2007, and 2011. In contrast, the differences between CDHP and traditional-plan enrollees prior to 2010 and in 2011 were not statistically significant.

Figure 1

Selected Demographics, by Type of Health Plan, 2005–2011

	2005	2006	2007	2008	2009	2010	2011
Male							
Traditional[a]	49%	49%	50%	48%	50%	50%	50%
HDHP[b]	53	49	51	50	48	46	47
CDHP[c]	57	50	57*	54*	52	44	44
Female							
Traditional[a]	51	51	50	52	50	50	50
HDHP[b]	47	51	49	50	52	54	53
CDHP[c]	43	50	43*	46	48	56*	56*
Married							
Traditional[a]	60	74	78	67	78	76	75
HDHP[b]	61	55*	64*	62*	64*	68	67*
CDHP[c]	59	61*	70*	71	70*	67	78
Has children							
Traditional[a]	34	42	47	42	44	40	43
HDHP[b]	33	35*	37*	37	39*	40	39*
CDHP[c]	40	44	45	46	49	47*	47
Age 21–34							
Traditional[a]	27	33	34	33	28	31	27
HDHP[b]	18*	24*	21*	20*	25	21*	18*
CDHP[c]	20*	24*	20*	23*	28	20*	19*
Age 35–44							
Traditional[a]	26	23	22	23	23	23	24
HDHP[b]	25	25	24	24	24	27*	22
CDHP[c]	31	32*	31	30	28	36*	30*
Age 45–54							
Traditional[a]	29	26	27	26	28	27	27
HDHP[b]	34	29	30	29	27	28	33*
CDHP[c]	34	28	30	28	27	27	30
Age 55–64							
Traditional[a]	17	18	18	19	21	19	22
HDHP[b]	24	22	25*	26*	25	24	27*
CDHP[c]	15	16	19	19	16*	16	22
White, non-Hispanic							
Traditional[a]	71	71	71	72	70	70	69
HDHP[b]	94*	83*	78*	77	72	72	74*
CDHP[c]	93*	81	75	76	72	78	79*
Minority							
Traditional[a]	28	29	29	28	30	30	31
HDHP[b]	6*	17*	22*	24	27	28	25*
CDHP[c]	7*	19	25	24	28	22	21*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2011.

[a] Traditional = health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = high-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and traditional is statistically significant at $p \leq 0.05$ or better.

Age—It is often assumed that CDHP enrollees are more likely to be young than those with traditional coverage, because they use less health care, on average. However, that is generally not what has been found in the surveys. In most years, the survey found that CDHP enrollees were less likely than those with traditional coverage to be between the ages of 21 and 34. In 2006, 2010 and 2011, the CDHP population was more likely than the population with traditional coverage to be ages 35–44. No differences between the two groups were found in the percentage between the ages of 45–54, and only in 2009 was it found that the population with traditional coverage was comprised of a larger share of 55–64-year-olds than the CDHP population.

Similar results were found when comparing the HDHP population with traditional-coverage enrollees. Other than in 2009, HDHP enrollees were less likely than those with traditional coverage to be ages 21–34; HDHP enrollees were more likely than those with traditional coverage to be ages 35–44 only in 2010; other than in 2011, there was no difference in the percentages between the ages of 45–54; and in 2007, 2008 and 2011 it was found that the HDHP population was comprised of a larger share of 55–64-year-olds than the population with traditional coverage.

Race—Few differences in enrollment were found by race. Other than in 2005 and 2011, there was no difference in the distribution of enrollees when comparing the CDHP population with those covered by traditional plans (the 2005 difference may be due to a small sample size of minorities, which was addressed in 2006). In 2011, it was found that the CDHP population was more likely to be white, non-Hispanic than the population with a traditional health plan.

When comparing HDHP enrollees and traditional-plan enrollees it was found that in 2005, 2006, 2007, and 2011 a higher percentage of HDHP enrollees were white, non-Hispanic. The 2005 finding may also be due to a small sample size.

Income Differences

Since 2007, CDHP enrollees have been more likely than traditional-plan enrollees to be in households with $50,000 or more in income, but the nature of the difference has been changing. During 2005–2008, CDHP enrollees were generally more likely than traditional-plan enrollees to have household income of $150,000 or more (Figure 2). In 2009 and 2010, CDHP enrollees were not more likely than traditional-plan enrollees to have household income of $150,000 or more, but in 2011 income jumped for the CDHP population, such that they were again more likely than traditional-plan enrollees to have household income of $150,000 or more.

Similarly, during 2006–2009 and again in 2011, CDHP enrollees were more likely than traditional-plan enrollees to have household income of $100,000–$150,000.

Until 2010, the trend seemed to indicate that while there were still differences by household income, but those were less than what they were in 2005. However, with the jump in income among CDHP enrollees in 2011, the trend may be reversing itself.

The trend is less clear with respect to differences in income when comparing HDHP enrollees with individuals with traditional coverage. In general, there have been few income differences between HDHP enrollees and traditional-plan enrollees, and in 2011, the differences that were statistically significant were nonetheless small.

