

## Employers, Workers, and the Future of Employment-Based Health Benefits

By Stephen Blakely, Employee Benefit Research Institute

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### EXECUTIVE SUMMARY

**EBRI'S BIENNIAL POLICY FORUM:** This *Issue Brief* summarizes presentations at EBRI's 65<sup>th</sup> biennial policy forum, held in Washington, DC, on Dec. 10, 2009, on the topic, "Employers, Workers, and the Future of Employment-Based Health Benefits." The forum brought together a wide range of economic, benefits, management, and labor experts to share their expertise at a time when major health reform legislation was being debated in Congress. The focus: How might this affect the way that the vast majority of Americans currently get their health insurance coverage?

**THE EMPLOYMENT-BASED HEALTH INSURANCE SYSTEM:** Most people who have health insurance coverage in the United States get it through their job: In 2008, about 61 percent of the nonelderly population had employment-based health benefits, 19 percent were covered by public programs, 6 percent had individual coverage, and 17 percent were uninsured.

**DIFFERENCES, AGREEMENTS:** Not surprisingly, given the deep conflicts that exist over President Obama's health reform plan and the different bills that have passed the House and Senate, benefits experts also do not agree on what "health reform" will mean for either workers or employers. Views ranged from "Will anyone notice?" to predictions of great upheaval for workers and their employers, patients and health care providers, and the entire U.S. health care system. One point of consensus among both labor and management representatives: Imposing a tax on health benefits is likely to cause major cuts in health benefits and might result in structural changes in the employment-based benefits system. A common disappointment voiced at the forum was that the initial effort to reform the *delivery and cost* of health care in America gradually became focused on just *financing and coverage* of health insurance.

**RECENT TRENDS:** The ever-rising cost of health insurance affects different employers and workers in different ways—with small employers and low-wage workers being the most disadvantaged. With health premiums having risen almost five times as much as the overall rate of inflation since 2000, employers face unsustainable cost increases in health benefits. For a minimum-wage worker, the cost of family coverage (averaging about \$13,700 a year in a small firm) exceeds their total annual income (about \$11,500 a year). Small employers, if they offer health benefits at all, pay proportionately more than large employers for the same health coverage.

**PUBLIC OPINION:** As reflected by the debate in Congress, the American public has conflicted opinions on both the U.S. health care system and on reform: Surveys find that people tend to be satisfied with the quality of their own care but not with costs and access, and a majority rates the system as fair or poor. Opinions divide sharply along partisan lines.

**PERSPECTIVES:** While large employers tend to express continued commitment to health benefits, small employers see themselves strongly disadvantaged by the current system. Consultants report many employers privately want to drop benefits to control costs, but realize there are risks to doing so and none wants to be first. Employers express strong interest in wellness and disease management programs as a way to control costs, even though some experts say there is no evidence these work. Consumer-driven health plans are expected to continue their slow rate of growth.

Stephen Blakely is editor and communications director at EBRI. This *Issue Brief* was written with assistance from the Institute's research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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**Recommended Citation:** Stephen Blakely, "Employers, Workers, and the Future of Employment-Based Health Benefits," *EBRI Issue Brief*, no. 339 (February 2010).

**Report availability:** This report is available on the Internet at [www.ebri.org](http://www.ebri.org)

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# Employers, Workers, and the Future of Employment-Based Health Benefits

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## Introduction

With many Democrats still considering the most sweeping national health legislation since Medicare was created almost 45 years ago, a pressing question arises: How will this affect the way that the vast majority of Americans currently get their health insurance coverage?

Given the deep conflicts that exist over President Obama's health reform plan and the different bills that have passed the House and Senate, it's no surprise that benefits experts also do not agree on what it will mean for either workers or employers. Some say that changes from the legislation would be dramatic and quick; others predict it would be slow and incremental.

But on one point there is widespread consensus from labor, management, and consumer groups: Imposing a one-size-fits-all tax on so-called "Cadillac" health plans is sure to cause health benefits to be cut and may mean structural changes to the employment-based health benefits system—which, for better or for worse, has been the lynchpin of health coverage for working Americans and their families since World War II.

And whether the new system would be better is largely unknown, experts say.

To take a closer look at what experts see coming down the road, the nonpartisan Employee Benefit Research Institute (EBRI) devoted its 65<sup>th</sup> biannual policy forum to the topic, "Employers, Workers, and the Future of Employment-Based Health Benefits." Held in Washington, DC, on Dec. 10, 2009 (while health reform legislation was being debated on the Senate floor and enactment seemed imminent), the forum brought together a wide range of economic, benefits, management, and labor experts to share their expertise.

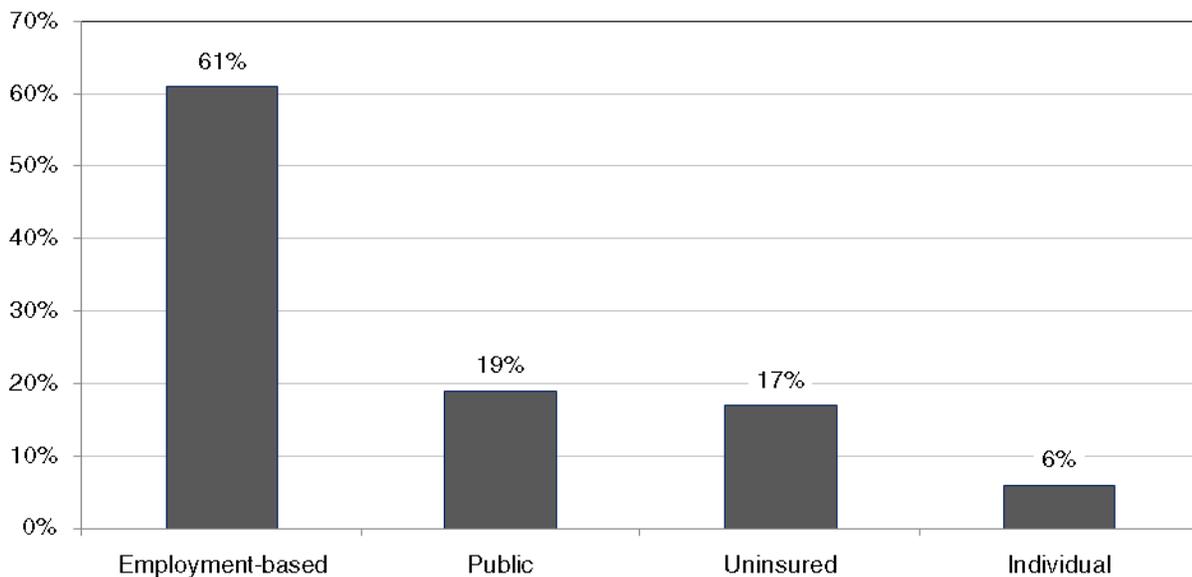
Views ranged from "Will anyone notice?" to predictions of great upheaval for workers and their employers, patients and health care providers, and the entire U.S. health care system. A common disappointment voiced at the forum was that the effort to reform the *delivery and cost* of health care in America gradually became focused on just *financing and coverage* of health insurance.

## The Employment-Based Health Benefits System

Today, if you have health benefits at all, chances are you get them through your job. Employment-based health benefits are the most common form of health insurance in the United States: In 2008, 160.6 million individuals under age 65, or about 61 percent of that population, had employment-based health benefits. Public program health coverage accounted for about 19 percent of the nonelderly population, while 6 percent had individual coverage. Those with no health coverage—the uninsured—amounted to 17 percent of the nonelderly population (Figure 1).<sup>1</sup>

The current tax-favored treatment of health coverage in the United States has been written into the Internal Revenue Code through a series of laws and rulings that date back to the 1920s. However, it was during World War II that many employers began to offer health coverage. Because the National War Labor Board (NWLB) froze wages during the war, employers sought ways to get around the wage controls in order to attract scarce workers. In 1943, the NWLB ruled that employer contributions to insurance did not count as wages, and thus did not increase taxable income to workers, and could therefore be offered in addition to wages and salaries. As a result, employers began to offer health coverage to their workers to be competitive in the labor market, and the number of persons with employment-based health coverage started to increase.<sup>2</sup>

Figure 1  
Sources of Health Coverage in America, 2008



Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 1995–2009 Supplements (see *EBRI Issue Brief*, no. 334, September 2009).

The growing economic pressures on the employment-based health benefits system are well-documented. In every year since 1998, premium increases have exceeded worker earnings increases and inflation: Health insurance premiums have more than doubled while worker earnings have increased 30 percent. Since health benefits have been voluntary—employers are not legally required to offer health insurance to their workers—coverage rates have responded directly to the growing costs and rising unemployment. Currently, employment-based health coverage is falling while the rate of the uninsured is rising.<sup>3</sup>

To examine what lies ahead for this system, the EBRI policy forum looked at current trends, public opinion on health benefits, consultant views, consumer perspectives, and employer and insurer views.

## Recent Trends in Employment-Based Health Benefits

**JON GABEL**, of the National Opinion Research Center presented recent results from the KFF/HRET Annual Employer Health Benefits Survey showing how rising health insurance costs are affecting employers in different ways—especially small employers.

Gabel noted that rising health insurance costs have priced out low-income workers from getting coverage even if it's offered by their employer. For instance, a worker's health insurance premium for family coverage in a small firm averages about \$13,700 a year—yet a minimum-wage worker earns only about \$11,500 a year. "Today, the cost of family coverage exceeds the annual earnings of a minimum-wage worker, which gives us an idea of the problems of affordability for low-income Americans," Gabel said.

Since 2000, Gabel added, health premiums have risen almost five times as much as the overall rate of inflation: Overall prices went up 20 percent over the period, workers' earnings went up 29 percent, and health insurance premiums for small firms shot up 108 percent.

