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NOTES

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Executive Summary:

- ***Consumer-driven health surveys:*** This report presents findings from the 2008 EBRI Consumer Engagement in Health Care Survey, as well as earlier surveys, examining the availability of HRA and HSA-eligible plans (so-called consumer-driven health plans). It also looks at employer and individual contribution behavior, time enrolled in such plans, account balances, and rollover behavior.
- ***CDHP enrollment:*** In 2008, 3 percent of the adult population with private health insurance was enrolled in a health reimbursement account (HRA) or had a high-deductible plan with a health savings account (HSA) in 2008. An additional 3.6 percent were eligible for an HSA but did not have such an account. Overall, 6.6 percent of adults with private insurance were either in a consumer-driven health plan (CDHP) or were in a high-deductible plan that was eligible for an HSA, but had not opened an account.
- ***CDHP eligibility:*** Among individuals with traditional employment-based health benefits and a choice of health plan, 40 percent were eligible for a CDHP in 2008, up from 33 percent in 2006. About 22 million workers were eligible for such a plan in 2008 but chose to remain in the more traditional plan.
- ***Contributions:*** Workers with employee-only coverage and an employer contribution have seen their annual employer contributions increase, and a majority of workers with family coverage receive a contribution of $1,000 or more. The percentage of individuals with employee-only coverage contributing nothing to an HSA was 19 percent in 2008. Persons both with and without health problems are about equally likely to contribute to an HSA, and their contribution levels are about the same.
- ***Longer time in plan:*** Between 2006 and 2008, the percentage of individuals in a CDHP for one to two years increased from 30 percent to 41 percent, and the percentage in these plans for three to four years increased from 9 percent to 19 percent.
- ***Account balances:*** The amount of money that individuals have accumulated in their accounts has grown. The percentage of individuals reporting that they had nothing in their account declined from 14 percent in 2006 to 9 percent in 2008. The percentage of individuals reporting an account balance of at least $1,000 increased from 25 percent in 2006 to 44 percent in 2007, and remained at 43 percent in 2008.
- ***Rollover behavior:*** The percentage of persons reporting no rollover fell from 23 percent to 16 percent between 2006 and 2008. The percentage reporting a rollover of $1,500 or more increased from 13 percent in 2006 to 27 percent in 2008.

Availability, Contributions, Account Balances, and Rollovers in Account-Based Health Plans

by Paul Fronstin, EBRI

Introduction

Employers have been interested in bringing aspects of consumerism into health plans for many years. As far back as 1978, they adopted Sec. 125 cafeteria plans and flexible spending accounts. More recently, employers have been increasingly turning their attention to consumer engagement in health care. In 2001, they focused on account-based health plans—a combination of health plans with deductibles of at least $1,000 for employee-only coverage and tax-preferred savings or spending accounts that workers and their families can use to pay their out-of-pocket health care expenses. A few employers first started offering account-based health plans in 2001, when they began to offer health reimbursement arrangements (HRAs).[1] In 2004, employers were able to start offering health plans with health savings accounts (HSAs).[2] By 2007, 7 percent of employers with 10–499 workers and 11 percent of those with 500 or more workers offered either an HRA- or HSA-eligible plan.[3] Employers have also taken a broader approach to consumer engagement through various other initiatives.[4]

This report presents findings from the 2008 EBRI Consumer Engagement in Health Care Survey and the 2006 and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys.[5] It examines the availability of HRA and HSA-eligible plans (so-called consumer-driven health plans or CDHPs), as well as employer and individual contribution behavior, time enrolled in such plans, account balances, and rollover behavior.

CDHP Eligibility

As reported in earlier research, 4.2 million adults ages 21–64 with private health insurance, or 3 percent of the adult population with private health insurance, was enrolled in an HRA or had a high-deductible plan with an HSA in 2008, up from 2 percent in 2007 and 1 percent in 2006.[6] An additional 5.6 million adults ages 21–64 with private health insurance, or 3.6 percent, reported that they were eligible for an HSA but did not have such an account. Thus, overall, 9.8 million adults ages 21–64 with private insurance, representing 6.6 percent of that market, were either in a CDHP or were in a high-deductible plan that was eligible for an HSA, but had not opened an account.

