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Notes

EXECUTIVE SUMMARY

Consumer Engagement in Health Care: The Use of Lower Cost Sharing

THE 2008 EBRI/MGA CONSUMER ENGAGEMENT IN HEALTH CARE SURVEY: This survey examined opinions regarding the appropriate use of lower cost sharing as an incentive to change the way individuals use the health care system.

HIGHLIGHTS: More than half (58 percent) of individuals support lower cost sharing for patients who actively participate in a program to maintain or improve their health; 40 percent support lower cost sharing for patients who use treatments that have been scientifically proven to be effective for their medical condition; one-third (34 percent) support lower cost sharing for patients who choose to see high-performing health care providers; and about one-half (47 percent) support lower cost sharing for patients who choose less invasive procedures to treat their medical conditions.

HEALTH AFFECTS OUTLOOK: Persons who self-rate their health status as excellent or very good are more supportive of lowered cost sharing than those whose health is not as good. Obese individuals and smokers are generally less likely than those who are not to support lowered cost sharing for engaged patients.

GENDER/AGE: Men are much more likely than women to think that cost sharing should vary with an individual's level of engagement in their own health care. Younger individuals are generally more likely than older individuals to support lower cost sharing for those who comply with patient engagement rules.

RACE/ETHNICITY: Asians are across the board more likely than other race/ethnic groups to support the concept. Non-Hispanic blacks were least likely to support lower cost sharing, while Hispanics and non-Hispanic whites were in the middle.

Income of the Elderly Population Age 65 and Over, 2007

IMPORTANCE OF SOCIAL SECURITY: In 2007, Social Security continued to be the largest source of income for those currently age 65 and older, accounting for 38.6 percent of their income on average. Pension and annuity income was 18.6 percent, income from assets 15.6 percent, and income from earnings was 25.3 percent.

Consumer Engagement in Health Care: The Use of Lower Cost Sharing

By Paul Fronstin, EBRI

Introduction

Employers have been interested in bringing aspects of consumerism into health plans for many years. As far back as 1978, they adopted Sec. 125 cafeteria plans and flexible spending accounts. In 2001, a handful of employers started offering account-based health plans in the form of health reimbursement arrangements (HRAs). In 2004, employers were able to start offering health plans with health savings accounts (HSAs).[1] By 2008, 9 percent of employers with 10–499 workers and 20 percent of those with 500 or more workers offered either an HRA or HSA-eligible plan, covering 7 percent of all workers.[2]

Concurrent with the movement toward account-based plans, or "consumer-driven" health plans as they are more frequently called, employers have increasingly focused their attention more broadly on consumer engagement in health care. In 2001, employers formed a coalition to report health care provider quality measures, and today the group is composed not only of employers but also of consumer groups and organized labor.[3] In 2005, employers started to focus on value-based insurance designs (VBIDs) that seek to encourage the use of high-value services while discouraging the use of services when the benefits are not justified by the costs.[4] A recent study found that 20–30 percent of large employers use some from of VBID strategy.[5]

This report presents findings from the 2008 EBRI/MGA Consumer Engagement in Health Care Survey,[6] focusing on pubic opinion regarding variation in cost sharing as it relates to consumer engagement in health care.

Questions Addressed

The 2008 EBRI/MGA Consumer Engagement in Health Care Survey examined opinions regarding the appropriate use of lower cost sharing as an incentive to change the way individuals use the health care system. The survey asked a series a questions regarding whether individuals agreed or disagreed with various ways patients could receive lower cost sharing. Specifically, adults with private insurance were asked whether they agreed with the following statements:

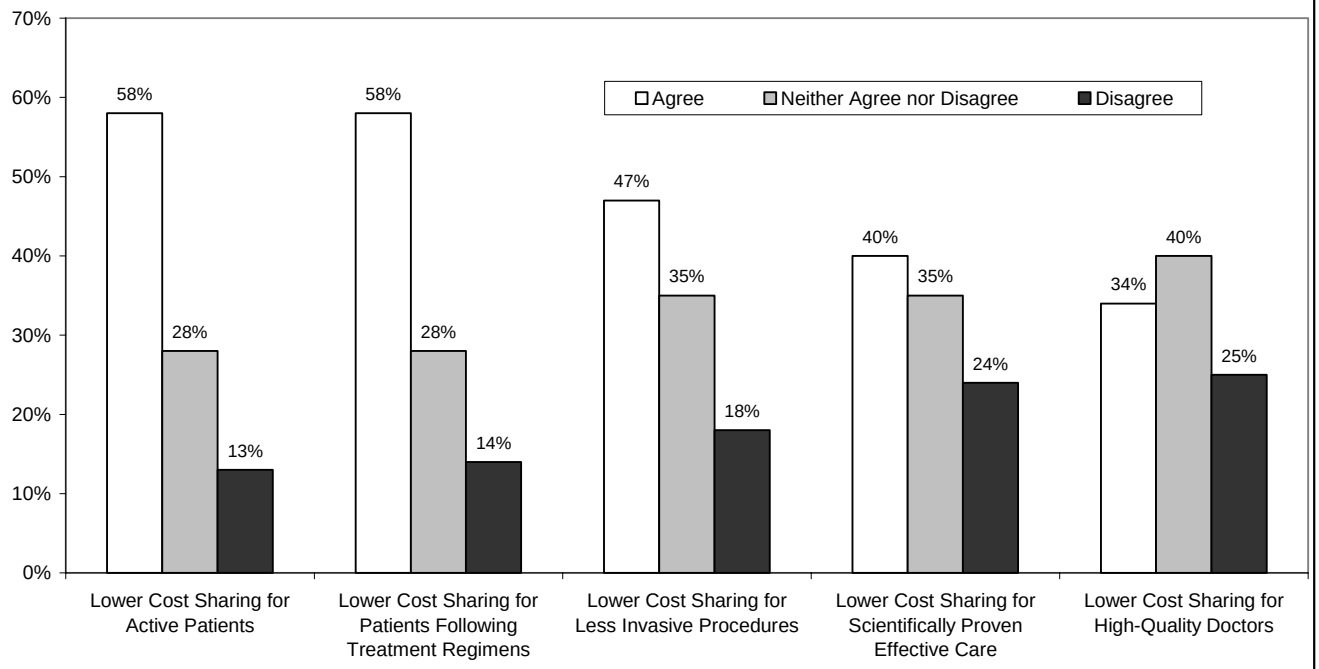
- Patients who are actively participating in a program to maintain or improve their health should pay less for medical services than a patient with the same health issues who is not participating in a health program.
- Patients should pay less for their treatments when the treatments have been scientifically proven to be effective for their medical condition, and pay more for treatments that are proven to be less effective for their condition.
- Patients who choose to see medical providers that are identified as high-performing should pay less than patients who choose providers who are not identified as high-performing.
- Patients who choose less-invasive procedures to treat their medical condition should pay less out-of-pocket for health care services than patients who choose more-invasive procedures.
- Patients who very carefully follow their treatment regimens should pay less out-of-pocket for health care services than patients who do not follow their treatment regimens very carefully.

