Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion

by Paul Fronstin, EBRI

EBRI
EMPLOYEE BENEFIT RESEARCH INSTITUTE®

Issue Brief

- This *Issue Brief* provides background information on the employment-based health insurance system and its alternatives. The report discusses the advantages and disadvantages of the current employment-based health insurance system, the current tax treatment of health insurance, and the strength and weaknesses of recent proposals to introduce tax credits. It presents findings from the public opinion survey conducted by the Employee Benefit Research Institute on public attitudes toward health insurance and summarizes recent research on the effects of tax changes on employment-based health benefits and the uninsured.

- Employment-based health plans are the most common source of health insurance among nonelderly individuals in the United States, providing coverage to nearly two-thirds of this population in 1997. Health insurance is probably the benefit most used and valued by workers and their families. Sixty-four percent of respondents to a recent survey rated employment-based health insurance benefits as the most important benefit.

- Despite essentially five years of very low health care cost increases and the recent increase in the percentage of Americans with employment-based health insurance coverage, the uninsured population has continued to rise. This has resulted in a new interest among policymakers in finding ways to reverse this trend. One question that continues to be asked is whether the employment-based health insurance system is the appropriate mechanism for expanding health insurance to the uninsured.

- Employment-based health plans are popular because they offer many advantages over other forms of health insurance and types of delivery systems. However, there are also potential drawbacks to the employment-based system. The advantages include reduced risk of adverse selection, group-purchasing efficiencies, employers acting as a workers' advocate, delivery innovation, and health care quality. The disadvantages include an unfair tax treatment, lack of portability and job lock, little choice of health plans, and lack of universal coverage.

- The tax credit proposals for health insurance, which come in all shapes and sizes, would either enhance the current employment-based health insurance system or put it at risk. This has potentially enormous public policy implications, since the vast majority of Americans get their health insurance coverage through employers. Such a change may also have political implications, as public opinion currently may not support such a fundamental change in the U.S. health insurance system. A recent public opinion survey conducted by the Employee Benefit Research Institute found that 68 percent of Americans with employment-based health insurance were satisfied with the current mix of benefits and wages.

- The EBRI survey found that under a changing tax code scenario, there is still strong support for the employment-based system. Strong support for the employment-based system may be the result of respondents' lack of confidence in their ability to choose the best health plan if their employer stopped offering health insurance.

Table of Contents

Text

Tables

Charts

Paul Fronstin wrote this *Issue Brief* with assistance from the Institute's research and editorial staffs. Any views expressed in this article are those of the author and should not be ascribed to the officers, trustees, members, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

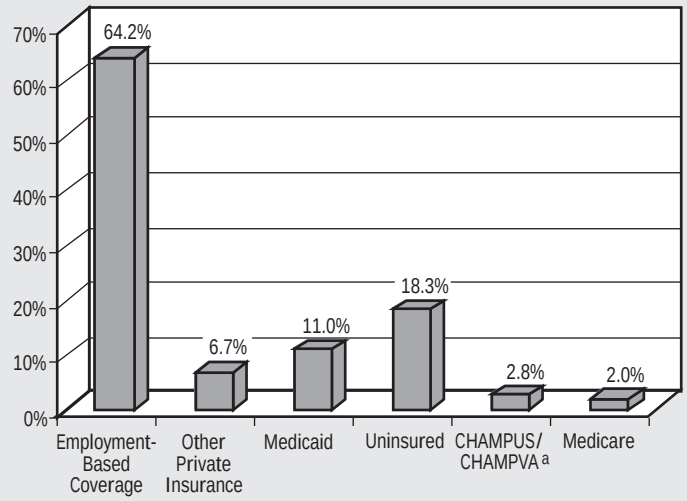
Introduction

Employment-based health plans are the most common source of health insurance among nonelderly individuals in the United States, providing coverage to nearly two-thirds of this population in 1997 (chart 1). In addition, 34 percent of individuals ages 65 and older had employment-based coverage in 1997, mainly as a supplement to Medicare (Fronstin, 1998b). The basic purpose for employers offering employment-based health benefits is to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. They also offer the benefits to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers. Health insurance is probably the benefit most used and valued by workers and their families. Sixty-four percent of respondents to a recent survey rated employment-based health insurance benefits as the most important benefit (Ostuw, 1996).

Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with employment-based health insurance coverage started to increase for several reasons. When wages were frozen by the National War Labor Board and there was a shortage of workers, employers sought ways to get around the wage controls in order to attract scarce workers, and offering health insurance was one option. Health insurance was an attractive means to attract and retain workers during a labor shortage for two reasons: Unions supported employment-based health insurance, and workers' health benefits were not subject to income tax or Social Security payroll taxes, as were cash wages.

Twelve million people (less than 10 percent of the population) were covered by private health insurance in 1940. By 1945 when the war ended, 32 million people (approximately 23 percent of the population) had private health insurance coverage, and by 1950, 77 million (approximately 51 percent) had such coverage (Health Insurance Association of America, 1996). In 1997, nearly 168 million nonelderly Americans (71 percent of the U.S. population) were covered by private health insurance, and 151.7 million of these individuals (just over 90 percent of those with private coverage) had employment-based plans (Fronstin, 1998c). While the number of Americans covered by employment-based health plans expanded between World War II and the 1980s, coverage levels fell in recent years from the record-high level reached during the 1980s (69.2 percent of the nonelderly population in 1987) to 63.5 percent in 1993 (chart 2). This decline

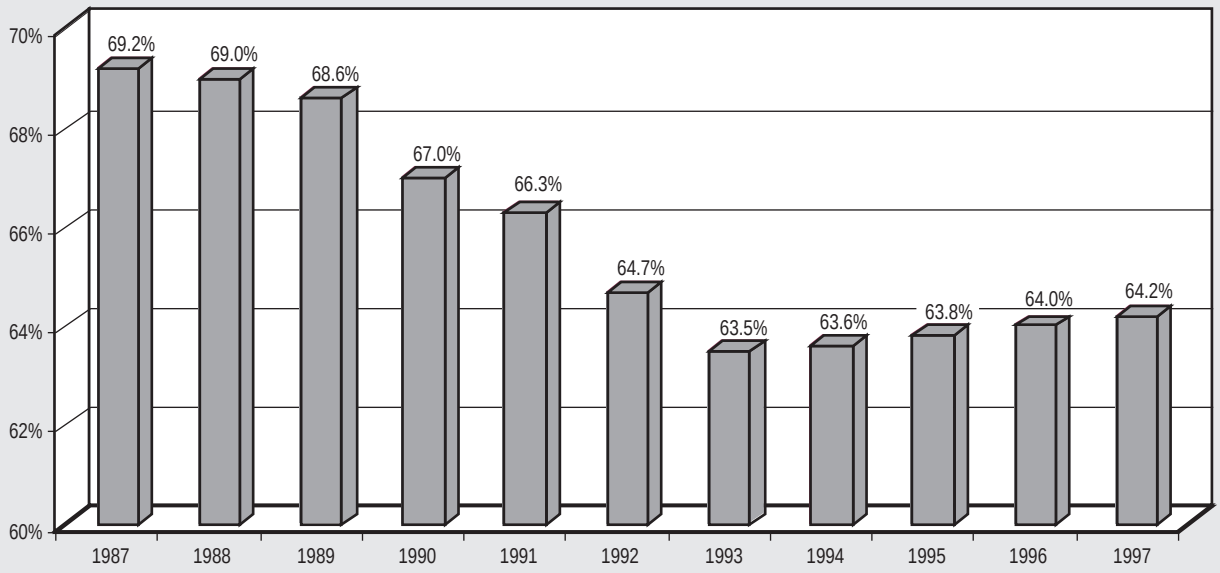
Chart 1
Health Insurance Coverage of Nonelderly Americans, 1997



Source: Employee Benefit Research Institute estimates from the March 1998 Current Population Survey.
[a]Civilian Health and Medical Program of the Uniformed Services/Civilian Health and Medical Program of the Veterans Administration.