It was found that a significant percentage of workers with traditional health benefits were eligible for account-based health plans and that the percentage has been growing. Among individuals with traditional employment-based health benefits and a choice of health plan, 40 percent were eligible for an HRA or HSA-based plan in 2008, up from 33 percent in 2006 (Figure 1). According to a recent study, slightly more than one-half (52 percent) of workers were eligible for at least two health plans, thus about 22 million workers were eligible for such a plan in 2008 but chose to remain in the more traditional plan.

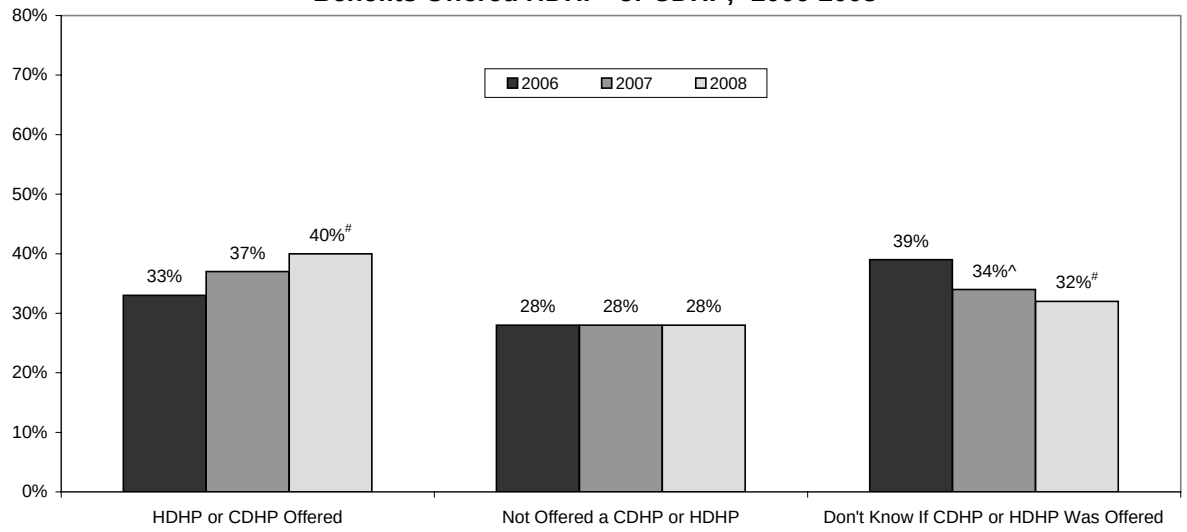
Employer Contributions

The percentage of workers with an HRA or HSA plan whose employer contributes to the account has not changed significantly since 2006. However, after falling between 2006 and 2007, the percentage with an employer contribution increased from 61 percent in 2007 to 66 percent in 2008 (Figure 2).

Among workers with an employer contribution, those with employee-only coverage have seen their annual employer contributions increase. Between 2006 and 2008 the percentage reporting that their employer contributed $1,000 or more to the account increased from 26 percent to 37 percent (Figure 3). Among workers with family coverage, the percentage reporting a contribution of $200–$499 decreased from 11 percent to 6 percent between 2006 and 2008, while the percentage reporting contributions of $500–$749 increased from 4 percent to 10 percent between 2007 and 2008 (Figure 4). A majority of workers with family coverage receive a contribution of $1,000 or more. The percentage of workers