Gabel said employer subsidies for health coverage, either by paying all or part of the premium or requiring no deductibles and modest copayments, mask the true costs of the benefit that workers actually receive. "When most Americans think of the rising cost of health care, they're not thinking of the *total* cost of health care—they're thinking

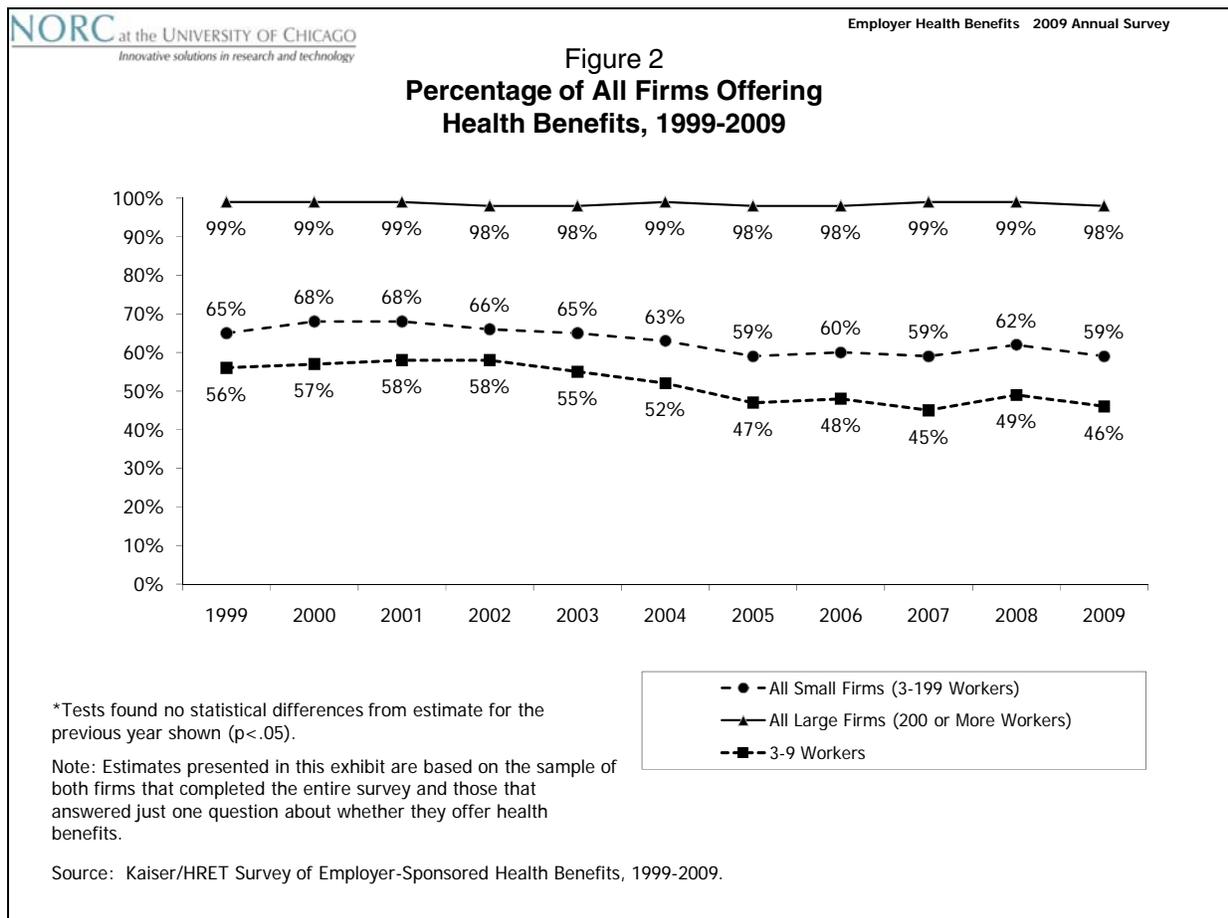
about what they pay, and this is what they see," Gabel said. "I doubt if most employees have any idea how much their employer is contributing."

In response, Gabel noted, many employers are raising the deductibles that workers must pay—the initial out-of-pocket amount that participants must pay before insurance kicks in. This has been especially dramatic in the shift from health maintenance organizations (HMOs), which have relatively low deductibles, to consumer-driven plans that tend to have high deductibles. For all workers, the average deductible has gone from \$266 in 2005 to \$528 in 2009, but workers at small firms suffered a much worse hit in their deductible payment: from \$403 to \$830—more than double.

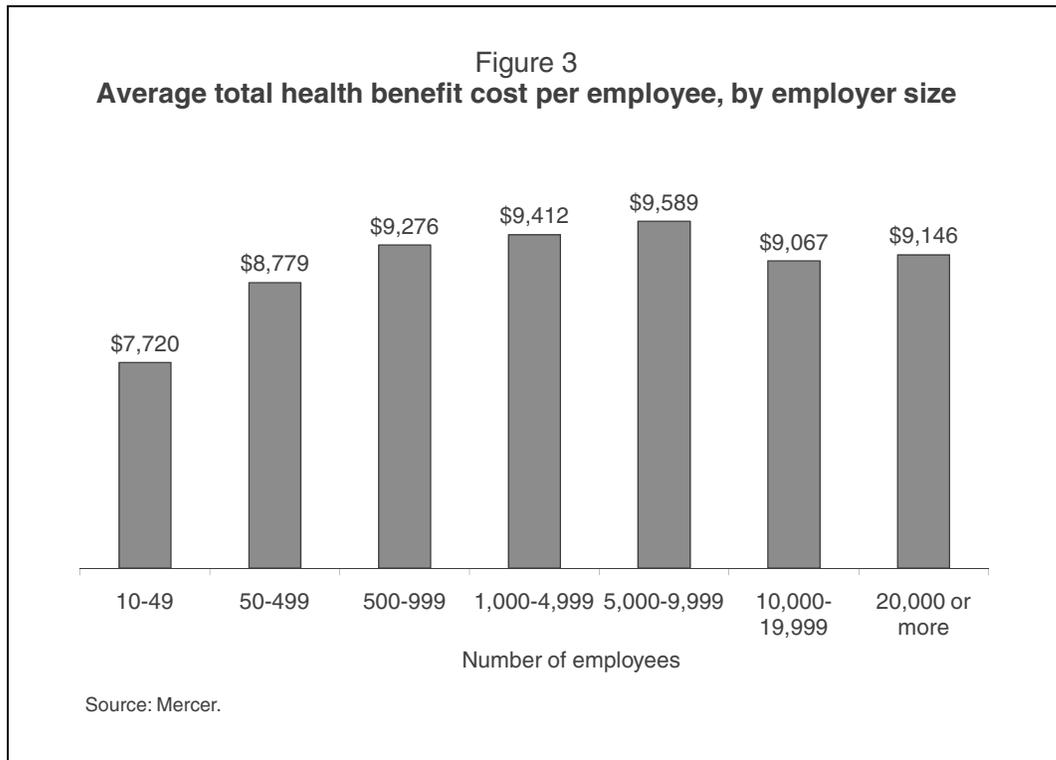
This increased cost sharing does tend to make people cut back on their health expenses. While this helps with short-term cost-control, Gabel said, it also has been shown to cause people with chronic diseases to put off care they need. Studies show increased cost-sharing equally reduces the use of appropriate and inappropriate services.

Not surprisingly, the share of workers obtaining coverage from their employer has been declining, especially among workers at small firms. In 2001 (the end of the economic expansion of the 1990s), 58 percent of workers at small firms obtained their coverage from their employer; by 2009, that had dropped to 46 percent. That compares with workers at large firms, where coverage dropped from 68 percent to 59 percent over the period (Figure 2).

**BETH UMLAND**, head of Mercer's health and benefits research unit, presented results from the Annual Mercer Employer-Sponsored Benefits Survey, focusing on what larger employers have been doing to manage health cost trends. The Mercer survey examines total health benefit costs per employee, which reflects the degree to which workers enroll their dependents in the health plan.



Umland said that health costs per employee tend to moderate among the largest employers (10,000 or more workers) since firms of this size have more leverage to negotiate discounts in the marketplace and use more sophisticated cost-management tactics, compared with smaller firms (Figure 3).



Among large firms, health management and consumer-oriented health plans appear to be more important as cost-control strategies than cutting benefits and shifting costs onto workers. In 2006, about three-quarters of large employers believed that health management would be a “very important” cost-management strategy in their organization over the next five years, Umland said. This was a far greater proportion than said they expected employee cost-shifting to be a very important strategy (37 percent). Based on an analysis of in-network deductibles in preferred provider organizations (PPOs, the type of plan most workers are in), “large employers were actually pretty restrained in the use of cost shifting between 2000 and 2009,” she said. The median individual deductible rose from \$250 to \$400 during that time period, while among employers with 10-499 employees, it rose from \$250 to \$1,000.

Umland noted that large employers embraced consumer-directed health plans with saving and reimbursement accounts (growing from just 5 percent offering such a plan in 2005 to 20 percent in 2008). Interestingly, this growth came to a complete halt in 2009 among large employers, even as small employers rushed to adopt consumer-driven plans last year.

Umland suggested a key difference is that large employers tend to offer a consumer-driven plan as part of their mix of health plan options and that worker enrollment in these plans tends to be low. Small firms, by comparison, are more likely to offer a consumer-driven plan as their only health plan option. In 2009’s tough business environment, large employers may have been reluctant to take on the administrative and communications costs of implementing a new plan when savings would depend on employee election choices.