Chart 2

Percentage of Nonelderly Americans Covered by an Employment-Based Health Plan, 1987-1997



Source: Employee Benefit Research Institute estimates from the March 1988–1998 Current Population Survey.

was due in large part to rising health care costs, but the changing labor force also contributed to the decline.[1] Since 1993, employment-based coverage has been increasing—partly due to downsizing in the military, efforts to move individuals from welfare to work, and the strong economy—and it now includes 64.2 percent of the nonelderly population.[2]

It should be noted, however, that the percentage of nonelderly Americans with employment-based coverage, while increasing in recent years, has not yet reached the level it attained in 1992. Despite essentially five years of very low health care cost increases and the recent increase in the percentage of Americans with employment-based health insurance coverage, the percentage of Americans who are uninsured has continued to rise, although the rate of increase has slowed. It appears that individuals leaving welfare (and Medicaid) are contributing to the increase in the uninsured population, although they are also likely contributing to the increase in the number of individuals receiving employment-based coverage. The continued rise in the uninsured has resulted in a new interest among policymakers and policy analysts in finding ways to reverse this trend.

One question that continues to be asked is whether the employment-based health insurance system is the appropriate mechanism for expanding health insurance to the uninsured. Many policymakers and policy analysts believe it is not, while others believe it is.

This *Issue Brief* provides background information on the employment-based health insurance system and its alternatives. (In addition, it presents data from a recent public opinion survey on attitudes toward the employment-based health insurance system and its alternatives, and summarizes papers that have examined the effects of tax reform on employment-based health insurance and the uninsured.) The report discusses the advantages and disadvantages of the current employment-based health insurance system, the current tax treatment of health insurance, and the strength and weaknesses of recent proposals to introduce tax credits. It presents findings from the public opinion survey conducted by the Employee Benefit Research Institute on public attitudes toward health insurance and summarizes recent research on the effects of tax changes on employment-based health benefits and the uninsured. The final section presents conclusions.

The Current System

Greatly simplified, the purpose of any insurance system is to

[1] *According to Fronstin and Snider (1996/97), the movement of workers into part-time jobs, nonunionized jobs, and service jobs, as well as declining real income, also contributed to the decline in employment-based health insurance.*

[2] *Much more research needs to be conducted to truly understand the recent dynamics among employment-based health insurance coverage, welfare, and the uninsured in the last few years.*

create an economically sustainable way to spread the risk of loss across high-risk and low-risk individuals. In the case of private health insurance, employment-based health plans are the major source of coverage in the United States today. These plans are popular because they offer many advantages over other forms of health insurance and types of delivery systems. However, there are also potential drawbacks to the employment-based system, some of which are discussed in this section.

When it comes to insuring a group of individuals, employment-based groups are often considered "natural groups" in the sense that they were formed for reasons other than the purchase of health insurance.

Among the Advantages:

Adverse Selection—Adverse selection exists when a disproportionate number of unhealthy individuals are enrolled in a specific health plan. In other words, a health plan may suffer from adverse selection when unhealthy individuals are more likely than healthy individuals to enroll in the plan. In a purely voluntary system, such as the U.S. system, the risk of adverse selection is relatively high. In order to reduce adverse selection, insurers often seek to enroll groups of individuals rather than the individuals themselves; even though they are not able to single out higher-risk or unhealthy individuals in the group, they often get the good risks along with the bad risks. When it comes to insuring a group of individuals, employment-based groups are often considered "natural groups" in the sense that they were formed for reasons other than the purchase of health insurance. Insurers are more willing to provide insurance for a naturally formed group than for a group that was formed solely for the purpose of buying health insurance because the risks of adverse selection are mitigated. Therefore, employment-based health insurance is a potent means for spreading risk among healthy and unhealthy individuals.

Group Purchasing Efficiencies—The existence of economies of scale in the purchase of group health insurance coverage results in a lower average premium. When economies of scale exist, the average administrative costs of insuring a group make up a smaller percentage of the cost of health insurance. As a result, large firms that are able to exert market power are more likely to offer health benefits than small firms because they can purchase the same plan at a lower cost. In addition, employers may be better at finding or negotiating for lower-cost health plans than workers would be in the individual market.

Employment-based health insurance has both positive and negative effects on the labor market. It benefits employers because it encourages workers to keep their jobs, thereby reducing "quit rates" and turnover costs. However, this form of insurance puts workers at a disadvantage because health benefits are not portable from job to job, which is a major cause of "job lock," as discussed below.

Employer as Advocate—Employers are not only able to find or negotiate lower health insurance costs than workers can on the individual market, they also often act as advocate for workers during coverage disputes between the insured and insurer. For example, an employer experiencing widespread dissatisfaction with a specific health plan will either find a new health plan or threaten to find a new health plan if the insurer does not respond to the issues raised by the plan's members. Insurers are more likely to respond to an employer than to an individual because of the risk of losing a large group contract covering individuals who are not adversely selected.

Delivery Innovation and Health Care Quality—Employers frequently become involved in health care quality assessment and policy development. Large employers began to pay closer attention to health care quality when costs rose sharply in the 1970s and 1980s. One result was the formation of employer coalitions for the purpose of sharing information about quality that would enable

members to contract with the best insurers and providers. Many believe that employers are better able to monitor quality of health care than individuals.

Among the Disadvantages:

Tax Treatment May Be Unfair—Under current tax law, individuals who receive health insurance benefits through the work place pay no taxes on the benefits received. Alternatively, those who purchase health insurance directly from an insurer are not able to deduct the cost of the insurance from taxable income.[3] As a result, there are real differences in the cost of employment-based vs. individual health insurance that are not attributable to differences in benefits. For example, an individual purchasing health insurance through an insurer would not receive the same tax benefits as one covered through the work place. Similarly, the self-employed are currently able to only partially deduct the cost of their health insurance. Extending the tax break to individuals who purchase health insurance on their own might encourage uninsured individuals to purchase health insurance on their own.[4]

Job Lock—Currently, health insurance is not usually portable from job to job, i.e., workers cannot usually continue to participate in their health plan when they change jobs.[5] As a result, they often remain with current employers for a number of reasons related to employment-based health insurance: A prospective employer may not offer health insurance; the worker may have to change doctors when changing health plans; a waiting period may be required before the worker becomes eligible for coverage;[6] and the benefits package offered through the prospective employer may be less generous than the worker's current benefits. These scenarios may result in job lock—employees forgoing job opportunities that could potentially increase their productivity and income, in order to preserve existing health insurance benefits. Portability of health insurance could help alleviate the loss of health benefits when a worker is offered a new job.

Little Choice of Plans—Currently, very few employers offer a choice of health plans.[7] However, the 1998 Health Confidence Survey conducted by the Employee Benefit Research Institute and Mathew Greenwald & Associates found that workers with a choice of health plans were more satisfied with their health benefits than those without a choice. Specifically, 56 percent of individuals with a choice of plans were either extremely or very satisfied with their current plan, compared with 43 percent who were either extremely or very satisfied with their current plan among individuals without a choice of plans. Even when employees do have a choice of plans, they may have a choice of only two or three plans.[8] Individuals might have a greater array of health insurance choices if insurance were not tied to employment.

---

[3] Individuals can deduct the portion of health care expenses (including health insurance premiums) that exceed 7.5 percent of adjusted gross income if they itemize their deductions. The number of individuals claiming this deduction is quite small and has been declining as a percentage of the number of returns filed (Internal Revenue Service, 1999).

[4] It may also induce those already covered to purchase more generous coverage.

[5] The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows workers at their own cost to continue their health benefits on job change, but only for 18 months. In addition, the premiums that a person pays toward COBRA are usually not excludable from taxable income as are premiums that employers pay toward a worker's health benefits.

[6] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prevents employers and insurers from imposing pre-existing condition exclusions for individuals with a history of prior health insurance. Employers and insurers may still require that workers fulfill a waiting period before becoming eligible for any health benefits.

[7] A recent survey of employers conducted by the RAND Corporation found that only 17 percent of employers offered their workers a choice of health plans. However, the 1999 Health Insurance Preference Survey conducted by the Employee Benefit Research Institute found that 59 percent of adults covered by an employment-based health plan were allowed to choose from more than one plan.