Figure 1

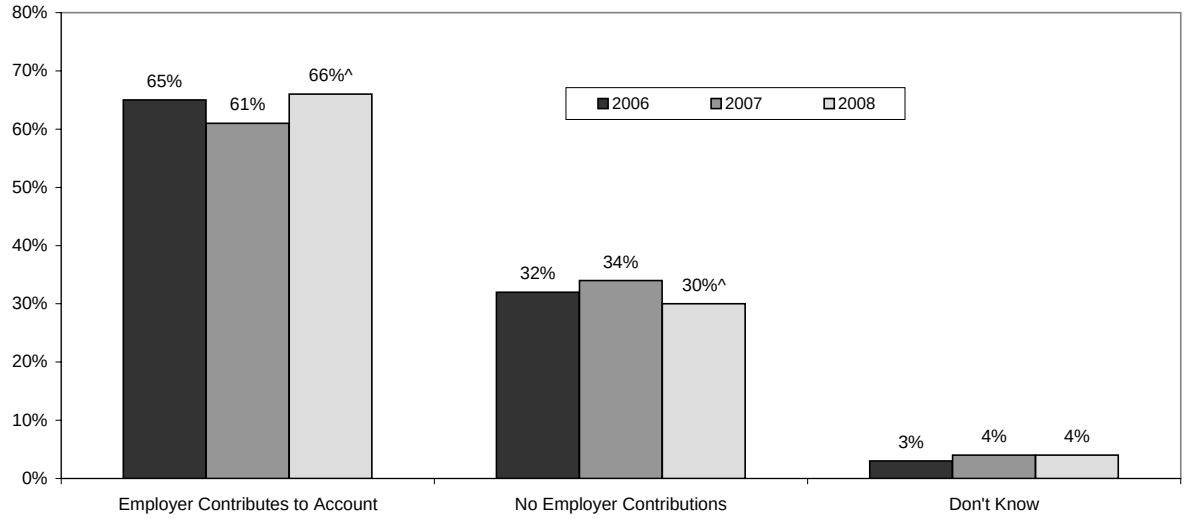
Percentage of Individuals With Comprehensive[1] Employment-Based Health Benefits Offered HDHP[2] or CDHP,[3] 2006-2008



Source: EBRI/Commonwealth Fund Consumerism in Health Care Surveys, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan w/ deductible $1,000+ (individual), $2 000+ (family), with account.
^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.
# Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

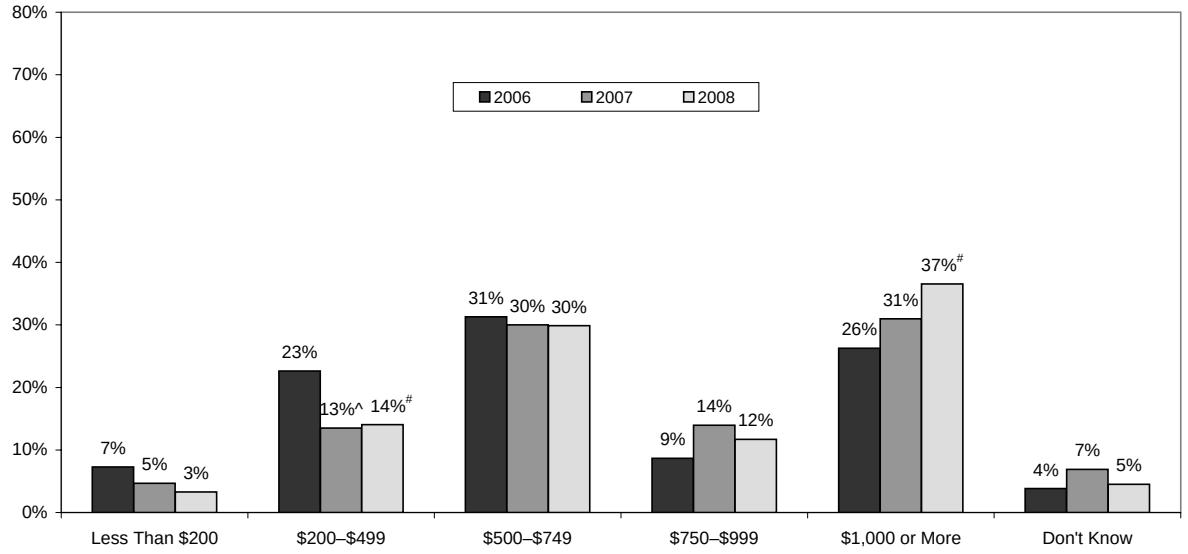
Figure 2

Percentage of Individuals With Employer Contribution to Account, Among Persons With Employment-Based Health Benefits and CDHP,[1] 2006–2008