Employers are more likely to implement health savings accounts (HSAs) than health reimbursement arrangements (HRAs). But average employee enrollment is higher in HRA-based plans. She added, “The HSA does not yet have really a broad appeal to employees.”

Nevertheless, large employers expect that consumer-driven plans will continue to grow, with 60 percent saying they will probably offer one of these plans within the next five years, Umland said. Since consumer-driven health plans generally cost about 20 percent less than the average PPO, this is clearly a way many employers hope to manage their health plan costs.

Of greater interest to large employers are health management programs (particularly the health risk assessment), behavioral modification programs, and health advocate services. Large employers are offering incentives—primarily cash incentives but also premium reductions—to get workers to participate in the programs, for which the health risk assessment is the “foundational element,” Umland said. About quarter of all large employers and half of “jumbo” employers use this technique, she said.

While there continues to be controversy over whether health management actually produces a measureable return on the investment, Umland stated that “data is starting to accumulate that show that these programs actually are cost effective.” Trying to measure that return is difficult and costly, she acknowledged, which is why Mercer is working with the Health Enhancement Research Organization in an attempt to identify the health management programs that produce the best outcomes. Among those employers that have tried to measure return on investment (ROI) on health management programs, “about three-quarters say it’s been very successful,” Umland said.

Among other ideas employers are starting to or likely will consider to manage their health care costs: Using evidence-based medicine in designing a health plan, using high-performance networks of health care providers, along with surgical centers of excellence, retail clinics for chronic care management, and medical homes.

Umland said employers are likely to be significantly affected under health insurance reform legislation before Congress, which was being amended at the time of the EBRI policy forum. In particular, the “pay-or-play” proposal (similar to what Massachusetts enacted) would force many employers to provide coverage (or payment for) their part-time workers (currently about 60 percent of employers offer coverage to part-time employees). Especially for retail employers, where fewer than half offer health benefits, “that could be a pretty big hit,” Umland said.

The so-called “Cadillac” health plan tax, also known as an excise tax, would affect about 20 percent of employers by 2013. If that happens, she said, fully two-thirds of employers surveyed by Mercer said they would be forced to reduce their health benefit in order to control costs.

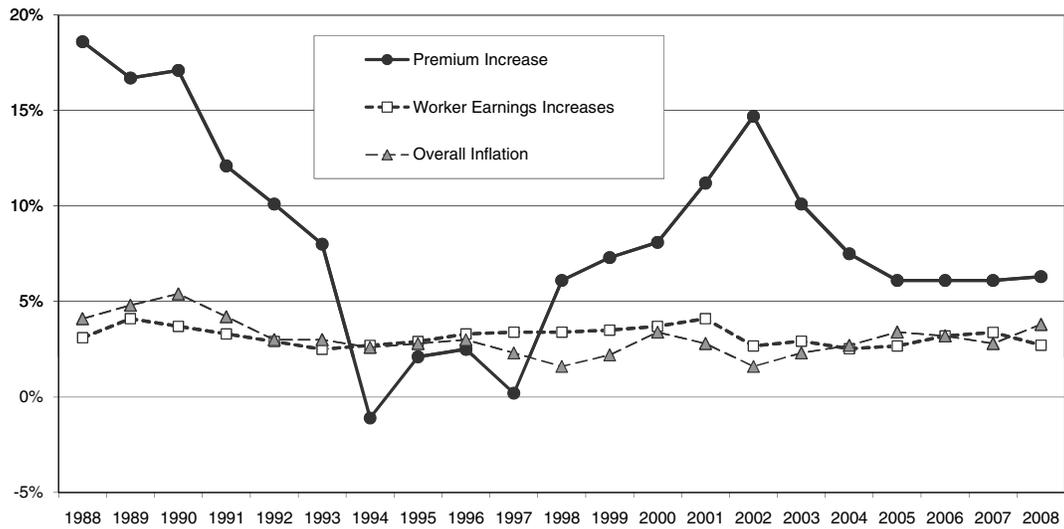
“Even though shifting costs may not be their preferred method of cost management,” Umland said, “they will go ahead and cut benefits if that’s what it takes to avoid an additional tax.”

**PAUL FRONSTIN**, senior research associate at EBRI, presented results of the 2009 Consumer Engagement and Health Care Survey, which continues to find that enrollment in consumer-driven health plans and high-deductible health plans is low but growing. He presented trend data on health premium increases over time and comparisons between traditional, high-deductible, and consumer-driven health plans (Figures 4 and 5).

In 2009, Fronstin said, about 4 percent of the population was enrolled in a consumer-driven plan, up 1 percentage point from the year before, and enrollment in high-deductible health plans increased from 11 percent to 13 percent over the period. This translates into about 5 million working-age adults in a consumer-driven health plan, and 16.2 million adults with a high-deductible health plan. While estimates vary, Fronstin noted, “we think somewhere between 15 and 19 million people are in these plans, and that represents between 9 and 11 percent of the total privately insured market.”

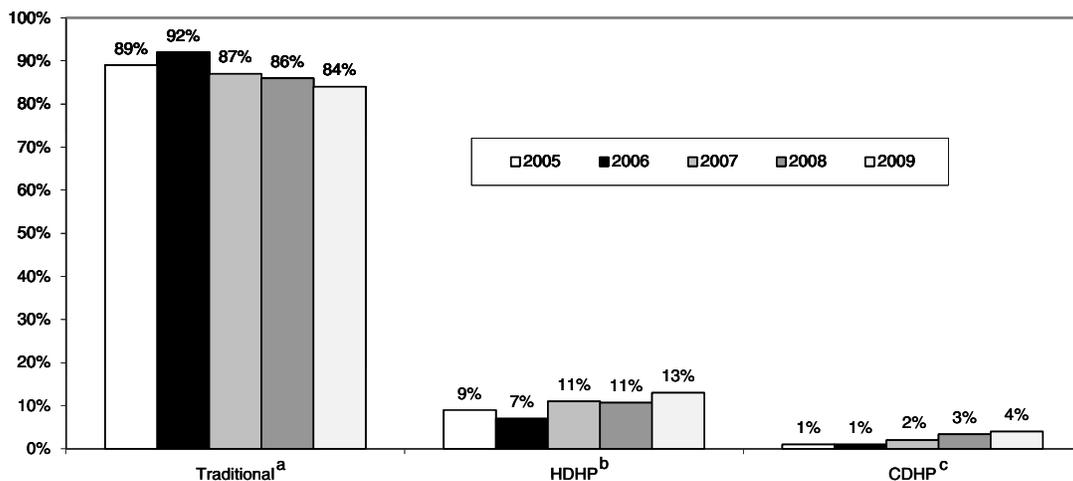
Fronstin said a \$1,000 deductible is the norm in these kinds of plan, so, not surprisingly, people who are enrolled in consumer-driven or high-deductible health plans tend to exhibit more cost-conscious behaviors than enrollees in traditional plans. The EBRI survey found they were more likely to say that they had checked whether the plan would cover care, asked for a generic drug instead of a brand name, and talked to their doctor about prescription drug options and costs.

**Figure 4**  
**Premium Increases Among Employers With 10 or More Employees, Worker Earnings and Inflation, 1988–2008**



Source: Mercer National Survey of Employer-Sponsored Health Plans and Bureau of Labor Statistics.

**Figure 5**  
**Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan, 2005–2009**



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).

<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.

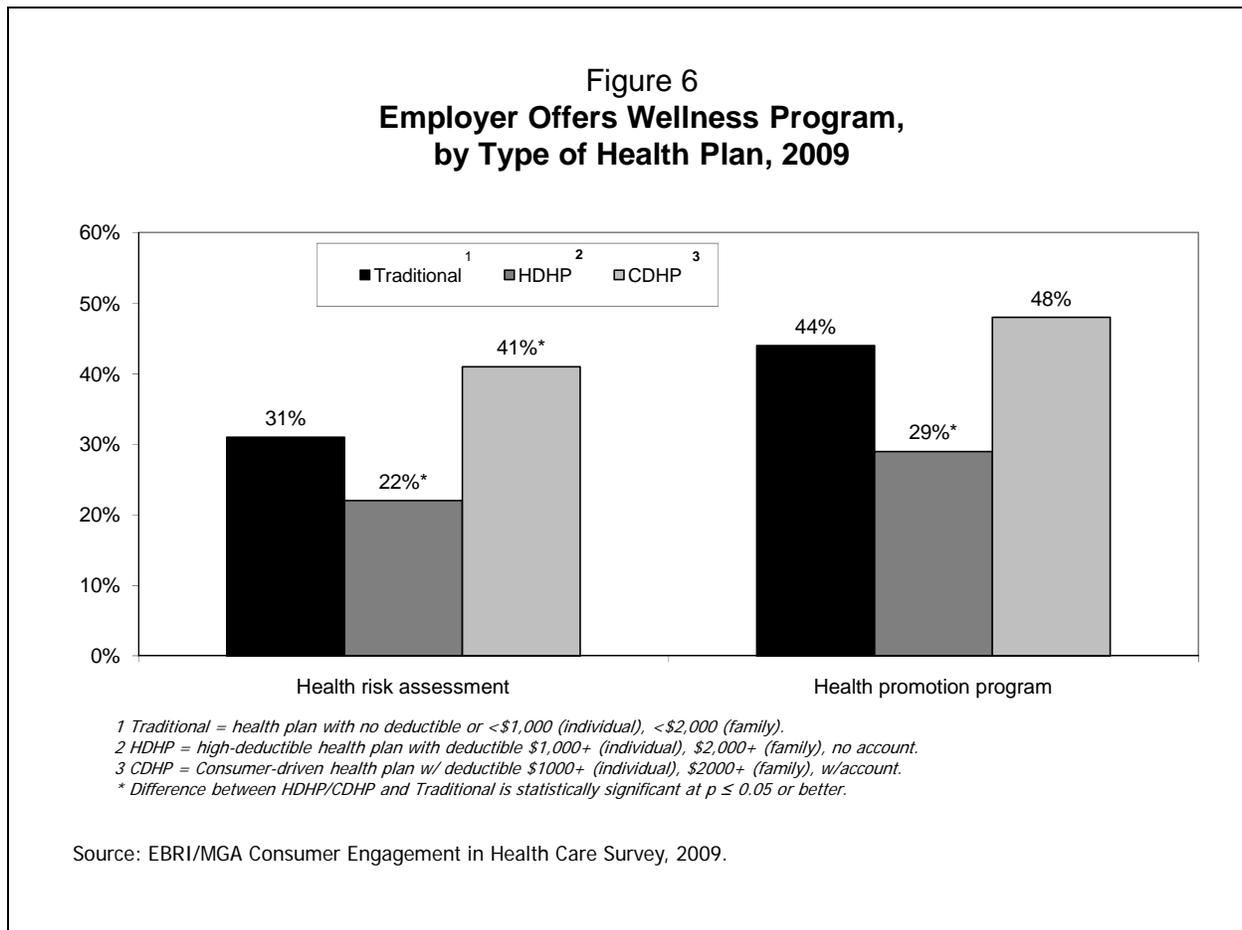
<sup>c</sup> CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2,000+ (family), with account.