[8] However, the two or three plans chosen by the employer could be the best plans available in the area.

Table 1
Value of Exclusion of Employer Contribution of $3,000 to Four Families of Different Income Levels, A Simple Illustration

	Family Income	Cost as a Percentage of Income	Marginal Tax Rate	Value of Exclusion	Exclusion as a Percentage of Income
Family 1	$ 12,000	25%	0%	$ 0	0%
Family 2	20,000	15	15	450	2.3
Family 3	50,000	6	28	840	1.7
Family 4	100,000	3	31	930	0.9

Source: Employee Benefit Research Institute calculations.

Lack of Universal Coverage—More than 43 million Americans, or 18.3 percent of the nonelderly population, were uninsured in 1997 (Fronstin, 1998c).

In a purely voluntary system such as the employment-based system in the United States, it is nearly impossible to achieve universal coverage. Many small companies choose to not provide health benefits,[9] and many workers choose to forego benefits when they are offered.[10] The absence of universal coverage has implications for worker productivity; the health of the population; access to health care; and the cost of health care and health insurance for the insured population and third-party payers of health care such as insurers, employers, and the public sector.

Current Tax Treatment

Currently, health insurance premiums paid by employers are deductible for employers as a business expense, and are also excluded, without limit, from workers' taxable income. In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for health care expenses with pretax dollars—meaning, they are not taxed on the amount of money that is put into the FSA. In contrast, the self-employed were able to deduct only 45 percent of the amount paid for health insurance during 1998.[11] Furthermore, for individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income, and only the amount that exceeds 7.5 percent of adjusted gross income is deductible.

The tax preference for health insurance is generally viewed as being regressive, although some analysts would argue that it could be viewed as progressive, depending on how the numbers are analyzed.[12] In dollar amounts, the tax exclusion can be viewed as regressive because it benefits higher-income individuals more than lower-income individuals. The regressive tax structure enables workers in higher tax brackets to receive greater tax advantages in dollar amounts than those received by lower-paid workers. This occurs because, although the value of the benefits is generally the same for all workers with the same employer regardless of income, higher-income workers face a higher marginal tax rate.[13] Table 1 illustrates the value of the health insurance tax exclusion to families with different income levels who work for the same firm. Under the current tax rate structure, the first family in table 1 faces a 0 percent marginal tax rate, while the marginal tax rates for the second, third, and fourth families are 15 percent, 28 percent, and 31 percent, respectively. If the employer contributes $3,000 for each family, the absolute reduction in taxes attributable to the health insurance tax exclusion would be worth: $0 to a family with income of $12,000; $450 to a family with taxable income of $20,000; $840 to a family with taxable income of $50,000; and $930 to a family with taxable income of $100,000. Thus, the tax exclusion is worth twice as much to families in the 31 percent tax bracket as it is to families in the 15 percent bracket in dollar amounts, and nothing at all to the lowest-income family.

However, for workers who receive employer contributions to their health insurance coverage, some analysts could make the argument that the exclusion may also be viewed as progressive. As a percentage of income, the exclusion represents greater savings for

[9] In 1998, 46 percent of firms with 200 or fewer workers did not offer health benefits (Gabel et al., 1999).

[10] Cooper and Schone (1997) found that 29.1 percent of uninsured workers had access to an employment-based health plan, either through their own employer or through their spouse's employer.

[11] Under current law, the self-employed will be able to deduct 100 percent of the cost of their health insurance beginning in the year 2003.

[12] Under a progressive tax system, marginal tax rates increase with income (Varian, 1987). However, a flat tax system may be progressive if income up to a certain level is exempt from taxes.

[13] This advantage was substantially reduced when the tax rate structure was condensed by the Tax Reform Act of 1986 (TRA '86). It has been slightly increased since the passage of the Omnibus Budget Reconciliation Act of 1993.

lower-income workers than for higher-income workers (Institute of Medicine, 1993). Again looking at table 1, if the employer contributes $3,000 for each family's health insurance premium, the tax preference would equal: 2.3 percent of the income of the family earning $20,000; 1.7 percent of the income of the family earning $50,000; and 0.9 percent of the income of the family earning $100,000. Thus, the table shows that, while the exclusion is greater in dollar amounts for the families with higher incomes, as a percentage of income, the value of the exclusion falls as income rises. When examining the tax exclusion by percentage of income it should be noted that it is not progressive at all income levels. Individuals with income of $12,000 receive no tax exclusion because they pay no taxes. A refundable tax credit would result in a reduction in taxes for these families.

Tax Credit Issues

The current tax code is often criticized as contributing to the uninsured population.[14] As a result, proposals to expand health insurance coverage through a tax credit have been receiving increased attention lately.[15] The tax credits proposals for health insurance, which come in all shapes and sizes, as seen in table 2, would either enhance the current employment-based health insurance system or put it at risk.

Reps. Dick Armey (R-TX) and Pete Stark (D-CA), in a recent editorial advocating health insurance tax credits, said the concept would "unavoidably" prompt some employers and employees to drop work place coverage. "But job-based coverage is already eroding," they said, although both support the continuation of the employment-based system as one option for obtaining health insurance.

One possibility is to replace the current tax exclusion with a tax credit for all persons with health insurance. Rep. Bill Thomas (R-CA) has been discussing replacing the employer deduction for health insurance with an individual tax credit. If the tax credit were refundable, all persons with the same health insurance coverage who claim the credit would get the same tax credit.[16] Another possibility is to leave the tax exclusion unchanged for individuals who get insurance through employment and add a refundable tax credit solely for individuals who do not qualify for employment-based health insurance. For example, under proposals made by House Majority Leader Dick Armey (R-TX) and Rep. Jim McDermott (D-WA), refundable tax credits would be available only to individuals who are not eligible for an employment-based health plan. Specifically, Armey has floated a proposal that would provide an $800 credit per individual and a $400 credit per child, up to an annual maximum of $2,400 per family, for those without access to an employment-based plan. McDermott is planning to reintroduce a measure he originally offered several years ago that would provide a partially refundable tax credit worth up to 30 percent of the cost of a health plan for low-income individuals. These proposals are intended to leave the employment-based health insurance system intact, as they are targeted to individuals who are less likely to be covered by an employment-based health plan or ineligible for one.

However, the movement to individual-based tax credits for any source of health insurance coverage may mean the end of the existing employment-based health insurance system. This has potentially enormous public policy implications, since the vast majority of Americans

---

[14] It can also be argued that the uninsured would be much higher if workers were not allowed to exclude any portion of health benefits from income, or if employers were not able to deduct health benefit expenses as a business expense.

[15] Unlike deductions or exemptions, which reduce the amount of income subject to a tax, a credit reduces the actual amount of tax owed, dollar-for-dollar.

[16] An individual with low income would have a very low tax bill, if he or she has one at all. An individual who does not pay taxes would be able to take advantage of the tax credit only if it is refundable. Refundable tax credits are needed when the objective is to allow individuals who do not pay taxes because they are in low-income families to benefit from the tax credit.

