

# Notes

Trends in Satisfaction and Confidence in Health Care, by Insurance and Health Status: Findings from the 2009 EBRI/MGA Health Confidence Survey, p. 2

Social Security Reform: How Different Options Might Affect Future Funding, p. 13

New Publications and Internet Sites, p. 19

---

## EXECUTIVE SUMMARY

### **Trends in Satisfaction and Confidence in Health Care, by Insurance and Health Status: Findings from the 2009 EBRI/MGA Health Confidence Survey**

**2009 HCS DATA:** This article examines public opinion by insurance status and health status, using data from the 2009 EBRI/Mathew Greenwald Associates Health Confidence Survey. It finds that the uninsured are more likely than individuals with insurance coverage to be dissatisfied with the quality of health care received and they are less confident in various aspects of health care. Similar differences in satisfaction and confidence are found by health status.

**THE FEW vs. THE MANY:** While these sharp differences in attitudes are not surprising, shoring up the U.S. health system for the uninsured and individuals with chronic conditions means changing the health care system for everyone—notably for those with insurance coverage and in good health. Ultimately, will the needs of the few outweigh the satisfaction of the many?

### **Social Security Reform: How Different Options Might Affect Future Funding**

**FUNDING SHORTFALL:** According to the latest (2009) Social Security Trustees' report, the program's long-term funding shortfall currently amounts to -2.00 percent of taxable payroll, meaning that the program would need additional revenues equal to 2 percent of taxable payroll for each year over the next 75 years to match the projected future current-law costs over that time frame.

**CUTTING BENEFITS, RAISING TAXES:** This article analyzes a range of possible reform provisions that would either reduce benefits (by lowering the scheduled increase in future benefit levels by changes to the benefit formula, or by raising the normal retirement age) or raise taxes (by changing the amount of earnings that are taxable and used for the calculation of benefits under Social Security). All of these provisions have been part of various comprehensive reform proposals over the last two decades.

# Trends in Satisfaction and Confidence in Health Care, by Insurance and Health Status: Findings from the 2009 EBRI/MGA Health Confidence Survey

By Paul Fronstin, EBRI

## Introduction

In general, Americans support concepts that are on the table for health reform. For instance, a majority either strongly or somewhat support health insurance market reform, the availability of a public plan option, mandates on employers and individuals, and expansion of public programs to cover more of the uninsured (Fronstin and Helman, 2009).

While the health reform debate rages on, Americans continue to hear that “If they like what they have, they can keep it”<sup>1</sup>—which comes as no surprise because most Americans are satisfied with their health coverage, and have been historically (Figure 1). But the question of whether Americans will be able to keep what they have has been raised by a number of analysts (Cohn, 2009; Fronstin and Ross, 2009), and while Americans are satisfied with the coverage they have now, they are concerned about the future.<sup>2</sup>

When the implications of health reform are raised in public opinion polls, support for health reform drops. Both the recent EBRI/MGA Health Confidence Survey (Fronstin and Helman, 2009), and a recent Wall Street Journal/NBC News (WSJ/NBC) poll found initial strong support for a public plan,<sup>3</sup> but when respondents to the WSJ/NBC poll were informed about the arguments for and against the plan, support for the public plan option dropped to nearly 50–50. Similarly, when it comes to willingness to pay for health reform, between 41 percent and 57 percent of the population are willing to pay, while 37 percent to 54 percent are not willing to pay.<sup>4</sup> Thus, there are a number of (competing) goals in health reform.

This article examines public opinion by insurance status and health status. It finds that the uninsured are more likely than individuals with insurance coverage to be dissatisfied with the quality of health care received and they are less confident in various aspects of health care. The gap in satisfaction and confidence has also grown over time. Similar differences in satisfaction and confidence are found by health status.

While these sharp differences in attitudes are not surprising, shoring up the system for the uninsured and individuals with chronic conditions means changing the health care system for everyone—notably for those with insurance coverage and in good health. Ultimately, will the needs of the few outweigh the satisfaction of the many?

**Figure 1**  
**Satisfaction With Current Health Plan, 1998–2009**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Extremely Satisfied	16%	15%	14%	12%	13%	14%	16%	17%	18%	17%	17%	21%
Very Satisfied	36	38	36	39	39	36	31	37	36	38	36	37
Somewhat Satisfied	35	36	38	35	34	41	36	35	35	33	33	30
Not Too Satisfied	8	6	7	7	7	7	9	6	6	5	9	7
Not at All Satisfied	3	3	4	3	6	2	6	4	3	7	5	4

Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 1998–2009 Health Confidence Surveys.

## Satisfaction and Confidence by Insurance Status

The 2009 EBRI/MGA Health Confidence Survey (HCS), an annual survey that examines a broad spectrum of health care issues, finds that Americans covered by health insurance are significantly more likely to be satisfied than uninsured Americans with the quality of medical care received in the past two years. Specifically, 62 percent of Americans with health insurance were *extremely* or *very* satisfied with the quality of health care they have received (Figure 2). In contrast, 26 percent of uninsured Americans were satisfied with the quality of health care received. Individuals without health insurance were more likely than the insured population to be *somewhat* satisfied and *not* satisfied with the quality of health care received. Forty-two percent of the uninsured population was *somewhat* satisfied with quality of care received, as compared with 29 percent of the insured population. While the uninsured population was more likely than the insured population to be *not too* or *not at all* satisfied with the quality of care received, only 20 percent of the uninsured population was *not* satisfied, while only 6 percent of the insured population was *not* satisfied.

Individuals with health insurance are significantly more likely than the uninsured to be confident in various aspects of their current health care, with relatively large percentages of uninsured individuals being *not* confident. Figure 3 shows the findings by insurance status related to whether individuals are confident in their ability to get needed treatments. Sixty-five percent of insured individuals are *extremely* or *very* confident they will be able to get needed treatments, compared with 17 percent among uninsured individuals. More than one-half (53 percent) of uninsured individuals are *not too* or *not at all* confident (not confident) that they will be able to get needed treatments, compared with only 7 percent among individuals with health insurance.

Confidence among uninsured individuals is much more lacking with respect to their ability to afford health care without financial hardship. Four-fifths (79 percent) of uninsured individuals report that they are *not* confident in their ability to afford health care without financial hardship (Figure 4). Only 3 percent of uninsured individuals were *extremely* or *very* confident that they could afford health care without financial hardship. Among insured individuals, 37 percent were *extremely* or *very* confident in their ability to afford health care without financial hardship, while 31 percent were *somewhat* confident. Even among insured individuals, 30 percent were *not* confident in their ability to afford health care without financial hardship.

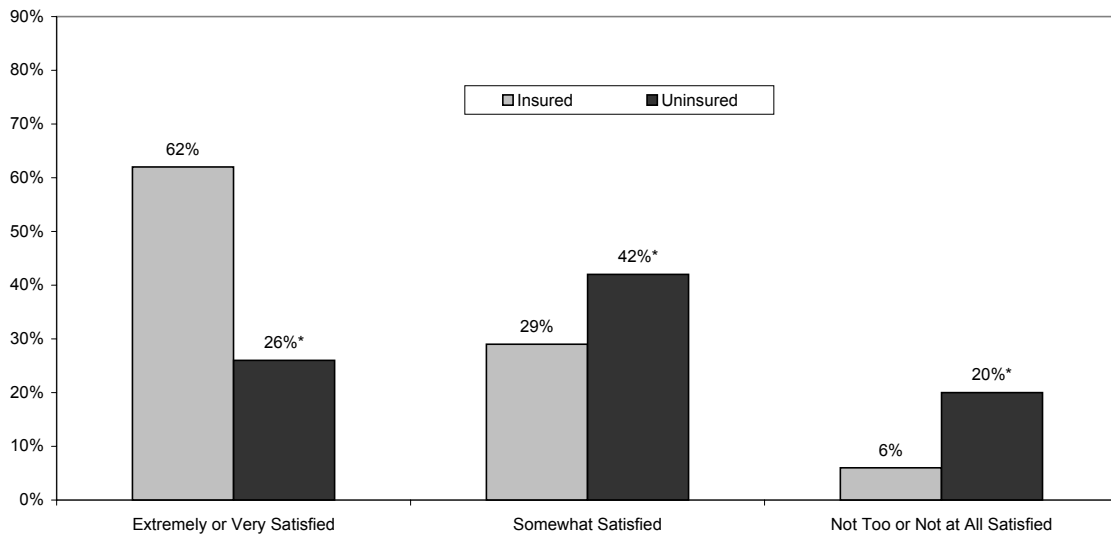
Uninsured individuals are not restricted to networks of providers and therefore can theoretically visit any health care provider of their choosing (entirely at their own out-of-pocket cost, however). However, only 21 percent reported being *extremely* or *very* confident that they will have enough choice about who provides their medical care, while 27 percent were *somewhat* confident (Figure 5). Nearly one-half (48 percent) were *not* confident they will have enough choice in who provides their medical care.