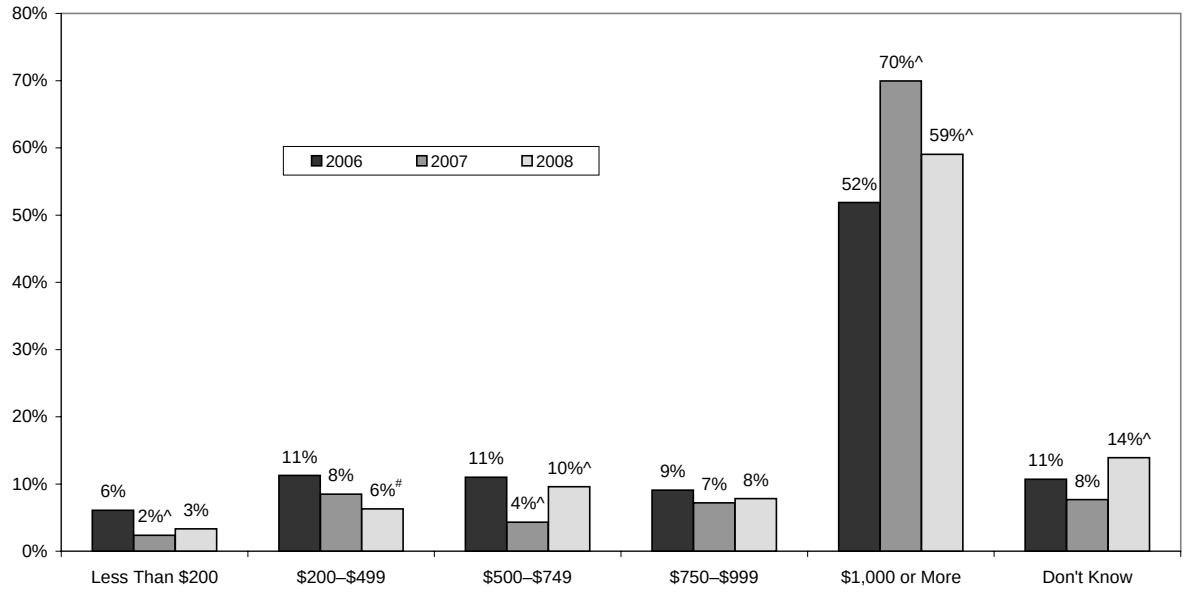
Source: EBRI/Commonwealth Fund Consumerism in Health Care Surveys, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.
# Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 3
Annual Employer Contributions to the Account, Among Persons With Employee-Only CDHP,[1] 2006–2008



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 4
Annual Employer Contributions to the Account, Among Persons With Family CDHP,[1] 2006–2008



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

receiving such a contribution increased substantially between 2006 and 2007, increasing from 52 percent to 70 percent, but then declined to 59 percent in 2008 (which was not statistically different from the 52 percent level in 2006).

Individual Contributions

Individuals' contributions to HSA plans have also increased. Between 2006 and 2007, the percentage of individuals with employee-only coverage contributing nothing to an HSA decreased from 28 percent to 18 percent, and it remained at 19 percent in 2008 (Figure 5). In contrast, the percentage contributing between $1,000 and $1,499 increased from 9 percent in 2006 to 21 percent in 2008, while the percentage contributing $1,500 or more increased from 21 percent to 30 percent. Among persons with the family coverage, the percentage not making any contributions was unchanged between 2006 and 2008, but the percentage contributing less than $500 fell from 16 percent to 5 percent, while the percentage contributing $1,500 or more increased from 36 percent in 2006 to 51 percent in 2008 (Figure 6). It is not surprising that individuals with family coverage contribute more than individuals with employee-only coverage, as deductibles are higher for family coverage.

Income Differences—Generally, lower-income persons with HSAs are less likely to make a contribution to the account than higher-income persons. About one-quarter of persons in households with less than $50,000 in income did not contribute to the account in 2008 (Figure 7), while about 15 percent of persons with $50,000 in household income did not contribute (Figure 8). For both income groups, the percentage contributing $1,500 or more increased between 2006 and 2008. Among the lower-income group, the percentage contributing at least $1,500 increased from 16 percent to 27 percent, while among the higher income group, 47 percent contributed at least $1,500 in 2008, up from 37 percent in 2006.

Health Differences—Persons both with and without health problems are about equally likely to contribute to an HSA, and their contribution levels are about the same.[7] Those with health problems contribute slightly more than those without health problems. Contribution levels increased significantly for both groups between 2006 and 2007 and were then unchanged in 2008. Among persons without health problems, 28 percent contributed $1,500 or more in 2006, while 41 percent contributed $1,500 or more in 2007 and 2008 (Figure 9). Similarly, 46 percent of those with a health problem contributed $1,500 or more in 2007 and 2008, up from 33 percent in 2006 (Figure 10).