Table 2
Summary of Tax Change Proposals

Sponsor	Description	Status
Rep. Dick Armey (R-TX)	Would provide a refundable tax credit of $800 per adult, $400 per child, up to a family maximum of $2,400. Unused federal funds earmarked for the tax credit would go to the states as block grants to provide coverage to the uninsured. The National Committee for Policy Research and the National Association of Health Underwriters have virtually identical proposals.	Not yet introduced.
Rep. Jim McDermott (D-WA) and Rep. James Rogan (R-CA) [H.R. 1819]	Would provide a 30 percent tax credit to individuals earning less than $30,000 and joint filers with income of less than $50,000 for the purchase of health insurance. Eligible individuals could not be covered by an employment-based health plan.	Referred to House Ways and Means Committee.
Rep. Nancy Johnson (R-CT) [H.R. 2020]; Sens. Charles Grassley (R-IA) and Diane Feinstein (D-CA) [S. 1160]	Would provide a 60 percent tax credit to individuals earning less than $30,000 and joint filers with income of less than $50,000 for the purchase of health insurance. Maximum credit is $1,200 per individual and $2,400 per family. The credit would be phased out for individuals with incomes between $30,000 and $40,000 and families with income between $50,000 and $70,000. The credit would apply only to previously uninsured individuals and those with COBRA[a] coverage.	Referred to the Ways and Means Committee and the Senate Finance Committee.
Rep. Charlie Norwood (R-GA) [H.R.1136]	Would create a refundable tax credit for the purchase of individual coverage, with a lower credit available for out-of-pocket payments for employment-based coverage. Adults would qualify for a $1,200 credit and children a $600 credit, up to a maximum of $3,600 per policy. For those covered under an employment-based plan, the credits would be $400 and $200, respectively. The bill would also create "Health Marts" and association health plans. It would also repeal the limits on the number of medical savings accounts and the types of employers that could offer them.	Referred to the House Commerce, Education and the Workforce, and Ways and Means committees.
Rep. John Shadegg (R-AZ) [H.R.1687]	Would provide a $500 refundable tax credit to individuals and $1,000 for families to be used to purchase health insurance. Would allow those currently covered by an employment-based plan to opt out and purchase insurance on their own. Would also establish a risk pooling arrangement, possibly styled as "Health Marts." Would expand eligibility for medical savings accounts (MSAs) (no details available).	Referred to the House Commerce, Education and the Workforce, and Ways and Means committees.
Sen. Barbara Boxer (D-CA) [S.194]	Would allow the first $2,000 of health insurance costs to be fully deductible, for both itemizers and nonitemizers.	Referred to the Senate Finance Committee.
Sen. Ben Nighthorse Campbell (R-CO) [S.799]	Would allow an individual to deduct amounts paid for medical insurance or long-term care insurance, including amounts paid for a spouse and dependents.	Referred to the Senate Finance Committee.
Rep. Gene Green (D-TX) [H.R.145]	Would allow a deduction, for both itemizers and nonitemizers, for health insurance premiums (including Medicare). Also would allow a deduction for qualified long-term care insurance premiums.	Referred to the House Ways and Means Committee.
Sen. Richard Durbin (D-IL) [S.825]	Would allow small businesses (those with nine or fewer employees) a credit against income taxes when they provide employee health insurance coverage.	Referred to the Senate Finance Committee.

Source: Employee Benefit Research Institute.
[a]Consolidated Omnibus Budget Reconciliation Act of 1985.

get their health insurance coverage through employers. Such a change may also have political implications, as public opinion currently may not support such a fundamental change in the U.S. health insurance system, as discussed later.

Different proposals for adding a tax credit would likely have different outcomes. For example, some proposals intend to preserve the employment-based health insurance system, while others intend to replace it.[17] Hence, a number of issues need to be considered in any debate over changing the tax treatment of health insurance coverage. Some of these issues are discussed below.

Rep. Thomas has argued that health insurance should be completely de-linked from employment and advocates changing the tax code to move away from the employment-based system. In general, Thomas argues that the major role played by employers in health insurance fundamentally distorts the economics of the health care market place. Specifically, he would com-

[17] *A number of members of Congress have introduced, or plan to introduce, additional proposals. Also, a number of associations have put forth similar tax credits proposals. They include the American College of Physicians - American Society of Internal Medicine (ACP-ASIM), the American Medical Association (AMA), the Blue Cross Blue Shield Association, and the National Association of Health Underwriters.*

pletely replace the current health insurance-related tax code with an individual tax credit. Employers would not be able to deduct the cost of workers' health insurance as a business expense; instead, they would be expected to give workers a cash payment to obtain health insurance on their own. Thomas and Rep. Jim McCrery (R-LA), who have been developing the concept over the past few years, envision a private system of universal access to health insurance; as of this writing they have not introduced specific legislation.

But the assumption that employers would continue to provide the same contribution to their workers' health plan is questionable. Employers might choose to eliminate their contribution to health benefits and instead pay workers a higher (taxable) wage. Also, limiting the employer deduction would directly affect only those employers that pay federal income tax; it would not, for instance affect state and local governments or nonprofit institutions. However, these organizations would be indirectly affected, as they would be competing for the same pool of workers in the labor market, and it is likely that these employers would follow the behavior of employers that are subject to federal income tax.[18]

Proposals by Reps. Armey and McDermott would have less of an effect on the employment-based system than Thomas' proposal, although the Armey and McDermott bills could have different effects. First, under the Armey plan, only persons not eligible for employment-based coverage would be able to take the tax credit, although some employers might use this as an incentive to terminate health benefits. However, as long as workers continue to demand health benefits and unemployment continues to remain low due to a growing economy, and employers have to compete for scarce labor resources, employers may be reluctant to reduce health benefits. In an economic recession it would be relatively easy for employers to terminate health benefits, especially if workers could get a tax credit when purchasing health insurance on their own.

The McDermott proposal would have a much smaller effect on the employment-based system because the bill is targeted at low-income individuals. Only single persons earning less than $25,000 and married persons earning less than $40,000 would qualify for the tax credit under his bill. Since low-income individuals are least likely to have employment-based health insurance to begin with, the proposal would not be expected to have much impact on employment-based health plans. Under this proposal, persons eligible for the tax credit would be able to claim 30 percent of the cost of health insurance.

Rep. Charlie Norwood (R-GA) has introduced a bill that is similar in nature to Armey's proposal. The tax credit under Norwood's bill would be available to persons with employment-based coverage, but the amount that could be claimed under the tax credit would be much smaller for individuals who are eligible for an employment-based health plan. For example, individuals not eligible for an employment-based health plan could take an annual tax credit of up to $1,200, while eligible individuals could only take a $400 credit. While the tax credit is targeted toward individuals who are not eligible for an employment-based health plan, employers could still terminate a plan because individuals could then claim the tax credit if they purchased health insurance on their own, as in the Armey proposal.

Additional Market Reforms

Proposals to change the tax treatment of health insurance in the past were generally combined with insurance market reform. These reforms usually included some type of "community rating," whereby all individuals who wished to enroll in a health plan were charged the same premium regardless of employment, family or health status. In essence, the goal of past proposals was to limit insurers' ability to charge different premiums to groups on the basis of risk, thereby allowing less healthy

[18] *The federal government introduced the Federal Employees Health Benefits Program (FEHBP) in 1959 in order to compete with private-sector employers for workers.*

individuals to buy insurance at the premium that reflects the community's average risk. Some, but not all, current proposals include provisions that would allow smaller entities to band together to purchase health insurance at favorable rates, but in general they allow the market to determine premiums.

Another issue to consider is how employers would distribute funds if they were to eliminate health benefits in favor of higher wages. Health insurance is generally more costly for older individuals than for younger ones, since older people tend to have more health problems. This was reflected in a recent advertisement in a local Washington, DC, newspaper, which showed premiums for a 30-year-old ranging from $71 to $86 per month, while premiums for a 60-year-old ranged from $225 to $254 per month. If individuals are charged different premiums because of their age in the nongroup market, employers would face a number of issues in deciding how much money to give workers to buy insurance on their own. For example, would a 25-year-old worker get the same pay raise as a 50-year-old worker, or would the 50-year-old receive a higher pay raise because of the higher expected premium when premiums are not determined by average community risk? With an average premium in the above advertisement being $163, 60-year-old workers would not receive enough money to purchase health insurance on their own if the distribution were based on a community rate. This might result in older workers becoming underinsured and younger workers overinsured.

How employers ultimately distribute the funds would partly depend on how flexible employers could be under any final legislation. For example, employers might be required to "community rate" the distribution, i.e., to divide the distribution equally among all workers. All workers would get the same distribution regardless of age, although single workers might get a lower distribution than married workers if the plan subsidized family coverage.

If all workers received an equal distribution level, it is likely that older workers would not be able to purchase health insurance on their own solely with the funds distributed from their employer. Under the assumption that insurance carriers operating in the individual market are allowed to age-rate the premium, unhealthy individuals would likely pay higher premiums than healthy ones. If insurers set premiums using experience rating, there might be added pressure on employers to "cash-out" the benefit plan based on an actuarial (age-based) formula instead of a community-rated basis.