Overall, 58 percent of individuals support lower cost sharing for patients who are actively participating in a program to maintain or improve their health; 40 percent support lower cost sharing for patients who use treatments that have been scientifically proven to be effective for their medical condition; 34 percent support lower cost sharing for patients who choose to see high-performing health care providers; 47 percent support lower cost sharing for patients who choose less invasive procedures to treat their medical conditions; and 58 percent support lower cost sharing for patients who

carefully follow their treatment regimens (Figure 1). Between 13 and 25 percent disagreed with the use of lower cost sharing, while 28–40 percent neither supported nor opposed it.

The following sections examine how the support for lower cost sharing related to patient engagement varies by health status and behaviors, demographics, and work status variables.

Figure 1
Agreement With Statements About Proposed Ways to Engage Consumers in Managing Health Care Costs, 2008



Source: 2008 EBRI/MGA Consumer Engagement in Health Care Survey.

Health Status and Behavior

Generally, persons who self-rate their health status as excellent or very good are more supportive of lowered cost sharing than those who rate their health as good, fair, or poor. Those in excellent or very good health are more likely to support lower cost sharing for persons who are actively engaged in a program to maintain or improve their health. Specifically, 62 percent agreed with the statement that patients actively participating in a health program should pay less than a patient not actively participating in the same type of program, whereas 55 percent of persons whose self-reported health status was good agreed with the statement, and 47 percent of those in fair or poor health agreed with the statement (Figure 2). Similarly, those in excellent or very good health are more likely than those in good, fair, or poor health to agree that patients should have lower cost sharing if 1) they use providers identified as high-performing, 2) they use less-invasive procedures, and 3) they follow treatment regimens.

While meaningful differences exist in opinions by self-reported health status, differences were not found in opinions by whether a person has at least one chronic health condition, or a chronic health condition combined with self-reported health status of fair or poor. However, differences were found by various personal health behaviors. Obese individuals are generally less likely than non-obese individuals to agree with the above statements about patient engagement and cost sharing. Similarly, individuals who smoke are less likely than persons who do not smoke to agree with the various statements about lower cost sharing for patients engaged in their health care. With respect to exercise, there is no

Figure 2

Agreement With Statements About Proposed Ways to Engage Consumers in Managing Health Care Costs, by Health Status and Health Behavior, 2008

	Patients who are actively participating in a program to maintain or improve their health should pay less than a patient with the same health issues who is not participating			Patients should pay less for their treatments when the treatments have been scientifically proven to be effective for their medical condition, and pay more for treatments that are proven to be less effective for their condition			Patients who choose to see medical providers that are identified as high-performing providers should pay less than patients who choose providers who are not identified as high-performing providers			Patients who choose less-invasive procedures to treat their medical condition should pay less out-of-pocket than patients who choose more-invasive procedures			Patients who very carefully follow their treatment regimens should pay less out-of-pocket for health care services than patients who do not very carefully follow their treatment regimens		
	Agree	Disagree	Neither	Agree	Disagree	Neither	Agree	Disagree	Neither	Agree	Disagree	Neither	Agree	Disagree	Neither
Total	58%	13%	28%	40%	24%	35%	34%	25%	40%	47%	18%	35%	58%	14%	28%
Self-Rated Health Status															
Excellent/very good	62	12	26	42	25	33	37	25	38	50	19	31	63	13	25
Good	55	15	30	35	25	41	30	25	45	44	19	38	52	15	33
Fair/poor	47	18	34	43	22	35	34	28	38	38	24	39	51	18	31
At least one chronic health condition*															
Yes	58	15	27	40	24	36	34	27	39	47	20	33	59	13	27
No	58	13	29	39	25	36	35	23	43	46	19	36	57	14	29
Health Problem**															
Yes	57	15	28	39	24	37	33	27	40	46	20	34	58	13	29
No	59	13	28	40	26	35	35	23	42	47	18	35	58	14	27
Obese															
Yes	50	18	32	38	25	37	33	30	37	40	22	38	53	17	30
No	61	12	26	40	25	36	35	24	42	49	18	33	60	13	28
Smokes															
Yes	43	19	38	36	26	38	29	25	46	45	19	37	50	21	29
No	62	13	26	40	24	35	35	25	39	47	19	34	60	12	28
Exercises															
Yes	59	14	27	38	25	37	33	25	41	46	19	35	59	14	28
No	55	15	29	44	25	31	37	25	38	49	19	32	56	15	29

Source: 2008 EBRI/MGA Consumer Engagement in Health Care Survey.

* 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.

clear message. For example, individuals who exercise are more likely than those who do not to think that there should be lower cost sharing for patients actively participating in health programs. However, they are less likely to think that there should be lower cost sharing for persons who use high-performing providers, scientifically proven treatments, or less-invasive procedures.

Demographics

Men are clearly much more likely than women to think that cost sharing should vary with an individual's level of engagement in their own health care. Men were across the board 10–15 percentage points more likely than women to think that cost sharing should be lower with respect to every question that was asked about proposed ways to engage consumers in managing health care costs (Figure 3).

With respect to age, there are some patterns. Younger individuals are generally more likely than older individuals to support lower cost sharing for individuals who comply with the various ideas for patient engagement. However, the relationship is not completely linear. For example, there is a linear relationship between age and support for lower cost sharing for patients participating in a health program between ages 18–54. Over 60 percent of individuals ages 18–24 support lower cost sharing for individuals actively participating in health programs, compared with 57 percent among 25–44 year olds, and 54 percent among 45–54 year olds, but the percentage supporting the lower cost sharing increases to 64 percent among 55–64 year olds.

When examining support for use of lower cost sharing for individuals engaged in various aspects of their health care, Asians are across the board more likely than other race/ethnic groups to support the concept. Non-Hispanic blacks were least likely to support lower cost sharing, while Hispanics and non-Hispanic whites were in the middle.

Concerning education, there was no clear-cut pattern across the five questions on lower cost sharing and increased patient engagement in health care. Highly educated individuals are more likely than less educated individuals to support lower cost sharing for patients actively participating in a health program. In contrast, less educated individuals are more likely than highly educated individuals to support lower cost sharing for patients who choose less-invasive procedures. There is no clear pattern with respect to household income as well.

Work Status

Figure 4 contains the findings on support for lower cost sharing for various patient engagement concepts by firm size and annual earnings. For three of the five questions on lower cost sharing and patient engagement, workers employed in larger firms are more likely to support the lower cost sharing than workers in smaller firms. Workers in larger firms were more likely than workers in smaller firms to support lower cost sharing for patients actively participating in a health program, patients who use treatments that have been scientifically proven to be effective for their medical condition, and for patients who choose high-performing providers. There was no pattern of support by firm size for lower cost sharing for patients who choose less-invasive procedures and for those who follow treatment regimens.

