

Health Insurance Portability: Access and Affordability

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Issue Brief

- This *Issue Brief* provides summary data on the nation's insured and uninsured populations. It describes the characteristics of those whose health insurance status changed between 1994 and 1995. The report also presents the characteristics of groups that did not experience a change in insurance status. Finally, it examines the implications of the current health care reform debate on the issues of access and affordability.
- The March 1995 Current Population Survey (CPS) is the first CPS to ask questions about health insurance status during a point in time. The data indicate that 127.3 million nonelderly Americans, or 55.8 percent, had some form of employment-based health insurance. Most of those reporting employment-based health insurance (30.5 percent) received coverage through their own employer. Approximately 61.2 million nonelderly Americans (26.8 percent) were uninsured during the reference week in March 1995. This number is in contrast with the data showing that 50.7 million individuals lacked health insurance for at least one month during a 32-month period between 1991 and 1993 and 39.4 million were uninsured during the 1994 calendar year.
- One clear element of the current health reform debate is an interest in making health insurance more portable. Portability would allow workers and their families to change insurers without being subject to a new waiting period for preexisting conditions. EBRI tabulations indicate that 19.5 million nonelderly Americans had employment-based health insurance in 1994 and were uninsured in 1995. This represents 8.5 percent of the nonelderly population. Not all of these individuals will benefit from increased portability. Some may not have preexisting conditions, and others may not have had employment-based coverage long enough to qualify for portability.
- The recent health reform legislation would remove barriers to portability of health insurance and increase access. The reforms are driven by the belief that individuals who have been covered by prior health insurance should not be penalized when they change jobs or insurance companies. Current reforms to remove barriers to health insurance also include provisions that may make health insurance more affordable. Ultimately, these reforms will do little to significantly increase health insurance coverage and make health insurance more affordable if the gap between health care cost inflation and overall inflation is not eliminated. However, for those who can afford health insurance coverage, access will be improved.

Table of Contents

Text

Introduction	3
Data	4
(table 1)	
Current Sources of Coverage	5
Changes in Coverage	6
(table 2, table 3)	
Work Status	9
Workers	9
(table 4, table 5)	
Family Income	9
(chart 1, chart 2, table 6, table 7)	
Age	14
(chart 3, chart 4, table 8)	
Family Type	14
(chart 5, table 9)	
Children	14
(table 10)	
Policy Implications	15
(table 11)	
Conclusion	20
References	21

Tables

Table 1, Nonelderly and Elderly Americans with Selected Sources of Health Insurance, 1995	5
Table 2, Nonelderly Population with Selected Sources of Health Insurance, by Region and State, 1995	7
Table 3, Nonelderly Population with Selected Combinations of Health Insurance in 1994 and 1995, by Own Work Status and Work Status of Family Head in 1994	10

Table 4, Workers Aged 18–64 with Selected Combinations of Health Insurance in 1994 and 1995, by Industry of Primary Employment in 1994	11
Table 5, Workers Aged 18–64 with Selected Combinations of Health Insurance in 1994 and 1995, by Firm Size of Primary Employment in 1994	12
Table 6, Nonelderly Americans with Selected Combinations of Health Insurance in 1994 and 1995, by Family Income as a Percentage of the Poverty Level in 1994	13
Table 7, Family Income, by Poverty Level and Family Size, 1994	14
Table 8, Nonelderly Americans with Selected Combinations of Health Insurance in 1994 and 1995, by Age	15
Table 9, Nonelderly Americans with Selected Combinations of Health Insurance in 1994 and 1995, by Family Type	16
Table 10, Children with Selected Combinations of Health Insurance in 1994 and 1995, by Poverty Level and Age	16
Table 11, Cost of Different Copayment Designs—Individual Plan	20

Charts

Chart 1, Nonelderly Population, Employment-Based Coverage in 1994, Uninsured in 1995, by Family Income as a Percentage of the Federal Poverty Level	13
Chart 2, Percentage Who Lost Employment-Based Coverage Between 1994 and 1995, by Family Income as a Percentage of the Federal Poverty Level	13
Chart 3, Nonelderly Population, Employment-Based Coverage in 1994 and Uninsured in 1995, by Age ..	14
Chart 4, Percentage Who Lost Employment-Based Coverage Between 1994 and 1995	14
Chart 5, Nonelderly Population, Employment-Based Coverage in 1994 and Uninsured in 1995, by Family Type	15

Introduction

One area of interest currently in health reform is in making health insur-

ance more portable. Portability would allow workers and their families to change insurers without being subject to a new waiting period for preexisting conditions. **Two groups would benefit from improved portability: (1) individuals (and their dependents) who lose health insurance, either when they change jobs or when their employer stops offering coverage, and (2) individuals who remain in jobs because they have a preexisting condition that may not be covered by a prospective employer's health insurance plan.** It is important to know the impact of this legislation on the U.S. population. The U.S. General Accounting Office (GAO) has found that as many as 25 million Americans could benefit from broader national portability legislation (U.S. General Accounting Office, 1995). These 25 million Americans are in large part workers (or their dependents) who changed jobs, with over 50 percent maintaining employment-based health insurance. However, some of the 25 million Americans who could benefit from broader portability standards may not be affected by additional legislation because they may change to a new job with a health plan that may either be regulated by the state or may not have a preexisting condition exclusion.

It is important to understand the provisions of current portability legislation. **The Health Insurance Reform Act of 1995 (S. 1028), sponsored by Sens. Nancy Kassebaum (R-KS) and Edward Kennedy (D-MA), primarily addresses access to health insurance. This bill would reduce barriers to portability by limiting preexisting condition exclusions; guaranteeing access to private health insurance for individuals already covered by private health insurance; and guaranteeing renewal of health insurance, regardless of health**

status. The bill also preempts state laws that make it difficult (or impossible) for employer groups to form purchasing coalitions; requires equal insurance treatment of mental health services; and increases the deductibility of health insurance for the self-employed. As long as individuals are willing and able to pay for insurance, they would have access to insurance under the provisions in this bill. Insurers will be free to set premium rates for individuals who move from group coverage to individual coverage within the states' guidelines. While some states have very strict rate restrictions, others have practically no restrictions. Individuals who move from the group health insurance coverage market to the individual market may find health insurance affordable in states with strict rating restrictions,¹ but unaffordable in states without any rating restrictions. Individuals in states without any rating restrictions may find individual health insurance premium rates for a new policy as high as 200 percent to 300 percent above the standard risk rate in the individual insurance market (American Academy of Actuaries, 1996).

The legislation passed by the House of Representatives, the Health Coverage Availability and Affordability Act (H.R. 3103), not only addresses the issue of access to health insurance but also attempts to address the issue of affordability. This bill includes provisions for increases in the deductibility of health insurance for the self-employed, tax-preferred medical savings accounts (MSAs), medical malpractice reform, and small employer pooling in the form of multiple employer welfare arrangements (MEWAs). While this bill attempts to address affordability, it does not set rating restrictions, which states will still be free to impose as they see fit. Taken together, these bills may do little, or nothing, to significantly increase health care coverage. Final legislation as a result of conference agreements

¹ Rating restrictions do not hold down premium levels as much as they restrict the variation between the highest and lowest premium rates.

may not address all of these issues, but it is likely that future proposals may attempt to address those that are not included in this round of reform.

This *Issue Brief* provides summary data on the nation's insured and uninsured populations. It describes the characteristics of those whose health insurance status changed between 1994 and 1995. The report also presents the characteristics of groups that did not experience a change in insurance status. Finally, it includes a section on the implications of the current health care reform debate on the issues of access and affordability.

Data

The data for this *Issue Brief* come from the March 1995 supplement to the Current Population

Survey (CPS). The March CPS is conducted annually by the Census Bureau and provides an important source of information about the economic and health insurance status of the U.S. population. In March of each year, the survey includes supplemental questions relating to work experience, income, and receipt of noncash benefits during the previous year. The March 1995 survey, for example, questions individuals about their health insurance coverage throughout 1994. Assuming accurate responses were given, the uninsured should include only those individuals who were without health insurance for the entire 12 months. However, many researchers believe that the majority of respondents actually answer the health insurance questions with reference to a particular point in time. This opinion is based in large part on comparisons of the results of the CPS with those of other selected surveys.

The March 1995 CPS includes, for the first time, detailed questions on current health insurance status, i.e., individuals' health insurance status in March 1995. Respondents were asked if they had any health insurance plan during the week prior to the survey and were then asked

about the types of coverage. These questions are in addition to questions about the sources of health insurance coverage that an individual received in 1994.

The new questions in the March 1995 CPS on current health insurance have several advantages over previous years' surveys. First, complaints that individuals have not responded accurately to past CPS questions on their health insurance coverage in the year prior to the interview can be rectified. Comparisons of the CPS with surveys such as the Survey of Income and Program Participation (SIPP) and the National Medical Expenditure Survey (NMES) have shown that the annual uninsured estimates from the CPS more closely resemble point-in-time estimates. SIPP data from 1991 suggest that 7.0 percent of the total population (including the elderly) was uninsured for all 12 months. The CPS showed that 14.7 percent of the total population was uninsured during 1991. NMES data show that 11.0 percent of the nonelderly population was uninsured during 1987, compared with 15.9 percent in 1988 from the CPS. However, the March 1995 CPS shows that 15.3 percent of the total population was uninsured in 1994, and 23.7 percent was uninsured in the week prior to the interview in March 1995. It is important to distinguish time periods, because other surveys have shown a lower percentage of uninsured, using point-in-time estimates. SIPP has shown that 20.3 percent of the total population was uninsured during any point in time. The reference period for SIPP data is one month, while the reference period for the CPS is one week. More individuals would be expected to be uninsured during a full week than during a full month.