### Trends

Over time, satisfaction with the quality of health care received has not changed significantly (for the most part) for insured individuals. Between 2004 and 2005, the percentage of insured individuals reporting that they were *extremely* or *very* satisfied with the quality of care received increased from 55 percent to 61 percent, a statistically significant increase (Figure 6). The percentage who were *extremely* or *very* satisfied gradually declined to 53 percent in 2008, before jumping to 62 percent in 2009 (another statistically significant increase). The percentage of insured individuals reporting that they are *not* satisfied with quality of health care received has remained below 10 percent.

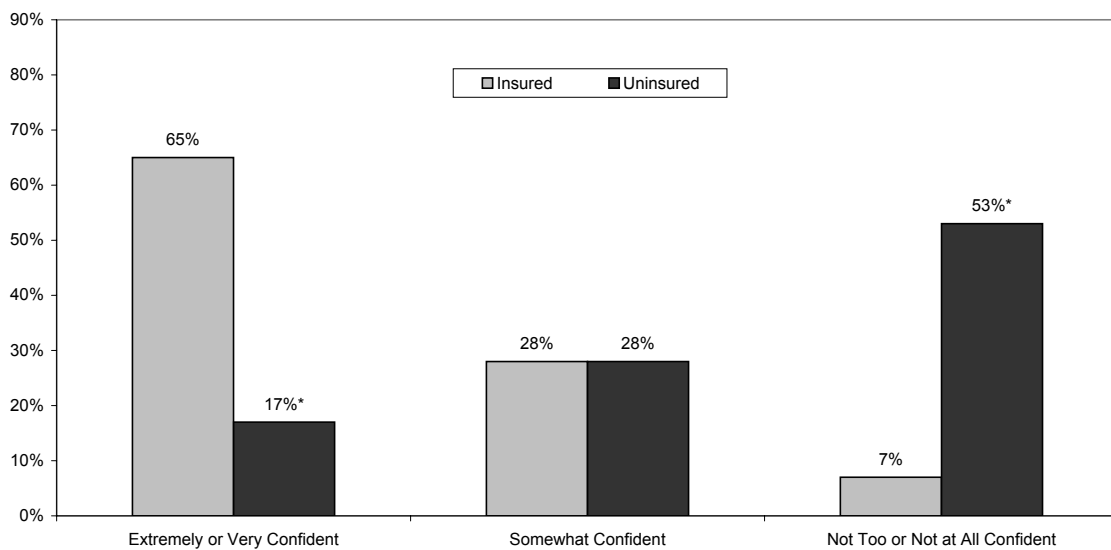
Among uninsured individuals, satisfaction levels have also bounced around since the HCS was first conducted in 1998. However, unlike the trend for insured individuals, the percentage of uninsured individuals who were satisfied with the quality of care received has declined since 2001. In 2001, 43 percent of uninsured individuals were *extremely* or *very* satisfied with the quality of health care received (Figure 6). By 2009, only 26 percent were *extremely* or *very* satisfied. In contrast, the percentage of uninsured individuals who were *somewhat* satisfied with the quality of health care received increased from 29 percent to 42 percent between 2001 and 2009, and the percentage *not* satisfied increased from 10 percent to 20 percent. The decline in the percentage reporting that they were *extremely* or *very* satisfied was statistically significant, whereas the increases in the percentages reporting they were *somewhat* satisfied and *not* satisfied were not statistically significant.

**Figure 2**  
**Satisfaction with Quality of Health Care**  
**Received, by Insurance Status, 2009**



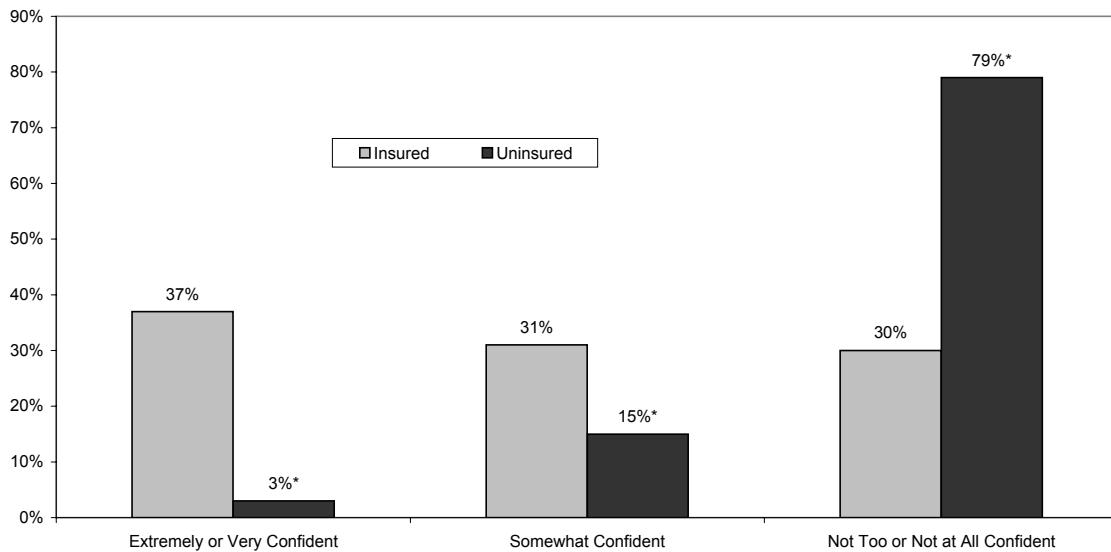
Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2009 Health Confidence Survey.  
 \* Difference is statistically significant at  $p \leq 0.05$  or better.

**Figure 3**  
**Confidence in Ability to Get Needed Treatments**  
**Today, by Insurance Status, 2009**



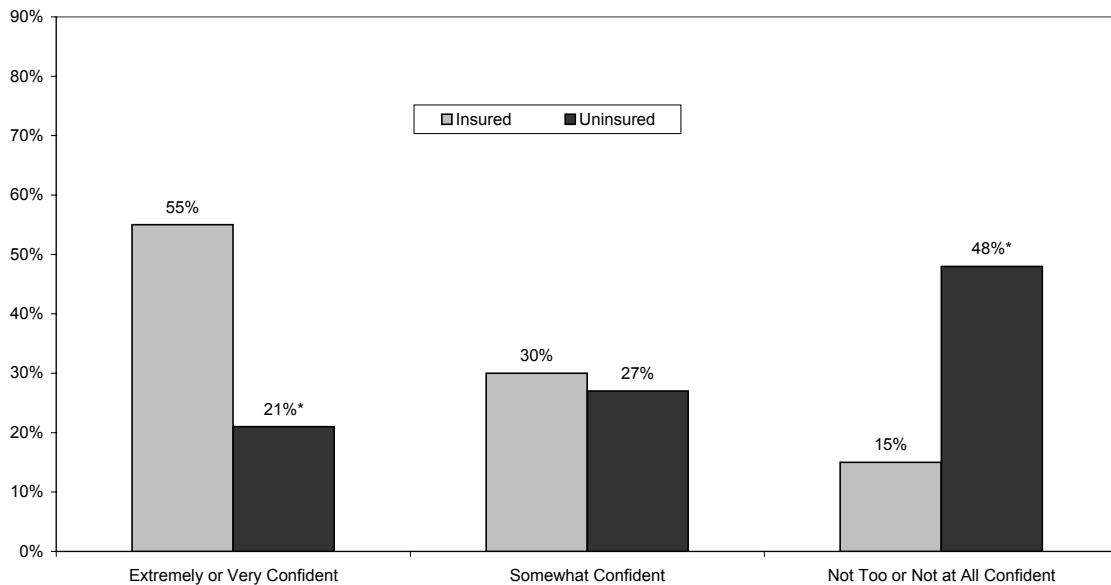
Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2009 Health Confidence Survey.  
 \* Difference is statistically significant at  $p \leq 0.05$  or better.

**Figure 4**  
**Confidence in Ability to Afford Health Care Without Financial Hardship Today, by Insurance Status, 2009**



Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2009 Health Confidence Survey.  
 \* Difference is statistically significant at  $p \leq 0.05$  or better.