Figure 2

Household Income, by Type of Health Plan, 2005–2011

	2005	2006	2007	2008	2009	2010	2011
Less than $30,000							
Traditional[a]	15%	12%	15%	14%	11%	14%	11%
HDHP[b]	11	17*	12*	9*	10	4*	8*
CDHP[c]	11	13	6*	4*	3*	3*	3*
$30,000–$49,999							
Traditional[a]	19	20	18	19	17	17	16
HDHP[b]	19	30*	18	14*	16	14	16
CDHP[c]	22	24	13	10*	10*	11	10*
$50,000–$99,999							
Traditional[a]	34	38	36	36	38	37	37
HDHP[b]	36	35	38	40	43*	47*	37
CDHP[c]	33	43	41	40	45*	54*	33
$100,000–$149,999							
Traditional[a]	14	14	14	14	17	15	17
HDHP[b]	11	5*	14	19*	16	19*	17
CDHP[c]	13	7*	20*	25*	24*	14	23*
$150,000 or more							
Traditional[a]	7	7	7	9	10	10	12
HDHP[b]	4	3*	9	9*	8	7*	14*
CDHP[c]	9*	4*	11*	15*	10	11	24*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

[a] Traditional = health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = high-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and traditional is statistically significant at p ≤ 0.05 or better.

Figure 3

Education, by Type of Health Plan, 2005–2011

	2005	2006	2007	2008	2009	2010	2011
High school graduate or less							
Traditional[a]	32%	38%	42%	33%	35%	38%	34%
HDHP[b]	14*	17*	14*	13*	14*	10*	12*
CDHP[c]	6*	11*	11*	10*	8*	10*	7*
Some college, trade or business school							
Traditional[a]	31	29	29	31	31	28	30
HDHP[b]	36	36*	30	28	26	26	29
CDHP[c]	28	33*	24	22*	24*	25	21*
College graduate or some graduate work							
Traditional[a]	24	22	20	24	23	22	24
HDHP[b]	34	35*	40*	42*	42*	45*	42*
CDHP[c]	46*	41*	41*	44*	46*	44*	48*
Graduate degree							
Traditional[a]	13	11	9	12	11	10	12
HDHP[b]	16	12	17*	17*	18*	18*	17*
CDHP[c]	20*	15	24*	24*	21*	21*	24*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

[a] Traditional = health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = high-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and traditional is statistically significant at p ≤ 0.05 or better.

Education Differences

CDHP enrollees were roughly twice as likely as individuals with traditional coverage to have a college or post-graduate education in all years of the survey (Figure 3). In 2011, 24 percent of CDHP enrollees had a graduate degree and 48 percent had a college degree, compared with 12 percent and 24 percent, respectively, of traditional plan enrollees. HDHP enrollees were also more likely than traditional-plan enrollees to have a college or graduate degree.

Health Status Differences

With the exception of 2007, the survey has never found differences in self-reported health status between HDHP enrollees and individuals with traditional coverage. In contrast, in six out of seven years of the survey (2009 was the exception), it was found that CDHP enrollees were more likely than traditional-plan enrollees to report excellent or very good health (Figure 4). Furthermore, in four of the seven years of the survey, CDHP enrollees were less likely to report being in fair or poor health or that they had at least one chronic health condition, though the actual differences were small.[3] Despite the differences in self-reported health status, in only select years between 2006 and 2009 have traditional-plan enrollees been more likely than CDHP enrollees to report some type of health problem or chronic condition.

CDHP enrollees exhibit more health-conscious behavior than individuals with traditional coverage. In all years of the survey, CDHP enrollees were less likely than those with traditional coverage to report that they smoke. Similarly, during 2005–2009 (but not in 2010 and 2011), CDHP enrollees were less likely to report that they did not regularly exercise. In only three years of the survey (2005, 2009, and 2010), CDHP enrollees were less likely to be obese.

With respect to HDHP and traditional-plan enrollees, there were no statistically significant differences in the percentage obese in any years of the survey and no recent differences in exercise. However, in all years of the survey except 2010, HDHP enrollees were less likely than traditional-plan enrollees to report that they smoked.

Employer Size Differences

In the earlier years of the survey (2005–2009), the CDHP population was more likely than the population of individuals with traditional coverage to have that coverage through a small employer (between two and 29 employees) (Figure 5). In 2010 and 2011, there were no statistically significant differences by employer size between the CDHP population and the population of individuals with traditional coverage.

When comparing HDHP enrollees with traditional-plan enrollees it was found that, in all years of the survey except 2007, HDHP enrollees were less likely than traditional-plan enrollees to be from large employers (500 or more employees). They were more likely to be from small employers in all years of the survey except for 2010.

Conclusion

It is very difficult to generalize the differences in characteristics among CDHP enrollees, HDHP enrollees, and individuals with traditional coverage, but a few differences stand out.

In most years of the survey, both the CDHP and HDHP populations were less likely to be young (ages 21−34) than the population with traditional coverage. There were no differences in the portion ages 45−54 and no recent differences in the portion ages 55−64. In 2006, 2010, and 2011, the CDHP population was more likely than the population with traditional coverage to be ages 35−44.

Figure 4

Selected Health Status Indicators, by Type of Health Plan, 2005–2011

Self-Rated Health Status	2005	2006	2007	2008	2009	2010	2011
Excellent/very good							
Traditional[a]	42%	54%	49%	56%	59%	59%	58%
HDHP[b]	50	53	54*	54	59	58	56
CDHP[c]	58*	60*	65*	66*	64	67*	66*
Good							
Traditional[a]	45	35	38	34	32	34	34
HDHP[b]	36	34	35	34	30	32	34
CDHP[c]	34	33	29*	30	27	28*	28*
Fair/poor							
Traditional[a]	13	12	13	10	9	7	9
HDHP[b]	13	13	10	12	11	10	10
CDHP[c]	9	7*	6*	5*	8	5	6*
At least one chronic health condition**							
Traditional[a]	54	49	49	52	52	50	52
HDHP[b]	56	50	53*	56	54	52	55
CDHP[c]	48	43*	45	45*	46*	45	48
Health problem***							
Traditional[a]	57	51	53	54	54	51	53
HDHP[b]	57	53	55	57	57	54	57
CDHP[c]	49	44*	46*	45*	49*	46	50
Obese							
Traditional[a]	36	30	27	26	31	29	29
HDHP[b]	33	28	30	29	28	27	28
CDHP[c]	26*	30	25	23	23*	22*	25
Smokes cigarettes							
Traditional[a]	23	24	24	20	18	15	15
HDHP[b]	14*	18*	14*	15*	13*	12	11*
CDHP[c]	14*	14*	15*	13*	13*	9*	9*
No regular exercise							
Traditional[a]	24	25	25	25	21	23	24
HDHP[b]	15*	25	20*	21	19	19	21
CDHP[c]	16*	19*	17*	17*	13*	20	20

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

[a] Traditional = health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = high-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and traditional is statistically significant at p≤ 0.05 or better.

** Arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure or stroke.

*** Health problem defined as fair or poor health or one of eight chronic health conditions.

CDHP enrollees had higher income than traditional-plan enrollees, although the differences had been declining until 2011, when income appears to have jumped for both the CDHP and HDHP populations. CDHP and HDHP enrollees have consistently reported higher education levels than traditional-plan enrollees.

CDHP enrollees had consistently reported better health status than traditional-plan enrollees. They have historically exhibited better health behavior than traditional-plan enrollees with respect to smoking, and until recently, exercise and sometimes obesity rates. HDHP enrollees have also been consistently less likely than those with traditional coverage to report that they smoke, but no recent differences were found in exercise rates, and differences have never been found in obesity rates. It cannot be determined from the survey whether plan design had an impact on health status, smoking, exercise, or obesity rates.

Figure 5

Firm Size, by Type of Health Plan, 2005–2011

Number of Employees	2005	2006	2007	2008	2009	2010	2011
Self-employed with no employees							
Traditional[a]	2%	4%	3%	2%	3%	3%	3%
HDHP[b]	9*	9*	9*	7*	7*	5*	9*
CDHP[c]	8*	5	6*	7*	5	5	3
2–49							
Traditional[a]	15	19	19	16	15	16	16
HDHP[b]	31*	32*	27*	26*	25*	26	27*
CDHP[c]	39*	32*	28*	25*	21*	23	20
50–199							
Traditional[a]	8	10	11	12	11	8	13
HDHP[b]	9	14	14	13	15*	13*	13
CDHP[c]	8	12	11	13	12	12	12
200–499							
Traditional[a]	9	8	9	8	10	8	9
HDHP[b]	6	8	7	7	7*	8	8
CDHP[c]	5*	10	8	7	7*	7	9
500 or more							
Traditional[a]	54	45	43	50	48	52	49
HDHP[b]	33*	29*	36	38*	37*	41*	37*
CDHP[c]	36*	31*	40	42	48	49	49

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005−2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008−2011.

[a] Traditional = health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = high-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and traditional is statistically significant at $p \leq 0.05$ or better.

Appendix

This study is based on data from the 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey and the 2008–2011 EBRI/MGA Consumer Engagement in Health Care Survey. They are online surveys of privately insured adults ages 21–64, fielded in August of each year. The surveys were conducted to provide nationally representative data regarding the growth of CDHPs and HDHPs, and the impact of these plans, and consumer engagement more generally, on the behavior and attitudes of adults with private health insurance coverage. High deductibles were defined as individual deductibles of at least $1,000 and family deductibles of at least $2,000. Those with high deductibles and either an HRA or an HSA comprise the CDHP sample, and those with deductibles that are generally high enough to meet the qualifying threshold to make tax-preferred contributions to an HSA, but without an account comprise the HDHP sample.

More information about the 2011 EBRI/MGA Consumer Engagement in Health Care Survey can be found in (Fronstin 2011).

References

Fronstin, Paul. "Findings from the 2010 EBRI/MGA Consumer Engagement in Health Care Survey." *EBRI Issue Brief*, no. 350 (Employee Benefit Research Institute, December 2010).

_____. "Findings from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey." *EBRI Issue Brief*, no. 365 (Employee Benefit Research Institute, December 2011).

Endnotes

[1] See (Fronstin 2011) for more information about health reimbursement arrangements and health savings accounts.

[2] See http://www.mercer.com//press-releases//1400235

[3] The conditions are arthritis; asthma, emphysema, or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure, or stroke.

Time Trends in Poverty for Older Americans Between 2001–2009

By Sudipto Banerjee, Ph.D., Employee Benefit Research Institute

Introduction

In the last three decades, the United States had a mixed experience in terms of poverty. Among younger Americans, poverty showed a slow but steady increase, while among older people it exhibited the opposite pattern—slowly but steadily decreasing (Card and Lemieux, 1997; Smith 1997; U.S Census Bureau, 2011). However, the last decade has been very difficult financially for many Americans. It saw the worst bear market since the Great Depression, a crippling housing crisis, and continued high unemployment. Amidst this, the broad trends of poverty remained the same, but there were some noteworthy changes.

This article studies the poverty trends among older Americans (age 50 or older) between 2001 and 2009. The data for this study come from the University of Michigan's Health and Retirement Study (HRS), sponsored by the National Institute on Aging, and the most comprehensive national survey of older Americans. Particularly, data are used from the RAND version of HRS, which provides a measure of poverty. RAND uses the poverty threshold levels from the U.S. Census Bureau (www.census.gov/hhes/www/poverty/methods/measure.html), the composition of HRS families, and the families' incomes to derive the poverty indicator. The measure used for this study does not include institutionalized family members.