The second advantage of the new CPS questions is that they allow determination of whether individuals were covered by health insurance in 1994 and 1995. This makes it possible to describe changes in health insurance coverage, i.e., those individuals who gained health insurance coverage and those who lost it between 1994 and 1995. While the data do not indicate the duration of insured and uninsured spells, they can be useful in

determining the types of individuals most likely to experience a change in their health insurance status.

A number of shortcomings of the CPS point-in-time estimates should be pointed out. Data on the annual estimates of insurance coverage are subject to a detailed recoding process by the Census Bureau. Individuals who are eligible for Medicare and/or Medicaid are coded as having Medicare and/or Medicaid even if they do not report being covered by these programs. The Census Bureau uses information on sources of income to appropriately recode such individuals. For example, if an individual is aged 65 or over and receives Social Security income, that individual is automatically coded as having Medicare coverage. The Census Bureau was not able to process these recodes for the March 1995 point-in-time estimates because questions on sources of income were not asked for the March 1995 reference week. As a result, there is a potential underreporting of Medicare and Medicaid. In order to adjust for this underreporting, the Employee Benefit Research Institute (EBRI) counts those having Medicare during 1994 as being Medicare eligible in 1995. Correcting for Medicaid eligibility is trickier because individuals move on and off the Medicaid ranks during their lifetimes, whereas once individuals qualify for Medicare, they are usually Medicare eligible for the rest of their lives. Fortunately, the CPS provides duration data on Medicaid spells. The number of months an individual qualified for Medicaid in 1994 was reported, and this information was used to determine eligibility in March 1995. It is assumed that if an individual was eligible for Medicaid during all

12 months of 1994, that individual was still eligible for Medicaid in March 1995. This methodology risks counting individuals who are not eligible for Medicaid benefits as being eligible but also runs the risk of not counting individuals who are Medicaid eligible. As a result of these methodological changes, EBRI has found that 61.5 million people were without health insurance coverage during the reference week in March 1995, compared with an uncorrected number of 71.4 million (table 1).

Table 1
Nonelderly and Elderly Americans with Selected Sources
of Health Insurance, 1995
Employee Benefit Research Institute Analysis of the
March 1995 Current Population Survey

	Total Population		Nonelderly		Elderly	
	Actual	Corrected ^a	Actual	Corrected ^a	Actual	Corrected ^a
(millions)						
Total	259.3	259.3	228.1	228.1	31.2	31.2
Total private	160.4	160.4	143.2	143.2	17.2	17.2
employment based	135.4	135.4	127.3	127.3	8.1	8.1
direct	76.0	76.0	69.5	69.5	6.4	6.4
indirect	60.7	60.7	59.0	59.0	1.7	1.7
other private	27.7	27.7	17.6	17.6	10.1	10.1
direct	20.4	20.4	10.9	10.9	9.5	9.5
indirect	7.4	7.4	6.8	6.8	0.6	0.6
outside household	5.4	5.4	5.1	5.1	0.3	0.3
Total public	47.4	55.1	22.7	24.9	24.7	30.2
Medicare	27.5	33.9	3.3	3.7	24.2	30.2
Medicaid	17.0	19.2	15.4	17.2	1.6	2.0
CHAMPUS/CHAMPVA ^b	6.2	6.2	5.0	5.0	0.9	0.9
Uninsured	71.4	61.5	67.0	61.2	4.4	0.4
(percentage)						
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total private	61.9	61.9	62.8	62.8	55.1	55.1
employment based	52.2	52.2	55.8	55.8	25.9	25.9
direct	29.3	29.3	30.5	30.5	20.6	20.6
indirect	23.4	23.4	25.9	25.9	5.5	5.5
other private	10.7	10.7	7.7	7.7	32.3	32.3
direct	7.9	7.9	4.8	4.8	30.5	30.5
indirect	2.8	2.8	3.0	3.0	1.8	1.8
outside household	2.1	2.1	2.3	2.3	0.8	0.8
Total public	18.3	21.3	10.0	10.9	79.0	96.8
Medicare	10.6	13.1	1.4	1.6	77.5	96.5
Medicaid	6.6	7.4	6.8	7.6	5.2	6.4
CHAMPUS/CHAMPVA ^b	2.4	2.4	2.2	2.2	2.9	2.9
Uninsured	27.5	23.7	29.4	26.8	14.1	1.2

Note: Numbers may not sum correctly because individuals may receive coverage from more than one source.

^aCorrected for Medicare and Medicaid eligibility. Individuals are Medicare eligible if they were covered by Medicare at any time during 1994. Individuals are Medicaid eligible if they were covered by Medicaid during all 12 months of 1994.

^bCivilian Health and Medical Program of the Uniformed Services/Civilian Health and Medical Program of the Veterans Administration.

*127.3 million
nonelderly Americans,
or 55.8 percent, had
some form of
employment-based
health insurance.*

Current Sources of Coverage

health insurance status of the respondents during the reference period, and it is also the first CPS to ask respondents if they had any coverage during the reference period. As a result, the uninsured data are not calculated as a residual from the other health insurance questions.

Table 1 contains data from tabulations of the March 1995 CPS on sources of health insurance for the total U.S. population, the nonelderly, and the elderly.² Almost 97 percent of the elderly receive health insurance from Medicare; therefore, this report will focus on the nonelderly. The data in table 1 indicate that 127.3 million nonelderly Americans, or 55.8 percent, had some form of employment-based health insurance. Most of those reporting employment-based health insurance (30.5 percent) received direct coverage, i.e., coverage through their own employer. An additional 25.9 percent received employment-based coverage as dependents of someone else. Almost 18 million nonelderly Americans reported having private health insurance purchased directly from a health insurer. Previous estimates have been closer to 10 million, which is approximately equal to the number of nonelderly Americans with privately purchased health insurance in their own name.

According to EBRI tabulations, approximately 61.2 million nonelderly Americans, or 26.8 percent of that population, were uninsured during the reference week in March 1995. This number is in contrast to 50.7 million who lacked health insurance for at least one month during a 32-month period between 1991 and 1993 and 39.4 million individuals who were uninsured during the 1994 calendar year (Bennefield, 1995;

The March 1995 CPS is the first CPS to ask questions about the

Fronstin and Rheem, 1996).

Geographic region is an important factor determining sources of health insurance. Medicaid (and welfare) eligibility requirements differ by state, and many states have implemented some form of small group market reform. Some states have implemented guaranteed renewal and guaranteed issue of health insurance, laws that are intended to increase access to health insurance. Many states have put limits on insurers' ability to deny coverage for individuals with preexisting conditions. Some states have implemented rating restrictions, the most popular being the National Association of Insurance Commissioners' model, which limits the variation of premiums within and between classes. Less popular among the states have been alternative rating systems that limit use of risk factors but allow rates to vary with demographics and other factors; modified community rating, which puts limits on the factors that can be used in rating (usually allows rating variation based on age, geographic region, and family type); and community rating, which allows little or no variation in rates for any factor.

The states with the largest percentage of their population with employment-based health insurance include Wisconsin (71.7 percent), Delaware (68.2 percent), Maryland (66.6 percent), New Hampshire (66.1 percent), and Hawaii (66.0 percent) (table 2). The states with the smallest percentage of their population with employment-based health insurance include Mississippi (42.4 percent), New Mexico (42.8 percent), Louisiana (44.6 percent), Arizona (46.6 percent), and California (47.9 percent). These states also tend to have a higher percentage of uninsured, meaning Medicaid is not offsetting the lack of employment-based health insurance in these states.

Changes in Coverage

Reducing barriers to portability would primarily benefit workers

² This sample excludes active duty military and members of their family.

Table 2
Nonelderly Population with Selected Sources of Health Insurance, by Region and State, 1995
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