The same pattern was found with respect to annual earnings. Higher-income workers were more likely than lower-income workers to support lower cost sharing for patients actively participating in a health program, patients who use treatments that have been scientifically proven to be effective for their medical condition, and for patients who choose high-performing providers. Similarly, there was no pattern of support by annual earnings for lower cost sharing for patients who choose less-invasive procedures and for those who follow treatment regimens.

Conclusion

This analysis finds support for using lower cost sharing as a way to engage patients, but the support varies with the type of patient engagement being proposed. Fifty-eight percent of adults with private insurance support lower cost sharing both for patients who are actively participating in a program to maintain or improve their health and for patients who very carefully follow treatment regimens. In both cases, about 14 percent oppose the use of lower cost

Figure 3

Agreement With Statements About Proposed Ways to Engage Consumers in Managing Health Care Costs, by Demographics, 2008

	Patients who are actively participating in a program to maintain or improve their health should pay less than a patient with the same health issues who is not participating			Patients should pay less for their treatments when the treatments have been scientifically proven to be effective for their medical condition, and pay more for treatments that are proven to be less effective for their condition			Patients who choose to see medical providers that are identified as high-performing providers should pay less than patients who choose providers who are not identified as high-performing providers			Patients who choose less-invasive procedures to treat their medical condition should pay less out-of-pocket than patients who choose more-invasive procedures			Patients who very carefully follow their treatment regimens should pay less out-of-pocket for health care services than patients who do not very carefully follow their treatment regimens		
	Agree	Disagree	Neither	Agree	Disagree	Neither	Agree	Disagree	Neither	Agree	Disagree	Neither	Agree	Disagree	Neither
Total	58%	13%	28%	40%	24%	35%	34%	25%	40%	47%	18%	35%	58%	14%	28%
Gender															
Male	63	10	27	47	17	36	39	19	41	52	13	35	64	10	26
Female	53	18	28	33	32	36	29	31	40	42	25	34	53	17	30
Age															
18–24	61	10	29	48	20	32	45	27	28	56	11	34	63	8	29
25–34	57	11	32	38	26	37	30	26	44	39	20	42	55	12	32
35–44	57	17	26	39	23	38	33	25	42	43	20	37	57	14	29
45–54	54	15	31	38	28	34	31	23	46	49	21	30	55	16	28
55–64	64	14	22	38	24	38	37	26	37	50	20	30	64	15	22
Race/Ethnicity															
White	59	15	25	39	26	35	34	26	40	47	21	33	59	14	27
Black	50	13	38	33	24	43	29	22	49	47	18	34	50	14	36
Hispanic	55	11	34	41	20	39	40	21	39	46	14	41	55	13	32
Asian	65	9	26	47	19	34	42	22	36	52	13	35	65	9	26
Other	52	10	38	54	18	28	29	36	35	35	17	48	69	10	21
Education															
High school or less	53	14	34	40	25	35	37	23	41	49	16	35	56	13	31
Some college	56	15	28	37	24	39	33	25	42	44	18	38	55	16	29
College graduate	62	13	25	40	25	35	32	28	40	48	19	32	61	12	27
Graduate degree	66	14	20	42	26	32	35	26	39	43	27	30	65	13	22
Household Income															
< $50,000	55	15	30	40	23	37	39	25	37	48	16	36	57	14	28
$50,000 or more	60	13	27	40	26	34	32	26	42	47	21	33	59	14	28
Don't know	57	15	28	34	21	45	30	22	49	41	22	37	56	13	31

Source: 2008 EBRI/MGA Consumer Engagement in Health Care Survey.

Figure 4

Agreement With Statements About Proposed Ways to Engage Consumers in Managing Health Care Costs, by Work Status Variables, 2008

	Patients who are actively participating in a program to maintain or improve their health should pay less than a patient with the same health issues who is not participating			Patients should pay less for their treatments when the treatments have been scientifically proven to be effective for their medical condition, and pay more for treatments that are proven to be less effective for their condition			Patients who choose to see medical providers that are identified as high-performing providers should pay less than patients who choose providers who are not identified as high-performing providers			Patients who choose less-invasive procedures to treat their medical condition should pay less out-of-pocket than patients who choose more-invasive procedures			Patients who very carefully follow their treatment regimens should pay less out-of-pocket for health care services than patients who do not very carefully follow their treatment regimens		
	Agree	Disagree	Neither	Agree	Disagree	Neither	Agree	Disagree	Neither	Agree	Disagree	Neither	Agree	Disagree	Neither
Total	58%	13%	28%	40%	24%	35%	34%	25%	40%	47%	18%	35%	58%	14%	28%
Employment Status															
Employed full time	57	13	30	39	24	38	33	24	44	46	19	35	57	14	29
Employed part time	60	13	27	34	32	34	30	26	44	49	22	30	60	13	27
Not employed, looking for work	77	12	11	68	17	15	63	14	22	66	12	23	77	10	14
Homemaker	54	19	27	34	33	33	33	37	30	41	23	36	54	15	31
Retired	59	16	24	40	22	38	32	24	43	47	18	35	56	16	28
other	41	10	49	27	14	59	38	39	23	18	15	67	57	7	36
Firm Size															
Self-employed	54	17	29	35	17	48	25	28	47	45	21	34	65	7	27
2–9	55	15	30	31	36	33	24	32	44	52	20	27	51	22	27
10–49	54	16	30	35	25	41	28	26	46	48	22	30	61	14	25
50–199	62	9	29	42	18	41	35	19	46	52	15	33	59	12	29
200 or more	60	12	28	41	25	34	35	23	42	47	20	33	60	13	27
Don't know	44	17	39	28	24	49	29	24	47	31	18	52	46	14	40
Annual Earnings															
Less than $20,000	51	20	29	27	38	35	28	28	45	51	16	33	55	15	30
$20,000–$29,999	55	13	32	37	22	41	29	23	49	42	22	36	53	16	31
$30,000–$39,999	59	10	32	39	22	39	35	26	39	46	17	38	58	12	30
$40,000–$49,999	56	14	30	43	20	37	39	22	39	48	19	33	57	14	29
$50,000–$69,999	58	12	30	41	25	34	34	25	41	48	20	32	59	16	26
$70,000–$99,999	64	11	24	41	22	37	32	21	47	51	19	30	66	8	26
$100,000–$149,999	61	15	25	38	27	35	32	28	39	45	23	32	58	14	27
$150,000 or more	61	18	21	45	25	30	42	22	36	49	20	32	63	14	22
Don't know	50	13	37	30	23	47	22	20	58	34	19	47	49	11	40
Source of Health Coverage															
Own employer	58	13	29	40	23	37	34	23	43	47	17	36	59	13	28
Other employer	54	15	31	32	30	38	28	25	47	43	25	32	53	15	32
Direct purchase	60	14	27	43	24	33	36	31	33	53	20	27	63	16	22
Don't know	36	16	49	34	17	49	23	27	49	37	16	47	47	30	23

Source: 2008 EBRI/MGA Consumer Engagement in Health Care Survey.

sharing, and 28 percent neither support nor oppose it. Nearly one-half (47 percent) support the use of lower cost sharing for patients who choose less-invasive procedures, while 18 percent oppose it, and 35 percent neither support nor oppose it. Less support was found for lower cost sharing for patients who use scientifically proven treatments (40 percent) and for patients who use high-performing providers (34 percent). For both questions, one-quarter opposed the lower cost sharing, and 35–40 percent neither supported nor opposed it.