Consumer-driven plan enrollees were also more likely than their counterparts in traditional and high-deductible plans to use information provided by their health plans about the quality of their doctors. Both consumer-driven and high-deductible enrollees also were more likely to try to find information on cost and quality of their doctors from sources other than their health plan.

In line with what Beth Umland of Mercer reported, the EBRI survey found that consumer-driven plan enrollees were more likely to report they had the option to fill out a health risk assessment, that their employer offered a health promotion program, and that they were also more likely to participate in these programs when they were offered (Figure 6).

Of those who chose not to participate, most said it was because they could make changes on their own, they didn't have time, or they were already healthy.

Fronstin also noted that "we found there are selection issues" in consumer-driven plans, meaning that those who are healthier tend to sign up for them. Consumer-driven enrollees are "less likely to have a health problem, less likely to smoke, more likely to exercise, less likely to be obese," Fronstin said. "They're also more likely to have higher income and more likely to be more educated."

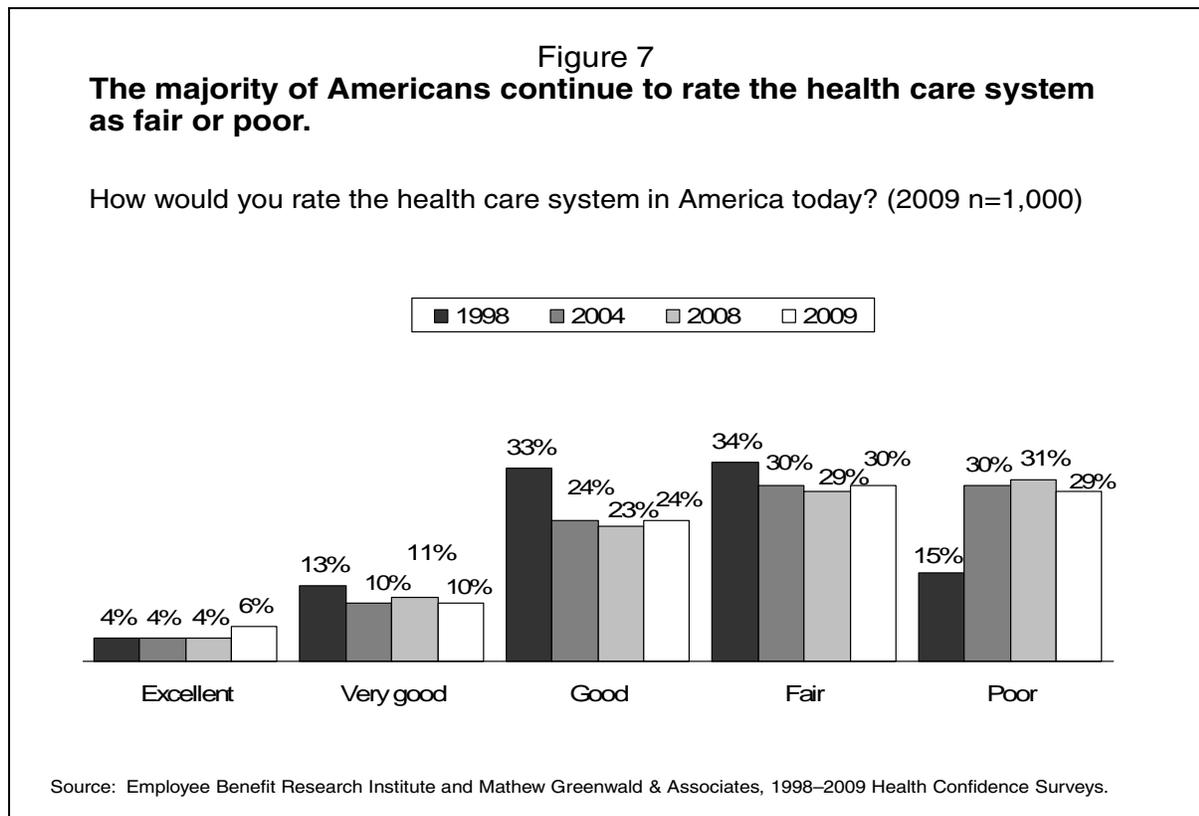


## Public Opinion on Health Benefits

**MATHEW GREENWALD**, principal of Mathew Greenwald and Associates, reported on results from the 2009 Health Confidence Survey (HCS), which took the public pulse in early 2009 just as the debate over health care reform began in earnest.

Greenwald noted that in the 12 years the HCS has been conducted, health care has persistently scored as one of the top problems that people believe they are facing—even as other problems such as energy, the economy, and terrorism rise and fall in perceived importance. “Health care has been pretty consistent—over this course of time, it’s been the second-most critical problem,” he said.

True to the complex nature of health care, public opinion on the subject is mixed and sometimes seemingly conflicted. While people say they are generally satisfied with the quality of the care they personally receive, they also tend to be very unhappy with the cost of health coverage and a majority—3 in 5—rank the health care system as either fair or poor. “That’s the divide: Quality is good, cost is not so good,” Greenwald said (Figure 7).

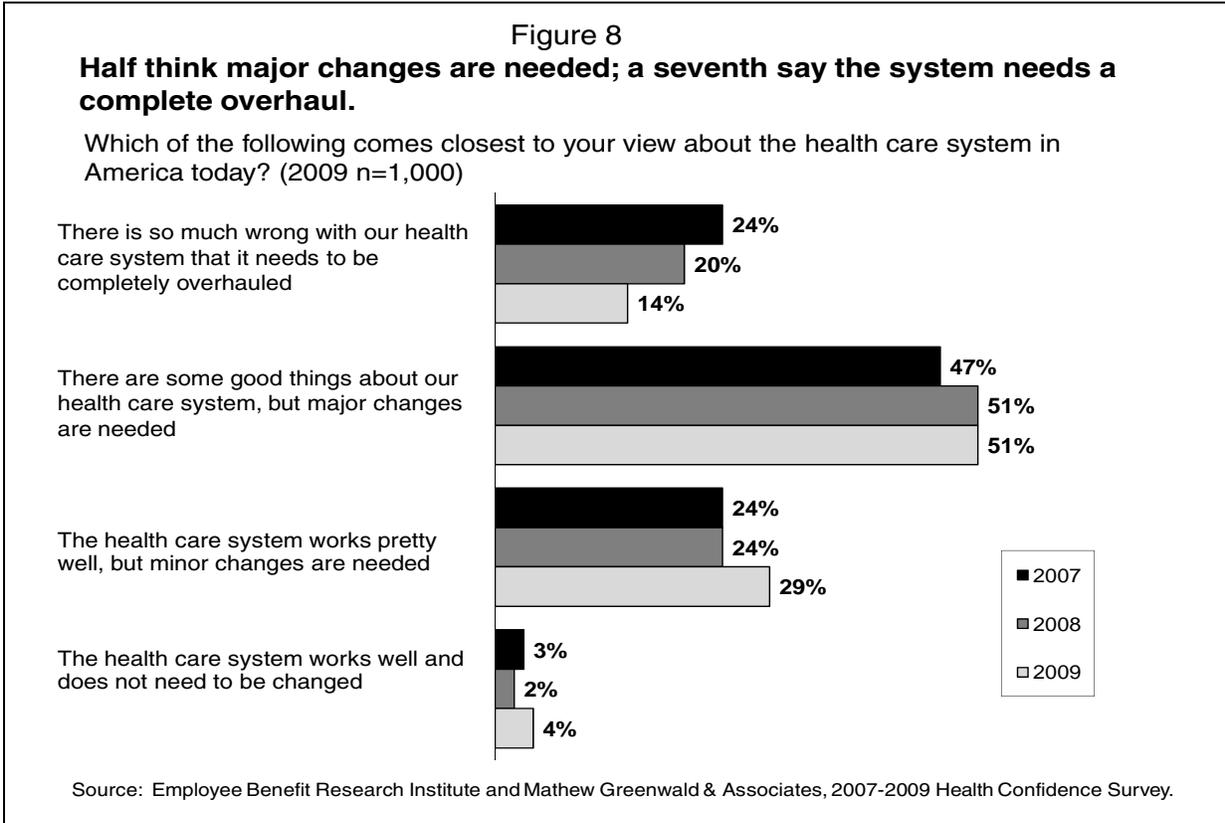


While the proportion of Americans who think the U.S. health care system needs to be completely overhauled has declined over 2006–2009 (from 24 percent to 14 percent), more than half agree that major changes are needed. And the HCS found that people are increasingly pessimistic about their ability in the future (in the next decade) to get the treatments they need, to choose a health care provider, and to afford health care without financial hardship (Figure 8).