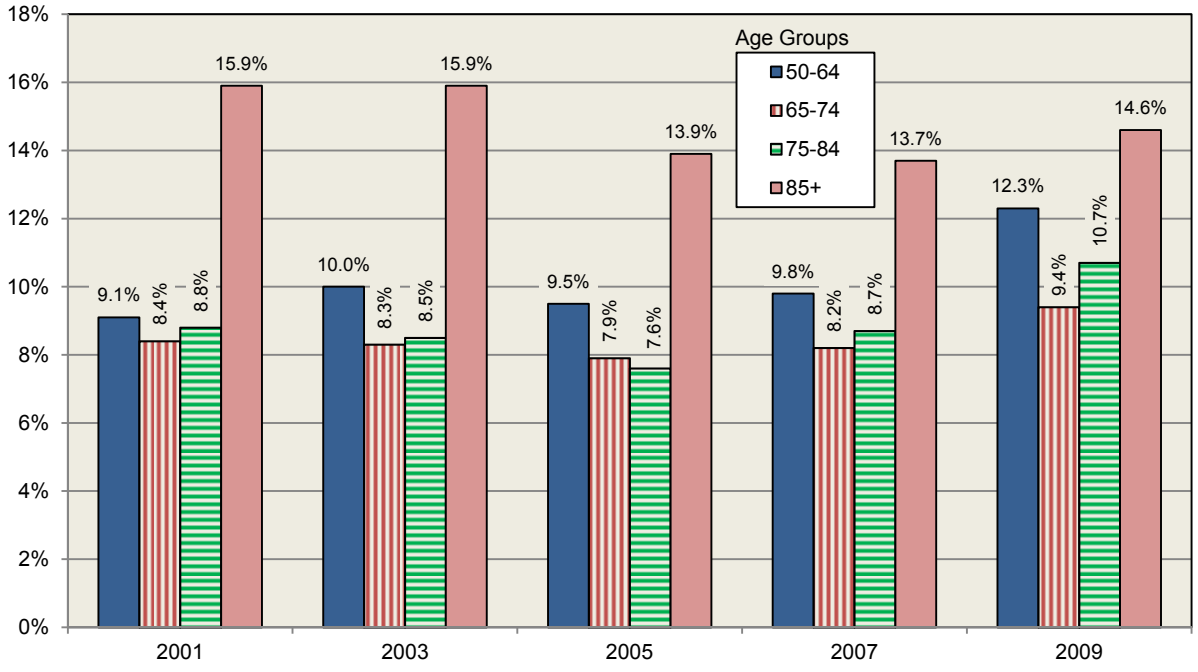
This study also examines how poverty rates have changed across different age groups and different demographic groups within the older section of the population in the last decade. Exploiting the panel nature of the survey, the study also reports estimates of what percentage of seniors fall into poverty as they age and how their poverty status evolved over the period of the study. It also shows differences in health conditions of the poor and the non-poor.

Poverty Rates Across Different Age Groups

Figure 1 shows the poverty rates for four different age groups (50–64, 65–74, 75–84, 85 or above) for the five different survey years between 2001 and 2009.[1] In every survey year, poverty rates in the 65–74 age group are lower than in the 50–64 age group. A possible explanation could be that around that point in their lives, individuals begin to receive Social Security payments, and also start to receive income from their employer provided pension plans, if they have any. The poverty rate begins to rise in the 75–84 age group in every year except 2005, and in all years it increases sharply for those 85 or above.

Poverty rates are highest for those age 85 or above. For comparison, in 2009, the U.S. Census Bureau reported poverty rate for all people above 65 was 8.9 percent. For HRS it was 10.5 percent. But for those above 85 it was 14.6 percent. What accounts for the increasing poverty rates of older Americans? As people age, personal savings and pension account balances deplete. The total Social Security benefit received by a family is reduced with the death of a spouse. These factors potentially lead to rising poverty at older ages. Also, as people age, their medical expenditure increases steadily (Banerjee, 2012). Looking closely at the individual age groups it can be noted that there has been a U-shaped trend over the years during the last decade. Generally, the poverty rates have fallen from 2001 to 2005 for almost all age groups and then started rising. This correlates to the two economic recessions that occurred during the last decade.

Figure 1
Poverty Rates for Different Age Groups Over Age 50, 2001–2009



Source: Employee Benefit Research Institute estimates from the Health and Retirement Study (2002–2010).

New Entrants Into Poverty

Although Figure 1 shows the trend in poverty rates across different age groups, it does not show what percentage of the population is slipping below the poverty line as people age. From a retirement income policy standpoint, it is important to distinguish the number of people who are falling into poverty as they age from those who simply remain poor as they get older. Figure 2 shows the rates of new entrants into poverty by age group. These entry rates are calculated as the percentage of people above the poverty line in the previous survey wave who moved below the poverty line in the current wave. Clearly, the entry rates are highest for the oldest age group (85 or above). In 2009, 6 percent in this age group were new entrants into poverty. From 2005 onwards, these rates have increased for every age group. For example among 75–84 year olds, 3.3 percent were new entrants in poverty in 2005. That increased to 5.6 percent in 2009.