**Figure 5**  
**Confidence in Enough Choice About Who Provides Medical Care Today, by Insurance Status, 2009**



Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2009 Health Confidence Survey.  
 \* Difference is statistically significant at  $p \leq 0.05$  or better.

Figure 7 shows findings from the three questions on confidence in various aspects of the health care system: ability to get needed treatments, ability to afford health care without financial hardship, and enough choice about who provides medical care. Responses to the questions on confidence have changed over time for uninsured individuals, but not for insured individuals. For instance, the percentage of insured individuals reporting that they were *extremely* or *very* confident in their ability to get needed treatments bounced around in the upper 50 percent range, and twice reached about 65 percent. In contrast, among uninsured individuals, the percentage who were *extremely* or *very* confident fell from 39 percent in 2002 to 17 percent in 2009, with the 2003–2007 period (with the exception of 2005) being in the lower 20 percent range before dipping to 17 percent in 2009. The percentage of uninsured individuals reporting that they were *not* confident in their ability to get needed treatments increased from 31 percent in 2002 to 53 percent in 2009. Similarly, the percentage of insured individuals who were *extremely* or *very* confident in their ability to afford health care without financial hardship was unchanged, but the percentage of uninsured individuals who were *extremely* or *very* confident fell from 14 percent in 2004 to 3 percent in 2009, and the percentage reporting that they were *not* confident increased from 65 percent in 2002 to 79 percent in 2009.

**Figure 6**  
**Satisfaction With Quality of Medical Care Received, by Insurance Status, 1998–2009**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
<b>Insured</b>												
Extremely or very satisfied	57%	51%	52%	54%	55%	57%	55%	61%	56%	55%	53%	62%
Somewhat satisfied	30	30	34	32	33	30	31	28	33	33	35	29
Not too or not at all satisfied	5	8	8	6	6	7	7	9	7	9	9	6
<b>Uninsured</b>												
Extremely or very satisfied	25	26	36	43	33	30	35	33	28	24	26	26
Somewhat satisfied	35	34	36	29	36	38	30	46	40	50	46	42
Not too or not at all satisfied	12	15	15	10	15	11	18	11	22	10	18	20

Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 1998–2009 Health Confidence Surveys.

## Satisfaction and Confidence by Health Status

The 2009 HCS also finds that persons in excellent, very good, or good health are more likely than those in fair or poor health to be *extremely* or *very* satisfied with the quality of health care received. Sixty percent of healthier persons were satisfied with quality of health care received as compared to 37 percent among those in fair or poor health (Figure 8). Less healthy individuals were more likely than healthier individuals to be *somewhat* satisfied with quality of care received. Eight percent of healthier individuals and 12 percent of less healthy individuals were *not* satisfied with the quality of care received, but the difference was not statistically significant.

Less healthy people are also less confident than healthier people in their ability to get needed treatments and in their ability to afford health care without financial hardship. Nearly 60 percent of healthier individuals were confident in their ability to get needed treatments, whereas 44 percent of less healthy individuals were confident (Figure 9). Twenty-two percent of less healthy people were *not* confident in their ability to get needed treatments, compared with 13 percent among healthier people, a difference that was statistically significant.

Individuals' confidence in their ability to afford health care without financial hardship is generally lower than their confidence in their ability to get needed treatments, regardless of health status. Still, less healthy individuals are less confident than healthier individuals in their ability to afford health care without financial hardship. Thirty-five percent of healthy individuals reported that they were confident in their ability to afford health care without financial hardship, compared with 18 percent among less healthy individuals (Figure 10). In contrast, 51 percent of less healthy individuals were *not* confident in their ability to afford health care without financial hardship, compared with 35 percent among healthier individuals. There were no statistically significant differences in confidence in having enough choice about who provides health care by health status (Figure 11).

**Figure 7**  
**Confidence in Selected Aspects of Today's Health Care System, by Insurance Status, 1998–2009**

	<b>Ability to Get Needed Treatments</b>							
	2002	2003	2004	2005	2006	2007	2008	2009
<b>Insured</b>								
Extremely or very confident	57%	56%	55%	64%	59%	57%	57%	65%
Somewhat confident	33	33	33	28	31	32	33	28
Not too or not at all confident	9	10	12	8	10	10	10	7
<b>Uninsured</b>								
Extremely or very confident	39	22	24	31	21	22	18	17
Somewhat confident	29	43	36	38	32	29	27	28
Not too or not at all confident	31	34	39	29	47	47	55	53
	<b>Ability to Afford Health Care Without Financial Hardship</b>							
	2002	2003	2004	2005	2006	2007	2008	2009
<b>Insured</b>								
Extremely or very confident	40	35	38	36	33	35	35	37
Somewhat confident	34	32	34	35	35	34	28	31
Not too or not at all confident	25	31	27	28	31	30	36	30
<b>Uninsured</b>								
Extremely or very confident	9	10	14	12	6	7	3	3
Somewhat confident	25	21	17	19	15	12	15	15
Not too or not at all confident	65	68	69	66	79	76	81	79
	<b>Enough Choice About Who Provides Medical Care</b>							
	2002	2003	2004	2005	2006	2007	2008	2009
<b>Insured</b>								
Extremely or very confident	47	46	45	54	46	46	47	55
Somewhat confident	35	36	36	32	39	37	34	30
Not too or not at all confident	17	17	18	14	14	16	18	15
<b>Uninsured</b>								
Extremely or very confident	34	22	27	27	19	25	16	21
Somewhat confident	39	36	36	37	39	23	30	27
Not too or not at all confident	26	41	36	33	39	46	53	48

Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2002–2009 Health Confidence Surveys.

**Trends**

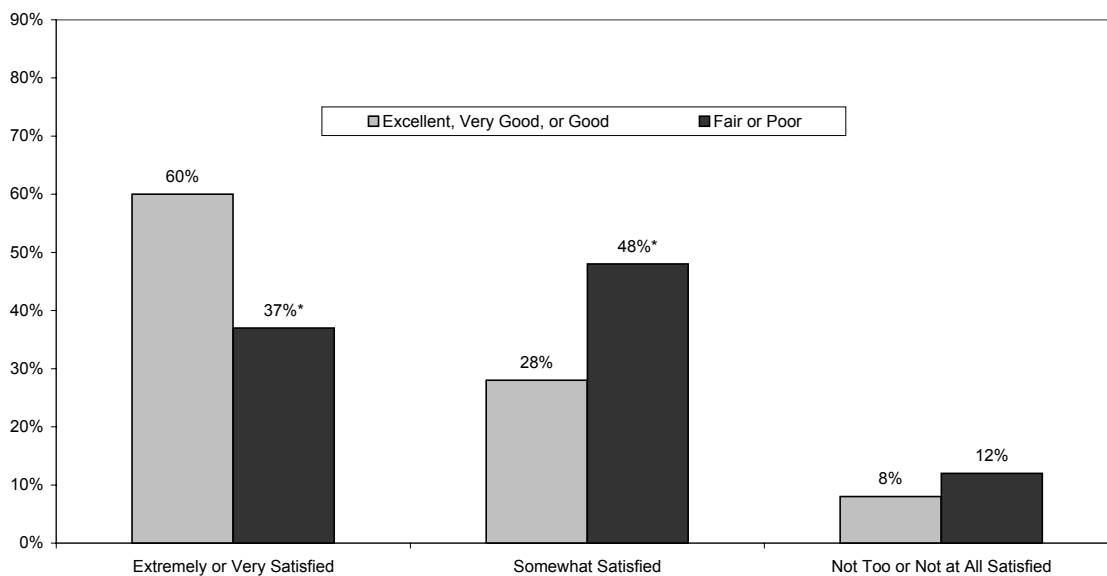
For the most part, satisfaction with quality of health care received has not changed over time for individuals in excellent, very good, or good health. In 1998, 53 percent reported that they were *extremely* or *very* satisfied with the quality of care received (Figure 12). By 2009, 60 percent were *extremely* or *very* satisfied, a statistically significant increase from 1998. However, the percentage reporting that they were *extremely* or *very* satisfied for the most part bounced around 50–55 percent range. Similarly, the percentage of individuals in fair or poor health reporting that they were *extremely* or *very* satisfied with the quality of health care received has not changed significantly between 1998 and 2009. However, the percentage of individuals in fair or poor health reporting that they were not satisfied with medical care received has increased over time. In 1999, 8 percent were *not* satisfied. By 2004, it was 18 percent and by 2008 it was 22 percent, but in 2009, it was 12 percent.