Region and State	Total	Total Private	Employment Based			Other Private			Total Public ^a	Medicaid ^a	Uninsured ^a
			Total	Direct	Indirect	Total	Direct	Indirect			
(millions)											
Total	228.1	143.2	127.3	69.5	59.0	17.6	10.9	6.8	24.9	17.2	61.2
New England	11.3	7.8	7.0	3.7	3.4	0.8	0.5	0.3	0.9	0.7	2.6
Maine	1.0	0.7	0.6	0.3	0.3	0.1	0.1	0.0	0.1	0.1	0.3
New Hampshire	1.0	0.7	0.6	0.3	0.3	0.1	0.0	0.0	0.1	0.0	0.2
Vermont	0.5	0.4	0.3	0.2	0.2	0.1	0.0	0.0	0.0	0.0	0.1
Massachusetts	5.2	3.6	3.2	1.7	1.5	0.4	0.2	0.2	0.4	0.3	1.2
Rhode Island	0.8	0.6	0.5	0.3	0.2	0.1	0.1	0.0	0.1	0.0	0.2
Connecticut	2.7	1.9	1.7	0.9	0.8	0.2	0.1	0.1	0.2	0.2	0.6
Middle Atlantic	33.0	20.9	18.8	10.2	8.7	2.4	1.5	0.9	3.7	3.0	8.5
New York	15.8	9.2	8.2	4.5	3.7	1.2	0.7	0.5	2.1	1.8	4.6
New Jersey	7.0	4.7	4.3	2.3	2.0	0.6	0.3	0.2	0.5	0.4	1.8
Pennsylvania	10.2	7.0	6.3	3.4	3.0	0.7	0.4	0.2	1.0	0.8	2.2
East North Central	38.3	26.6	24.0	12.5	11.8	3.1	1.8	1.3	3.9	3.0	8.0
Ohio	9.7	6.5	5.9	3.0	3.0	0.8	0.4	0.3	1.0	0.7	2.2
Indiana	5.3	3.9	3.3	1.8	1.6	0.7	0.4	0.4	0.4	0.3	1.0
Illinois	10.4	6.9	6.2	3.4	2.9	0.8	0.5	0.3	1.1	0.9	2.5
Michigan	8.4	5.9	5.3	2.7	2.7	0.6	0.3	0.3	1.1	0.8	1.6
Wisconsin	4.5	3.4	3.2	1.6	1.6	0.3	0.2	0.1	0.3	0.2	0.7
West North Central	15.5	11.1	9.5	5.1	4.5	1.7	1.0	0.7	1.4	0.9	3.1
Minnesota	4.0	3.0	2.6	1.4	1.3	0.3	0.2	0.1	0.3	0.2	0.8
Iowa	2.4	1.8	1.5	0.7	0.8	0.4	0.2	0.2	0.2	0.1	0.4
Missouri	4.3	3.0	2.7	1.5	1.2	0.3	0.2	0.1	0.5	0.3	0.9
North Dakota	0.5	0.4	0.3	0.2	0.2	0.1	0.1	0.0	0.0	0.0	0.1
South Dakota	0.6	0.5	0.4	0.2	0.2	0.1	0.1	0.0	0.1	0.0	0.1
Nebraska	1.4	1.1	0.9	0.5	0.4	0.2	0.1	0.1	0.1	0.0	0.2
Kansas	2.1	1.4	1.1	0.6	0.5	0.2	0.1	0.1	0.2	0.1	0.5
South Atlantic	39.9	25.0	22.3	12.9	9.6	3.1	2.1	1.0	4.6	2.7	10.7
Delaware	0.6	0.4	0.4	0.2	0.2	0.0	0.0	0.0	0.1	0.0	0.1
Maryland	4.4	3.2	2.9	1.6	1.3	0.3	0.3	0.1	0.4	0.2	0.8
District of Columbia	0.5	0.3	0.3	0.2	0.1	0.0	0.0	0.0	0.1	0.1	0.1
Virginia	5.7	3.9	3.6	2.0	1.6	0.3	0.2	0.1	0.6	0.2	1.3
West Virginia	1.5	0.9	0.8	0.4	0.4	0.1	0.0	0.0	0.2	0.2	0.4
North Carolina	5.8	3.8	3.4	2.1	1.3	0.5	0.3	0.1	0.7	0.4	1.4
South Carolina	3.3	1.9	1.7	1.0	0.7	0.2	0.2	0.0	0.3	0.2	1.1
Georgia	6.4	4.0	3.5	1.9	1.6	0.5	0.3	0.2	0.8	0.4	1.8
Florida	11.8	6.8	5.8	3.3	2.5	1.1	0.7	0.4	1.5	0.9	3.7
East South Central	14.0	8.7	7.6	4.2	3.5	1.2	0.8	0.4	1.8	1.2	3.6
Kentucky	3.3	2.1	1.9	1.0	0.9	0.3	0.2	0.1	0.5	0.3	0.8
Tennessee	4.7	3.2	2.8	1.6	1.2	0.5	0.3	0.1	0.7	0.4	0.8
Alabama	3.7	2.2	2.0	1.0	1.0	0.2	0.1	0.1	0.4	0.2	1.2
Mississippi	2.2	1.2	0.9	0.6	0.4	0.2	0.1	0.1	0.3	0.2	0.8
West South Central	25.8	14.0	12.4	6.8	5.8	1.7	1.0	0.7	2.5	1.7	9.2
Arkansas	2.1	1.2	1.1	0.6	0.5	0.2	0.1	0.1	0.2	0.1	0.6
Louisiana	3.9	2.0	1.7	0.9	0.9	0.3	0.2	0.1	0.5	0.4	1.4
Oklahoma	2.7	1.6	1.4	0.8	0.6	0.2	0.2	0.1	0.3	0.1	0.9
Texas	17.1	9.2	8.2	4.5	3.8	1.1	0.6	0.5	1.5	1.1	6.3
Mountain	13.7	8.5	7.4	4.0	3.5	1.1	0.7	0.4	1.2	0.5	4.1
Montana	0.7	0.5	0.4	0.2	0.2	0.1	0.1	0.0	0.1	0.0	0.2
Idaho	1.0	0.7	0.6	0.3	0.3	0.1	0.1	0.1	0.1	0.0	0.3
Wyoming	0.4	0.3	0.2	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.1
Colorado	3.3	2.3	1.9	1.0	0.9	0.3	0.2	0.1	0.2	0.1	0.8
New Mexico	1.5	0.7	0.6	0.3	0.3	0.1	0.0	0.0	0.2	0.1	0.6
Arizona	3.7	1.9	1.7	1.0	0.7	0.2	0.1	0.1	0.4	0.2	1.4
Utah	1.7	1.2	1.1	0.4	0.6	0.1	0.1	0.1	0.1	0.0	0.5
Nevada	1.3	0.9	0.8	0.5	0.4	0.1	0.1	0.0	0.1	0.0	0.3

(continued)

Table 2 (continued)

Region and State	Total	Total Private	Employment Based			Other Private			Total Public ^a	Medicaid ^a	Uninsured ^a
			Total	Direct	Indirect	Total	Direct	Indirect			
(millions)											
Pacific	36.7	20.6	18.3	10.2	8.3	2.5	1.5	1.0	4.8	3.7	11.3
Washington	4.6	3.0	2.5	1.4	1.1	0.5	0.3	0.3	0.4	0.3	1.1
Oregon	2.8	1.8	1.6	0.9	0.7	0.2	0.1	0.1	0.3	0.1	0.8
California	27.9	14.9	13.4	7.4	6.1	1.7	1.0	0.7	3.9	3.2	9.1
Alaska	0.5	0.3	0.3	0.2	0.1	0.0	0.0	0.0	0.1	0.0	0.1
Hawaii	0.9	0.6	0.6	0.4	0.2	0.1	0.0	0.0	0.1	0.0	0.2
(percentage within state and region categories)											
Total	100.0%	62.8%	55.8%	30.5%	25.9%	7.7%	4.8%	3.0%	10.9%	7.6%	26.8%
New England	100.0	68.9	62.1	32.8	29.9	7.2	4.5	2.7	8.4	5.8	22.9
Maine	100.0	64.9	56.4	29.3	27.4	9.4	5.8	3.6	9.3	5.4	24.9
New Hampshire	100.0	73.0	66.1	34.9	31.3	6.9	5.1	1.8	7.6	4.1	19.8
Vermont	100.0	73.7	64.9	34.3	30.7	9.9	6.5	3.3	8.3	6.2	17.8
Massachusetts	100.0	68.3	61.2	32.1	29.3	7.0	4.0	3.0	8.3	5.9	23.5
Rhode Island	100.0	70.6	63.0	33.2	30.3	9.5	7.6	1.9	8.1	4.7	21.9
Connecticut	100.0	68.5	63.6	34.5	31.2	5.7	3.4	2.3	8.7	6.6	23.2
Middle Atlantic	100.0	63.3	57.0	31.0	26.5	7.2	4.4	2.9	11.3	9.2	25.8
New York	100.0	58.3	52.1	28.8	23.7	7.4	4.4	3.0	13.5	11.5	29.1
New Jersey	100.0	67.2	61.2	33.1	28.9	8.1	4.8	3.3	7.7	5.7	25.3
Pennsylvania	100.0	68.3	61.7	33.0	29.1	6.4	4.1	2.4	10.3	7.9	21.2
East North Central	100.0	69.4	62.5	32.6	30.7	8.2	4.7	3.5	10.2	7.9	20.9
Ohio	100.0	66.9	60.9	30.7	30.6	7.8	4.6	3.2	10.4	7.4	22.9
Indiana	100.0	72.4	61.8	33.7	29.2	13.5	6.6	6.8	7.8	6.1	19.5
Illinois	100.0	66.5	59.7	32.6	27.9	7.8	5.0	2.8	10.6	8.7	23.5
Michigan	100.0	70.1	63.4	32.0	32.3	7.1	3.9	3.1	12.7	9.9	18.8
Wisconsin	100.0	77.1	71.7	36.4	36.4	5.8	3.7	2.1	7.3	5.2	15.9
West North Central	100.0	72.0	61.4	32.9	29.1	10.9	6.6	4.3	9.0	5.5	20.1
Minnesota	100.0	73.4	64.6	34.4	31.3	8.1	5.3	2.8	7.8	5.3	19.1
Iowa	100.0	76.0	61.5	30.4	31.5	15.6	8.2	7.7	6.9	4.5	18.0
Missouri	100.0	68.4	61.8	35.7	26.7	6.8	4.6	2.2	11.3	7.7	21.4
North Dakota	100.0	77.2	60.0	30.0	30.4	18.1	11.1	7.0	7.9	3.6	16.6
South Dakota	100.0	72.9	59.5	28.0	31.5	16.6	10.5	6.1	10.5	3.7	20.5
Nebraska	100.0	76.7	61.7	31.4	30.5	16.3	9.6	6.7	8.5	3.4	17.0
Kansas	100.0	67.9	54.8	30.3	24.7	11.7	7.1	4.6	9.0	5.0	24.3
South Atlantic	100.0	62.7	55.9	32.3	24.1	7.7	5.2	2.6	11.6	6.7	26.7
Delaware	100.0	71.5	68.2	39.9	28.6	4.2	2.9	1.3	9.5	4.6	20.5
Maryland	100.0	74.0	66.6	37.0	29.9	7.4	5.9	1.6	9.7	5.7	17.5
District of Columbia	100.0	55.3	49.3	35.7	13.7	6.3	5.4	1.0	18.6	15.0	26.3
Virginia	100.0	67.9	62.3	35.4	27.2	5.8	3.7	2.1	10.6	4.2	22.9
West Virginia	100.0	56.5	52.1	29.0	23.4	4.6	2.9	1.8	14.0	10.1	29.2
North Carolina	100.0	65.2	58.6	36.6	23.1	8.3	5.9	2.5	11.3	6.2	23.7
South Carolina	100.0	57.2	51.5	30.3	22.1	5.9	4.7	1.5	10.7	7.5	33.5
Georgia	100.0	61.9	55.4	30.2	25.6	8.2	4.7	3.5	11.9	6.9	27.5
Florida	100.0	57.6	49.2	28.4	21.0	9.4	6.1	3.3	12.5	7.5	31.2
East South Central	100.0	61.7	54.2	30.1	24.7	8.3	5.4	2.8	13.2	8.2	25.9
Kentucky	100.0	63.7	57.5	31.2	26.5	7.8	4.9	2.9	13.9	10.4	23.6
Tennessee	100.0	67.7	58.9	33.6	26.2	10.1	7.1	3.0	14.6	8.0	17.4
Alabama	100.0	58.3	52.3	27.0	26.0	5.5	3.4	2.1	9.5	5.6	33.1
Mississippi	100.0	51.9	42.4	26.4	16.6	9.7	6.1	3.6	15.2	10.0	35.0
West South Central	100.0	54.5	48.3	26.2	22.5	6.8	4.1	2.7	9.7	6.5	35.8
Arkansas	100.0	59.8	52.3	31.2	22.2	8.0	5.2	2.9	10.0	3.4	30.1
Louisiana	100.0	51.3	44.6	22.7	22.2	8.2	4.8	3.4	13.7	10.6	36.5
Oklahoma	100.0	58.7	51.0	28.1	23.3	7.8	5.7	2.1	9.4	4.8	32.3
Texas	100.0	53.9	48.3	26.1	22.5	6.2	3.5	2.7	8.7	6.2	36.9
Mountain	100.0	61.9	53.9	28.9	25.6	8.0	5.1	3.0	8.5	4.0	30.2
Montana	100.0	69.1	56.7	27.1	30.3	12.1	7.0	5.1	8.6	4.3	23.3
Idaho	100.0	67.9	56.8	29.5	27.7	12.5	6.8	5.6	8.2	4.9	24.7