“It’s interesting to note that our confidence in things getting better in the future is not there when it comes to health care,” Greenwald said.

**CLAUDIA DEANE**, associate director of public opinion and survey research at the Kaiser Family Foundation, described public opinion on health reform as “schizophrenic,” because the same groups of people hold two sets of sometimes contradictory feelings.

“One the one hand, you have extreme unhappiness about cost and extreme worry that even if I’m okay today, I might not be okay in five years depending on what happens with my job, my husband’s job, my kids,” Deane said. On the other side, she added, people “are plenty happy to complain about stuff, but they give their own health insurance high ratings.” Given these clashes, and ambivalence about health coverage, “you’re going to be able to manipulate that public opinion,” she said.



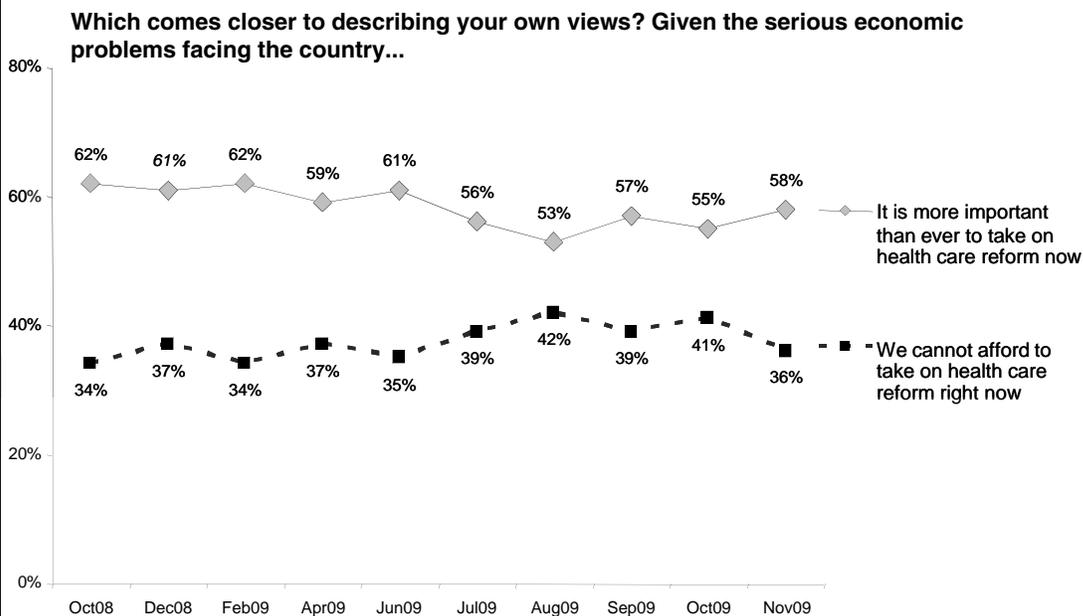
Even though public opinion surveys clearly show the economy being ranked as the most important issue facing the nation, the KFF Health Tracking Poll has consistently found that most Americans feel health reform needs to be tackled now, Deane said. However, those views divide sharply by party affiliation, with most Democrats (77 percent) favoring health reform now, a small majority of independents favoring it (56 percent), and a distinct minority of Republicans (33 percent) favoring it (Figures 9 and 10).

"The party leaders really are reflecting their rank and file," Deane said. "The reason you see this majority is because independents are tilting toward wanting you to take this on," she said. "Usually, when you look at independents, they're almost always 50/50 on everything, and these pies usually are like a big hunk on one side and then a big hunk on the other. This is the tilt that's making this possible."

While trying to measure exactly what "reform" people want, Deane said the KFF survey found, in order, affordable health care (meaning both the cost of actual care and also of health insurance coverage), guaranteed issue of health coverage, deficit neutrality, and an individual mandate (that people purchase health insurance) all receive majority support. While these vary by party affiliation, she added, affordability is the one common issue: "This is the one thing that is in common across the three groups: 'Try and make these plans cheaper for me,'" she said.

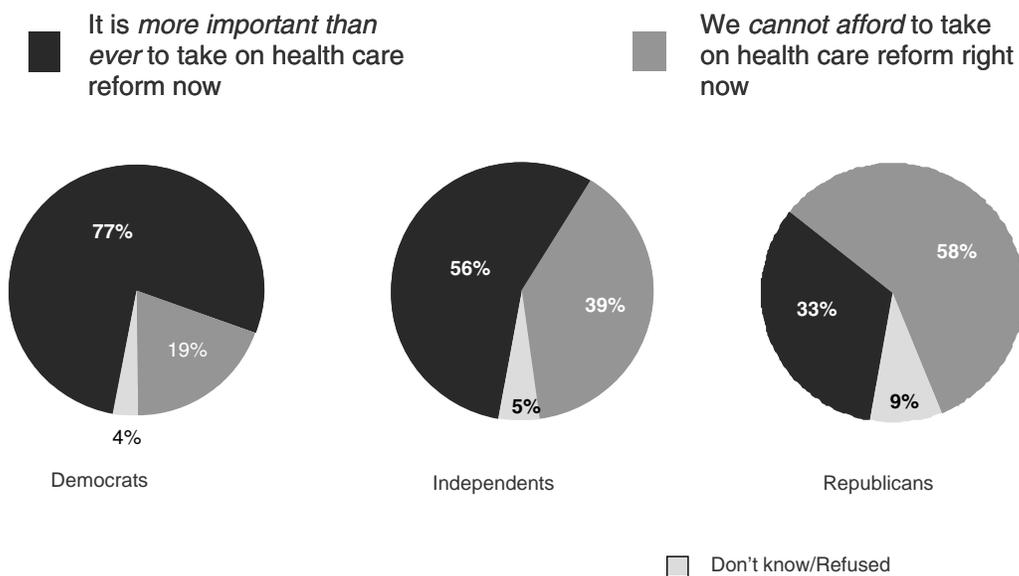
Breaking down the data by demographics, the KFF Health Tracking Poll found that seniors—already eligible for Medicare—are less likely to think health reform will help them. African-Americans and Latinos are much more likely to think they will benefit from health reform than are whites. And not surprisingly, low-income people are much more likely to think they will benefit from health reform.

**Figure 9**  
**Where there's a will... (and there IS a will)**



Note: Asked of half sample in November 2009. "Don't know/Refused" responses not shown.  
Sources: Kaiser Family Foundation polls.

**Figure 10**  
**The will differs, though**



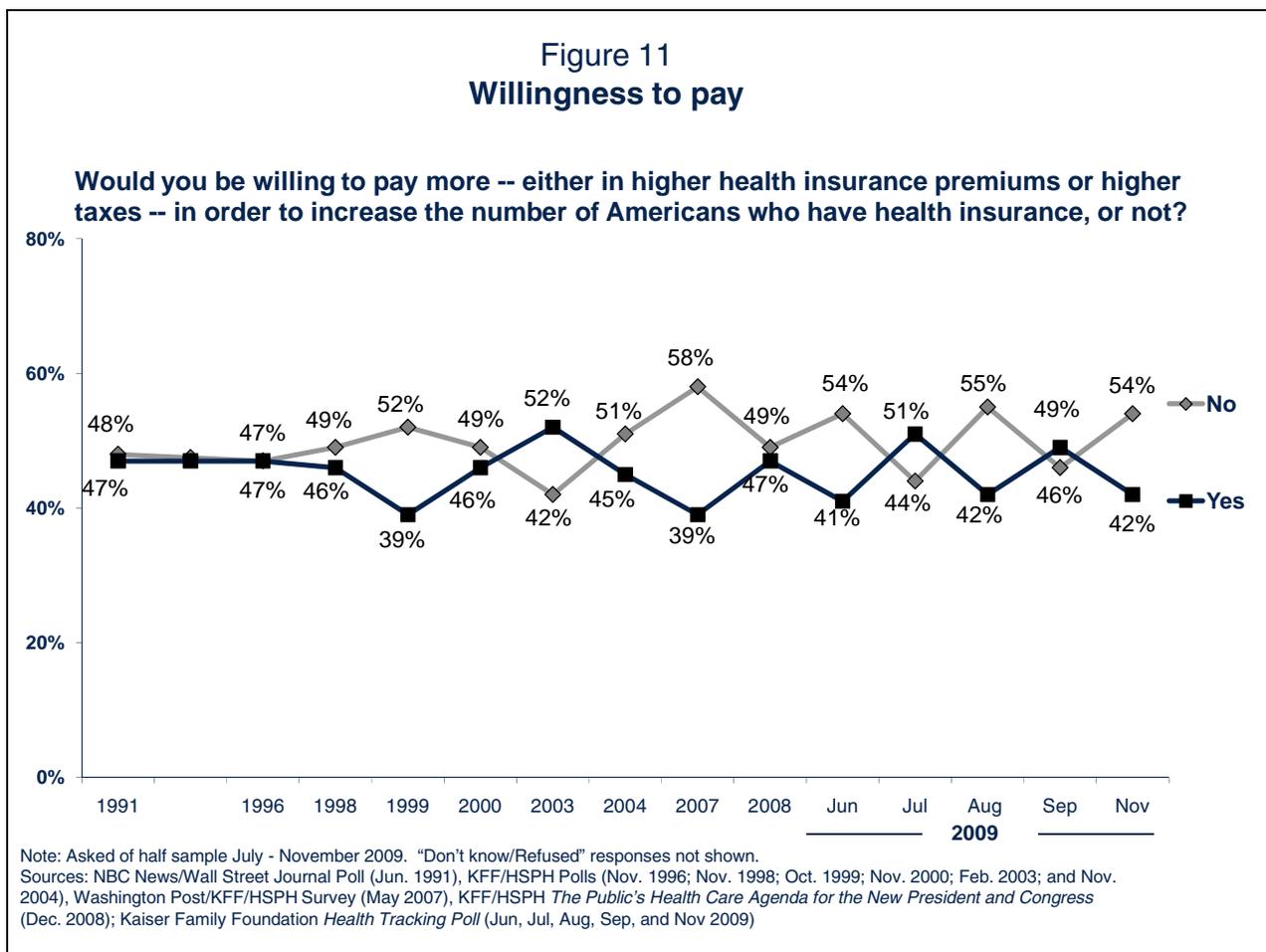
Source: Kaiser Family Foundation Health Tracking Poll (conducted November 5-12, 2009).