Length of Time in Plan

While HRAs and HSAs are still relatively new and a relatively small percentage of the health insurance market, a significant change has already occurred in the length of time individuals have been enrolled in these plans. Between 2006 and 2008 the percentage of individuals in these plans for one to two years increased from 30 percent to 41 percent, and the percentage in these plans for three to four years increased from 9 percent to 19 percent (Figure 11).

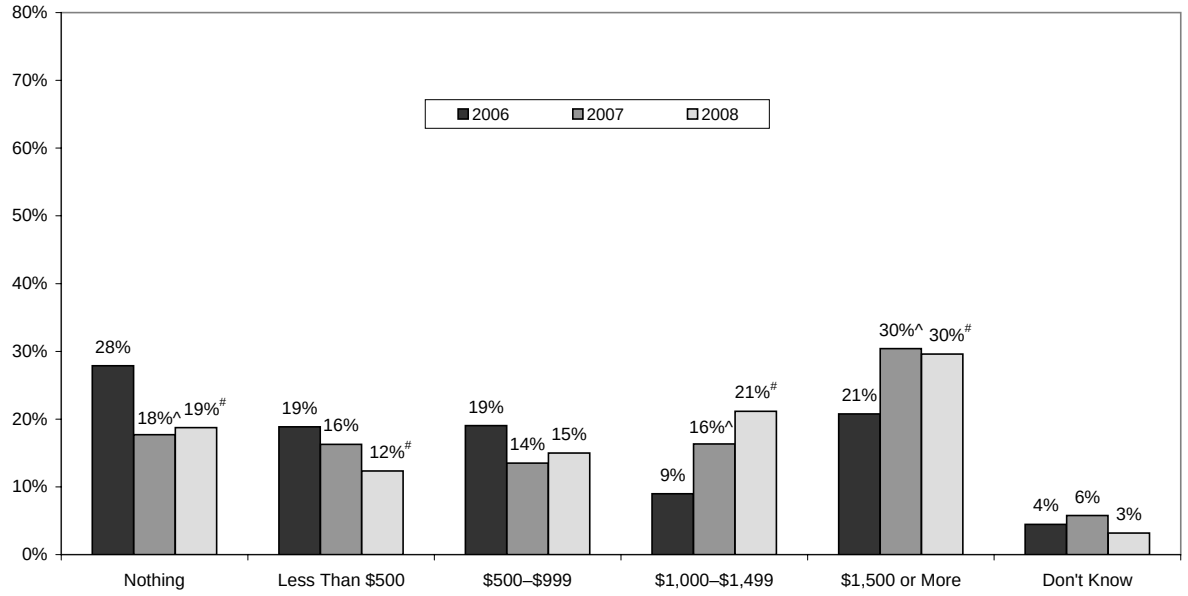
Account Balances and Rollover Behavior

The amount of money that individuals have accumulated in their accounts has grown over time. The percentage of individuals reporting that they had nothing in their account at the time of the survey declined from 14 percent in 2006 to 9 percent in 2008 (Figure 12). There were also statistically significant declines in the percentage of individuals with less than $200 and $200–$499. In contrast, the percentage of individuals reporting an account balance of at least $1,000 at the time of the survey increased from 25 percent in 2006 to 44 percent in 2007, and remained at 43 percent in 2008.

The amount of money being rolled over in the accounts from one year to the next has also increased. The percentage of persons reporting no rollover fell from 23 percent to 16 percent between 2006 and 2008 (Figure 13). The percentage reporting a rollover of $1,500 or more increased from 13 percent in 2006 to 27 percent in 2008. Some of the increase in rollover amounts may be due to the statistically significant decline in the percentage of individuals who reported that they did not know how much money had been rolled over.