(continued)

Table 2 (continued)

Region and State	Total	Total Private	Employment Based			Other Private			Total Public ^a	Medicaid ^a	Uninsured ^a
			Total	Direct	Indirect	Total	Direct	Indirect			
(percentage within state and region categories)											
Wyoming	100.0%	62.8%	50.7%	25.6%	25.3%	12.7%	7.3%	5.5%	6.4%	2.9%	31.3%
Colorado	100.0	69.1	58.0	31.5	27.0	10.4	7.2	3.2	7.2	3.0	25.1
New Mexico	100.0	46.6	42.8	22.6	21.0	3.9	2.9	1.1	15.1	7.8	39.1
Arizona	100.0	52.8	46.6	28.1	19.2	5.5	4.0	1.6	9.7	4.5	37.4
Utah	100.0	69.1	62.0	25.6	36.6	7.6	3.5	4.1	3.9	1.6	26.4
Nevada	100.0	68.0	63.1	37.8	26.8	6.7	4.0	2.7	7.6	3.3	25.7
Pacific	100.0	56.2	49.9	27.8	22.6	6.8	4.1	2.8	13.1	10.0	30.8
Washington	100.0	65.8	54.0	30.1	24.6	11.7	6.3	5.5	9.4	6.4	23.8
Oregon	100.0	64.0	57.1	31.9	26.1	6.5	4.2	2.2	9.8	3.6	27.5
California	100.0	53.3	47.9	26.5	21.8	6.0	3.6	2.4	14.1	11.5	32.7
Alaska	100.0	60.9	55.6	31.5	24.7	5.1	2.9	2.1	14.8	4.8	26.8
Hawaii	100.0	71.7	66.0	41.7	25.0	9.5	5.9	4.0	8.0	4.2	19.6

Note: Numbers may not sum correctly because individuals may receive coverage from more than one source.

^a Corrected for Medicare and Medicaid eligibility. Individuals are Medicare eligible if they were covered by Medicare at any time during 1994. Individuals are Medicaid eligible if they were covered by Medicaid during all 12 months of 1994.

(and their families) who change jobs and, as a result, potentially have their health insurance status affected. The March 1995 CPS allows us to determine the number of individuals who lost their employment-based health insurance between 1994 and March 1995. These individuals may have changed jobs or may be dependents of a policyholder who changed jobs or lost his or her health insurance coverage. **EBRI tabulations indicate that 19.5 million nonelderly Americans had employment-based health insurance in 1994 and were uninsured in 1995 (table 3). This represents 8.5 percent of the nonelderly population. Over 121 million nonelderly Americans (53.1 percent) had employment-based health insurance in both 1994 and March 1995, 34.5 million were uninsured during both periods, and 3.7 million were uninsured in 1994 and had employment-based health insurance in March 1995. An additional 49.3 million (21.6 percent) experienced some other combination of health insurance change.**³

Work Status

An important determinant of health insurance changes is work status. **Over 80 percent of those who had employment-based health insurance in 1994 and were uninsured in 1995 were in a family whose head of household was a full-year, full-time worker**

(table 3). However, most of those with insurance changes would be expected to have a full-year, full-time worker as the head of the family because 71.6 percent of all nonelderly have a family head working full-year, full-time. The most likely group to experience a loss of employment-based health insurance between 1994 and March 1995 were individuals whose family head was a full-year worker with some unemployment (10.7 percent).

Workers

Workers were more likely than the general nonelderly population to lose employment-based health insurance between 1994 and March 1995 (table 4). Almost 9 percent of workers lost health insurance coverage, compared with 8.5 percent for the nonelderly population. **The most likely workers to lose health insurance between 1994 and March 1995 were the self-employed (9.3 percent) and those employed in construction (9.6 percent); manufacturing (9.4 percent); wholesale trade (9.9 percent); retail trade (9.3 percent); finance, insurance, and real estate (9.7 percent); and business and repair services (9.1 percent).** Workers employed in firms with between 100 and 999 workers were most likely to have lost employment-based health insurance between 1994 and March 1995 (table 5).

Family Income

Typically, income is highly related to health insurance coverage. In general, individuals with higher levels of

³ These combinations include those who had public insurance during both periods; those who had private insurance purchased directly from a health insurer in both periods; and those who experienced any movement onto or off of public insurance, such as Medicaid, or any movement onto or off of private health insurance purchased directly from a health insurer.

Table 3
**Nonelderly Population with Selected Combinations of Health Insurance in 1994 and 1995,
by Own Work Status and Work Status of Family Head in 1994**
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

Work Status	Total	Employment Based in 1994 and 1995	Uninsured in 1994 and 1995	Employment Based in 1994 and Uninsured in 1995	Uninsured in 1994 and Employment Based in 1995	Other Combination
(millions)						
Total	228.1	121.1	34.5	19.5	3.7	49.3
Own Work Status						
Child	69.5	33.2	8.5	6.1	1.0	20.7
Family head worker	79.7	48.9	12.3	6.6	1.5	10.5
Other worker	49.3	30.2	7.3	4.9	0.9	5.9
Nonworker	29.6	8.7	6.5	1.8	0.3	12.2
Work Status of Family Head						
Full-year, full-time worker	163.4	106.4	19.0	15.7	2.8	19.5
Full-year, part-time worker	11.4	3.8	2.9	0.8	0.2	3.7
Full-year, some unemployment	16.2	4.9	4.3	1.7	0.4	4.9
Part-year worker	11.2	2.7	2.7	0.7	0.2	5.0
Nonworker	25.8	3.4	5.6	0.6	0.2	16.1
(percentage within coverage categories)						
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Own Work Status						
Child	30.5	27.4	24.5	31.5	27.5	42.0
Family head worker	35.0	40.4	35.6	33.8	39.0	21.3
Other worker	21.6	25.0	21.1	25.4	25.3	11.9
Nonworker	13.0	7.2	18.9	9.3	8.2	24.9
Work Status of Family Head						
Full-year, full-time worker	71.6	87.9	55.1	80.6	74.0	39.6
Full-year, part-time worker	5.0	3.1	8.4	4.1	5.9	7.6
Full-year, some unemployment	7.1	4.0	12.5	8.9	9.6	10.0
Part-year worker	4.9	2.2	7.7	3.5	5.3	10.1
Nonworker	11.3	2.8	16.2	2.9	5.3	32.6
(percentage within work status categories)						
Total	100.0%	53.1%	15.1%	8.5%	1.6%	21.6%
Own Work Status						
Child	100.0	47.8	12.2	8.8	1.5	29.8
Family head worker	100.0	61.4	15.4	8.3	1.8	13.2
Other worker	100.0	61.4	14.8	10.0	1.9	11.9
Nonworker	100.0	29.5	22.0	6.1	1.0	41.3
Work Status of Family Head						
Full-year, full-time worker	100.0	65.1	11.6	9.6	1.7	11.9
Full-year, part-time worker	100.0	33.0	25.4	7.1	1.9	32.7
Full-year, some unemployment	100.0	30.0	26.7	10.7	2.2	30.5
Part-year worker	100.0	23.8	23.7	6.1	1.8	44.6
Nonworker	100.0	13.1	21.7	2.2	0.8	62.2

Table 4
**Workers Aged 18–64 with Selected Combinations of Health Insurance in 1994 and 1995,
by Industry of Primary Employment in 1994**
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