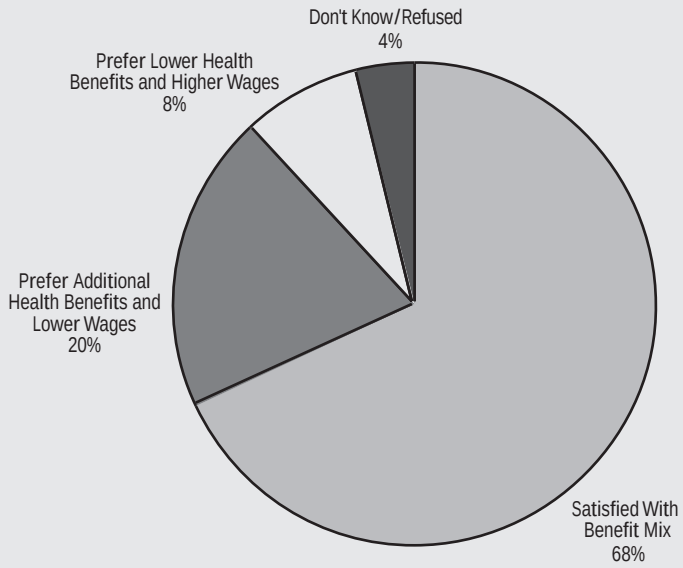
A question also arises concerning how the tax credit would be distributed. Current proposals set the credit either on a per-person basis or as a fixed percentage of the premium, and some proposals limit eligibility for the credit to individuals in low-income families. It is also possible to vary the tax credit by health status and/or age. The need to vary the tax credit by age and health status, and the subsequent effects of varying the tax credit, are highly dependent on whether premiums are community-rated or experience-rated.[19] If Congress continues to allow health insurance premiums to be experienced-rated, older and unhealthy individuals will likely pay more for insurance than younger healthy individuals. Under an experience-rated system, policymakers would ultimately have to decide whether to vary the tax credit by age and health status to address the issue of affordability.

Public Reaction

The success or failure of proposals to change the tax treatment of health insurance ultimately depends on the public's reaction. Since

[19] The value of the tax credit is also affected by geographic region, as health care costs and health insurance premiums vary by geographic region. Policymakers will also need to determine whether the value of the tax credit should be higher in high-cost regions, though they could simply set it at a fixed percentage of the health insurance premium.

Chart 3
Satisfaction With Current Wage-Benefit Composition

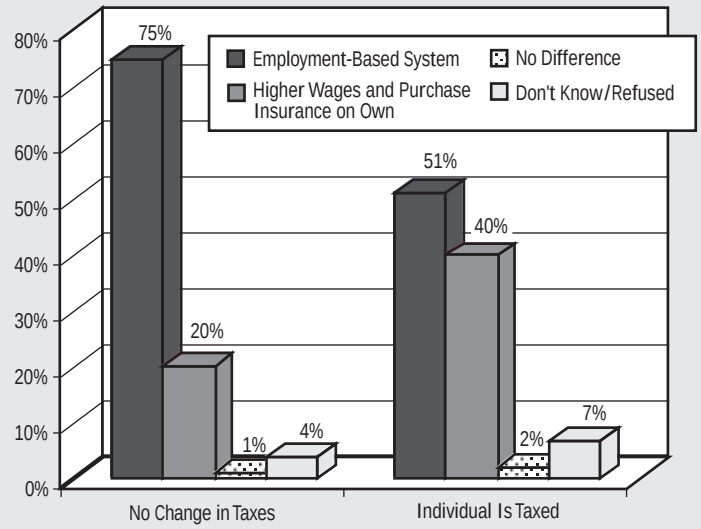


Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

any change in the tax preference for health benefits may affect the real price of health insurance, it is important to understand how the public currently feels about employment-based health insurance, alternatives to the employment-based system, and changes to the tax code. For example, a recent public opinion survey conducted by the Employee Benefit Research Institute found that 68 per-cent of Americans with employment-based health insurance were satisfied with the current mix of benefits and wages (chart 3).[20] Twenty percent of respondents reported that they preferred *higher* health benefits and *lower* wages, while 8 percent reported the opposite preference—for lower health benefits and higher wages.

The survey asked two questions in order to gauge who might opt out of the employment-based system. The first question asked about a proposal that would simply de-link health insurance from employment by giving workers higher income that could be used to purchase health insurance on their own. The second question was geared toward determining whether individuals would opt out of the employment-based system if health insurance benefits were subject to taxes. Under both questions, respondents were asked whether they would prefer that workers continue to get health insurance through employers or receive higher wages and purchase insurance on their own. Under the scenario in which the tax code is unchanged, 75 percent of respondents prefer that workers get health insurance through an employer (chart 4). Twenty percent would prefer a higher wage to purchase health insurance on their own, and 5 percent were indifferent, did not know, or refused to answer the question.

Chart 4
Preference for Employment-Based Insurance Under Various Proposals



Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

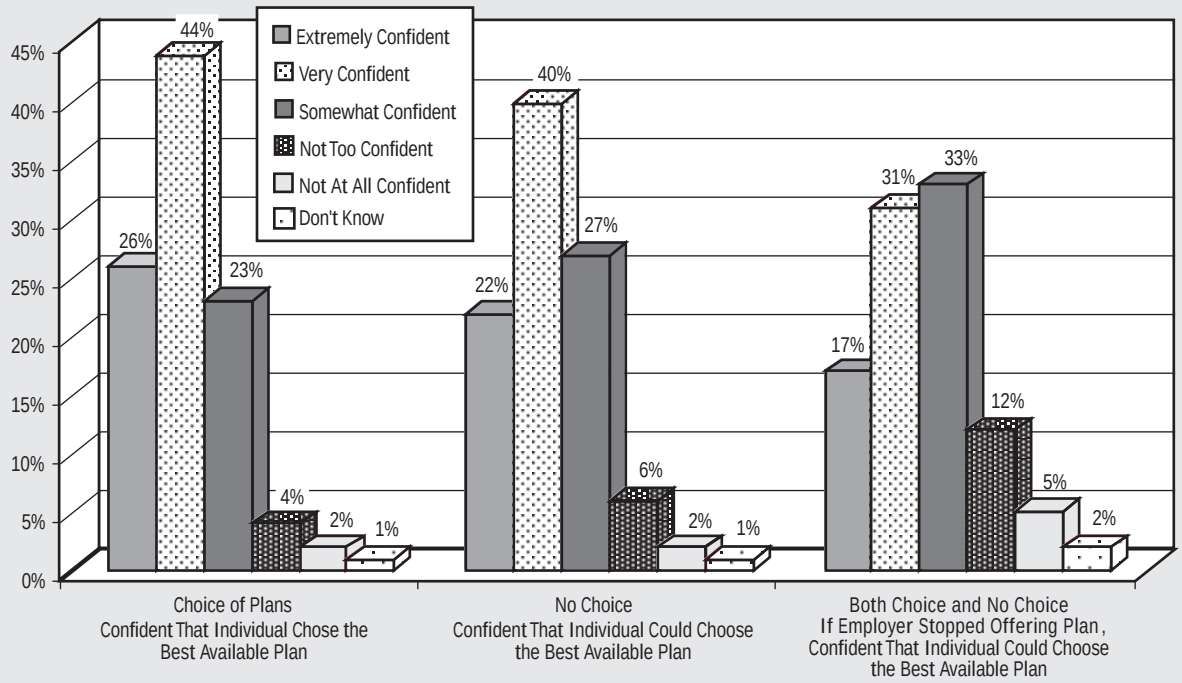
Under the changing tax code scenario, there is still strong support for the employment-based system, but support doubles for higher wages to purchase health insurance in the individual market, increasing from 20 percent to 40 percent (chart 4).