Unlike the erosion in confidence in various aspects of health care that were found with respect to insurance status, no erosion in confidence was found when examining it by health status (Figure 13).

**Rating of the U.S. Health System**

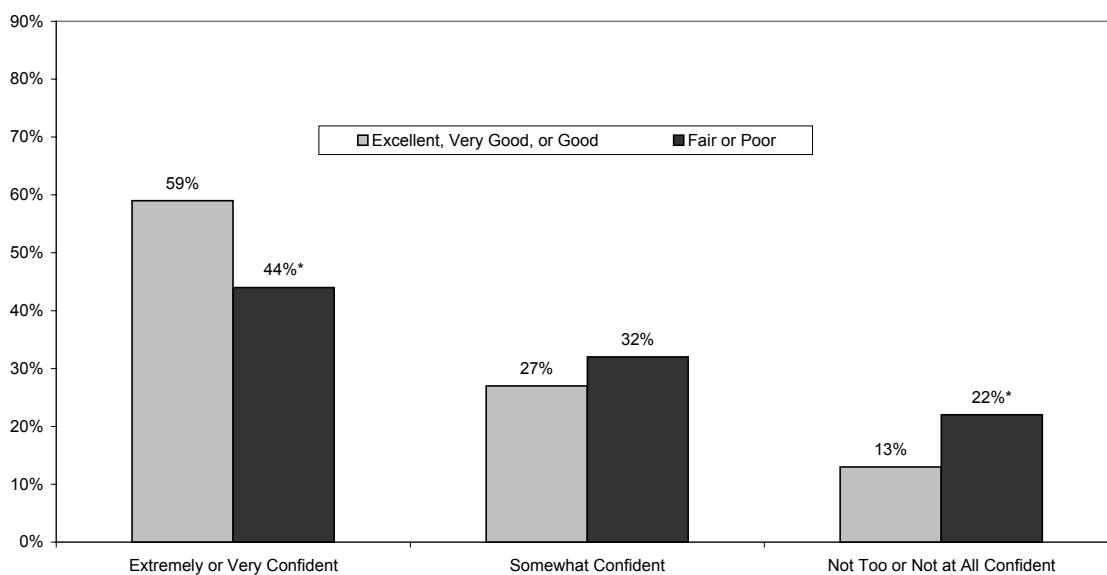
When asked to rate the health care system, a majority described it as *fair* or *poor* (59 percent) in 2009 (Fronstin and Helman, 2009). Uninsured individuals are much more likely than insured individuals to rate the system as *fair* or *poor*. Four-fifths (81 percent) of uninsured individuals rated the system as *fair* or *poor*, compared with 54 percent among insured individuals (Figure 14). Similarly, 70 percent of less healthy persons rated the U.S. health care system as *fair* or *poor* compared with 56 percent among healthy individuals.

**Figure 8**  
**Satisfaction With Quality of Health Care**  
**Received, by Health Status, 2009**



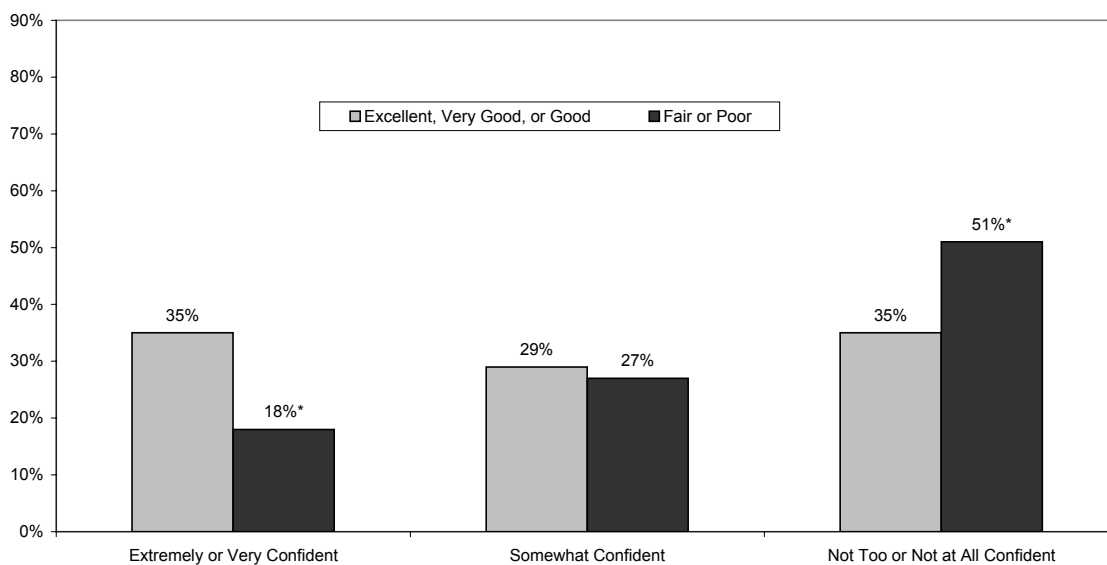
Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2009 Health Confidence Survey.  
 \* Difference is statistically significant at  $p \leq 0.05$  or better.

**Figure 9**  
**Confidence in Ability to Get Needed**  
**Treatments Today, by Health Status, 2009**



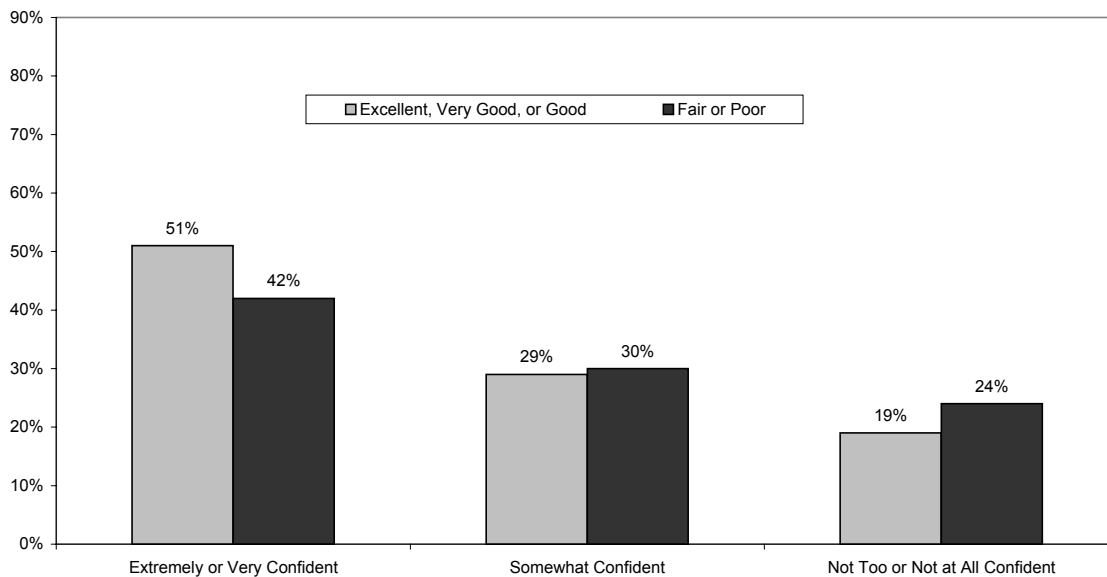
Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2009 Health Confidence Survey.  
 \* Difference is statistically significant at  $p \leq 0.05$  or better.

Figure 10  
**Confidence in Ability to Afford Health Care  
 Without Financial Hardship Today, by Health Status, 2009**



Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2009 Health Confidence Survey.  
 \* Difference is statistically significant at  $p \leq 0.05$  or better.

Figure 11  
**Confidence in Enough Choice About Who  
 Provides Medical Care Today, by Health Status, 2009**



Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2009 Health Confidence Survey.

Over time, not much of a change was found in the ratings of the U.S. health care system by either insurance status or health status. However, one notable trend is that between 1998–2004, between 64 percent and 72 percent of uninsured individuals rated the health care system as *fair* or *poor*. During 2005–2009, between 74 percent and 81 percent rated the system as *fair* or *poor*.

## The 2009 HCS

The EBRI/MGA Health Confidence Survey (HCS) was conducted within the United States between May 8 and June 2, 2009, through 21-minute telephone interviews. One thousand individuals age 21 and older were interviewed. Random digit dialing with a cell phone supplement was used to obtain a representative cross-section of the U.S. population. Interview quotas were established by sex of respondent and employment status, and the data were weighted by gender, age, and education to reflect the actual proportions in the population.