Industry	Total	Employment Based in 1994 and 1995	Uninsured in 1994 and 1995	Employment Based in 1994 and Uninsured in 1995	Uninsured in 1994 and Employment Based in 1995	Other Combination
(millions)						
Total	129.0	79.2	19.6	11.5	2.4	16.3
Self-Employed	12.6	4.9	2.7	1.2	0.2	3.6
Wage and Salary Workers	116.5	74.2	16.9	10.4	2.2	12.7
Government	19.6	15.1	1.1	1.6	0.2	1.6
Agriculture	2.2	0.8	0.8	0.2	0.0	0.4
Mining	0.6	0.5	0.1	0.1	0.0	0.0
Construction	5.9	2.7	1.8	0.6	0.1	0.7
Manufacturing	20.5	14.7	2.2	1.9	0.3	1.3
Transportation, communications, and utilities	6.7	4.8	0.8	0.6	0.1	0.5
Wholesale	4.4	3.0	0.6	0.4	0.1	0.4
Retail	19.6	9.7	4.5	1.8	0.5	3.1
Finance, insurance, and real estate	7.0	5.1	0.5	0.7	0.1	0.6
Business and repair services	6.3	3.1	1.5	0.6	0.2	1.0
Personal services	3.8	1.5	1.1	0.3	0.1	0.7
Entertainment and recreation services	1.7	0.9	0.3	0.1	0.0	0.3
Professional services	18.0	12.3	1.7	1.6	0.4	2.1
(percentage within coverage categories)						
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Self-Employed	9.7	6.2	13.6	10.1	8.3	22.1
Wage and Salary Workers	90.3	93.8	86.4	89.9	91.7	77.9
Government	15.2	19.1	5.4	13.7	8.8	10.0
Agriculture	1.7	1.0	4.2	1.4	1.7	2.6
Mining	0.5	0.6	0.3	0.4	0.2	0.1
Construction	4.6	3.4	9.2	4.9	5.8	4.4
Manufacturing	15.9	18.6	11.3	16.7	14.0	7.7
Transportation, communications, and utilities	5.2	6.1	3.9	5.0	5.4	2.8
Wholesale	3.4	3.7	2.8	3.8	3.6	2.3
Retail	15.2	12.3	23.0	15.8	20.2	19.0
Finance, insurance, and real estate	5.4	6.4	2.7	5.9	4.7	3.9
Business and repair services	4.9	3.9	7.5	5.0	6.6	6.2
Personal services	2.9	1.9	5.8	2.6	4.2	4.5
Entertainment and recreation services	1.3	1.2	1.6	1.1	1.9	1.6
Professional services	14.0	15.6	8.7	13.5	14.6	12.7
(percentage within industry categories)						
Total	100.0%	61.4%	15.2%	8.9%	1.9%	12.7%
Self-Employed	100.0	39.3	21.2	9.3	1.6	28.7
Wage and Salary Workers	100.0	63.8	14.5	8.9	1.9	10.9
Government	100.0	77.1	5.4	8.1	1.1	8.3
Agriculture	100.0	34.8	36.8	7.0	1.9	19.4
Mining	100.0	77.7	10.3	7.9	0.6	3.5
Construction	100.0	45.2	30.6	9.6	2.4	12.3
Manufacturing	100.0	71.9	10.8	9.4	1.6	6.2
Transportation, communications, and utilities	100.0	71.5	11.3	8.5	1.9	6.7
Wholesale	100.0	67.1	12.5	9.9	2.0	8.5
Retail	100.0	49.5	22.9	9.3	2.5	15.8
Finance, insurance, and real estate	100.0	72.2	7.4	9.7	1.6	9.1
Business and repair services	100.0	49.0	23.4	9.1	2.5	16.0
Personal services	100.0	40.0	29.8	7.9	2.7	19.6
Entertainment and recreation services	100.0	55.2	18.5	7.8	2.7	15.7
Professional services	100.0	68.5	9.4	8.6	1.9	11.6

Table 5
**Workers Aged 18–64 with Selected Combinations of Health Insurance in 1994 and 1995,
 by Firm Size of Primary Employment in 1994**
 Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

Industry	Total	Employment Based in 1994 and 1995	Uninsured in 1994 and 1995	Employment Based in 1994 and Uninsured in 1995	Uninsured in 1994 and Employment Based in 1995	Other Combination
(millions)						
Total	129.0	79.2	19.6	11.5	2.4	16.3
Self-Employed	12.6	4.9	2.7	1.2	0.2	3.6
Wage and Salary Workers	116.4	74.2	16.9	10.4	2.2	12.7
Public sector	19.6	15.1	1.1	1.6	0.2	1.6
Private sector	96.8	59.1	15.8	8.8	2.0	11.1
fewer than 10 employees	14.8	5.8	4.6	1.2	0.3	2.9
10–24 employees	10.5	5.0	2.6	0.9	0.3	1.7
25–99 employees	14.8	8.8	2.7	1.3	0.3	1.7
100–499 employees	15.7	10.4	2.0	1.6	0.3	1.5
500–999 employees	6.2	4.3	0.6	0.7	0.1	0.5
1,000 or more employees	34.8	24.9	3.3	3.1	0.6	2.9
(percentage within coverage categories)						
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Self-Employed	9.7	6.2	13.6	10.1	8.3	22.1
Wage and Salary Workers	90.3	93.8	86.4	89.9	91.7	77.9
Public sector	15.2	19.1	5.4	13.7	8.8	10.0
Private sector	75.1	74.7	81.0	76.1	82.9	67.9
fewer than 10 employees	11.5	7.3	23.4	10.6	12.7	18.0
10–24 employees	8.1	6.3	13.1	8.1	14.4	10.2
25–99 employees	11.5	11.1	14.1	10.9	14.1	10.4
100–499 employees	12.2	13.1	10.3	13.5	11.1	8.9
500–999 employees	4.8	5.4	3.2	5.8	4.9	2.9
1,000 or more employees	27.0	31.4	16.9	27.2	25.7	17.6
(percentage within firm size categories)						
Total	100.0%	61.4%	15.2%	8.9%	1.9%	12.7%
Self-Employed	100.0	39.3	21.2	9.3	1.6	28.7
Wage and Salary Workers	100.0	63.8	14.5	8.9	1.9	10.9
Public sector	100.0	77.1	5.4	8.1	1.1	8.3
Private sector	100.0	61.1	16.3	9.1	2.1	11.5
fewer than 10 employees	100.0	39.0	30.9	8.3	2.1	19.9
10–24 employees	100.0	47.5	24.4	8.9	3.3	15.9
25–99 employees	100.0	59.3	18.5	8.5	2.3	11.5
100–499 employees	100.0	66.3	12.8	10.0	1.7	9.3
500–999 employees	100.0	69.5	10.2	10.7	1.9	7.6
1,000 or more employees	100.0	71.5	9.5	9.0	1.8	8.3

income are more likely to have employment-based coverage, while those with lower levels of income are more likely to be covered by government-sponsored plans. However, **individuals with income above 200 percent of the poverty level comprised the majority (73 percent) of those who had employment-based health insurance in 1994 and were uninsured in March 1995** (chart 1). The data also show that individuals with family income between 150 percent and 199 percent of the poverty level were the most likely to lose employment-based health insurance

between 1994 and March 1995 (10.7 percent), followed by those with family income between 200 percent and 399 percent of the poverty level (10.0 percent), and those with family income at or above 400 percent of the poverty level (9.2 percent) (chart 2). Low income individuals were most likely to experience some other combination of health insurance coverage (table 6).

The level of family income that corresponds to the poverty level varies by family size. For example, in 1994, the poverty threshold for a family of three was \$11,817, while the poverty level for a family of four was

Chart 1
Nonelderly Population, Employment-Based Coverage in 1994, Uninsured in 1995, by Family Income as a Percentage of the Federal Poverty Level
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

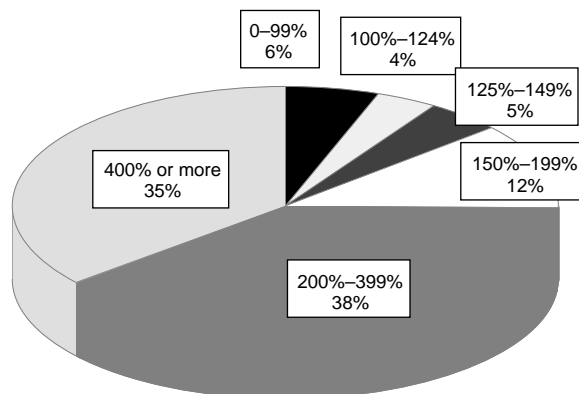


Chart 2
Percentage Who Lost Employment-Based Coverage Between 1994 and 1995, by Family Income as a Percentage of the Federal Poverty Level, Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

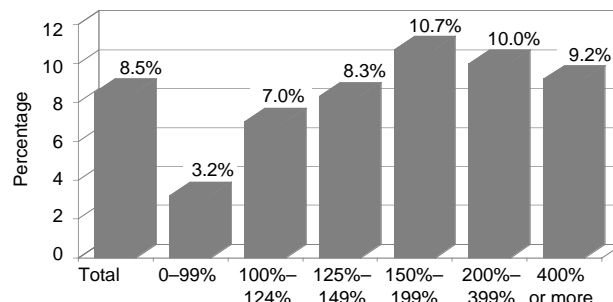


Table 6
Nonelderly Americans with Selected Combinations of Health Insurance in 1994 and 1995, by Family Income as a Percentage of the Poverty Level in 1994
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

Family Income as a Percentage of the Poverty Level	Total	Employment Based in 1994 and 1995	Uninsured in 1994 and 1995	Employment Based in 1994 and Uninsured in 1995	Uninsured in 1994 and Employment Based in 1995	Other Combination
(millions)						
Total	228.1	121.1	34.5	19.5	3.7	49.3
0-99%	34.7	2.9	10.3	1.1	0.5	20.0
100%-124%	10.1	2.1	3.1	0.7	0.2	3.9
125%-149%	10.5	3.1	3.1	0.9	0.3	3.1
150%-199%	21.1	8.5	5.1	2.3	0.5	4.8
200%-399%	74.8	46.6	9.1	7.5	1.3	10.3
400% or More	76.8	57.9	3.9	7.0	1.0	7.0
(percentage within coverage categories)						
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
0-99%	15.2	2.4	29.7	5.7	12.3	40.6
100%-124%	4.4	1.7	9.0	3.6	5.7	8.0
125%-149%	4.6	2.6	8.9	4.5	8.0	6.4
150%-199%	9.3	7.0	14.7	11.6	12.5	9.8
200%-399%	32.8	38.5	26.5	38.5	34.4	20.9
400% or More	33.7	47.8	11.2	36.1	27.1	14.3
(percentage within poverty status categories)						
Total	100.0%	53.1%	15.1%	8.5%	1.6%	21.6%
0-99%	100.0	8.3	29.6	3.2	1.3	57.6
100%-124%	100.0	20.9	30.8	7.0	2.1	39.2
125%-149%	100.0	29.5	29.3	8.3	2.8	30.0
150%-199%	100.0	40.2	24.0	10.7	2.2	22.9
200%-399%	100.0	62.3	12.2	10.0	1.7	13.8
400% or More	100.0	75.4	5.0	9.2	1.3	9.1