Strong support for the employment-based system may be

[20] *This survey was designed by the Employee Benefit Research Institute and Mathew Greenwald & Associates, and conducted by telephone in February and March 1999. Individuals ages 20 and older with employment-based health insurance were interviewed, with a sample size of 1,004. The margin of error for questions asked of all 1,004 is approximately +/– 3 percent.*

Chart 5

Confidence That Individual Chose or Could Choose the Best Health Plan



Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

the result of respondents' lack of confidence in their ability to choose the best health plan if their employer stopped offering health insurance. According to chart 5, 17 percent of respondents reported that they were not confident they would be able to choose the best health plan if their employer stopped offering health insurance. This compares with 6 percent who were not confident that they *did* choose the best health plan from the choices that their employer gave them and 8 percent not confident that they *could* choose the best health plan if their employer gave them a choice of plans.

Who Would Opt Out of Employment-Based Insurance?

The two questions used above to determine public attitudes toward employment-based health insurance and the alternatives through changes in the tax code were used to define three insurance personalities, as follows:

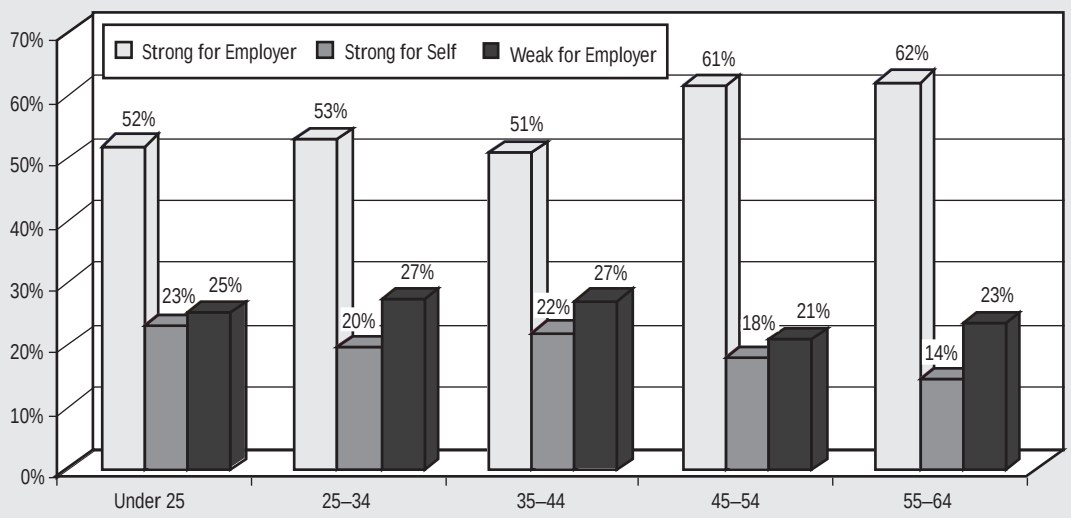
- Individuals with strong preference for the employment-based system.
- Individuals with strong preference for an individual-based system.
- Individuals with weak preference for the employment-based system.

Individuals categorized as having a strong preference for the employment-based system reported that they favored workers getting their health insurance through employers whether or not the tax code was changed. Individuals categorized as having a strong preference for an individual-based system also reported that they favored it in both questions. Individuals categorized as having a weak preference for the employment-based system reported that workers should get health insurance through employers if the tax code was not changed, and reported that workers should receive higher wages to purchase health insurance if the tax exclusion for health benefits was removed. Overall, approximately 85 percent of the sample fit into one of these three categories.

The insurance personalities defined above were used to determine the characteristics of individuals most likely to be associated with the odds of opting out of employment-based coverage. It is important to understand who would and would not opt out of an employment-based health plan when given the choice, as the composition of those in and out of the system would affect the average premiums paid by these two groups, and ultimately, the sustainability of these two market systems.

For example, if younger individuals are more likely to opt out than older individuals, or if healthy

Chart 6
Health Insurance Preference, by Age



Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

individuals are more likely than unhealthy individuals to opt out, average premiums would rise for individuals in the employment-based health insurance system, while average premiums would fall for individuals buying insurance on their own. It is also important to understand the characteristics of those likely to remain in an employment-based health plan, as this may indicate whether an employer would decide to continue or terminate a plan. This section summarizes the findings on the characteristics most likely associated with a person's decision to opt out of employment-based health insurance.

Gender and Age—The survey showed that men are more likely than women to have a strong preference for an individual-based health insurance system. Specifically, 22 percent of males are categorized as having a strong preference for higher wages to buy health insurance on their own, compared with 17 percent of women. It was also found that older persons are more likely than younger persons to strongly support the employment-based system and less likely to support an individual-based system, as shown in chart 6. The difference in support for an individual-based system is larger between the 55–64 age group and the under-45 group than it is for the 45–54 age group and the group under age 45. Since younger individuals are less costly than older individuals to insure, and males are less costly than females under age 45, if opting out of employment-based system became an option, the insurance risk pool would become more segmented, driving up premiums in the employment-based system and driving down premiums in the individual-based system.

Health Status—While the survey did not find any difference in system preference by general health status (chart 7), it did find weak evidence that individuals with a serious health condition are more likely than those who do not have a serious health condition to support the employment-based system (chart 8). This suggests that individuals with a serious health condition may be uncertain about getting insurance on their own because of their health status. The findings do not suggest that individuals with health problems would be more likely to opt out of the employment-based system because of their dissatisfaction with managed care.[21]

Other Findings—The survey findings also show the following:

- Republicans are more likely than Democrats to support an individual-based system (chart 9).
- Persons dissatisfied with their health plan are more likely than satisfied persons to opt out of the employment-based system (chart 10).
- Individuals least confident in their employers' ability to select a health plan or extremely confident in their

[21] *These findings are consistent with what we know about elections under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): Workers in unhealthy families are more likely than workers in healthy families to continue coverage under COBRA, as evidenced by the large difference in utilization and expenditures between COBRA beneficiaries and active worker enrollees (Fronstin, 1998a).*

own ability to select a health plan are more likely than other individuals to opt out of the employment-based health insurance system (chart 11 and chart 12).

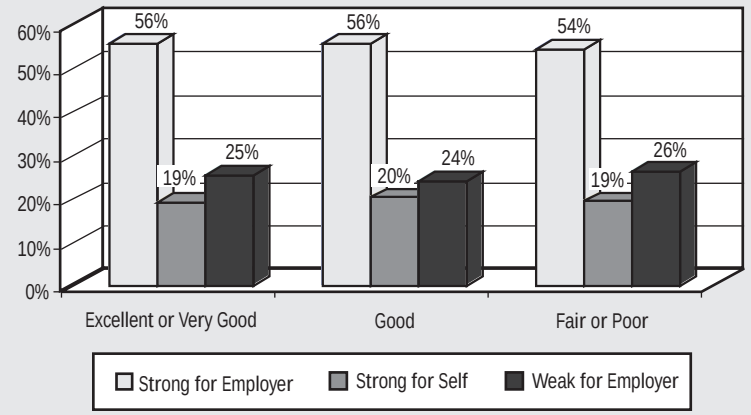
- Individuals who think their health plan is easy to understand are more likely than individuals who think it is hard to understand to opt out of the employment-based system (chart 13).
- There is evidence that individuals in health plans with a lot of managed care features (HMO-type plans) are more likely than individuals in fee-for-service plans to opt out of the employment-based system (chart 14).

The Uninsured

While public opinion is always helpful in understanding support for various proposals and how individuals may respond, it is just as important to use existing data to determine the likely effects of changing the tax treatment of employment-based health insurance on coverage rates and the uninsured. This section summarizes recent studies that have examined various implications under a range of assumptions.