In theory, the weighted sample of 1,000 yields a statistical precision of plus or minus 3.5 percentage points (with 95 percent confidence) of what the results would be if the entire population age 21 and older were surveyed with complete accuracy. However, there are other possible sources of error in all surveys (bias) that may be more serious than theoretical calculations of sampling error. These include refusals to be interviewed and other forms of nonresponse, the effects of question wording and question order, interviewer bias, and screening.

While it is impossible to quantify the errors that may result from these factors, attempts are made to minimize them. In particular, the four weeks during which the HCS is conducted allows for better sample management, including conversion of soft refusals, more attempts to reach each phone number in the sample, and greater likelihood of reaching people who are seldom at home, than is possible with surveys conducted in a short time frame. These efforts improve the representativeness of the survey and reduce bias or unmeasurable error, thereby increasing the accuracy of the HCS data.

The HCS is co-sponsored by the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan public policy research organization, and Mathew Greenwald & Associates, Inc., a Washington, DC-based market research firm. The 2009 HCS data collection was funded by grants from 14 private organizations. Staffing was donated by EBRI and Greenwald & Associates. HCS materials and a list of underwriters may be accessed at the EBRI Web site: [www.ebri.org/hcs](http://www.ebri.org/hcs). Additional findings from the survey can be found in Fronstin and Helman (2009).

## References

- Cohn, Jonathan. "Diagnosis: Inertia." *The New Republic* (July 15, 2009), [www.tnr.com/politics/story.html?id=aca67416-f26c-4790-86b5-bbb76b02cb6c](http://www.tnr.com/politics/story.html?id=aca67416-f26c-4790-86b5-bbb76b02cb6c)
- Fronstin, Paul, and Ruth Helman. "The 2009 Health Confidence Survey: Public Opinion on Health Reform Varies; Strong Support for Insurance Market Reform and Public Plan Option, Mixed Response to Tax Cap." *EBRI Issue Brief*, no. 331 (Employee Benefit Research Institute, July 2009).
- Fronstin, Paul, and Murray Ross. "Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider." *EBRI Issue Brief*, no. 330 (Employee Benefit Research Institute, June 2009).

## Endnotes

- <sup>1</sup> For examples, see <http://abcnews.go.com/Politics/HealthCare/story?id=7920012&page=1> and [www.latimes.com/features/printedition/health/la-he-healthreform2-2009mar02\\_0,1986914.story](http://www.latimes.com/features/printedition/health/la-he-healthreform2-2009mar02_0,1986914.story)
- <sup>2</sup> See Figure 13 in Fronstin and Helman (2009).
- <sup>3</sup> See <http://online.wsj.com/article/SB124527518023424769.html>
- <sup>4</sup> See [www.kff.org/kaiserpolls/upload/7931.pdf](http://www.kff.org/kaiserpolls/upload/7931.pdf)

**Figure 12**  
**Satisfaction With Quality of Medical Care Received, by Health Status, 1998–2009**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Excellent, Very Good, or Good	53%	49%	52%	54%	53%	56%	55%	60%	55%	53%	52%	60%
Extremely or very satisfied	29	30	33	31	32	29	29	28	33	34	36	28
Somewhat satisfied	6	8	8	5	6	5	6	8	6	9	8	8
Not too or not at all satisfied												
Fair or Poor	46	45	39	46	43	40	38	46	43	41	36	37
Extremely or very satisfied	36	33	44	34	39	37	38	40	35	41	38	48
Somewhat satisfied	8	16	11	14	15	17	18	12	19	11	22	12
Not too or not at all satisfied												
Fair or Poor												

Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 1998–2009 Health Confidence Surveys.

**Figure 13**  
**Confidence in Selected Aspects of Today's Health Care System, by Health Status, 1998–2009**

	Ability to Get Needed Treatments												
	2002	2003	2004	2005	2006	2007	2008	2009	Ability to Afford Health Care Without Financial Hardship				2009
Excellent, Very Good, or Good	58%	55%	55%	63%	56%	55%	54%	59%					59%
Extremely or very confident	32	33	33	27	31	31	33	27					27
Somewhat confident	10	11	12	10	12	14	13	13					13
Not too or not at all confident													
Fair or Poor	40	35	32	45	42	42	38	44					44
Extremely or very confident	37	40	38	35	30	36	28	32					32
Somewhat confident	22	24	30	17	28	21	33	22					22
Not too or not at all confident													
Fair or Poor													
Excellent, Very Good, or Good	39	35	38	36	33	33	32	35					35
Extremely or very confident	33	32	32	35	32	33	28	29					29
Somewhat confident	28	32	29	28	34	33	39	35					35
Not too or not at all confident													
Fair or Poor													
Extremely or very confident	19	18	19	21	15	19	22	18					18
Somewhat confident	33	24	26	23	33	26	18	27					27
Not too or not at all confident	47	57	53	53	52	49	59	51					51
Not too or not at all confident													
Fair or Poor													
Excellent, Very Good, or Good	47	45	44	52	44	45	44	51					51
Extremely or very confident	36	36	36	31	38	35	35	29					29
Somewhat confident	17	18	19	16	17	19	20	19					19
Not too or not at all confident													
Fair or Poor													
Extremely or very confident	37	33	33	42	35	36	34	42					42
Somewhat confident	33	33	35	36	41	36	25	30					30
Not too or not at all confident	29	34	29	20	21	24	38	24					24

Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2002–2009 Health Confidence Surveys.

Figure 14

**Rating of the U.S. Health Care System, by Insurance Status and Health Status, 1998–2009**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
<b>Insured</b>												
Excellent or very good	18%	16%	16%	14%	17%	15%	15%	15%	15%	16%	17%	19%
Good	35	30	31	34	30	26	24	24	28	26	24	26
Fair or poor	46	53	52	51	51	57	59	60	57	57	57	54
<b>Uninsured</b>												
Excellent or very good	11	9	7	12	8	7	9	6	11	2	5	5
Good	19	20	21	20	22	29	20	13	13	22	19	13
Fair or poor	67	69	72	68	70	64	69	81	74	74	74	81
<b>Excellent, Very Good, or Good</b>												
Excellent or very good	18	16	16	15	17	16	16	15	15	14	17	18
Good	35	30	32	35	31	29	27	24	28	29	25	25
Fair or poor	45	52	52	49	51	54	56	60	57	56	56	56
<b>Fair or Poor</b>												
Excellent or very good	12	10	9	8	8	8	7	8	11	13	7	10
Good	19	20	21	19	21	16	12	16	17	13	18	20
Fair or poor	69	68	69	72	71	74	80	75	71	73	74	70

Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 1998–2009 Health Confidence Surveys.