Table 7
Family Income, by Poverty Level and Family Size, 1994

Family Income as a Percentage of the Poverty Level	Family Size					
	Two Persons	Three Persons	Four Persons	Five Persons	Six Persons	Seven Persons
100%	\$ 9,977	\$11,817	\$15,141	\$17,896	\$20,223	\$22,956
125%	12,471	14,771	18,926	22,370	25,279	28,695
150%	14,966	17,726	22,712	26,844	30,335	34,434
200%	19,954	23,634	30,282	35,792	40,446	45,912
300%	29,931	35,451	45,423	53,688	60,669	68,868
400%	39,908	47,268	60,564	71,584	80,892	91,824

Source: Employee Benefit Research Institute estimates based on preliminary data in U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin Annual Statistical Supplement, 1995* (Washington, DC: U.S. Government Printing Office, 1995).

\$15,141. While it appears as though most individuals are in families with income above 200 percent of the poverty level, this translates into a wide range of income levels. A two person family is counted as having family income of 200 percent of the poverty level if their income is at least \$19,954 (table 7). However, a four person family would have to have family income of \$30,282 in order to be at 200 percent of the poverty level. In fact, the range of income levels for families with two to seven persons is \$19,954 to \$91,824 in order to be in the 200 percent to 400 percent range of the poverty level.

Age

Individuals under age 18 comprised the largest proportion of the uninsured in March 1995 who had had employment-based health insurance in 1994 (chart 3). Children under age 18 also had an above average chance of having had employment-based health insurance in 1994 and being uninsured in March 1995 (chart 4). However, individuals aged 18–24 had the

highest probability (9.0 percent) of having had employment-based health insurance in 1994 and being uninsured in March 1995 (chart 4). It is likely that many of these individuals were students who did not qualify for coverage under their parents' health insurance plan. Individuals aged 55–64 were least likely to experience a movement from employment-based health insurance to being uninsured between 1994 and March 1995 (table 8).

Family Type

Married individuals comprised the majority (76.6 percent) of those individuals who had employment-based health insurance in 1994 and were uninsured in March 1995 (chart 5). Married individuals were also most likely to lose employment-based health insurance between 1994 and March 1995 (table 9). However, single individuals were least likely to have employment-based health insurance in both 1994 and March 1995, and were most likely to have experienced some other combination of health insurance in 1994 and March 1995.

Chart 3
Nonelderly Population, Employment-Based Coverage in 1994 and Uninsured in 1995, by Age
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

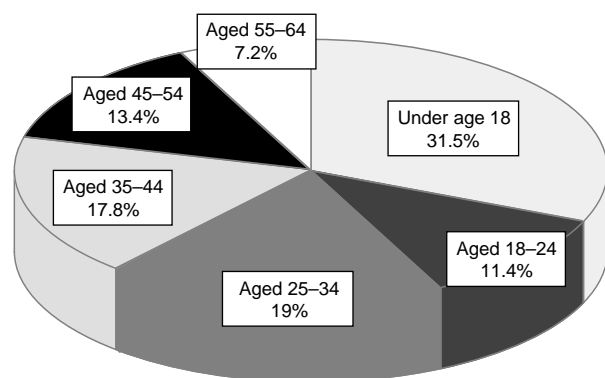


Chart 4
Percentage Who Lost Employment-Based Coverage Between 1994 and 1995, by Age
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

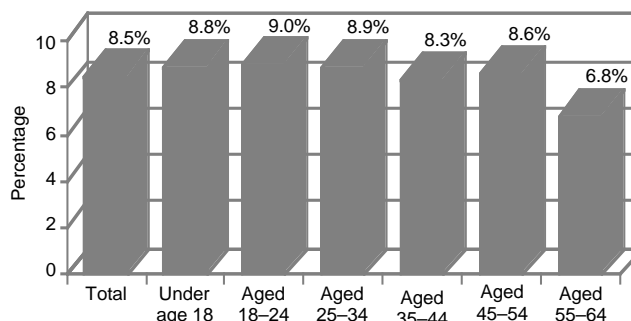


Table 8
Nonelderly Americans with Selected Combinations of Health Insurance in 1994 and 1995, by Age
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

Age	Total	Employment Based in 1994 and 1995	Uninsured in 1994 and 1995	Employment Based in 1994 and Uninsured in 1995	Uninsured in 1994 and Employment Based in 1995	Other Combination
(millions)						
Total	228.1	121.1	34.5	19.5	3.7	49.3
Under age 18	69.5	33.2	8.5	6.1	1.0	20.7
18-24	24.8	10.0	6.0	2.2	0.5	6.0
25-34	40.6	21.9	8.1	3.6	0.9	6.2
35-44	41.9	25.4	6.0	3.5	0.7	6.4
45-54	30.6	19.4	3.4	2.6	0.4	4.8
55-64	20.7	11.3	2.5	1.4	0.2	5.2
(percentage within age categories)						
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under age 18	30.5	27.4	24.5	31.5	27.5	42.0
18-24	10.9	8.3	17.5	11.4	13.2	12.3
25-34	17.8	18.1	23.4	18.6	23.5	12.6
35-44	18.3	20.9	17.4	17.8	17.8	12.9
45-54	13.4	16.0	9.9	13.4	12.0	9.7
55-64	9.1	9.3	7.4	7.2	6.0	10.6
(percentage within age categories)						
Total	100.0%	53.1%	15.1%	8.5%	1.6%	21.6%
Under age 18	100.0	47.8	12.2	8.8	1.5	29.8
18-24	100.0	40.4	24.3	9.0	2.0	24.3
25-34	100.0	53.8	19.9	8.9	2.2	15.2
35-44	100.0	60.6	14.3	8.3	1.6	15.2
45-54	100.0	63.3	11.1	8.6	1.5	15.6
55-64	100.0	54.6	12.3	6.8	1.1	25.2

Children

Almost 9 percent of all children—or 6.1 million children—were uninsured in March 1995 after being covered by an employment-based health plan in 1994 (table 10). Not surprising, there is a positive relationship between family income and whether a child had employment-based health insurance in both 1994 and March 1995. However, children with family income of at least 150 percent of the poverty level were the most likely to be uninsured in March 1995 after having employment-based health insurance in 1994.

Policy Implications

The main purpose of current health reform legislation is to reduce barriers to portability of health insurance for individuals who have established a history of prior health insurance coverage. In order to reduce barriers to obtaining health insurance, the legislation passed in the Senate sets out a number of

provisions. First, the legislation limits preexisting condition exclusions. The legislation prohibits health plans and employers from denying coverage for more than 12 months for preexisting conditions. A medical condition must have been diagnosed or treated during

Chart 5
Nonelderly Population, Employment-Based Coverage in 1994 and Uninsured in 1995, by Family Type
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

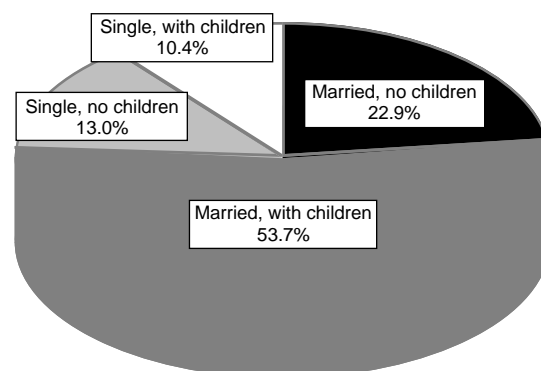


Table 9
Nonelderly Americans with Selected Combinations of Health Insurance in 1994 and 1995, by Family Type
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

Family Type	Total	Employment Based in 1994 and 1995	Uninsured in 1994 and 1995	Employment Based in 1994 and Uninsured in 1995	Uninsured in 1994 and Employment Based in 1995	Other Combination
(millions)						
Total	228.1	121.1	34.5	19.5	3.7	49.3
Married, No Children	52.1	31.7	6.9	4.5	0.9	8.1
Married, with Children	103.7	63.8	11.9	10.5	1.5	16.0
Single, No Children	40.6	17.5	10.3	2.5	0.7	9.5
Single, with Children	31.7	8.1	5.3	2.0	0.6	15.7
(percentage within coverage categories)						
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Married, No Children	22.8	26.1	20.1	22.9	25.5	16.4
Married, with Children	45.4	52.7	34.6	53.7	39.9	32.4
Single, No Children	17.8	14.5	29.9	13.0	19.5	19.3
Single, with Children	13.9	6.7	15.5	10.4	15.1	31.9
(percentage within family type categories)						
Total	100.0%	53.1%	15.1%	8.5%	1.6%	21.6%
Married, No Children	100.0	60.8	13.3	8.6	1.8	15.5
Married, with Children	100.0	61.5	11.5	10.1	1.4	15.4
Single, No Children	100.0	43.1	25.4	6.2	1.8	23.4
Single, with Children	100.0	25.6	16.8	6.4	1.8	49.5

Table 10
Children with Selected Combinations of Health Insurance in 1994 and 1995, by Poverty Level and Age
Employee Benefit Research Institute Analysis of the March 1995 Current Population Survey