Employers and insurers are going to continue experimenting with various ways in which they can use features of their benefits plan to increasingly engage workers and their families in their health care in order to manage health care costs more effectively. They will find that some things work while others do not. The support for consumer engagement initiatives will vary across employees and may ultimately affect the success of specific programs.

Endnotes

[1] More information about HRAs and HSAs can be found in Paul Fronstin, *Consumer Driven Health Benefits: A Continuing Evolution?* (Washington, DC: Employee Benefit Research Institute, 2002); and Paul Fronstin, "Health Savings Accounts and Other Account-Based Health Plans," *EBRI Issue Brief* no. 273 (Washington, DC: Employee Benefit Research Institute, September 2004).

[2] See www.mercer.com/summary.htm?idContent=1328445

[3] See www.healthcaredisclosure.org/

[4] See Michael E. Chernew, Allison B. Rosen, and A. Mark Fendrick, "Value-Based Insurance Design," *Health Affairs* Web Exclusive (January 10, 2007): w195–w203.

[5] Niteesh K. Choudhry, Meredith B. Rosenthal, and Arnold Milstein, "Innovative Ideas Around Value-Based Insurance Designs," unpublished manuscript (November 11, 2008).

[6] More information about the survey can be found in Paul Fronstin, "Findings from the 2008 EBRI Consumer Engagement in Health Care Survey," *EBRI Issue Brief,* no. 323 (Employee Benefit Research Institute, November 2008).

Income of the Elderly Population Age 65 and Over, 2007

By Ken McDonnell, EBRI

The U.S. retirement income system—including employment-based retirement plans, Social Security, individual saving, and post-retirement employment—can be assessed in part by examining the income of the current elderly population (age 65 and older). This article reviews the latest available data on the older population's income (from the U.S. Census Bureau's March 2008 Current Population Survey) and how it has changed over time, as well as how the elderly's reliance on these sources varies across demographic characteristics.

Income Sources

In 2007, Social Security was the largest source of income for those currently age 65 and older, accounting for 38.6 percent of their income on average (Figure 1). Pension and annuity income was 18.6 percent, income from assets 15.6 percent, and income from earnings was 25.3 percent.

Nearly all individuals (89.3 percent) age 65 and over were receiving income from Social Security in 2007 (Figure 2), while 52.9 percent received income from assets, 34.3 percent received income from pensions and annuities, and 19.9 percent received income from earnings.

Income Levels

The *median* income level (mid-point, half above and half below) of the elderly population increased from $13,311 (in constant 2008 dollars) in 1974 to $17,560 (in 2008 dollars) in 1999 (Figure 3). By 2004, the median income of the elderly had declined to $17,146. Real median income increased by 2007, to $17,898, the highest point in this time series. The average income of the elderly increased from $18,782 in 1974 to $24,162 by 1989. Following 1989, *average* income of the elderly was up and down, being higher in 2007 than in 1989 by $5,052 (calculated from Figure 3).

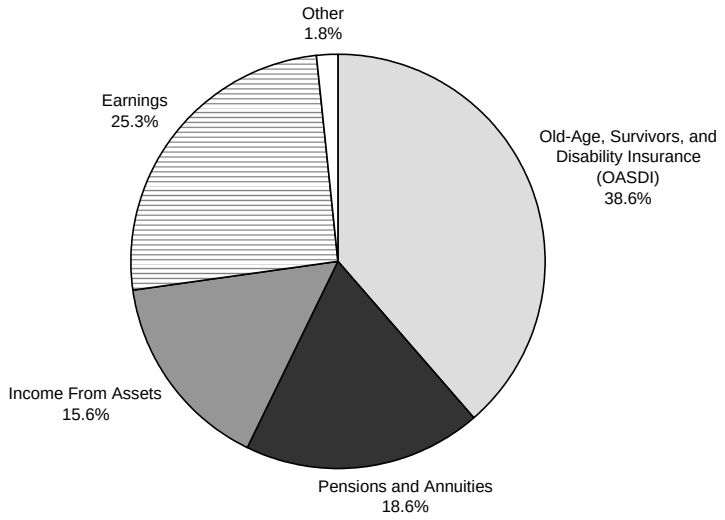
Income Composition

Income Group—Income composition varies significantly across income groups. In 2007, the lowest income quintile among the elderly received 88.7 percent of its income from Social Security, and the highest income quintile received 17.2 percent of its income from Social Security (Figure 4). The other three main sources of the elderly's income (pensions and annuities, assets, and earnings) all increase in importance for the higher-income quintiles. In 2007, the lowest-income quintile received 2.6 percent of its income from pensions and annuities, 4.4 percent from assets, and 1.8 percent from earnings. By comparison, the highest-income quintile received 21.0 percent of its income from pensions and annuities, 21.8 percent from assets, and 38.1 percent from earnings.

Age—The oldest age group of the elderly, those age 85 and over, receive a greater percentage of their total income from Social Security than those in the younger age groups. In 2007, elderly persons age 85 and over derived 54.1 percent of their income from Social Security, compared with 28.3 percent for those ages 65–69 (Figure 5). Younger age groups derive a greater share of their total income from earnings from work. In 2007, among those elderly ages 65–69, 39.9 percent of their income was from work-related earnings, compared with 6.7 percent of the income of individuals age 85 and over.