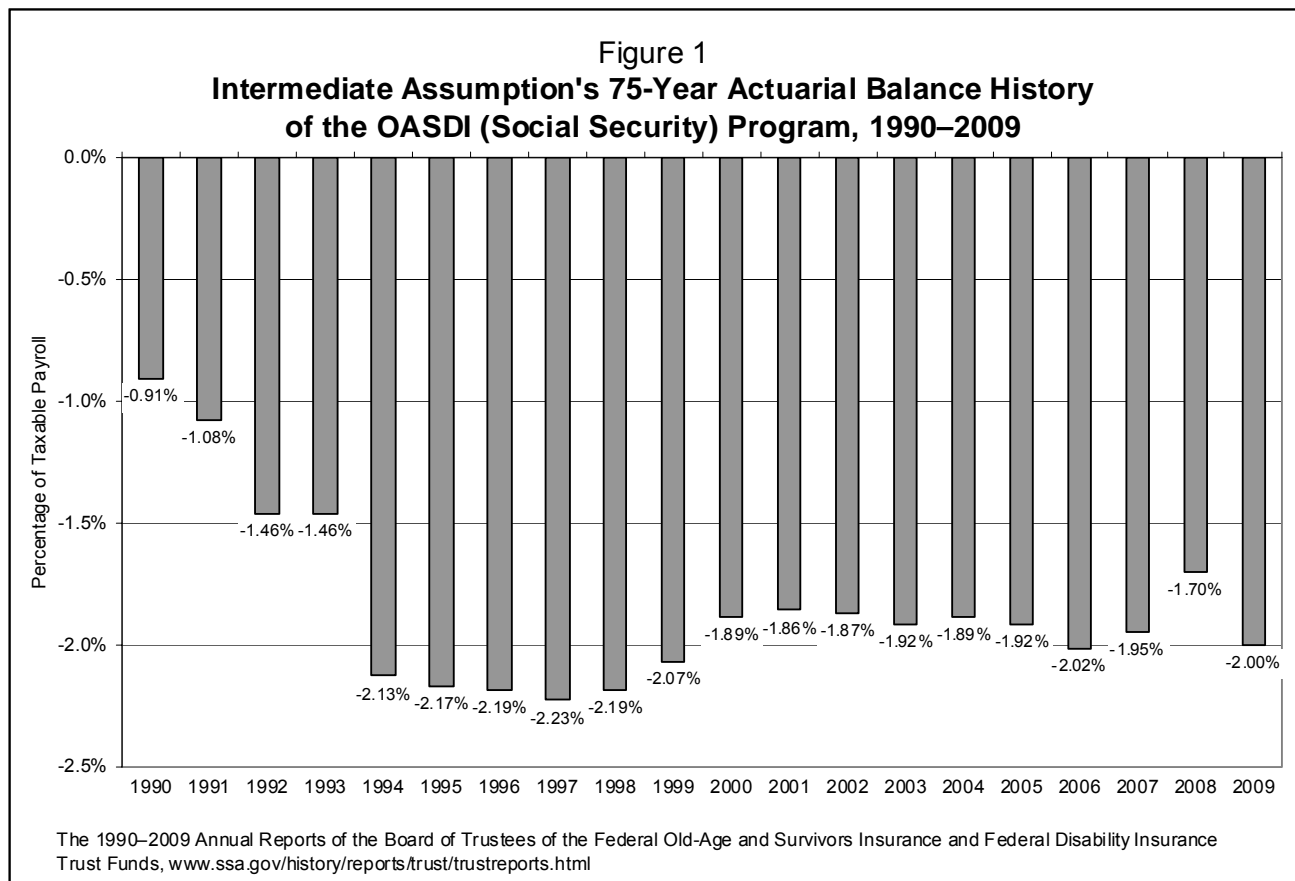
# Social Security Reform: How Different Options Might Affect Future Funding

by Craig Copeland, EBRI

## Introduction

Social Security (technically called the Old-Age, Survivors, and Disability Insurance Program, or OASDI) traditionally has been a strongly supported and popular program for providing income protection from old-age, death, and disability for workers and their dependents. Social Security by most accounts has been a successful program, particularly in helping to lower the poverty rate for the elderly from 35.2 percent in 1959 to 9.7 percent in 2007.<sup>1</sup> According to Current Population Survey (CPS) data, 38.6 percent of the income received by all those age 65 or over comes from Social Security; for the poorest of the elderly (those age 65 or over with incomes in the lowest three income quintiles), at least 75 percent of their income is attributable to Social Security benefits.<sup>2</sup> As these data indicate, America's elderly depend heavily on Social Security.

However, the program is currently facing a long-term projected financial shortfall, due in large part to the changing demographics and aging of the U.S. population, and it has been in this position for a number of years (a significant worsening in the funding status was reported in 2009) (Figure 1). This projected shortfall has been the center of discussion whenever advocates and policymakers have called for significant changes to the program to address the issues that are pushing it into financial trouble. Without changes to eliminate the shortfall, the program ultimately will be able to pay only about 75 of promised benefits called for under current law.



This article analyzes various potential reform provisions that have been widely discussed that would affect the benefit levels and program revenues of Social Security. This analysis also discusses the potential impact of these provisions on the financial status of the OASDI program. The provisions discussed are those that would:

- Lower the scheduled increase in future benefit levels by changes to the benefit formula.
- Change the contribution and benefit base (amount of earnings that are taxable and used for the calculation of benefits under OASDI) and the taxation of benefits.
- Increase the retirement age.

All of these approaches have been part of various comprehensive reform proposals over the last two decades.<sup>3</sup>

The financial status of the OASDI program is measured annually in the OASDI Trustees' Report in terms of the percentage of taxable payroll in the entire U.S. economy (the amount of total income that workers earn, both in salary and wages that is subject to the OASDI payroll tax)<sup>4</sup> that the program's present value of future *revenues* is relative to the present value of its future *costs* over the next 75 years.<sup>5</sup> This measure is called the "75-year actuarial balance" of the program. In 2009, the program's actuarial balance was reported as -2.00 percent of taxable payroll, meaning that the program would need additional revenues equal to 2 percent of taxable payroll for each year over the next 75 years to match the projected future current-law costs over the 75-year timeframe. The impact of the proposed changes discussed in this study is expressed as the improvement in the percentage of taxable payroll (or actuarial balance) due to the provision.<sup>6</sup>

The degree to which any of the options analyzed in this report would improve the actuarial balance of Social Security depends on how much emphasis policymakers might place on a specific provision. Consequently, a range of provisions is presented showing a variety of possible results.

## Provisions Affecting the Level of Monthly Benefits

There are various methods to reduce the growth of future Social Security benefits, such as:

- Slowing the scheduled annual growth of benefits for those already receiving them.
- Reducing current benefits for all by a fixed percentage.
- Making changes to the formula that determines a recipient's benefit.

**SLOWING COLA GROWTH**—Under current law, Social Security benefits for those currently receiving them are adjusted annually for inflation through a cost-of-living adjustment (COLA). The COLA is based on the change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) from third quarter to third quarter each year. One way to reduce this increase in benefits is to use less than the full change in the CPI-W when the COLA is applied to Social Security benefits. For instance, this could be done by subtracting 1 percentage point from the CPI-W to get the COLA. Under this provision, the actuarial balance of the program would improve by 1.43 percent of taxable payroll (Figure 2). If instead, the CPI-W was reduced by 0.5 percentage point to arrive at the COLA, the improvement would be 0.75 percent.

**BENEFIT FORMULA CHANGES**—A simple method to reduce benefits under the current-law determination of them is to reduce the resulting benefit by a fixed percentage. If this fixed percentage reduction were 3.0 percent, the actuarial balance improvement would be 0.36 percent; for a 5.0 percent fixed reduction, the improvement would rise to 0.60 percent.

Making specific changes to current-law formula for the calculation of benefits could also be done to reduce the future growth of benefits. One method is to increase the number of years used in the calculation of the average indexed monthly earnings.<sup>7</sup> Currently, the formula takes the highest 35 years for those receiving retiree benefits, but the calculation could be increased to 38 or 40 years. If this is done only for retirees and survivors (but not for disabled beneficiaries), the improvement in actuarial balance would be 0.31 percent for 38 years and 0.49 percent for 40 years. If dropout years are eliminated (which vary for those receiving disability benefits but equal to five years for retiree benefits), so that retiree workers would have 40 years used for the calculation of benefits and disability benefits would have one to five more years in the calculation, the improvement would be larger (at 0.65 percent), due to the inclusion of the effect on disability beneficiaries.

The calculation of OASDI benefits uses a formula that has lower percentage factors as income increases. The benefit claimed at normal retirement age or primary insurance amount (PIA) is calculated using three threshold—or “bend-point”—factors, which are 90 percent, 32 percent, and 15 percent. The amount of average indexed monthly earnings under each of these thresholds is indexed to the growth in the economy-wide average wage index calculated by the Social Security Administration. In 2009, up to \$744 of average indexed monthly earnings is under the first the cutoff, where 90 percent is included in the PIA. Above \$744 through \$4,483 of monthly earnings, the factor is 32 percent, while a 15 percent factor is applied to the monthly income above \$4,483. Each recipient’s earnings history is used to calculate their own average indexed monthly earnings; these bend-point factors are then applied to the average indexed monthly earnings to determine the recipient’s PIA, which would be the benefit if the recipient begins claiming benefits at the normal retirement age and does not have other reasons for qualifying for benefits (spousal or survivor). By adjusting the income that each bend-point factor applies to or changing the bend-point factors, the growth in future benefits can be reduced.<sup>8</sup>

By making this type of change, the largest improvement in Social Security’s actuarial balance would be to reduce the PIA bend-point factors so that benefits grow only by inflation, instead of by the wage growth that typically has been larger than inflation. This would eliminate real benefit increases for future beneficiaries, so that benefits would stay at the same real level as what beneficiaries received just before the change began. If this switch occurred in 2015, the actuarial balance improvement would be 2.30 percent.

Another option would be to reduce the PIA factors to something below the current 90, 32, and 15 percent levels. If the higher two bend-point factors are reduced gradually to 21 percent and 10 percent, respectively, by 2039, an improvement in actuarial balance of 1.55 percent would result.