Poverty Level and Age	Total	Employment Based in 1994 and 1995	Uninsured in 1994 and 1995	Employment Based in 1994 and Uninsured in 1995	Uninsured in 1994 and Employment Based in 1995	Other Combination
(millions)						
Total	69.5	33.2	8.5	6.1	1.1	20.7
Infants	3.8	1.5	0.4	0.3	0.2	1.3
Aged 1-5	20.2	8.8	2.3	1.7	0.3	7.1
Aged 6-12	26.8	13.2	3.2	2.4	0.3	7.6
Aged 13-17	18.6	9.6	2.5	1.7	0.2	4.6
0-99% of Poverty	15.7	1.1	3.2	0.4	0.2	10.8
Infants	0.9	0.0	0.2	0.0	0.0	0.7
Aged 1-5	5.3	0.3	0.8	0.1	0.0	4.0
Aged 6-12	6.0	0.4	1.2	0.2	0.1	4.1
Aged 13-17	3.5	0.3	1.0	0.1	0.0	2.0
100%-149% of Poverty	7.8	2.1	1.7	0.6	0.3	3.2
Infants	0.5	0.1	0.1	0.0	0.1	0.2
Aged 1-5	2.5	0.6	0.5	0.2	0.1	1.1
Aged 6-12	2.9	0.8	0.6	0.2	0.1	1.2
Aged 13-17	1.9	0.5	0.5	0.2	0.0	0.7
150%-199% of Poverty	7.4	3.1	1.3	1.0	0.1	1.9
Infants	0.4	0.1	0.1	0.0	0.0	0.1
Aged 1-5	2.1	0.8	0.4	0.3	0.0	0.6
Aged 6-12	3.0	1.3	0.5	0.4	0.0	0.7
Aged 13-17	1.9	0.8	0.4	0.2	0.0	0.5

(continued)

Table 10 (continued)

Poverty Level and Age	Total	Employment Based in 1994 and 1995	Uninsured in 1994 and 1995	Employment Based in 1994 and Uninsured in 1995	Uninsured in 1994 and Employment Based in 1995	Other Combination
(millions)						
200%–399% of Poverty	22.8	14.9	1.8	2.6	0.3	3.2
Infants	1.2	0.7	0.1	0.1	0.1	0.2
Aged 1–5	6.2	4.0	0.5	0.7	0.1	0.9
Aged 6–12	9.1	6.1	0.7	1.1	0.1	1.2
Aged 13–17	6.4	4.1	0.6	0.7	0.1	0.9
400% or More of Poverty	15.8	12.1	0.5	1.6	0.2	1.5
Infants	0.8	0.6	0.0	0.1	0.0	0.1
Aged 1–5	4.2	3.1	0.1	0.5	0.0	0.5
Aged 6–12	5.8	4.5	0.2	0.6	0.1	0.5
Aged 13–17	4.9	3.8	0.1	0.5	0.0	0.4
(percentage within age and poverty categories)						
Total	100.0%	47.7%	12.2%	8.8%	1.6%	29.7%
Infants	100.0	40.5	11.6	8.0	5.8	34.1
Aged 1–5	100.0	43.7	11.3	8.4	1.5	35.2
Aged 6–12	100.0	49.3	11.9	9.1	1.3	28.4
Aged 13–17	100.0	51.4	13.5	9.1	1.2	24.8
0–99% of Poverty	100.0	7.1	20.1	2.7	1.1	69.1
Infants	100.0	5.3	17.1	2.5	1.9	73.2
Aged 1–5	100.0	5.4	15.7	1.9	0.9	76.2
Aged 6–12	100.0	7.2	19.8	3.3	0.9	68.7
Aged 13–17	100.0	9.9	28.1	3.0	1.3	57.8
100%–149% of Poverty	100.0	26.6	21.6	7.8	3.3	40.7
Infants	100.0	22.2	14.5	5.3	15.8	42.2
Aged 1–5	100.0	25.8	20.0	7.0	2.9	44.2
Aged 6–12	100.0	28.1	21.7	8.5	2.4	39.3
Aged 13–17	100.0	26.5	25.2	8.3	2.1	38.0
150%–199% of Poverty	100.0	41.3	17.8	13.0	1.8	26.1
Infants	100.0	34.0	18.4	11.4	3.8	32.4
Aged 1–5	100.0	37.7	16.5	14.2	2.3	29.2
Aged 6–12	100.0	45.4	17.3	12.8	1.5	23.0
Aged 13–17	100.0	40.5	19.7	12.2	1.3	26.3
200%–399% of Poverty	100.0	65.1	8.1	11.2	1.3	14.2
Infants	100.0	57.0	8.3	11.3	5.5	18.0
Aged 1–5	100.0	65.5	7.7	10.8	1.4	14.5
Aged 6–12	100.0	66.6	7.6	11.6	1.0	13.2
Aged 13–17	100.0	64.1	9.0	11.2	1.0	14.7
400% or More of Poverty	100.0	76.4	2.9	10.1	1.4	9.3
Infants	100.0	70.4	5.0	9.5	5.9	9.3
Aged 1–5	100.0	73.5	3.3	10.9	1.0	11.2
Aged 6–12	100.0	77.7	3.1	9.6	1.2	8.3
Aged 13–17	100.0	78.1	2.1	10.0	1.0	8.8

the previous six months in order to be considered a preexisting condition. The 12-month limit on preexisting condition exclusions is a one-time limit, which may not be imposed again on individuals even if they change jobs or health insurance. The legislation also provides for credits that can be applied against preexisting condition exclusions for individuals who have had continuous qualifying coverage prior to obtaining the new health insurance coverage.⁴ Second, the bill guarantees access to health insurance. Groups of two or more individuals cannot be denied coverage because of their health status.

In addition, individuals without access to group health insurance are guaranteed access to health insurance in the individual market if they were covered by group health insurance for at least 18 months. As long as an individual is willing and able to pay for health insurance,

⁴ Under the bill, coverage of less than 12 months may be credited against any preexisting condition exclusion under a new health plan. For example, an individual who has had coverage for 6 months when he or she changes jobs or health plans would face a maximum additional exclusion of 6 months, rather than the normal 12 months.

he or she would have access to the insurance. Third, the bill guarantees renewal of health insurance. As long as premiums are paid, health plans must renew coverage for groups and individuals, except in the case of fraud or misrepresentation. Fourth, the bill preempts state laws that obstruct (or prohibit) employer groups from forming purchasing coalitions. Fifth, the bill requires equal insurance treatment of mental health services. Employers and insurers would be prohibited from placing treatment limitations or financing requirements on individuals with mental illnesses if similar requirements are not imposed on other covered benefits. Sixth, the bill includes a provision to increase the deductibility of health insurance for the self-employed from 30 percent to 80 percent.

One provision in the Senate bill addresses group-to-group portability, but not all individuals changing jobs or insurers will benefit from the provisions. EBRI tabulations of the March 1995 CPS indicate that 19.5 million nonelderly Americans were covered by employment-based health insurance in 1994 and were uninsured in March 1995. Some of these individuals may have chosen to relinquish their health insurance voluntarily. They may have found that health insurance was not affordable anymore. They may have had a preexisting condition that prevented them from qualifying for health insurance. While this action does not directly address health insurance affordability, the issue is addressed indirectly by making it easier for small employers and individuals to form purchasing coalitions. These coalitions can potentially provide small employers and individuals the same market power that large employers seem to realize while bargaining with health care providers and health insurers.

The duration of prior health insurance coverage is not known for the 19.5 million uninsured individuals in 1995 who had prior employment-based health insurance in 1994. Some of these individuals may have preexisting conditions that prohibit them from getting health insurance coverage in the individual market. The legislation would not benefit individuals who were not

covered by health insurance for at least 18 months prior to becoming uninsured in 1995. In fact, some of them would have to have been covered for at least 36 months, if they were eligible for benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).⁵ Many individuals choose to remain uninsured because COBRA coverage is unaffordable for them. Individuals who need health insurance coverage may find premiums levels even higher in the individual market. As a result, these individuals may find it more affordable to remain uninsured, especially if they can receive uncompensated health care.

One controversial provision in the Senate bill is the provision that allows individuals access to health insurance in the individual market if they do not qualify for group health insurance and they were previously covered by group health insurance for at least 18 months. This provision could have the effect of reducing health insurance coverage in states with rating restrictions if only unhealthy individuals take advantage of this provision. Thirty-four states do not have rating restrictions in the individual market, four states have rating restrictions without comprehensive guaranteed issue, and eleven states have guaranteed issue (American Academy of Actuaries, 1996).⁶ Individuals with private nongroup health insurance in states with rating restrictions may see premium levels rise as the cost of insurance increases due to cross subsidization. These individuals may determine that the higher premium levels are not affordable. However, in states with no rating restrictions, individuals who already have private health insurance coverage may not experience premium increases if the premium rates for the newly insured are adjusted to reflect the actuarial fair rate of insuring

⁵ Individuals eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 would have to have had 18 months of continuous coverage while working for the employer that offered coverage and then another 18 months of COBRA coverage with that employer before being eligible for guaranteed access to health insurance in the individual market.

⁶ Hawaii was not included in the study.

*Affordability is
promoted among the
self-employed by
increasing the deduc-
tion for health
insurance expenses.*

these individuals. Newly insured individuals may be required to pay between 200 percent and 300 percent of the premium paid by the existing insured population (American Academy of Actuaries, 1996).

Another controversial provision is parity for mental health services. Employers and insurers would be required to provide equal insurance treatment of mental health services. This provision could have the effect of increasing premiums or reducing benefits. A 1996 study conducted on the impact of such a provision concluded that premiums for employment-based health insurance would increase between 8.4 percent and 11.4 percent if employers and insurers were prohibited from imposing limitations on mental health benefits when similar limitations are not imposed on other covered benefits (Association of Private Pension and Welfare Plans, 1996). Another study found that health insurance premiums would increase between 2.5 percent and 3.2 percent (Melek and Pyenson, 1996). Alternatively, employers and insurers could cut back on coverage for all health benefits except for mental health in order to maintain parity.