During the summer of 2009, Deane said, as details of the five different major health reform plans were debated and the angry “town hall” meetings across the country generated heavy and negative press coverage, the KFF Health Tracking poll and numerous other surveys measured support for health reform falling while opposition rose sharply. But surprisingly, by fall the opinion tracking data snapped back to close to what it had been before. In addition, as time went on, a growing share of the public came to the conclusion that health reform would not benefit them personally, even though many (especially Democrats) felt reform would be good for the country.

Despite the consistently favorable overall public support for key elements of health reform, Deane said, KFF polling found the support was fairly malleable, even for issues such as the inclusion of a public plan or an employer mandate to offer health insurance. Opinions on willingness to pay for reform have bounced up and down (Figure 11).

“It’s pretty easy to bully people out of their opinions on this. These opinions are favorable, but they are not deeply held,” Deane said. “It’s pretty much easier to talk somebody out of something than into something, so you generally see a more dramatic change toward opposition than toward favorability.”



**MICHAEL DIMOCK**, a pollster with the Pew Research Center for the People and the Press, agreed the political battles reflect Americans’ individual and collective ambivalence about health reform, but said the public’s “two-mindedness” is not surprising—especially when compared with the Clinton administration’s failed attempt at health reform in 1993–1994.

“In the end, [the public] is insisting that the government do something, but they’re very skeptical about most of the options that come forward to them,” Dimock said. “The politicians, of course, feel like they’re in this damned-if-you-do,

damned-if-you-don't situation...every package that comes through, there's this broad level of public concern and worry and skepticism about it."

Dimock noted that former President Clinton opted for a less-public, hands-on, more back-room approach to negotiating health reform, while President Obama opted for a more open, hands-off, "sunshine" approach that allowed the public a greater chance to participate in the debate. While Clinton's strategy failed, Obama's approach hasn't been popular either: "Watching how the sausage gets made looks messy to people, and they also feel like they're getting lost in all of the details and that the big picture is not there for them," he said.

Dimock said the Pew surveys—like others—had found that "the ideological divide over this issue is huge," which is not surprising. "At its root, this is the fundamental ideological debate of American politics, the role of government, the scope of the private sector, the scope of the market versus government's responsibility to take care of people who are facing hard challenges in their lives."

He also noted that this reflects a growing ideological division in America. "It's not just your imagination that this country has become a little bit more polarized and a little bit more edgy in terms of these red and blue divisions," Dimock said. "The average distance between self-identified Democrats and Republicans across all of these dimensions is just getting wider. It really is."

One result is a growing number of political independents who are turned off by the ever-growing partisan fighting, and who tend to be far more solution-oriented and "want to see something that works." But, he added, "independents also have a tendency to be the most skeptical and negative about the government process, and "the longer and more drawn-out it gets, the more likely those independents are to sort of throw up their hands and be frustrated about where this thing is going."

Ultimately, Dimock suggested, public opinion will be driven by whether or not Congress enacts—or fails to enact—something that can be labeled as "reform": "The act of progress itself can bring some people onboard," he said. "The public fundamentally wants to see something done in this situation."

## **Consultant Views on the Future of Employment-Based Health Benefits and Health Care**

**JEFF MUNN**, a benefits consultant with Hewitt Associates who deals with top-level HR executives at large firms across the country, said private-sector employers are paying very close attention to proposals in Congress on the excise tax on "Cadillac" health care plans. As others have noted, Munn said the plan for a \$750 per worker penalty for employers that either drop or do not offer health benefits has many employers at least considering the offer, since it would be a huge savings over what they currently pay for health coverage.

However, Munn said there are several reasons why he thinks that will not happen—at least, not yet.

No employer wants to be the first to pull the trigger and receive the inevitable flood of negative publicity. "I have talked to over 100 employers who have expressed a desire in being the *second* large employer to drop health insurance benefits," Munn said. "I've not yet heard a single employer say that they are willing to be the one that does it first, that they're willing to be the one that is on the front page of *The Wall Street Journal* and take all the flack for leading the way."

Current economic conditions will change, and the potential competitive advantage of cutting health costs by dropping benefits now may not last when the economy recovers. "The cost advantage to doing so may be temporary and perhaps even illusory," Munn said. Plus, Congress could always increase the penalty, and rebuilding the administrative structure of operating a benefits system would be expensive and difficult if the decision to drop health benefits turns out to be wrong.

Workers inevitably turn to their employers for benefits advice—which would be difficult to provide in an individual-based (as opposed to employer-based) benefits system where there may be a bewildering number of options.

The key reason why employers offer health benefits is to maintain a healthy and productive work force. Ending health insurance would make it extremely difficult to also manage effective health improvement programs, he said.

Also, moving from a group insurance model (where risks are pooled and premiums are averaged) to an individual, age-rated health insurance model would most negatively affect older and longer-service workers—which means senior executives would personally experience huge health premium increases.

As Munn sees it, the current health benefits system will continue to evolve slowly, unless one of two things happen: A larger employer is willing to be the first to drop health benefits, and senior executives are willing to subject themselves to the big health premium hikes they would have to pay in the individual market.

"If we see either of those or both, I think that will signal the beginning of a fairly major shift in employer-provided health coverage," he said.

**DAVID GUILMETTE**, of the consulting firm Towers Perrin, said the rising cost to employers of providing health benefits, coupled with the possibility of new government pressure or mandates to provide the benefit, is causing many large employers to re-think the entire concept and purpose of employment-based health coverage.

He noted that the 2009 congressional debate started with health care reform but eventually turned into health insurance reform, and suggested that the message to employers was to reconsider how to maintain or improve work force health with or without health insurance as the mechanism to do so.

"I think health care reform fundamentally is going to come down to a question around tax-effective compensation," Guilmette said. "This is all about how we're going to pay our people." How a company answers that question will depend in part on the industry involved and the demographics and pay levels of the particular work force, he said.

"As you look at the composition of your work force, there really isn't any such thing as an average employee. You're going to have cohorts of employees, and you're going to need to think about how you're attracting and retaining those individuals," Guilmette said.

That opens a larger discussion of all employer-provided benefits, including retirement plans, 401(k)s, and defined benefit pensions (if they are still being offered)—especially if Congress were to include some "maintenance of benefit" mandate in health reform legislation.

Will large employers finally decide to pull the plug on providing health benefits and simply provide higher cash compensation instead? Guilmette said many employers are discussing it, but agreed with others that no one wants to be first. But at least some top-level managers he has talked to say there is likely to come a point where they may have no choice; one chief financial officer of a Fortune 500 company told him: "This is pretty straightforward—we've got to get out because the economics are compelling for us to exit."

Guilmette noted a recent Towers Perrin health reform survey of large firms, showing that employers will take a variety of steps to reduce health costs, starting with cutting benefits and progressing down through raising prices, cutting jobs, cutting pay. Accepting a reduction in profits was ranked as a near-final option (see Figure 12).

Part of the reason that's not a universal sentiment among business leaders, he said, is because of worries that the employer-worker bond would be fundamentally ruptured, that work-force health (and productivity) might suffer, and that a firm's competitive advantage might disappear when the economy recovers.

As employer costs for health benefits continue to skyrocket, Guilmette said it is becoming more difficult for HR executives to justify the ever-growing costs—and the prospect of a government tax (either for dropping the benefit or for offering "rich" benefits) only adds to the pressure of getting out of the benefits game entirely.

While measuring the return employers get on their health benefit expenditures is notoriously difficult, Guilmette predicted that “measurement is going to be hugely important when you say you want to stay in the game and you want to start spending the kind of dollars we’re talking about, because health care’s cost is not going to abate in the short term.”

Ultimately, among those employers that decide to keep offering health benefits, Guilmette suggested they will have to start communicating directly with their workers about why the benefit is being offered, what it’s worth, why it’s important to the business, and what responsibilities the workers will have to shoulder if some sort of health benefit is to be maintained. That is not happening yet, he added.

Among those employers that want to stop offering health benefits, he suggested, it will take a deliberate and orderly process to explain why the changes are being made and what offsetting compensation will be provided in lieu of health insurance. That is not happening yet, either.

“It’s about the bond that you have with your employees and what the dialogue is going to be with your workforce, with employees and their families,” he said. “To the extent you’re looking to reposition yourself and exit over time, how do you engage your employee population to accept that without that having a real negative backlash effect on you?”

Either way—whether employers keep health benefits or drop them—“it’s going to come down to what’s the cost impact to the company for doing what we’re going to do, and what potentially is the competitive advantage that we’re going to derive from whatever decision we decide,” Guilmette said (Figure 13).