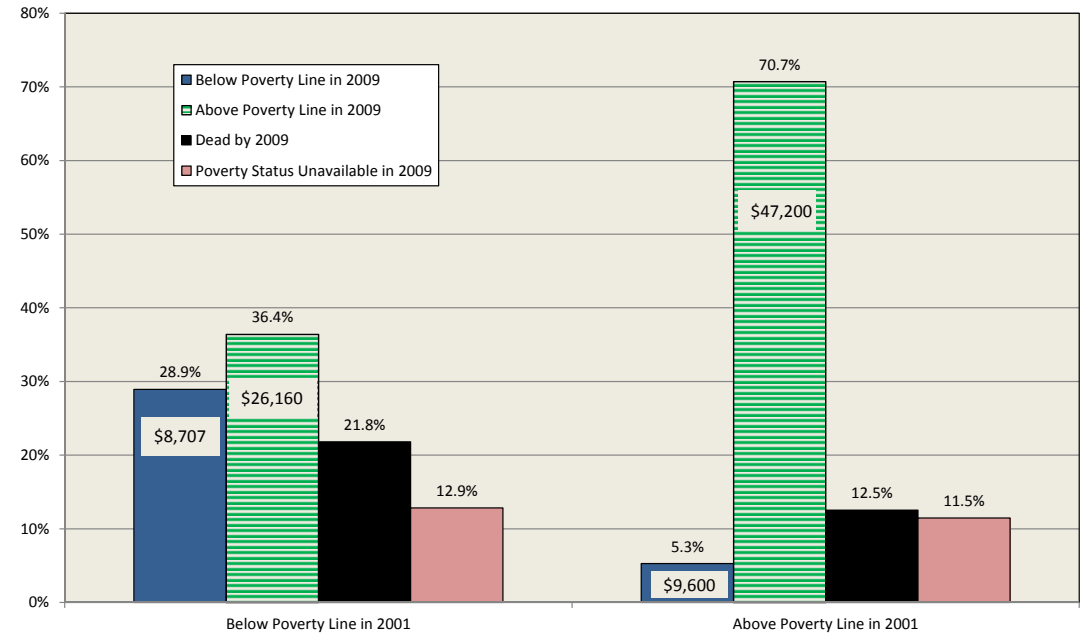
Tracking Poverty Status in a Longer Panel

Figure 2 uses two-year panels to construct the entry rates into poverty. But data on poverty are available to construct a longer panel from 2001 to 2009. Figure 3 uses this longer panel to track the poverty status of those who were 55–70 years old in 2001. Of those who were below the poverty line in this group, 28.9 percent remained poor in 2009, and 36.4 percent moved above the poverty line. Just over 1-in-5 (21.8 percent) of them were deceased by 2009, and no poverty status was available for the rest. In contrast, of those who were above the poverty line in 2001, 70.7 percent continued to be so. But 5.3 percent in this group fell into poverty by 2009, and 12.5 percent were deceased. Median household income for those with an assigned poverty status is also shown in Figure 3. Even though 36.4 percent of those who were poor in 2001 moved out of poverty by 2009, their median income ($26,160) was much lower than the median income ($47,200) of those who continued to be above the poverty line.

Figure 2
Entry Rate Into Poverty for Individuals Ages 65+

Source: Employee Benefit Research Institute estimates from the Health and Retirement Study (2002-2010)..
Note: Entry rate is calculated as the percentage of people above the poverty line in the previous wave who moved below the poverty line in the current wave.

Figure 3
Tracking the Poverty Status Between 2001 and 2009 for Those Ages 55–70 in 2001



Source: Employee Benefit Research Institute estimates from the Health and Retirement Study (2002-–2010).
Note: The dollar amounts represent the median income of the corresponding groups in 2009.

Poverty Rates for Men and Women 65 or Above

Figure 4 shows the poverty rates for men and women who are 65 or above. Poverty rates for women are nearly double of that of men for almost all survey years. For example, in 2001, the poverty rate for men was 5.7 percent, while for women it was 11.9 percent. In 2009, the poverty rates were 7 percent and 13 percent, respectively. So, there has not been any closing of the poverty rate gap between men and women at these older ages. Also, the previously noted U-shape in figure 1 is evident in figure 4 as well. Starting from the highs of 2001, poverty rates declined through 2005 for both men and women and then increased steadily.

Poverty Rates Across Different Races for Ages 65 and Above

Figure 5 shows the poverty rates for different races for ages 65 and above. Whites have a much lower poverty rate than blacks or Hispanics. The poverty rates for blacks and whites generally exhibit the U-shape described earlier (rates increased slightly for whites in 2003), with the poverty rates generally declining from 2001 through 2005 and increasing from 2005 through 2009. Also, the difference between the poverty rates of blacks and whites has not changed much during the period of this study. In 2001, the difference was a little more than 19 percentage points, decreasing to about 16 percentage points in 2005, before increasing again to around 17 percentage points in 2009. Similarly, the difference between the poverty rates of whites and Hispanics has not changed drastically. In 2001, the difference was approximately 26 percentage points, which narrowed to little over 21 percentage points in 2009. However, the poverty rate of "Others," which includes Asians, has shown a continuous decline over this period, with the gap between whites and others narrowing. For example, in 2001, poverty rates of whites and others were 6.2 percent and 20 percent, respectively, a difference of nearly 14 percentage points. However, in 2009, the respective poverty rates were 7.7 percent and 11.7 percent, a difference of only 4 percentage points.