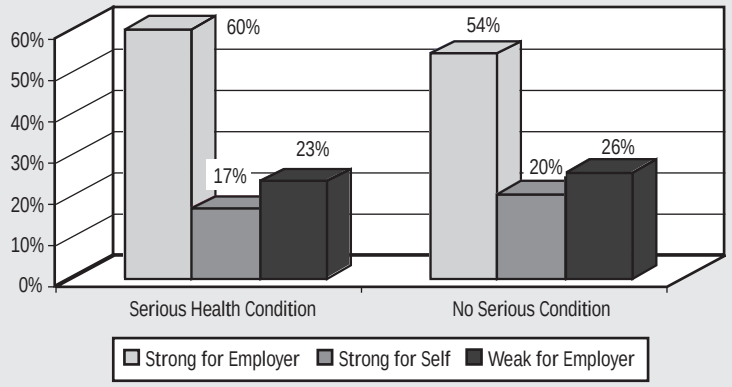
One of the concerns over changing the tax treatment of employment-based health insurance is that the change would erode (and potentially destroy) the employment-based system. As mentioned above, a tax credit may induce individuals to purchase health insurance on their own or it may make it harder for vulnerable populations to continue coverage. This has different implications for various segments of the insured and uninsured

Chart 7
Health Insurance Preference, by General Health Status



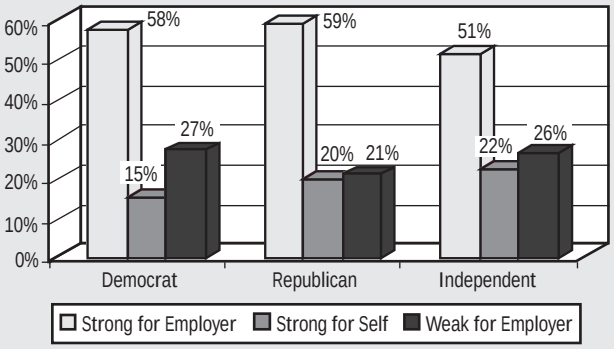
Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

Chart 8
Health Insurance Preference, by Serious Health Condition



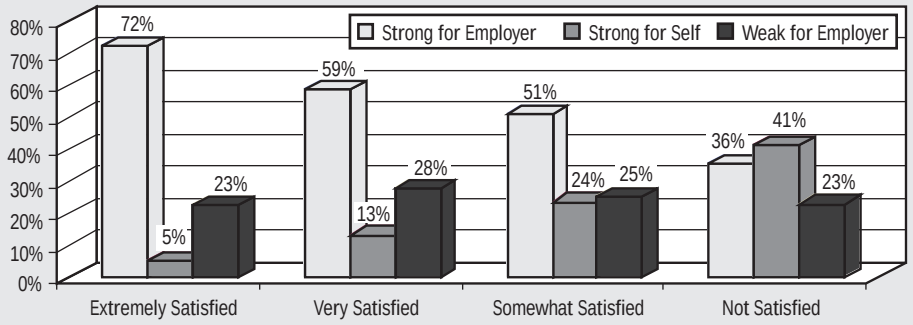
Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

Chart 9
Health Insurance Preference, by Political Affiliation



Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

Chart 10
Health Insurance Preference, by Satisfaction With Current Health Plan

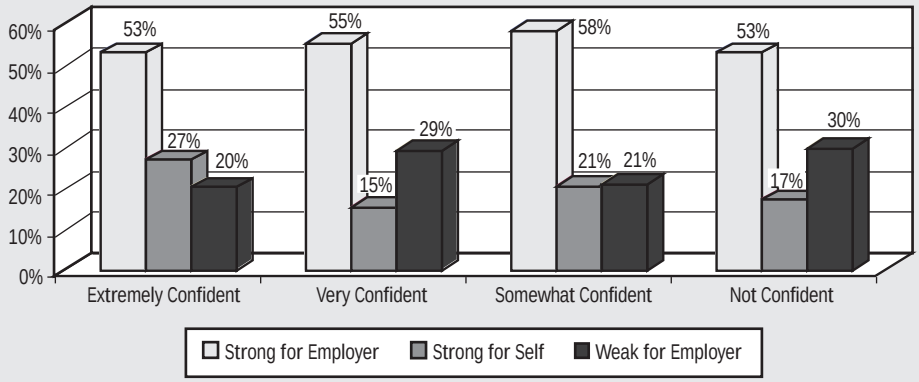


Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

Chart 11
Health Insurance Preference, by Confidence That Employer Selected Best Health Plan

Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

Chart 12
Health Insurance Preference, by Confidence That Individual Could Choose Best Available Health Plan



Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

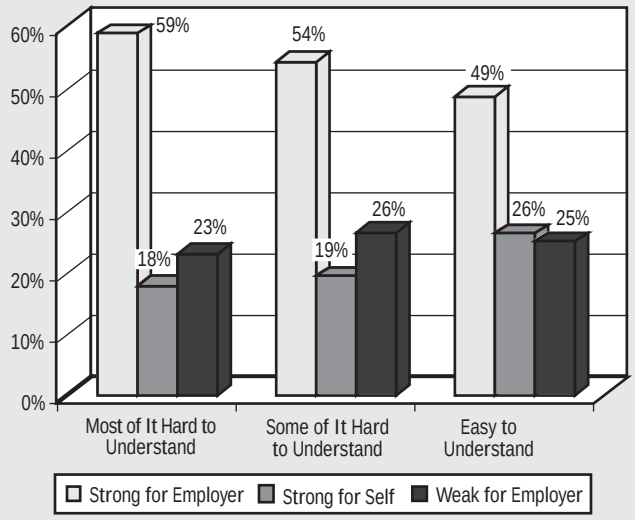
populations. For example, if only young healthy people choose to opt out of their employment-based plans, premiums would increase for individuals remaining in employer plans, while they would decline for individuals who opt out. This might have the unintended side effect of reducing coverage among individuals who remain in the employment-based system if the cost of employment-based health insurance is less affordable, ultimately increasing the uninsured population.

The current tax treatment of employment-based health insurance has been shown to be regressive in table 1, as discussed above. However, removing (or simply changing) the tax subsidy might not increase social welfare, as discussed in Custer (1999). The assertion that the tax treatment of employment-based health insurance distorts the market for health insurance, thereby creating an inefficient allocation of resources, is based on the assumption that the tax preference is the only reason the market for health care services is inefficient. If other factors prevent the health care system from performing optimally, the "theory of second best" suggests that changing the tax preference might not increase social welfare.

Custer (1999) found that removing the tax preference for employment-based health insurance would have a larger effect on individuals in families with at least one family member in fair or poor health than on families in which all members are in good health or better. Specifically, he found that if the tax preference for employment-based health insurance were eliminated, employment-based coverage would decline 17 percent for individuals in healthy families and 34 percent for individuals in unhealthy families.[22] Similarly, Monheit, Nichols, and Selden (1995/96) found that the employment-based system and its tax treatment act to transfer income from individuals in good health to those in poor health. Essentially, the tax treatment of employment-based health insurance acts to promote participation in health plans among low-risk individuals, which ultimately assists the pooling of risk.

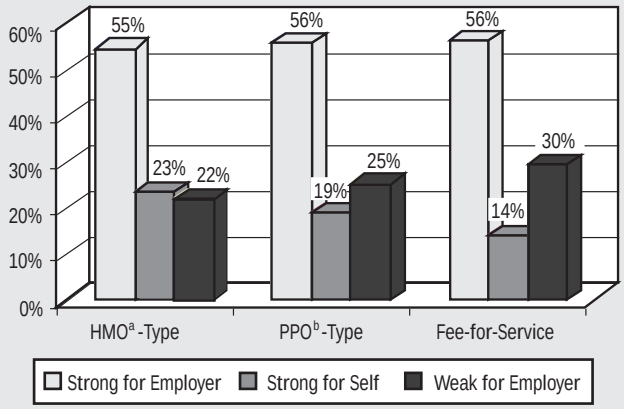
Changing the tax treatment of employment-based health benefits might affect the overall level of the uninsured. Custer (1999), for example, found that removing the tax subsidy would reduce the number of

Chart 13
Health Insurance Preference, by Understanding of Health Plan



Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

Chart 14
Health Insurance Preference, by Type of Health Plan



Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.
[a] Health maintenance organization.
[b] Preferred provider organization.