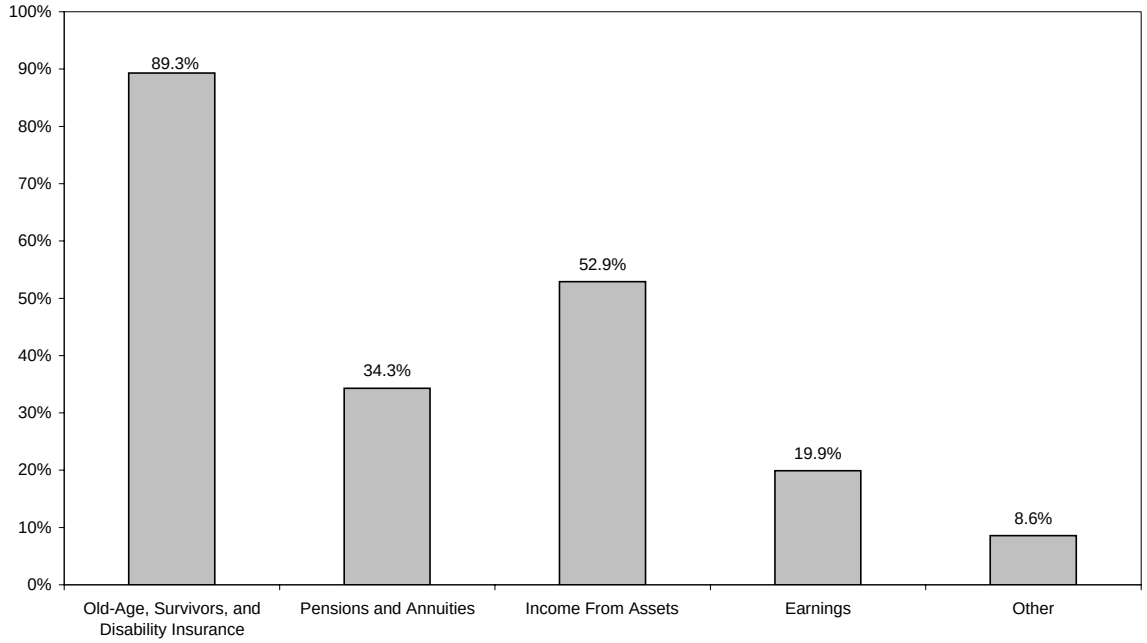
For the two younger age groups (65–69 and 70–74) earnings from work increased significantly as a source of income from 1985 to 2007. For the youngest group (65–69 year olds) the increase was most significant, increasing 16.8 percentage points from 1985 to 2007 (calculated from figure 5). Among the two oldest age groups (80–84 and 85 and over) pension and annuities have increased as a source of income. Pension and annuities increased from 9.2 percent of total income (in 1975) for individuals age 85 and over to 20.2 percent in 2007. For individuals ages 80–84, pension

Figure 1
Distribution of the Older Population's Income, 2007



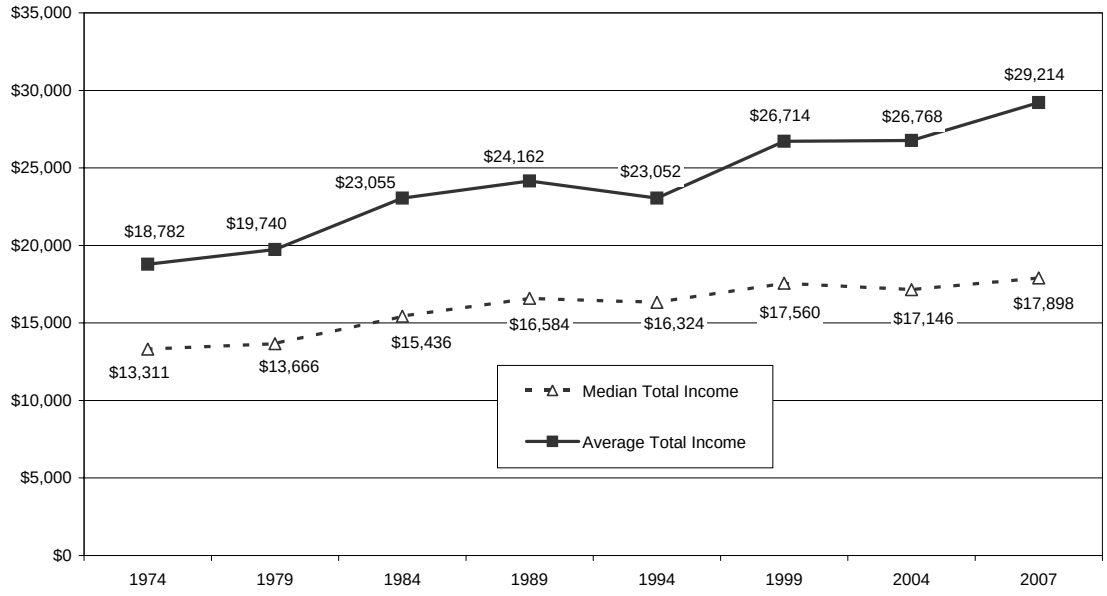
Source: EBRI estimates of the March 2008 Current Population Survey.

Figure 2
Percentage of the Older Population Receiving Income From Various Sources, 2007



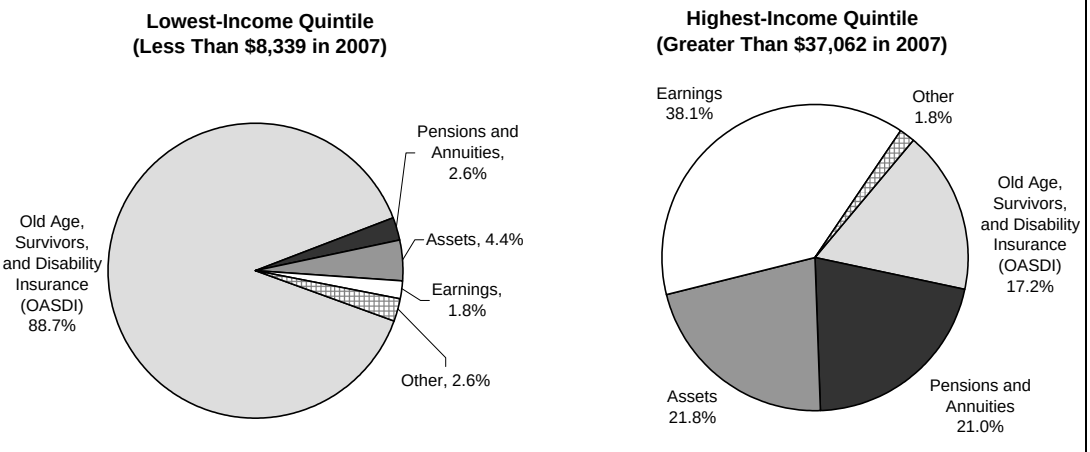
Source: EBRI estimates of the March 2008 Current Population Survey.

Figure 3
Income of the Older Population, Selected Years 1974–2007
(2008 $s)



Source: EBRI estimates of the March 1975, 1980, 1985, 1990, 1995, 2000, 2005, and 2008 Current Population Survey.
Data are in 2005 dollars.

Figure 4
Income of the Elderly, Lowest and Highest Quintiles, 2007



Source: EBRI estimates of the March 2008 Current Population Survey.

and annuity income, while slightly decreasing from 1975 (12.6 percent) to 1985 (11.7 percent), showed a significant increase from 1985 to 2007 (20.3 percent).