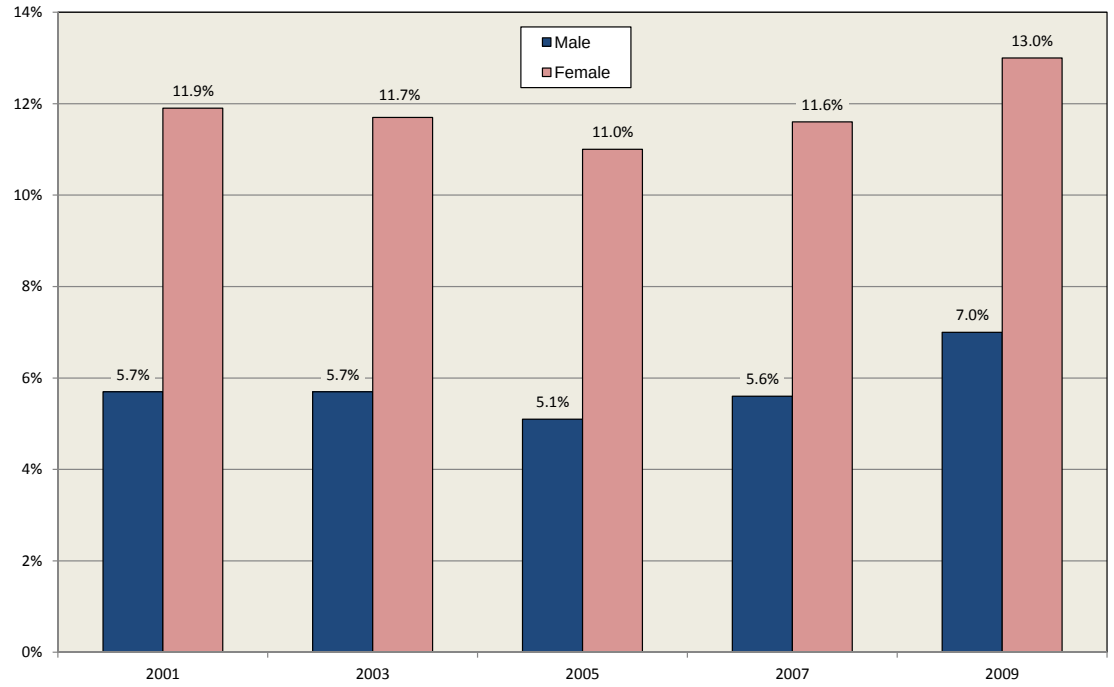
Poverty Rates Across Different Marital Groups for Ages 65 and Above

Figure 6 shows the poverty rates for different marital groups age 65 or above. Clearly, poverty among couples is much lower than among singles. Again, the U-shape described in the previous sections is evident (except among single women, where the poverty rate increased in 2003). However, for couples, the changes in poverty rates are very low: The highest two-year change in poverty rate for couples is less than half a percentage point (between 2007 and 2009). Among singles, women have a higher poverty rate than men. For example, in 2009, poverty rates for couples, single men and single women were 4.1 percent, 15.6 percent and 20.9 percent, respectively. This means that every 1 in 5 single women age 65 or above lived in poverty in 2009. But between 2007 and 2009, the poverty rate for single men increased by close to 4 percentage points, compared with a 2.5 percentage point increase for single women.

Health Conditions of Those Below and Above the Poverty Line

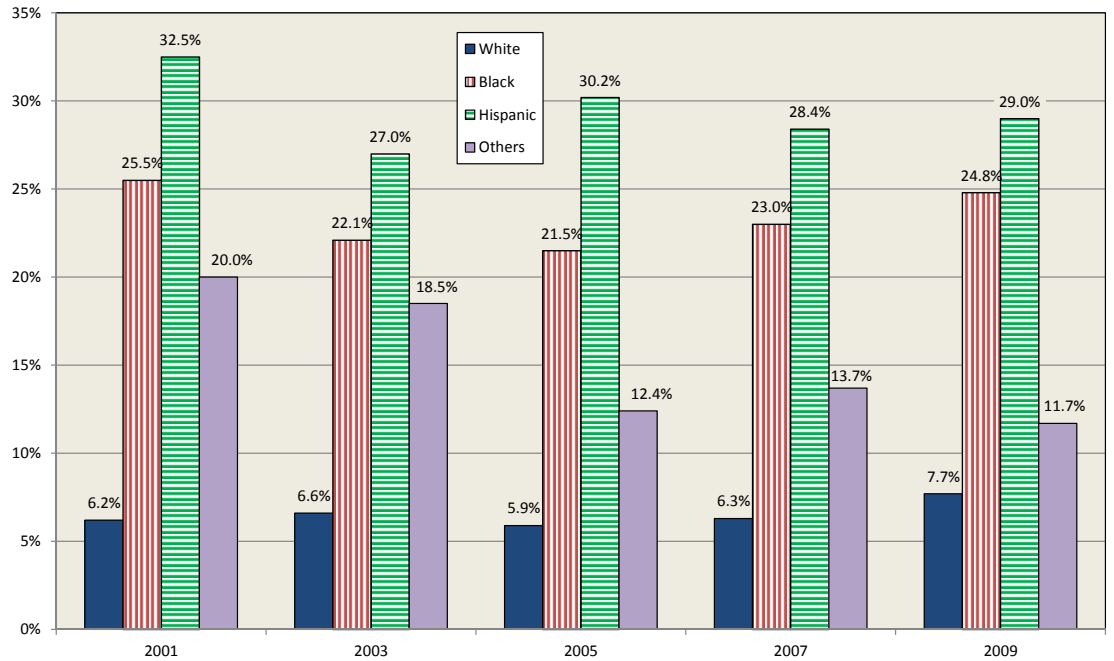
Declining health and rising medical expenditures could be among the drivers of poverty. A positive correlation between health and wealth is well-documented in economics literature (Wilkinson, 1996; Smith, 1999). The direction of causation has been a subject of extensive research as well. Several studies (Grossman, 1972; Smith, 2005; Michaud and Soest, 2008) have explored whether declining health causes declining wealth. Others (Hurd and Kapteyn, 2003; Smith 2005) have explored whether declining wealth causes declining health. Figure 7 shows the poverty health correlation in the HRS data: Among respondents below the poverty line, 69.6 percent of respondents have suffered acute health conditions—defined as a diagnosis of cancer, lung disease, heart problems or stroke—compared with 48.1 percent for those above the poverty line.