Other more involved changes to the PIA formula (using the same principal as above) based on reducing only the benefits for those with higher average monthly indexed earnings are termed “progressive price-indexing.” These involve creating a new bend point where benefits below that level are preserved under current law, while benefits above that level are reduced so that the upper two current-law bend points are adjusted to maintain growth at the inflation-increase standard instead of the real wage growth standard. If the new bend point is set at the 30<sup>th</sup> percentile of benefits, the improvement in actuarial balance would be 1.36 percent. If the new bend point is set at the 60<sup>th</sup> percentile, the improvement in actuarial balance would be smaller, at 0.68 percent. If disability benefits are held to current-law levels, the new 30<sup>th</sup> percentile bend point would lead to a 1.18 percent improvement in actuarial balance.

## **Provisions Affecting OASDI Contribution and Benefit Base**

There are other options for raising OASDI revenue than just raising the current tax rate under the existing structure. The current maximum taxable earnings cap could be removed, making all earnings taxable for covered workers. If the current-law benefit cap for the calculation of benefits is retained, the improvement in the system’s financing would be 2.19 percent (Figure 3). If all earnings are credited toward benefits, the improvement would be 1.84 percent.

Another option would be to increase the maximum taxable amount to 90 percent of OASDI covered earnings (currently the maximum is at just over 80 percent). If this option is phased in from 2010 to 2015 and all newly taxed earnings

Figure 2 Provisions Affecting Level of Monthly Benefits	
Provision	Improvement in Actuarial Balance
<b>Reduction in Cost-of-Living Adjustment (COLA)...</b>	
by 1.0 percentage point	1.43%
by 0.5 percentage point	0.75%
<b>Benefit Formula Changes</b>	
<i>Reduce benefits for newly eligibles by a flat percentage...</i>	
3.0 percent reduction	0.36%
5.0 percent reduction	0.60%
<i>Increase number of years to calculate benefits (OASI)...</i>	
from 35 to 38 years	0.31%
from 35 to 40 years	0.49%
<i>Eliminate dropout years from OASDI computation from 2010 to 2018</i>	0.65%
<i>Adjustments to PIA<sup>a</sup> formula factors</i>	
Beginning in 2015, OASDI benefits for newly eligibles will grow by inflation by reducing the PIA <sup>a</sup> formulas accordingly	2.30%
Phase in reduction of 32 percent and 15 percent factors by 2039 to 21 percent and 10 percent	1.55%
Progressive price indexing of PIA <sup>a</sup> formulas beginning in 2015. Create new bendpoint at the 30th percentile of earners. Maintain current-law benefits for earners at the 30th percentile and below and reduce upper two formula factors (32% and 15%) such that maximum worker benefit grows by inflation rather by wage growth	1.36%
Same as above, but new bend point at 60th percentile of earners	0.68%
Progressive price indexing beginning in 2015, but new disabled workers unaffected by the change for disability benefits but a proportional reduction at retirement	
New bend point at 30th percentile	1.18%

Source: Social Security Administration, Office of the Actuary, *Provisions That Could Change the Social Security Program*, <http://ssa.gov/OACT/solvency/provisions/index.html>

<sup>a</sup> Primary insurance amount.

Figure 3 Provisions Affecting OASDI Contributions and Benefit Base and Taxation of Benefits	
Provision	Improvement in Actuarial Balance
Make all earnings subject to payroll tax (but retain the current-law taxable maximum for benefit calculations)	2.19%
Make all earnings subject to payroll tax and credit them for benefits	1.84%
Raise the taxable maximum amount to 90 percent of OASDI-covered earnings. Phase in increase between 2010 and 2015. Benefit computations would reflect all earnings up to the new maximum	0.84%
Impose a 3 percent payroll tax on OASDI-covered earnings above the current taxable maximum. Benefit computation would not reflect any earnings above the maximum	0.64%
Tax OASDI benefits in a manner similar to private pension income, phasing out lower-income thresholds by 2018	0.27%

Source: Social Security Administration, Office of the Actuary, *Provisions That Could Change the Social Security Program*, <http://ssa.gov/OACT/solvency/provisions/index.html>

are included in the benefit calculation, the improvement in the actuarial balance would be 0.84 percent. A lower rate could be applied on earnings above the maximum taxable earnings to raise extra revenue for the program. If a 3 percent tax rate is applied to the earnings above the current-law maximum earnings and benefits are not included in benefit calculations, the actuarial balance would improve by 0.64 percent.

Taxation of benefits could also be changed. Currently, there is a low-income threshold below which none of the OASDI benefits received are taxed; however, above the income threshold, 50 percent of the benefits are taxed. Currently, the thresholds are \$25,000 for single tax filer beneficiaries and \$32,000 for joint tax filer beneficiaries. This threshold could be removed so that all OASDI beneficiaries have 50 percent of their benefits taxed. This would lead to an actuarial balance improvement of 0.27 percent.

## Provisions Affecting Retirement Age

One often-discussed proposal is to increase the age at which beneficiaries qualify for full Social Security benefits (when the PIA is *not* reduced for early retirement). This change can be done in many ways, depending on how quickly the normal retirement age is increased and if the increase is linked to the growing longevity of the covered population. Figure 4 lists a few ideas on how the age could be raised, and shows the resulting improvement in the actuarial balance of OASDI by doing so. The improvements range from 0.10 percent for increasing the normal retirement age to 67 now, instead of waiting until 2017, to 0.62 percent for increasing the normal retirement age now to 67 and then by one month every two years until reaching age 70.

Figure 4 Provisions Affecting Retirement Age	
Provision	Improvement in Actuarial Balance
Shorten the hiatus in normal retirement age increase now instead of for those turning 62 in 2017	0.10%
Shorten the hiatus in normal retirement age increase now instead of for those turning 62 in 2017, then increase normal retirement age to 68 by one month every two years	0.46%
Shorten the hiatus in normal retirement age increase now instead of for those turning 62 in 2017, then increase normal retirement age to 70 by one month every two years	0.62%
Shorten the hiatus in normal retirement age increase now instead of for those turning 62 in 2017, then increase normal retirement age to 68 by two months every year	0.58%
Index benefits to longevity after the normal retirement age reaches 67 under current law. This would increase the normal retirement age one month every other year.	0.37%
Source: Social Security Administration, Office of the Actuary, <i>Provisions That Could Change the Social Security Program</i> , <a href="http://ssa.gov/OACT/solvency/provisions/index.html">http://ssa.gov/OACT/solvency/provisions/index.html</a>	

## Conclusion

This article discusses various provisions that could improve the funding status of the OASDI (Social Security) program. Each provision has certain drawbacks, but if the projected funding status of the program is to be improved, some compromises will have to be made: either benefits will need to be cut, or revenues raised, or some combination of these two options.

There are numerous provisions that could be implemented. However, the goal of this study was to present those provisions that have been most often discussed for improving the funding status of Social Security, and to measure the impact that the provisions, depending upon the emphasis on the provisions, would have on the program's funding status. An important note is that these improvement percentages are not cumulative (meaning they cannot simply be

added together), because there are interactive (and sometimes offsetting) effects. Therefore, depending on the various combinations of provisions chosen, the improvement in the funding status will be something less than the sum of the individual effects. Consequently, a number of these provisions may be necessary to achieve an actuarial balance where the projected revenues will fully match the projected costs.

## Endnotes

<sup>1</sup> U.S. Bureau of the Census, Current Population Survey, *Annual Social and Economic Supplements*, Table 3, "Poverty Status of People, by Age, Race, and Hispanic Origin: 1959 to 2007," at [www.census.gov/hhes/www/poverty/histpov/hstpov3.xls](http://www.census.gov/hhes/www/poverty/histpov/hstpov3.xls)

<sup>2</sup> *EBRI Databook*, "Chapter 7: Sources of Income for Persons Age 55 and Over," available online at [www.ebri.org/pdf/publications/books/databook/DB.Chapter%2007.pdf](http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2007.pdf)

<sup>3</sup> See Social Security Administration, Office of the Actuary, *Actuarial Publications*, "Long-Range Solvency Proposals," [www.ssa.gov/OACT/solvency/index.html](http://www.ssa.gov/OACT/solvency/index.html) for an overview of some recent comprehensive reform proposals.

<sup>4</sup> In 2009, the payroll tax rate was 6.2 percent on each the employee and employer (12.4 percent total), on earnings up to \$106,800.