[22] *Custer (1999) found that the percentage of individuals in healthy families with employment-based health insurance would decline from 70 percent to 58 percent. The percentage of individuals in unhealthy families with employment-based coverage would fall from 47 percent to 31 percent.*

individuals covered by an employment-based health plan by more than 20 million. While he finds that 3.5 million individuals would purchase coverage in the individual market, many others would not, resulting in a substantial net increase in the uninsured. Even if the tax treatment were changed so that anyone purchasing health insurance qualified for a tax credit, affordability would continue to be an issue for low-income workers.

Even repackaging the tax credit might affect the level of the uninsured. Thorpe (1999) found that introducing a tax credit would reduce the level of the uninsured, but the reduction would depend in large part on the level of the tax credit. Specifically, he found that an annual tax credit of $400 would result in 18 percent of single uninsured workers with incomes at 150 percent of poverty participating in a health plan. At a tax credit of $800, their participation would rise to 22 percent. As mentioned earlier, some proposals would set the tax credit at $500 for a single person. In order to achieve a take-up rate of 75 percent, Thorpe (1999) determined that the tax credit would need to be set at $2,800 a year for a single low-income uninsured worker.

While some members of the uninsured population would gain coverage under a tax credit system, others in the employment-based system might drop coverage, leading to a net change in the level of the uninsured that could be positive or negative. Attempting to model this net increase, Cox and Topoleski (1999) found that the uninsured would increase between 0.2 million and 24 million people, depending on the generosity of the tax credit and the parameters used to determine eligibility for the tax credit.

Conclusion

Employment-based health plans are the most common source of health insurance in the United States, providing coverage to nearly two-thirds of the nonelderly population. Employment-based health benefits are also perceived by workers as the most important employee benefit. The question continues to arise as to whether the employment-based health insurance system is the most appropriate system for expanding health insurance coverage to the 43.1 million uninsured Americans in the United States.

The major complication involved in designing any system to expand coverage among uninsured individuals is how to avoid disrupting the current system that covers nearly two-thirds of the nonelderly population

While the employment-based health insurance system has numerous advantages over other types of financing and delivery methods, it also has many drawbacks. Job-lock and the differential tax treatment of health insurance by source of coverage are major concerns of policymakers and of many Americans.

The major complication involved in designing any system to expand coverage among uninsured individuals is how to avoid disrupting the current system that covers nearly two-thirds of the nonelderly population and inadvertently cause an increase among the uninsured in the United States.

Issues such as adverse selection, substitution of private insurance by public insurance, or substitution of individual coverage for group coverage are inherent in the current voluntary employment-based health insurance system, and will not be resolved by incremental changes made to improve this system. For example, young and healthy individuals are more likely than older unhealthy individuals to opt out of the employment-based system under certain circumstances. As long as the purpose of insurance continues to be the spreading of risk across higher-risk and lower-risk individuals, attempts to augment or replace the employment-based health insurance system may have unintended side effects that do not benefit the majority of the U.S. population.

References

Cooper, Philip F., and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996." *Health Affairs* (November–December 1997).

Cox, Donald F., and Christopher Topoleski. "Individual Choice Initiatives: Analysis of a Hypothetical Model Act." Paper presented at the Employee Benefit Research Institute - Education and Research Fund (EBRI-ERF) policy forum, "Severing the Link Between Health Insurance and Employment: What Happens if Employers Stop Offering Health Benefits?" Washington, DC, May 5, 1999.

Custer, William S. "The Tax Preference for Employment-Based Health Insurance Coverage." Paper presented at the Employee Benefit Research Institute - Education and Research Fund (EBRI-ERF) policy forum, "Severing the Link Between Health Insurance and Employment: What Happens if Employers Stop Offering Health Benefits?" Washington, DC, May 5, 1999.

Fronstin, Paul. "Portability of Health Insurance: COBRA Expansions and Job Mobility." *EBRI Issue Brief* no. 194 (Employee Benefit Research Institute, February 1998a).

_____. "64.2 Percent of Nonelderly Americans Have Employment-Based Health Insurance, 18.3 Percent are Uninsured." *EBRI Notes*, no. 11 (November 1998b): 1–7.

_____. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey." *EBRI Issue Brief* no. 204 (Employee Benefit Research Institute, December 1998c).

Fronstin, Paul, and Sarah C. Snider. "An Examination of the Decline in Employment-Based Health Insurance Between 1998 and 1993." *Inquiry* (Winter 1996/97): 317–325.

Gabel, Jon, Kimberly Hurst, Heidi Whitmore, Samantha Hawkins, Catherine Hoffman, and Gail Jensen. "Health Benefits of Small Employers in 1998." Report prepared for The Henry J. Kaiser Family Foundation. February 1999.

Health Insurance Association of America. *Source Book of Health Insurance Data, 1996*. Washington, DC: Health Insurance Association of America, 1996.

Institute of Medicine. *Employment and Health Benefits: A Connection at Risk*. Washington, DC: National Academy of Sciences, 1993.

Internal Revenue Service. *Statistics of Income Bulletin* (Winter 1998–1999): 1998.

Monheit, Alan C., Len M. Nichols, and Thomas M. Selden. "How Are Net Health Insurance Benefits Distributed in the Employment-Related Market?" *Inquiry* (Winter 1995/96): 379–391.

Ostuw, Pamela. "Health Insurance Continues to be Most Valued Benefit According to Recent EBRI/Gallup Survey." *EBRI Notes* no. 11 (November 1996): 9–12.

Thorpe, Kenneth E. "Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured." Paper presented at the Employee Benefit Research Institute - Education and Research Fund (EBRI-ERF) policy forum, "Severing the Link Between Health Insurance and Employment: What Happens if Employers Stop Offering Health Benefits?" Washington, DC, May 5, 1999.

Varian, Hal. R. *Intermediate Microeconomics: A Modern Approach*. New York: W.W. Norton & Co., 1987.

EBRI
EMPLOYEE BENEFIT RESEARCH INSTITUTE ®

Issue Brief

EBRI Issue Brief (ISSN 0887-137X) is published monthly at $300 per year or is included as part of a membership subscription by the Employee Benefit Research Institute, 2121 K Street, NW, Suite 600, Washington, DC 20037-1896. Periodicals postage rate paid in Washington, DC. POSTMASTER: Send address changes to: *EBRI Issue Brief*, 2121 K Street, NW, Suite 600, Washington, DC 20037-1896.

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 monthly periodicals providing expert evaluations of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. Each issue, ranging in length from 16–28 pages, thoroughly explores one topic. ***EBRI Notes*** is a monthly periodical providing current information on a variety of employee benefit topics. **EBRI's *Washington Bulletin*** provides sponsors with short, timely updates on major federal developments in employee benefits. **EBRI's *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 volume on employee benefit programs and work force related issues.

Subscriptions/orders

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) or for $7.50 (as an e-mailed electronic file) by calling EBRI or from www.ebri.org. ***Change of Address:*** EBRI, 2121 K Street, NW, Suite 600, Washington, DC 20037, (202) 775-9132; fax number, (202) 775-6312; e-mail: Publications Subscriptions@ebri.org. ***Membership Information:*** Inquiries regarding EBRI membership, and/or contributions to EBRI-ERF should be directed to EBRI President Dallas Salisbury at the above address, (202) 659-0670; e-mail: salisbury@ebri.org

EBRI Issue Brief is registered in the U.S. Patent and Trademark Office. ISSN: 0887-137X 0887-137X/90 $ .50+.50

Could we send a friend or colleague a complimentary copy of *EBRI Issue Brief?*

Send an issue to _____

Organization _____

Address _____

City/State/ZIP _____

Your Name _____

Mail to: EBRI, 2121 K Street, NW, Suite 600, Washington, DC 20037
or Fax to: (202) 775-6312

Did you read this as a pass-along? Stay ahead of employee benefit issues with your own subscription to *EBRI Issue Briefs* for only $49/year electronically e-mailed to you or $99/year printed and mailed. For more information about subscriptions, visit our Web site at www.ebri.org or complete the form below and return it to EBRI.

Name _____

Organization _____

Address _____

City/State/ZIP _____

Mail to: EBRI, 2121 K Street, NW, Suite 600, Washington, DC 20037
or Fax to: (202) 775-6312