Figure 4
Poverty Rates for Men and Women Ages 65 or Above, 2001–2009



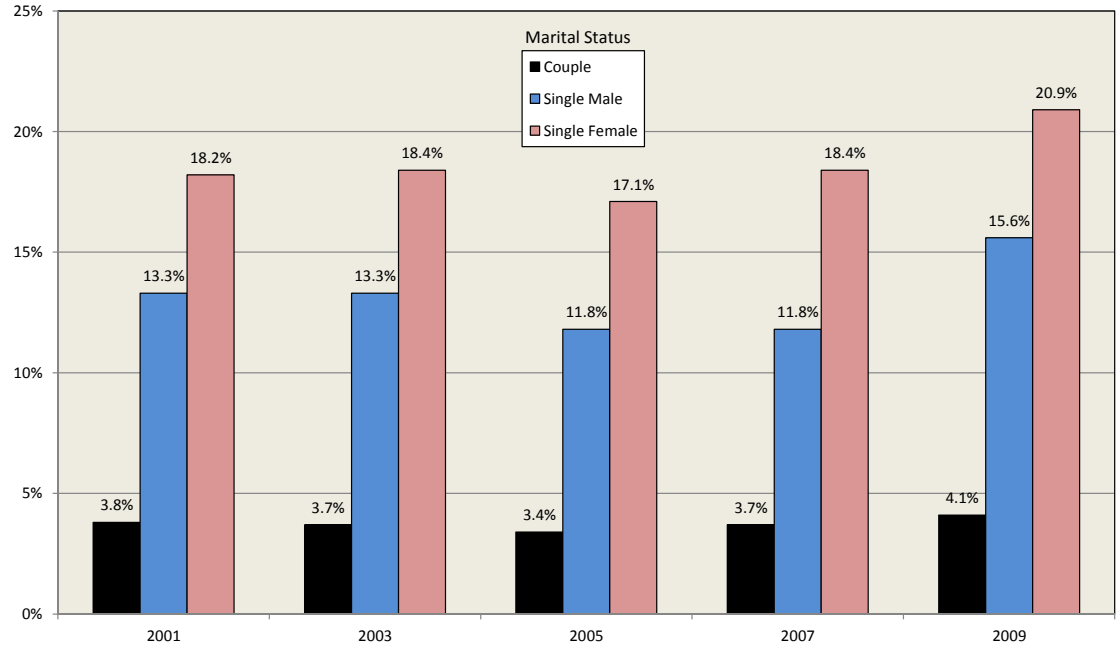
Source: Employee Benefit Research Institute estimates from the Health and Retirement Study (2002–2010).

Figure 5
Poverty Rates Across Different Races for Ages 65 or Above, 2001–2009



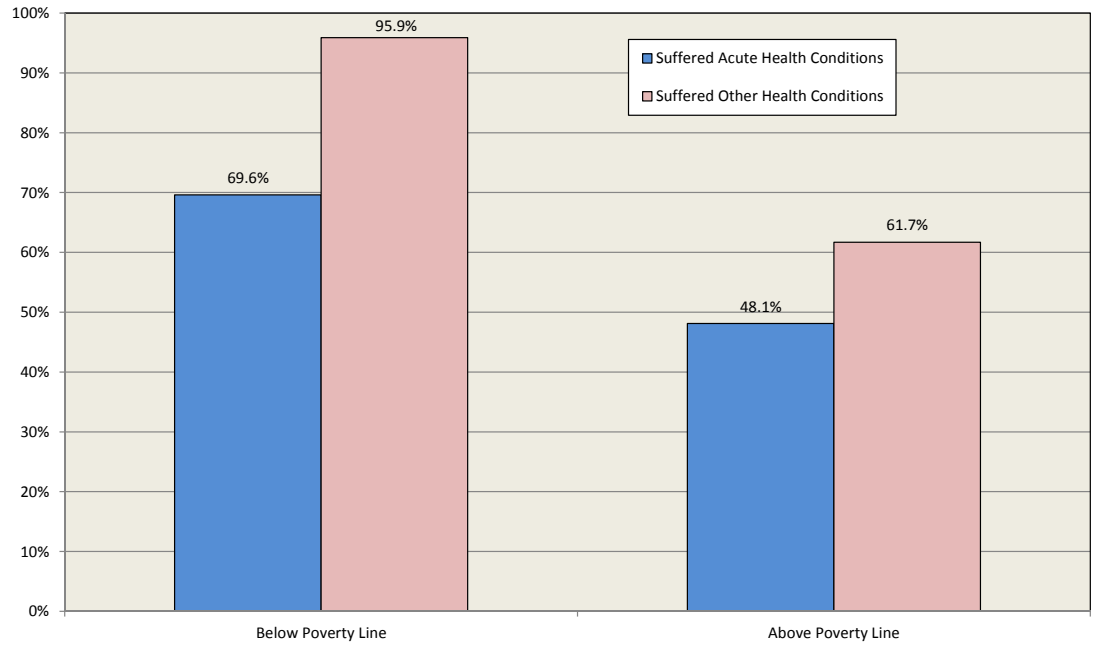
Source: Employee Benefit Research Institute estimates from the Health and Retirement Study (2002–2010).

Figure 6
Poverty Rates Across Different Marital Groups
Ages 65 or Above, 2001–2009



Source: Employee Benefit Research Institute estimates from the Health and Retirement Study (2002–2010).