Marital Status—Nonmarried persons receive a larger share of their income from Social Security than married persons (45.7 percent vs. 34.2 percent), and a noticeably smaller share from earnings (18.0 percent vs. 29.8 percent) (Figure 6). In addition, married persons receive a slightly smaller share of their income from pensions and annuities.

Gender—Elderly women derived a greater share of their income from Social Security and assets than elderly men in 2007. Social Security accounted for 46.3 percent of elderly women's income, compared with 33.0 percent of elderly men's income (Figure 7). Income from assets accounted for 18.1 percent of elderly women's income, compared with 13.8 percent of elderly men's. By comparison, elderly men derived a larger share of their income from employment-based sources, including pensions and annuities and earnings, than elderly women. In 2007, pensions and annuities accounted for 20.7 percent of elderly men's income, compared with 15.9 percent of elderly women's. Income from earnings accounted for 30.4 percent of the elderly men's income, compared with 18.3 percent of elderly women's.

For elderly men, income from earnings (employment income) has increased significantly as a percentage of income from 1985 (18.9 percent) to 2007 (30.4 percent). Correspondingly, their income from assets has declined as a percentage of income from 1985 (21.1 percent) to 2007 (13.8 percent).

The percentage of elderly women's income coming from employment-based sources, has increased over time, reflecting the growing presence of women in the work force. In 1975, pensions and annuities accounted for 11.9 percent of elderly women's income and earnings accounted for 11.0 percent. By 2007, these percentages had increased to 15.9 percent and 18.3 percent, respectively (Figure 7).

Additional Data

For additional data on income sources of the elderly, please see the *EBRI Databook on Employee Benefits*, Chapters 6 and 7. www.ebri.org/publications/books/index.cfm?fa=databook

Figure 5

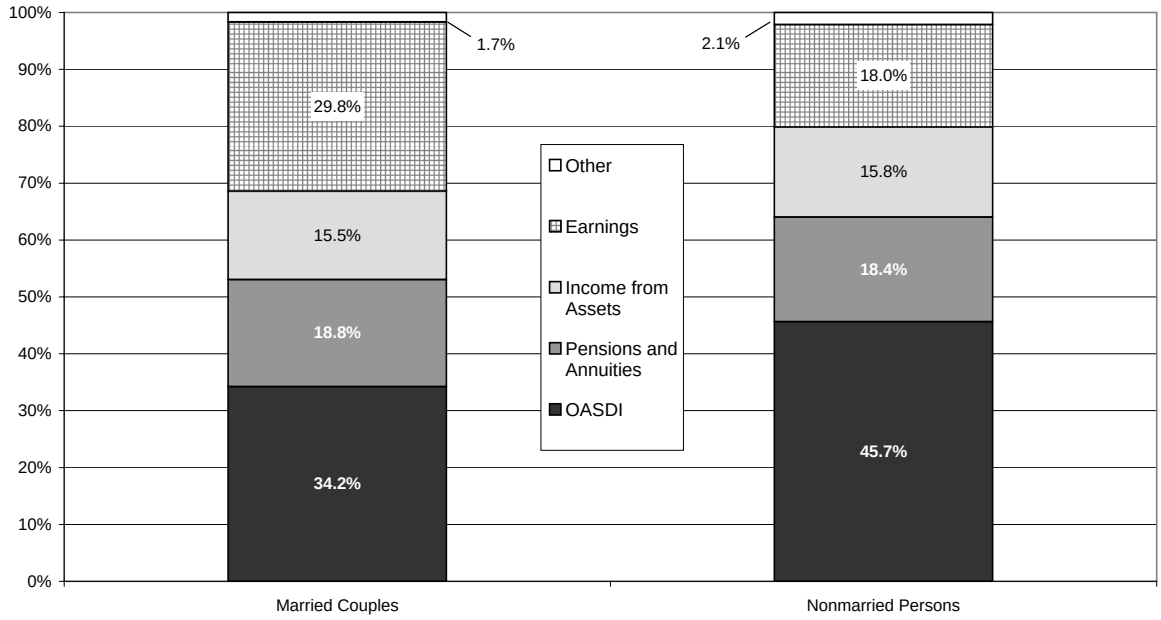
Distribution of the Older Population's Average Annual Income, by Source and Age, 1975, 1985, 1995, and 2007

	1975		1985		1995		2007	
	Income	Percentage	Income	Percentage	Income	Percentage	Income	Percentage
Age 65–69								
Total income	$5,404	100.0%	$12,783	100.0%	$20,005	100.0%	$34,078	100.0%
Social Security	1,864	34.5	4,326	33.8	6,632	33.1	9,649	28.3
Pensions	798	14.8	2,224	17.4	3,661	18.3	5,555	16.3
Assets	841	15.6	2,902	22.7	3,184	15.9	4,765	14.0
Earnings	1,711	31.7	2,957	23.1	6,089	30.4	13,607	39.9
Other	191	3.5	375	2.9	439	2.2	502	1.5
Age 70–74								
Total income	4,651	100.0	11,286	100.0	17,388	100.0	27,102	100.0
Social Security	2,135	45.9	5,009	44.4	7,416	42.7	10,558	39.0
Pensions	670	14.4	1,821	16.1	3,747	21.5	5,309	19.6
Assets	957	20.6	2,886	25.6	3,072	17.7	4,338	16.0
Earnings	714	15.4	1,256	11.1	2,724	15.7	6,528	24.1
Other	174	3.8	313	2.8	429	2.5	369	1.4
Age 75–79								
Toal income	4,322	100.0	10,243	100.0	15,651	100.0	23,459	100.0
Social Security	2,115	48.9	4,821	47.1	7,746	49.5	10,712	45.7
Pensions	562	13.0	1,512	14.8	3,033	19.4	4,821	20.5
Assets	973	22.5	3,099	30.3	3,135	20.0	4,056	17.3
Earnings	449	10.4	548	5.4	1,343	8.6	3,331	14.2
Other	223	5.2	262	2.6	394	2.5	540	2.3
Age 80–84								
Total income	4,107	100.0	9,869	100.0	14,268	100.0	22,724	100.0
Social Security	2,088	50.8	4,772	48.4	7,930	55.6	10,959	48.2
Pensions	519	12.6	1,153	11.7	2,398	16.8	4,606	20.3
Assets	941	22.9	3,224	32.7	3,019	21.2	3,915	17.2
Earnings	269	6.6	408	4.1	716	5.0	2,669	11.7
Other	290	7.1	311	3.2	206	1.4	575	2.5
Age 85+								
Total income	3,581	100.0	9,172	100.0	13,511	100.0	21,120	100.0
Social Security	1,877	52.4	4,416	48.1	7,625	56.4	11,423	54.1
Pensions	330	9.2	1,014	11.1	2,101	15.5	4,263	20.2
Assets	948	26.5	3,265	35.6	3,111	23.0	3,449	16.3
Earnings	112	3.1	116	1.3	392	2.9	1,409	6.7
Other	314	8.8	361	3.9	282	2.1	576	2.7

Source: Employee Benefit Research Institute tabulations of data from the Current Population Survey March 1976, 1986, 1996, and 2008 Supplements.