**BRUCE PYENSON**, principal and consulting actuary with Milliman, Inc., in New York, presented a laid-back perspective of federal health care reform, predicting that “perhaps not much is really going to change—for sure, there’s going to be additional administration. I see a lot of different changes in rules and compliance...but fundamentally, there’s almost nothing in the legislation that’s going to improve the health care delivery system.” Perhaps his strongest criticism of the pending legislation in Congress was that the ever-growing cost of health care in the United States—to the point where it will consume over 16 percent of gross domestic product—is “essentially being ignored.” “Overall, the problem of high cost isn’t being fixed by healthcare reform,” he predicted.

Pyenson suggested that the sustained economic recession, combined with the proposed federal legislation “creates an opportunity to break the status quo” of health benefits. “Probably now is the time to sweep out some of that trash that has accumulated over the years in benefits plans—plan design, spending, and other things” (Figure 14).

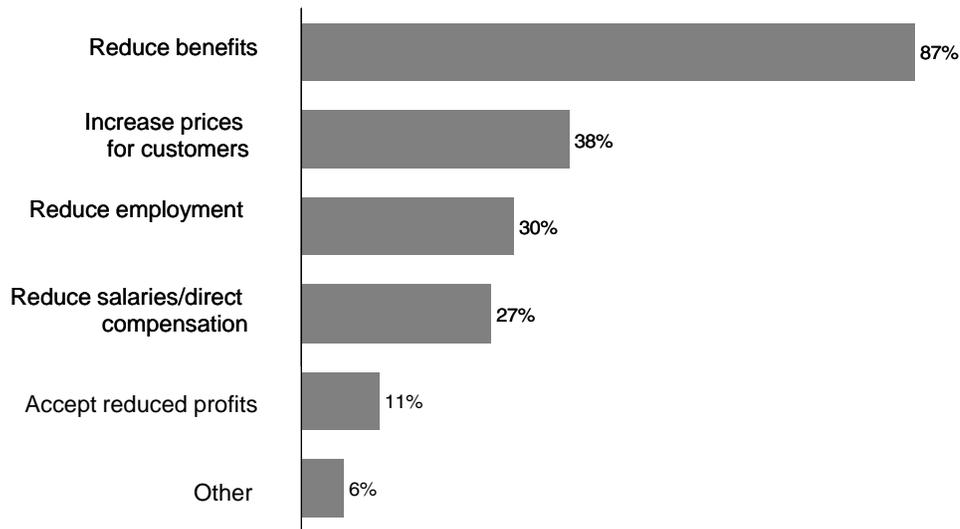
Pyenson said there is ground-breaking new research and data about the health care system that is beginning to be used in the private sector that did not exist 10 or 20 years ago, and that innovation is “going on whether or not there’s health care reform.”

Pyenson said there are some provisions in the congressional legislation that employers should pay a lot of attention to, citing in particular the “shared responsibility” for employers for workers’ health coverage, which imposes penalties on firms for non-coverage or if a low-income worker gets coverage through an insurance exchange. Since this penalty would be tied to family income, rather than a workers’ wage, it has potentially major administrative and financial ramifications for employers. The impact would vary by low-income vs. high-income areas of the country and low-wage vs. high-wage industries. Pyenson noted that a requirement by the state of Hawaii that employers provide health coverage to all their full-time workers seems associated with a high portion of part-time workers there.

Pyenson was also critical of ancillary programs that he said are ineffective, such as disease management, employee assistance programs, wellness programs, and value-based insurance design. “The theory that you can spend more now to save money later in health care is just wrong. If you want to spend less in health care, you should spend less in health care,” he said.

Figure 12

**Employer Actions If Health Care Reform Increases Employer Costs**  
(Percent Responding Very Likely/Likely)



Source: "Towers Perrin Health Care Reform 2009: Leading Employers Weigh In," *Pulse Survey Report* (September 2009).

Figure 13

**Employers face costs, risks and opportunities**

**Costs and Risks**

- Increased enrollment in employer-sponsored plans.
- Penalties for employees who fail to enroll in employer coverage.
- Consequences of pay-or-play decisions.
- Tax cap/excise tax on "high cost" plans.
- Increased charges by insurers/medical suppliers to recoup assessments.
- Cost shifting due to reduced Medicare payments to providers.
- Reduced government subsidy for Medicare Advantage plans.
- P&L impact of change in RDS tax treatment.
- "Vested" retiree health benefits.
- New reporting requirements (tax cap, W2).

**Opportunities**

- Possible benefit reduction/ redesign for active or inactive employees and/or dependents to offset cost increases or change strategy.
- Reduction in cost shifting due to uncompensated care.
- Effect of Medicare payment reforms addressing quality of care and comparative effectiveness research.
- Potential reinsurance program for employer-sponsored pre-65 coverage.
- Reduced need for employer role in retiree medical (e.g., improved pre-65 access in private market, Part D benefit enhancements).

Source: David Guilmette, Towers Perrin.

Major savings in health coverage costs could be achieved by employers moving to limited networks (perhaps for certain benefits, such as radiology and lab), tighter medical management, and limited or no out-of-network benefits. “Those are all the kinds of changes that would save employers real money,” he said. The tough economic times make these seem more realistic than in the past.

**Figure 14**  
**Will Healthcare Reform/Recession Break the Employee Benefits Status Quo?**

- We’ve Had 10 years of “Spend More Now to Spend Less Later”
  - It doesn’t work!

Recession creates a new environment

- With 10% unemployment, benefits are less important to job-seekers
- State/local crisis is forcing the biggest purchasers to consider benefit cuts
- Healthcare reform may be opportunity for hard look at value of programs
- Watch for *Accountable Care Organizations (ACOs)*!

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## Consumer Views on the Future of the Health System

**REBECCA BURKHOLDER**, of the National Consumers League, noted that her organization has a long history of supporting increased health insurance access and coverage. NCL also backs the proposed ban on pre-existing conditions as a reason to deny coverage, and favors the public health plan option. Patients need better information on the quality of medical care, especially in ways that are “understandable and consumer-friendly,” she said.

Burkholder said it is vital that any health reform legislation stress disease prevention, which can help lower both the incidence and cost of major chronic diseases such as diabetes.

One of the simplest but potentially most effective steps toward health reform would be in medication adherence—simply taking medication as directed. “Poor medication adherence is often referred to as America’s other drug problem,” Burkholder said, noting NCL is making this issue a major priority. “Particularly for employers, poor adherence, we believe, results in reduced productivity as a consequence of absenteeism and ‘presenteeism.’”

Burkholder said that whatever health reform is implemented will need a major public education effort—including by employers—both to communicate accurate information and to avoid the inevitable attempts at consumer fraud by criminal elements looking to exploit confusion for their own profit.

"With any new large government program, there's a potential for fraud. We're anticipating, just like with the Medicare Part D program, that there's fraudsters out there that's going to be preying on certain segments of the population, particularly seniors but others as well," she said.

**KEVIN KELLEHER**, a representative for the New Jersey Education Association (NJEA), provided the union perspective on health reform. NJEA represents about 200,000 active members who work in 625 school districts in the state, along with about 30,000 retirees. Since New Jersey is a collective bargaining state, every two or three years NJEA negotiates new salary and benefit contracts for its members with all 625 school districts.

"It needs to be kept in mind that health benefits are part of the overall compensation of NJEA members," Kelleher said. "NJEA members put a high priority on health insurance, and so they do give back in their wages and they do give back in their contractual language in order to hold onto good-quality health insurance."

Like other unions, NJEA strongly believes that national health reform should maintain the tax exclusion of employment-based health insurance, and that "the biggest issue" is that any reform package should not include any excise tax on so-called "Cadillac" health plans. "The excise tax, we believe, will be a killer to the health insurance reform," he said.

NJEA supports the proposed health insurance exchange and public health insurance option. "We believe that a public health insurance plan option will keep the private insurance companies honest and the private insurance companies will keep the pool honest," he said.

Kelleher was sharply critical of the Senate bill's proposed 40 percent tax on health benefits that exceed certain thresholds (\$8,500 for an individual in 2013 and \$23,000 for a family, increasing by the consumer product index plus 1 percent). Since the bill would include medical, dental, prescription drug, and vision benefits, along with contributions to a health savings account (HSA) or flexible savings account (FSA), "I can tell you in New Jersey we will definitely be above that threshold very quickly," he said.

If the tax were to be enacted, Kelleher said, "I know employers and employees in New Jersey will sit down and we will start to negotiate a lower level of health insurance to try to stay under that excise tax. No employer is going to want to pay that excise tax. No employee is going to want to pay that excise tax."

"I call it the race to the bottom. We're just going to continue to lower the level of benefits based on the threshold," he said.

Even though the excise tax thresholds in the Senate-passed health bill are designed to ramp up over time with general inflation, and high-cost regions would get special rates, Kelleher said the much higher rate of medical inflation would ultimately impose the tax on many companies and their workers whether or not they have "Cadillac" health plans.

"We believe it's not just New Jersey—it's many states." Kelleher said. "At some point, everybody will hit the threshold because your medical inflation will certainly be greater than 3 percent over the next 10 years."

## **Employer and Insurer Views on the Future of Employment-Based Health Benefits**

**PAM FRENCH**, director of global benefits and integration at Boeing, Inc., noted that her company has unusual business and demographic factors that make health benefits an essential—if extremely expensive—part of their business model. Boeing's health plans cover about half a million employees, retirees and dependents; cost the company more than \$2 billion a year; and represent about 77 percent of the company's net earnings.

Given the firm's high-tech line of business (aerospace and defense) and its older, experienced, and highly educated work force (a lot of engineers), health benefits are something Boeing's workers both understand and value highly, she noted. She acknowledged that the firm's health benefits are generous, and "that is by design, to some degree."