The House-passed Health Coverage Availability and Affordability Act expands on the legislation passed by the Senate. This bill not only includes provisions to increase access to health insurance similar to the provisions spelled out in the Senate bill but also includes provisions that affect health insurance affordability. Some policymakers believe that affordability needs to be addressed because the percentage of income devoted to paying for health insurance and other medical expenses is highest for low-income families (Consumers Union, 1996).⁷ The bill includes a provision that increases the deductibility of health insurance for the self-employed, a provision that allows individuals to contribute to MSAs on a tax-preferred basis, medical malpractice reform, and a provision to increase federal jurisdiction over MEWAs in order to encourage small employer pooling.

Affordability is promoted among the self-employed by increasing the deduction for health insurance expenses from 30 percent to 50 percent. While this provision is fair because it is a movement toward allowing the self-employed the same tax advantage that workers have for health insurance contributions, it may do little to increase coverage. Assume that the health insurance premium for a self-employed individual is \$3,000 per year. If the self-employed were able to deduct 50 percent of this expense, tax savings would amount to an additional \$168 per year for an individual in the 28 percent tax bracket. This is an additional tax savings of 5.6 percent of the health insurance premium, but it may not be large enough to induce the self-employed to purchase health insurance. If the deduction was increased to 80 percent, as passed in the Senate, a self-employed worker in the 28 percent tax bracket, with a health insurance premium of \$3,000 per year, would receive an additional tax savings of \$420 per year, or 14 percent of the premium.

The House bill appears to promote affordability by allowing individuals to contribute to MSAs on a tax-preferred basis. The theory behind MSAs is that they will be coupled with high deductible health plans that can be purchased with lower premiums. The savings from the lower premiums will, in theory, be used to finance the MSA. However, if an individual purchases a high deductible health plan and puts the savings into an MSA, he or she is effectively spending the same amount of money on health insurance as before. The MSA option does not make health insurance more affordable if the premium savings always fund the MSA. However, MSAs may make health insurance more affordable in the long run for two reasons. First, an individual with an MSA may not need to contribute to this account each year. If funds are rolled over, the account earns interest, and the account accumulates contributions, at some point in time there may be enough money in the MSA to cover all potential out-of-pocket expenses for a given year. Second, the theory behind MSAs also includes the idea that individuals will be

⁷ See Blumberg and Liska (1996) for a summary of studies on the implications of being uninsured on access to health insurance and health status.

Table 11
Cost of Different Copayment Designs—Individual Plan

Deductible/ Maximum Out-of-Pocket	Premium	Reduction from Baseline Premium	Reduction from Baseline Premium as a Percentage of the Deductible
\$200/\$1,000	\$2,699	0	—
\$1,000/\$2,000	2,176	523	52.3%
\$1,500/\$2,500	1,996	703	46.9
\$2,000/\$3,000	1,871	828	41.4
\$3,000/\$4,000	1,666	1,033	34.4
\$4,000/\$5,000	1,501	1,198	30.0
\$5,000/\$6,000	1,369	1,330	26.6

Source: American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, Public Policy Monograph no. 1 (Washington, DC: American Academy of Actuaries, 1995).

spending, in large part, their own money on health care, therefore

promoting competition among health care providers and causing the price of health care to fall. There are two potential problems with this argument. First, if individuals view the account as an extension of their health insurance and not as their personal savings, they will not promote competition among health care providers. Second, individuals may not have adequate information and purchasing power to affect price. In fact, an uninformed consumer of health care may end up spending more money for health care services under these arrangements.⁸

Premium savings from high deductible health plans could be small relative to the level of the deductible. The American Academy of Actuaries (1995) has shown that as the deductible gets larger, premium savings as a percentage of the deductible that would be available to fund the MSA get smaller (table 11). As a result, low income individuals, who are in greatest need of insurance affordability, may choose a catastrophic health plan with a relatively low deductible that allows them to apply a higher percentage of their premium savings to fund a tax-preferred MSA.

Any type of incremental health reform runs the risk of making things worse instead of improving the situation. Because we live in a voluntary system of health insurance—individuals and employers can participate in the health insurance market voluntarily—it is possible that incremental reforms will result in an increase in adverse selection. For example, MSAs may result in adverse selection if only healthy individuals choose this health insurance arrangement. As a result, health insurance premiums will rise for individuals who do not utilize high deductible health insurance plans

with MSAs, and health insurance premiums will decline for individu-

als who do use MSAs.

Recent health reforms do not address the chronically uninsured and individuals on public insurance. It is estimated that almost 40 million individuals did not have health insurance of any kind in 1994, and an additional 37.2 million were covered by some form of public insurance, mostly Medicaid (Fronstin and Rheem, 1996). In the short run, these individuals will not benefit from current portability reform measures because they have not been participating in an employment-based health plan for at least one year. If, in the future, these individuals get employment-based health insurance and participate in an employment-based health plan for a continuous amount of time, they would become eligible for the portability provisions of these bills. In fact, very few uninsured individuals move from being uninsured to having employment-based health insurance. EBRI tabulations indicate that only 3.7 million individuals who were uninsured in 1994 were participating in an employment-based health plan in March 1995 (table 3).

Conclusion

Only 8.5 percent of nonelderly Americans (19.5 million) had employ-

ment-based health insurance in 1994 and were uninsured in 1995, and 1.6 percent (3.7 million) were uninsured in 1994 and had employment-based health insurance in March 1995. Individuals who became uninsured after having employment-based health insurance may have lost their health insurance for many reasons. While some of these insurance changes may have been voluntary, some of these individuals may prefer to have continued coverage under employment-

⁸ For more information on medical savings accounts, see Paul Fronstin, "Medical Savings Accounts: Issues to Consider," EBRI Notes, no. 7 (Employee Benefit Research Institute, July 1995): 1–7.

This *Issue Brief* was written by Paul Fronstin of EBRI with assistance from the Institute's research and editorial staffs.

based health insurance but were unable to participate in the health plan because of a preexisting condition. As a result, current health reform would remove barriers to portability and increase access to health insurance. The reforms are driven by the belief that individuals who have been covered by prior health insurance should not be penalized when they change jobs or insurance companies. Current reforms to remove barriers to health insurance also include provisions that may make health insurance more affordable. However, these reforms will not directly impact health care cost inflation rates. Ultimately, these reforms will do little to significantly increase health insurance coverage and make health insurance more affordable if the gap between health care cost inflation and overall inflation is not eliminated. However, for those who can afford health insurance coverage, access to health insurance will be improved.

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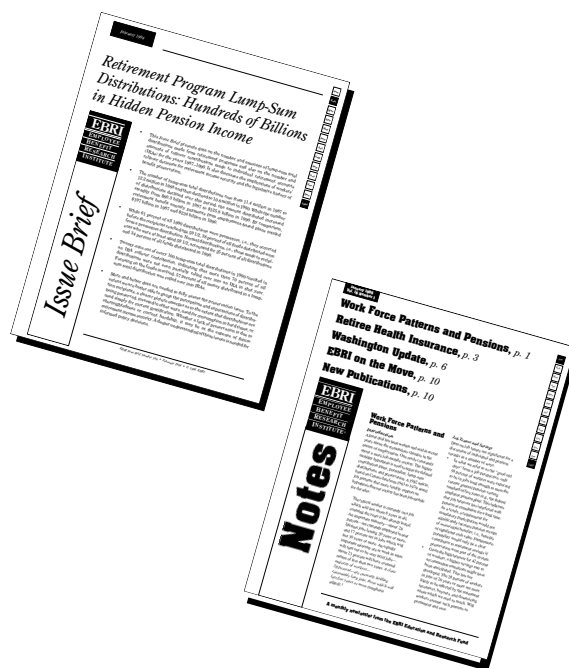
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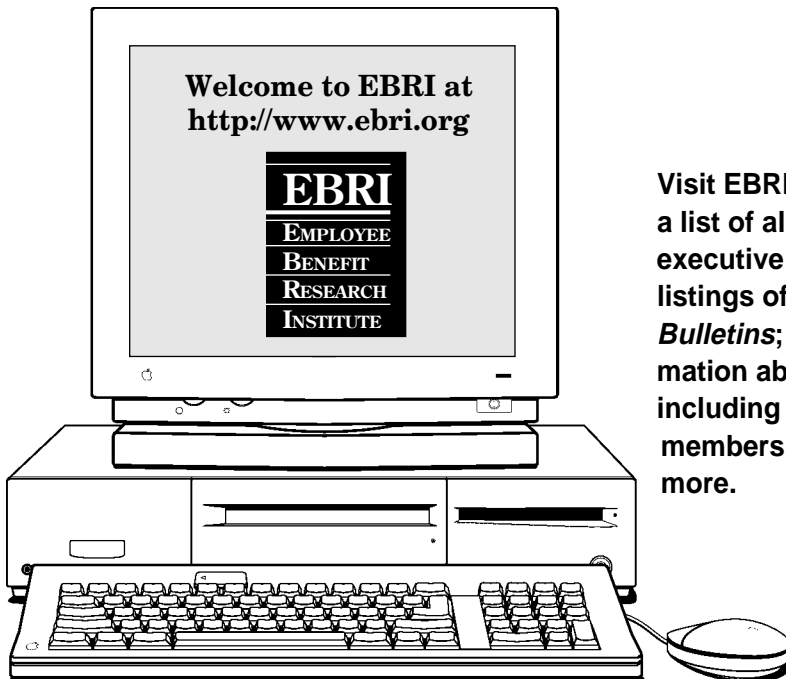
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