[a] Includes public assistance, Supplemental Security Income, unemployment compensation, workers' compensation, veterans' benefits, nonpension survivors' benefits, nonpension disability benefits, educational assistance, child support, alimony, regular financial assistance from friends or relatives not living in the individual's household, and other sources of income.

Figure 6
Distribution of the Older Population's Annual Income, Persons Age 65 and Over, by Martial Status, 2007



Source: EBRI estimates from the March 2008 Current Population Survey.

Figure 7
Distribution of the Older Population's Average Annual Income, by Source and Gender, Various Years

	Males		Females	
	Income	Percentage	Income	Percentage
1975 Data				
Total income	$6,929	100.0	$3,209	100.0
Social Security	2,496	36.0	1,668	52.0
Pensions and annuities	1,054	15.2	382	11.9
Assets	1,345	19.4	613	19.1
Earnings	1,796	25.9	351	11.0
Other	237	3.4	194	6.1
1985 Data				
Total income	14,748	100.0	8,845	100.0
Social Security	5,443	36.9	4,120	46.6
Pensions and annuities	2,998	20.3	897	10.1
Assets	3,116	21.1	2,917	33.0
Earnings	2,790	18.9	634	7.2
Other	401	2.7	277	3.1
1995 Data				
Total income	23,409	100.0	12,536	100.0
Social Security	8,592	36.7	6,415	51.2
Pensions and annuities	5,317	22.7	1,766	14.1
Assets	3,467	14.8	2,863	22.8
Earnings	5,452	23.3	1,251	10.0
Other	581	2.5	241	1.9
2005 Data				
Total income	33,833	100.0	17,383	100.0
Social Security	11,267	33.3	8,700	50.5
Pensions and annuities	7,235	21.4	2,844	16.4
Assets	4,252	12.6	2,630	15.1
Earnings	10,312	30.5	2,854	16.4
Other	768	2.3	355	2.0
2007 Data				
Total income	36,639	100.0	20,005	100.0
Social Security	12,083	33.0	9,268	46.3
Pensions and annuities	7,568	20.7	3,176	15.9
Assets	5,070	13.8	3,624	18.1
Earnings	11,132	30.4	3,653	18.3
Other	785	2.1	284	1.4

Source: Employee Benefit Research Institute tabulations of data from the Current Population Survey March 1976, 1986, 1996, 2006, and 2008 Supplements.
[a] Includes public assistance, Supplemental Security Income, unemployment compensation, workers' compensation, veterans' benefits, nonpension survivors' benefits, nonpension disability benefits, educational assistance, child support, alimony, regular financial assistance from friends or relatives not living in the individual's household, and other sources of income.

New Publications and Internet Sites

Employee Benefits

Employee Benefit Research Institute. *Fundamentals of Employee Benefit Programs*. Sixth Edition. $19.95 (EBRI members get a 55 percent discount) plus shipping. EBRI member organizations, or those interested in bulk purchases of *Fundamentals*, should contact Alicia Willis at (202) 659-0670 or e-mail: publications@ebri.org. To place individual orders online, contact publications@ebri.org or go to www.brightdoc.com/ebri

Hewitt Associates. *SpecSummary™: Salaried Employee Benefits Provided by Major U.S. Employers, 2008-2009*. $575. Hewitt Associates LLC, Attn: Hewitt Information Desk, 100 Half Day Rd., Lincolnshire, IL 60069, (847) 295-5000, e-mail: BenefitSpecSelect@Hewitt.com, www.hewitt.com

Employee Stock Ownership Plans (ESOPs)

The National Center for Employee Ownership. *Issue Brief: The State of Employee Ownership 2009* [25-page printout, not a bound book]. NCEO members, $15; nonmembers, $25. National Center for Employee Ownership, 1736 Franklin St., 8th Floor, Oakland, CA 94612, (510) 208-1300, fax: (510) 272-9510, e-mail: nceo@nceo.org, www.nceo.org

Executive Compensation

Watson Wyatt Worldwide. *Executive Compensation in Uncertain Economic Times: 2008/2009 Report on Executive Pay*. $45. Watson Wyatt Worldwide, 901 N. Glebe Rd., Arlington, VA 22203, (800) 388-9868 or (703) 258-8000, fax: (703) 258-8585, www.watsonwyatt.com

Health Care

Buck Consultants. *Working Well: A Global Survey of Health Promotion and Workplace Wellness Strategies*. $150. Buck Consultants, an ACS Company, Attn: Global Survey Resources, 500 Plaza Dr., Secaucus, NJ 07096-1533, (800) 887-0509, www.bucksurveys.com

International Foundation of Employee Benefit Plans. *Health Care Cost Control: Industry Approaches and Attitudes*. IFEBP members, $67; nonmembers, $100. International Foundation of Employee Benefit Plans, Publications Department, P.O. Box 68-9953, Milwaukee, WI 53268-9953, (888) 334-3327, option 4; fax: (262) 786-8780, e-mail: books@ifebp.org, www.ifebp.org/bookstore

Human Resource Management

Watson Wyatt Worldwide. *The Power of Integrated Reward and Talent Management: 2008/2009 Global Strategic Rewards Report and United States Findings*. $49. Watson Wyatt Worldwide, 901 N. Glebe Rd., Arlington, VA 22203, (800) 388-9868 or (703) 258-8000, fax: (703) 258-8585, www.watsonwyatt.com

Web Documents

AARP: AARP Bulletin Survey on Retirement Savings: Executive Summary
http://assets.aarp.org/rgcenter/econ/bulletin_retiresavings.pdf

America's Health Insurance Plans: Small Group Health Insurance in 2008: A Comprehensive Survey of Premiums, Product Choices, and Benefits www.ahipresearch.org/pdfs/smallgroupsurvey.pdf

American Benefits Council: "The Savings for American Families' Future Act of 2009" [Summary]
www.americanbenefitscouncil.org/documents/affa_pomeroy-summary_111th.pdf

Charles Schwab: Charles Schwab 2009 Young Adults & Money Survey Findings: Insights into Money Attitudes, Behaviors, and Concerns of 23- to 28-Year-Olds
www.aboutschwab.com/media/pdf/YoungAdults_and_MoneyFactSheet.pdf

Congressional Research Service:
Early Withdrawals and Required Minimum Distributions in Retirement Accounts: Issues for Congress
http://assets.opencrs.com/rpts/R40192_20090204.pdf