"We're the kind of company when you say, 'it doesn't take a rocket scientist,' well, in some cases, it *does* for us," French said. "We believe our health care program does attract and retain top-performing talent. We think it's a competitive advantage when we're out there recruiting."

She also noted that the proposed excise tax on "Cadillac" health plans "doesn't take into account your demographics—we tend to have an older-age work force, so our health care costs tend to be higher just purely based on our demographics."

While some employers may be thinking about dropping health benefits, French added, "that's not the case" with Boeing, adding: "I personally am a supporter of maintaining employer-based coverage."

Boeing's health benefits encourage preventive care, by offering 100 percent coverage of common preventive services, wellness programs, and the company pushes for continuous innovations and improvements in the health programs it offers. She pointed to a pilot program the firm launched for customized care of workers with complex, chronic conditions, which ultimately delivered better care, reduced their medical costs by more than 20 percent (largely by reducing emergency room use), and won support of both doctors and patients.

Because of its size and presence in the communities where it is largely based, French said Boeing is able to negotiate rates with health care providers that might not otherwise be possible. She said the health payment system needs to be changed, since "fee-for-service isn't working that well for us, where providers are sometimes reimbursed based on the quantity of services versus the quality of the outcome." She also said more information on health quality is needed so workers can become "cost- and quality-conscious health care consumers."

Unlike Bruce Pyenson of Milliman, French said Boeing does see return on its investment in prevention and wellness programs, since preventable illnesses are such a large factor in health costs: "For a company like us, actually, we do see a payoff, an ROI on it." French believes the key issue in controlling health costs is improving the health care delivery system, and expressed disappointment that the congressional debate over health care reform shifted away from health *delivery* reform to health *financing and coverage* reform.

**ALISSA FOX** of the BlueCross BlueShield Association (BCBSA), representing the 39 independent BCBS plans across the country, noted that her group has long supported comprehensive health care reform and came up with its own reform proposal two years ago that would build on the employer-based system.

Key elements of the plan are that it would provide guaranteed issue of health insurance regardless of pre-existing conditions, and end varying premiums based on health status and gender. However, she noted, that would work only if "everybody is in the pool, and that there are incentives for people to buy, and that's really one of our key problems" with the congressional legislation.

To measure how the Senate-passed health bill would affect the individual and small-employer market, BCBSA recently released a study concluding that the proposal would expand individual-market coverage by slightly less than half (from 17 million to 25 million people), while premiums after five years would increase an average of 54 percent, after inflation.

That would mean a premium increase of almost \$1,600 for a single policy and \$3,300 for a family policy. In the small-employer market (up to 50 workers), the study estimates premiums would increase by 20 percent five years after reform was enacted, while coverage would decline by about 3 million people as younger, healthier workers dropped coverage and went to the individual market.

Fox said the chief causes for these big premium hikes in the small-group market are that the bill would allow healthy workers to wait until they're sick to buy insurance coverage (because of the guaranteed issue and the low penalty for not buying insurance); insurance companies would be restricted in giving discounts to young (and healthy) people; and the benefit package would be significantly more generous than what is offered today.

Even though the provisions in the Senate bill would likely have little impact on the large-employer health insurance market, “there are a number of changes that are going to make everyone’s coverage more expensive,” she said—such as the excise tax on “Cadillac” health plans, the penalty on employers for not offering a health benefit, and taxes on health insurers.

Fox noted the Senate bill would force a significant reduction in benefits offered to federal workers through the Federal Employee Health Benefit Program, which would be hit by the proposed excise tax by 2015 for single coverage. Since insurers serving the FEHB are prohibited by contract to pass along excise fees, the overwhelming probability is that benefits would have to be cut to avoid the tax, Fox said.

Another major concern is that the “grandfathering” provisions—protecting many existing health plan benefits—would take effect as soon as the bill becomes *enacted*, and not on its *effective date*. That would effectively kill the grandfathering provisions for any health insurer that subsequently made any changes to a health plan after the bill was signed into law.

While the BCBSA supports a number of provisions in the bill, Fox said the association sees major problems with several key provisions. Among the most critical, she said, are being able to offer premium discounts to young people, and “to drop the taxes that are going to make everyone’s coverage much more expensive.”

**ROBERT GRABOYES**, representing the National Federation of Independent Business (NFIB), expressed discontent with the basic structure of the employment-based benefits system, at least where small business is concerned.

“I’ve not been a big fan of the whole idea of employer-sponsored insurance,” he said. “I’m an agnostic on whether it will disappear, whether it should disappear,” while acknowledging that “for most people who are in it, it works pretty well.”

Graboyes recounted the various ways that small businesses are disadvantaged by the employment-based health insurance system. He noted that for large employers the system is very good at creating large stable risk pools and as “a kind of vaccine against adverse selection.” He observed that large companies especially can exert market power in the purchase of both health insurance and health services, and that large firms can afford human resources departments to help workers navigate the health benefits system.

However, he quickly added, employment-based health insurance is “not so good to the guys I represent, which is small business.” Part of that is because small firms are not a particularly good or stable way to organize a risk pool, saying “they essentially end up being risk puddles.” Also, small businesses do not have much in the way of market power, in part because federal and state laws have been structured so as to largely prohibit them from aggregating into large groups. Federal tax laws also favor large-group employees, especially compared with small-group or nongroup employees.

Also, he noted, individual small firms are generally unable to get sizeable discounts from insurers, typically do not have HR departments, and do not have in-house expertise in health insurance. As a result, small firms that do offer health coverage tend to pay far higher premiums than large employers pay for similar coverage.

“Because of these and other reasons, small business faces a lot of problems that the larger entities don’t. The small business typically pays—we use the number 18 percent—more than equivalent coverage in a large firm, and the premiums have skyrocketed over the last decade,” Graboyes said.

In the health insurance reform debate, Graboyes said NFIB favors health insurance exchanges (“as long as they’re done right”), and guaranteed issue (“no one feels more strongly the agonies of rating on health experience and on pre-existing conditions than people in the small-group market”). NFIB opposes excessive benefit mandates and has concerns about inflexible fee-for-service payment systems for health care providers.

Fittingly for a bastion of private enterprise, the small businesses that comprise the NFIB oppose the so-called public option for health insurance, Graboyes said. “We believe private insurance markets are the way to go, competitive private insurance markets.” But for NFIB’s members, he added, that means creating “broader markets, not splitting small business by size, by type of business.”

**JEANNE DENZ** of General Mills, based in Minneapolis, noted that the firm has about 30,000 workers worldwide, including about 17,000 in the United States, and that the firm “has been working in the health care reform arena for about 20 years now, most of it featured at a Minnesota level.”

Denz described Minnesota’s efforts in tackling health reform within the state, driven by a relatively few large employers that have pushed highly innovative and experimental programs that have succeeded in improving health delivery while reducing costs.

She noted that an insurance mandate may help increase coverage, but that mandates are not completely successful. For instance, about 7–8 percent rate of people in Minnesota currently are without health insurance, compared with a 9 percent uninsured rate for drivers—and auto insurance is mandatory in the state. “So we’ve been doing better than auto insurance—there’s no mandate [for health insurance], but people have coverage,” she said.

For instance, Denz said, Minnesota’s health plans are all not-for-profit, and “we are very efficient in our health care delivery system.” A major factor in that has been the Business Healthcare Action Group (BHCAG), which brought together about 20 of the largest private-sector employers in the state to create a common plan design, created a payment mechanism that rewarded providers for good outcomes, and changed delivery systems.

“You know what? It worked. It absolutely worked,” Denz said. “And we actually had made a huge difference in both the delivery of health care and the payment options within health care.”

Unfortunately, the BHCAG represented only about 10 percent of the providers’ revenues in the state, and the model became unsustainable in the market. In addition, Medicare payments went down, which effectively penalized the employers for providing effective care.

Another innovation currently underway among some Minnesota employers is the development of “care-based packages” to more effectively and inexpensively manage the cases of people with chronically ill conditions.

“Health care reform can work,” Denz said, but it’s not just about getting everyone into the insurance pool—it’s about changing the way health care is delivered.

Denz expressed disappointment with the health reform bills in Congress, noting that they address coverage and payment but not the more important issue of cost. “Things that we’re doing now aren’t changing those underlying fundamentals about what’s broken in the system, and until we decide what’s broken in the system and find some innovative ways of working together to fix it, we’re not going to get any better than we are today,” she said.

Denz views the “Cadillac” tax proposal as “just a way to talk about beginning to take the tax-free benefit away from people.” Over time, she predicted, it will cause the end of health care spending accounts, pre-tax premium payments, and vision and dental care benefits.

While Denz thinks that “large and mid-size employers are not going to walk away from health insurance,” she acknowledged that small employers are at a sharp disadvantage, and that over time the employment-based health benefits system may not survive.

## Endnotes

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<sup>1</sup> See Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2009 Current Population Survey," EBRI Issue Brief, no. 334 (Employee Benefit Research Institute, September 2009).

<sup>2</sup> See Paul Fronstin, "Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers," EBRI Issue Brief, no. 325 (Employee Benefit Research Institute, January 2009).

<sup>3</sup> See Paul Fronstin, "Findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey," EBRI Issue Brief, no. 337 (Employee Benefit Research Institute, December 2009).

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*EBRI Employee Benefit Research Institute Issue Brief* (ISSN 0887-137X) is published monthly by the Employee Benefit Research Institute, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, at \$300 per year or is included as part of a membership subscription. Periodicals postage rate paid in Washington, DC, and additional mailing offices. POSTMASTER: Send address changes to: *EBRI Issue Brief*, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051. Copyright 2010 by Employee Benefit Research Institute. All rights reserved. No. 339.

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