Figure 7
Percentage of People Suffering Acute and Other Health Conditions



Source: Employee Benefit Research Institute estimates from the Health and Retirement Study (2002-–2010).
Note: Cancer, Lung disease, Heart Problems and Stroke are classified as acute health conditions.
High blood pressure, diabetes, psychological problem, arthritis are classified as other health condition.

Similarly, 95.9 percent and 61.7 percent of those below and above the poverty line, respectively, have suffered "other" health conditions, defined as a diagnosis of high blood pressure, diabetes, psychological problems, or arthritis. So, the chance of suffering a health condition (acute or otherwise) goes up roughly 45–55 percent for those below the poverty line.

Conclusion

Living in poverty is painful, but especially so for the elderly because their options for escaping poverty are limited. They typically have fewer employment options, and those may be further limited by health issues. Programs such as Social Security were created to reduce the probability that people would fall into poverty during old age, and indeed old-age poverty rates have fallen notably compared to three or four decades ago. Still, a significant number of seniors live in poverty, and data from the Health and Retirement Study (2002–2010) show that poverty rates increase with age. For most age groups above 50, poverty rates declined during the first half of the past decade and then started rising again.

In every survey wave during that period, a significant percentage of the poor are new entrants into poverty, and new entries into poverty generally increase with age. The data show that 36.4 percent of those in poverty in 2001 came out of poverty by 2009, while more than 5 percent fell into poverty during this period. Among demographic sub-groups, single females and blacks have the highest poverty rates. Also, those in poverty are almost 45–55 percent more likely to suffer from various health conditions as compared with those who are not classified as poor.

Even though the broad trend (annual U.S. Census poverty rates) shows that old-age poverty is declining, this study shows that there are still areas of concern: First, among seniors, poverty rates increase as they age. Secondly, since 2005 new entries into poverty also increased with age. Finally, Hispanics, blacks, and single women face a much higher poverty rate than the rest of the seniors.

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Endnotes

[1] The HRS surveys are conducted every two years. The poverty measure has been reported since 2002, but the income reported in every survey corresponds to the income of the previous calendar year. For example, the 2002 survey reports the income for the calendar year 2001. Since poverty status is decided by comparing income to the poverty threshold, the reported poverty rates correspond to the calendar years for which income was reported.

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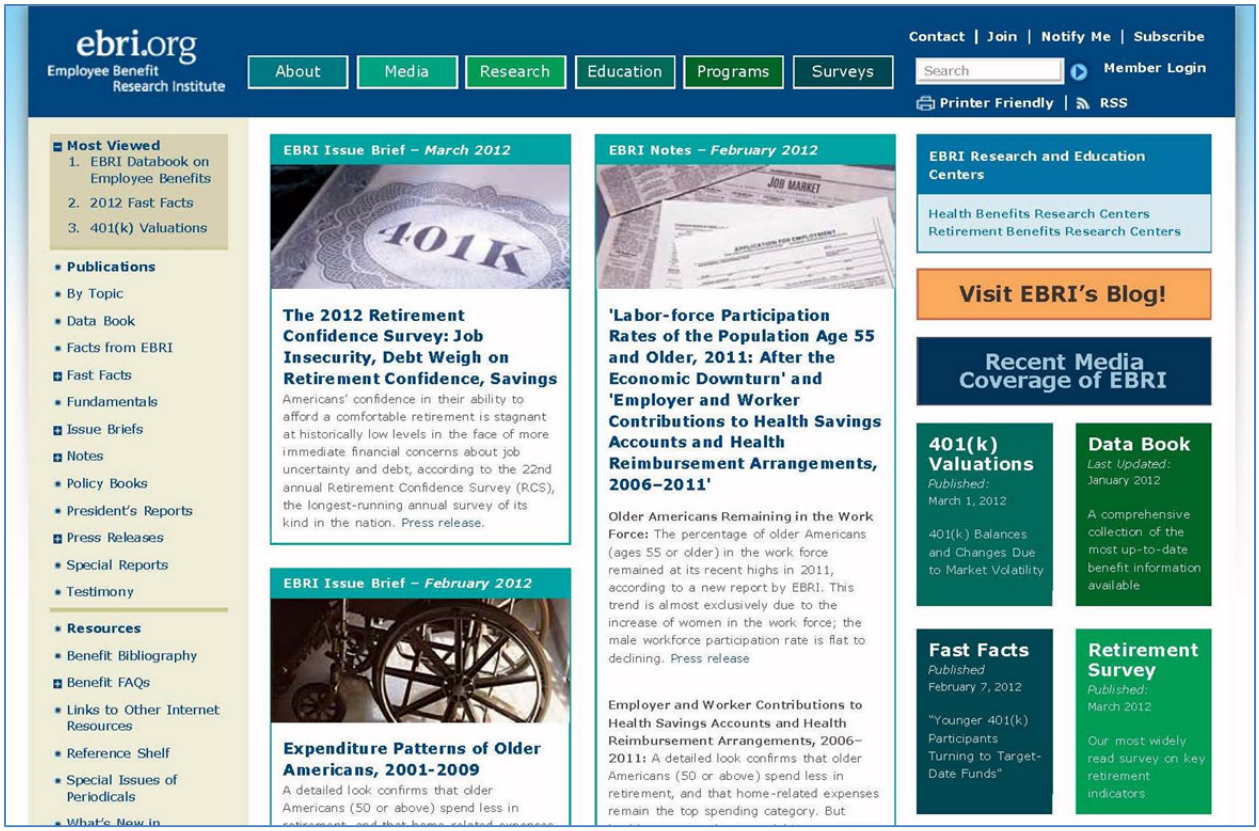

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