Unemployment and Health Insurance: Current Legislation and Issues
http://assets.opencrs.com/rpts/R40165_20090217.pdf

Economic Policy Institute: Who Is Adversely Affected by Limiting the Tax Exclusion of Employment-Based Premiums? [Working Paper] www.epi.org/page/-/pdf/wp281.pdf

Hewitt Associates: Special Report: The American Recovery and Reinvestment Act of 2009 and Its Impact on Employers
www.hewittassociates.com/_MetaBasicCMAssetCache_/Assets/Legislative%20Updates/2009/Special_Report_American_Recovery_and_Reinvestment_Act.pdf

Internal Revenue Service: Premium Assistance for COBRA Benefits [Notice 2009-27]
www.irs.gov/pub/irs-drop/n-09-27.pdf

Kaiser Family Foundation: National Health Insurance—A Brief History of Reform Efforts in the U.S.
www.kff.org/healthreform/upload/7871.pdf

The Lewin Group: The Cost and Coverage Impacts of a Public Plan: Alternative Design Options
www.lewin.com/content/publications/LewinCostandCoverageImpactsofPublicPlan-Alternative%20DesignOptions.pdf

MetLife: Seventh Annual Study of Employee Benefits Trends: Findings from the National Survey of Employers and Employees http://whymetlife.com/trends/downloads/MetLife_EBTS09.pdf

PensionTsunami.com: PensionWatch: Newsclips Focusing on Public Employee Pensions, Corporate Pensions, Social Security, and International Trends www.pensiontsunami.com/

Retirement USA: Principles for a New Retirement System [Working Paper]
www.retirement-usa.org/wp-content/uploads/2009/03/working-paper-031209.pdf

Robert Wood Johnson Foundation and Urban Institute: How Effectively Does The American Recovery and Reinvestment Act Help Laid-Off Workers and States Cope with Health Care Costs?
www.rwjf.org/files/research/20090318quickstrikearra.pdf

Vanguard Investment Counseling & Research:
Implications of a Bear Market for Retirement Security https://institutional.vanguard.com/iam/pdf/ICRRSBM.pdf

Stock Market Volatility Measures in Perspective https://institutional.vanguard.com/iam/pdf/ICRSMV.pdf

Wellness Council of America Special Report: Financial Wellness: Thrifty Ideas for Turbulent Times
www.welcoa.org/freeresources/pdf/financial_wellness.pdf

Wilshire Consulting: 2009 Wilshire Report on State Retirement Systems: Funding Levels and Asset Allocation
www.wilshire.com/BusinessUnits/Consulting/Investment/2009_State_Retirement_Funding_Report.pdf

WorldatWork: Trends in 401(k) Plans: A Survey of WorldatWork Members and American Benefits Council Members
www.worldatwork.org/waw/adimLink?id=31878

Washington Watch

Congressional Hearings of Note

House Ways and Means Committee: *Health Reform in the 21st Century: Reforming the Health Care Delivery System* (April 1, 2009): http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=670

House Education and Labor Committee: *401(k) Fair Disclosure for Retirement Security Act of 2009* (April 22, 2000): http://edlabor.house.gov/hearings/2009/04/401k-fair-disclosure-for-retir.shtml

House Energy and Commerce Health Subcommittee: *Making Health Care Work for American Families: The Role of Public Health* (March 31, 2009)*:* http://energycommerce.house.gov/index.php?option=com_content&task=view&id=1559&Itemid=95

Senate Commerce, Science, and Transportation Committee:

- *Part I: Deceptive Health Industry Practices – Are Consumers Getting What They Paid For?* (March 26, 2009): http://commerce.senate.gov/public/index.cfm?FuseAction=Hearings.Hearing&Hearing_ID=4edbd03a-bf22-4783-87db-dfd57d980123
- *Part II: Deceptive Health Industry Practices – Are Consumers Getting What They Paid For?* (March 31, 2009): http://commerce.senate.gov/public/index.cfm?FuseAction=Hearings.Hearing&Hearing_ID=63b0f558-ec43-4ab8-82f0-070bcc699e38

Notable Government Documents Available Online

Bureau of Labor Statistics Program Perspectives: *Defined-Contribution Plans More Common Than Defined-Benefit Plans:* www.bls.gov/opub/perspectives/issue3.pdf

Congressional Budget Office: *Historical Effective Federal Tax Rates: 1979 to 2006:* http://cbo.gov/ftpdocs/100xx/doc10068/effective_tax_rates_2006.pdf

Department of Labor Employment & Training Administration: *Comparison of State Unemployment Laws:* www.ows.doleta.gov/unemploy/uilawcompar/2009/comparison2009.asp

Social Security Administration: *Social Security Bulletin: Annual Statistical Supplement, 2008:* www.socialsecurity.gov/policy/docs/statcomps/supplement/2008/index.html

The White House: *Executive Order: Establishment of the White House Office of Health Reform:* www.whitehouse.gov/the_press_office/Executive-Order-Establishing-The-White-House-Office-Of-Health-Reform/

EBRI Congressional Testimony

Testimony by Dallas Salisbury, EBRI, before the Senate Special Committee on Aging, on "Boomer Bust? Securing Retirement in a Volatile Economy" www.ebri.org/pdf/publications/testimony/t157.pdf

EBRI Activity

Fast Facts from EBRI

#117, March 19, 2009: *Average Worker Contribution Rates to 401(k)-Type Plans:* www.ebri.org/pdf/FFE117.19March09.Final.pdf

#118, April 2, 2009: *Workers' Primary Retirement Plan Type:* www.ebri.org/pdf/FFE118.2April09.Final.pdf

#119, April 16, 2009: *How Much Have American Workers Saved for Retirement?*
www.ebri.org/pdf/FFE119.16April09.Final.pdf

Sample Media Coverage of the 2009 Retirement Confidence Survey

Associated Press: www.google.com/hostednews/ap/article/ALeqM5hWfCM1tcJYNZv4Sq4t1uALg__bmgD97I1GS82

Bloomberg News: www.bloomberg.com/apps/news?pid=20601103&sid=aalioI1L1WoQ&refer=news

Thompson Reuters: http://uk.reuters.com/article/gc04/idUKTRE53D5OW20090414

Wall Street Journal: http://online.wsj.com/article/SB123967208769515763.html?mod=googlenews_wsj

Washington Post: www.washingtonpost.com/wp-dyn/content/article/2009/04/14/AR2009041402854.html

ASEC Activities:

The American Savings Education Council's Spring 2009 Partners Meeting was held April 15, with 81 individuals attending. Presentations, handouts, documents, and Web sites mentioned during the meeting are online at www.ebri.org/pdf/spring2009.pdf

Social Media Sites

EBRI's Twitter page is @EBRI (if on Twitter) or can be found on the Web at http://twitter.com/EBRI

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