<sup>5</sup> See *The 2009 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*, online at [www.ssa.gov/OACT/TR/2009/trTOC.html](http://www.ssa.gov/OACT/TR/2009/trTOC.html)

<sup>6</sup> See Social Security Administration, Office of the Actuary, *Actuarial Publications*, "Provisions That Could Change the Social Security Program," <http://ssa.gov/OACT/solvency/provisions/index.html> for more detail on these various provisions. The next sections are a summary of the more often-discussed provisions found on this Web site. The reported improvements in actuarial balance are from the Social Security actuaries, reported on this Web site, and are based on the intermediate assumptions from the 2008 OASDI Trustees' Report.

<sup>7</sup> See Social Security Administration, Office of the Actuary, *Automatic Increases*, "Social Security Benefit Amounts," [www.ssa.gov/OACT/COLA/Benefits.html#aime](http://www.ssa.gov/OACT/COLA/Benefits.html#aime) on the calculation of the average indexed monthly earnings.

<sup>8</sup> See Social Security Administration, Office of the Actuary, *Automatic Increases*, "Primary Insurance Amount," [www.ssa.gov/OACT/COLA/piaformula.html](http://www.ssa.gov/OACT/COLA/piaformula.html) on the calculation of the primary insurance amount.

# 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](mailto:publications@ebri.org)

Leopold, Ronald S. *The Benefits Edge: Honing the Competitive Value of Employee Benefits*. Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166. Order a free copy online at [www.whymetlife.com/benefitsedge/](http://www.whymetlife.com/benefitsedge/)

## Employee Stock Purchase Plans

Burmeister, Ed, et al. *Equity Compensation in a Down Market: Repricing, Accounting, ESPP, and Employee Communications Issues* [63-page printout, not a bound book]. NCEO members, \$15; nonmembers, \$25. National Center for Employee Ownership, 1736 Franklin St., 8<sup>th</sup> Floor, Oakland, CA 94612, (510) 208-1300, fax: (510) 272-9510, e-mail: [nceo@nceo.org](mailto:nceo@nceo.org), [www.nceo.org](http://www.nceo.org)

## Health Insurance

Buck Consultants. *Prescription Drug Benefit Survey*. \$100. Buck Consultants, An ACS Company, Attn: Global Survey Resources, 500 Plaza Dr., Secaucus, NJ 07096-1533, (800) 887-0509, [www.bucksurveys.com](http://www.bucksurveys.com)

Mercer. *National Survey of Employer-Sponsored Health Plans, 2008 Survey Report*. Report, \$600, Report and tables, \$1,200 (tables not sold separately). Mercer Health & Benefits, Attn: Tara Lewis, 1166 Avenue of the Americas, 29<sup>th</sup> Floor, New York, NY 10036-2708, (212) 345-2451, e-mail: [tara.lewis@mercer.com](mailto:tara.lewis@mercer.com)

## Pension Plans/Retirement

Hewitt Associates. *Survey Findings: Hot Topics in Retirement 2009*. Free. To access a PDF of the survey report, go to [www.hewittassociates.com/Intl/NA/en-US/KnowledgeCenter/ArticlesReports/ArticleDetail.aspx?cid=6306&tid=46](http://www.hewittassociates.com/Intl/NA/en-US/KnowledgeCenter/ArticlesReports/ArticleDetail.aspx?cid=6306&tid=46)

## Web Documents

Ariel/Hewitt Study: *401(k) Plans in Living Color: A Study of 401(k) Savings Disparities Across Racial and Ethnic Groups* [www.arielinvestments.com/images/stories/PDF/arielhewittstudy\\_finalweb\\_7.3.pdf](http://www.arielinvestments.com/images/stories/PDF/arielhewittstudy_finalweb_7.3.pdf)

Charles Schwab: *Getting Retirement Savings Back on Track: Employer Views on the 401(k) and Financial Education in the Workplace* [a report prepared by CFO Research Services in collaboration with Charles Schwab] [www.aboutschwab.com/media/pdf/getting\\_retirement\\_back\\_on\\_track.pdf](http://www.aboutschwab.com/media/pdf/getting_retirement_back_on_track.pdf)

Families and Work Institute: *The Impact of the Recession on Employers* <http://familiesandwork.org/site/research/reports/Recession2009.pdf>

Families USA: *Understanding the Role of the "Exchange" or "Gateway"* [www.familiesusa.org/assets/pdfs/health-reform/understanding-the-role-of-the-exchange.pdf](http://www.familiesusa.org/assets/pdfs/health-reform/understanding-the-role-of-the-exchange.pdf)

Prudential Retirement: *The Search for a Safe Way to Save for Retirement* [www.prudential.com/media/managed/Search\\_for\\_Safe\\_Way\\_to\\_Save\\_for\\_Retirement.pdf](http://www.prudential.com/media/managed/Search_for_Safe_Way_to_Save_for_Retirement.pdf)

## Retirement 20/20 Call for Models

The Society of Actuaries Pension Section Council has announced a call for models to solicit ideas for new tier II retirement systems that align with the principles outlined in its Retirement 20/20 initiative. The Pension Section encourages submissions either by individuals or organizations for new tier II retirement systems that fit within the context of the social insurance system, culture, work patterns and social values in Canada and/or the United States. In addition, the section plans to support this call for models by awarding cash prizes for the top qualified submissions. For additional information, go to the following Web site: <http://retirement2020.soa.org/call-models.aspx>



# Notes

---

*EBRI Employee Benefit Research Institute Notes* (ISSN 1085-4452) is published monthly by the Employee Benefit Research Institute, 1100 13<sup>th</sup> 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 Notes*, 1100 13<sup>th</sup> St. NW, Suite 878, Washington, DC 20005-4051. Copyright 2009 by Employee Benefit Research Institute. All rights reserved, Vol. 30, no. 9.

---

## Who we are

---

The Employee Benefit Research Institute (EBRI) was founded in 1978. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI is the only private, nonprofit, nonpartisan, Washington, DC-based organization committed exclusively to public policy research and education on economic security and employee benefit issues. EBRI's membership includes a cross-section of pension funds; businesses; trade associations; labor unions; health care providers and insurers; government organizations; and service firms.

## What we do

---

EBRI's work advances knowledge and understanding of employee benefits and their importance to the nation's economy among policymakers, the news media, and the public. It does this by conducting and publishing policy research, analysis, and special reports on employee benefits issues; holding educational briefings for EBRI members, congressional and federal agency staff, and the news media; and sponsoring public opinion surveys on employee benefit issues. **EBRI's Education and Research Fund (EBRI-ERF)** performs the charitable, educational, and scientific functions of the Institute. EBRI-ERF is a tax-exempt organization supported by contributions and grants.

## Our publications

---

**EBRI Issue Briefs** are periodicals providing expert evaluations of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. **EBRI Notes** is a monthly periodical providing current information on a variety of employee benefit topics. EBRI's **Pension Investment Report** provides detailed financial information on the universe of defined benefit, defined contribution, and 401(k) plans. EBRI **Fundamentals of Employee Benefit Programs** offers a straightforward, basic explanation of employee benefit programs in the private and public sectors. The **EBRI Databook on Employee Benefits** is a statistical reference work on employee benefit programs and work force-related issues.

## Orders/ Subscriptions

---

Contact EBRI Publications, (202) 659-0670; fax publication orders to (202) 775-6312. Subscriptions to *EBRI Issue Briefs* are included as part of EBRI membership, or as part of a \$199 annual subscription to *EBRI Notes* and *EBRI Issue Briefs*. Individual copies are available with prepayment for \$25 each (for printed copies). **Change of Address:** EBRI, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, (202) 659-0670; fax number, (202) 775-6312; e-mail: [subscriptions@ebri.org](mailto:subscriptions@ebri.org) **Membership Information:** Inquiries regarding EBRI membership and/or contributions to EBRI-ERF should be directed to EBRI President/ASEC Chairman Dallas Salisbury at the above address, (202) 659-0670; e-mail: [salisbury@ebri.org](mailto:salisbury@ebri.org)

**Editorial Board:** Dallas L. Salisbury, publisher; Stephen Blakely, editor. Any views expressed in this publication and those of the authors should not be ascribed to the officers, trustees, members, or other sponsors of the Employee Benefit Research Institute, the EBRI Education and Research Fund, or their staffs. Nothing herein is to be construed as an attempt to aid or hinder the adoption of any pending legislation, regulation, or interpretative rule, or as legal, accounting, actuarial, or other such professional advice.

*EBRI Notes* is registered in the U.S. Patent and Trademark Office. ISSN: 1085-4452 1085-4452/90 \$ .50+.50