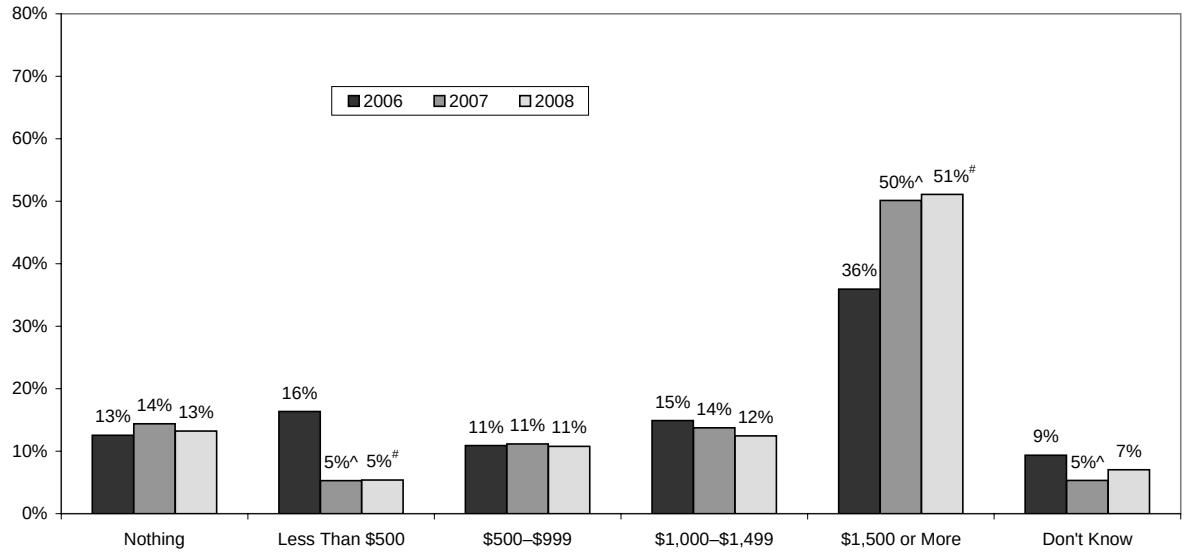
Health Status— Persons with health problems (as defined earlier) rolled over less money than persons with no health problems. In 2008, 11 percent of persons with no health problems did not roll over any money, whereas 21 percent of persons with health problems did not roll over any money, although that had fallen significantly from 35 percent in 2006 (Figures 14 and 15). Rollover amounts

Figure 5
Annual Individual Contributions to the Account, Among Persons With Employee-Only CDHP,[1] 2006–2008



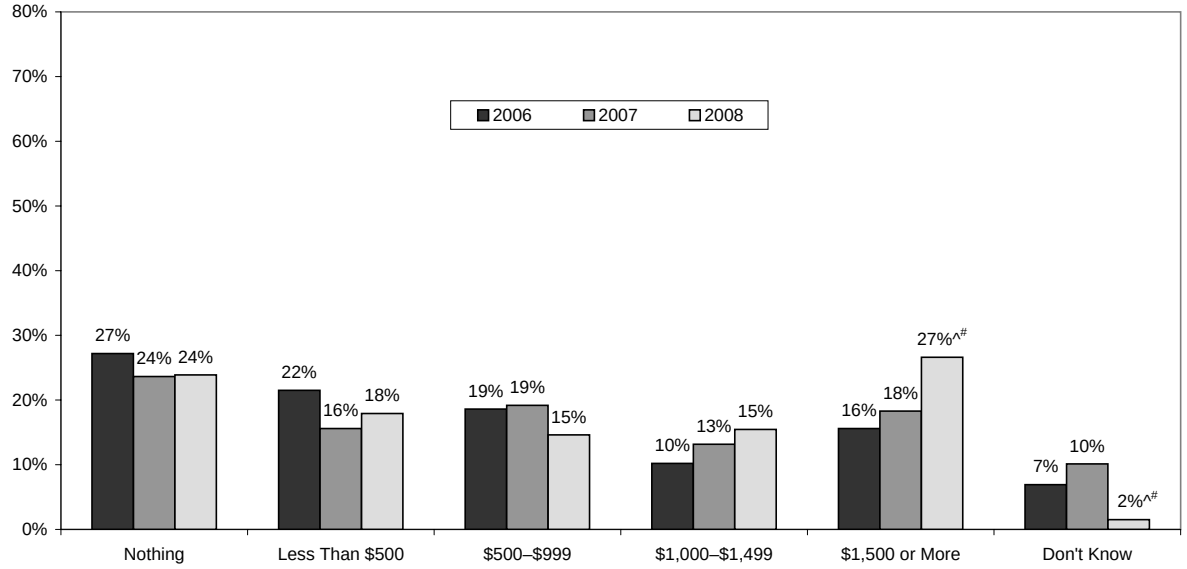
Source: EBRI/Commonwealth Fund Consumerism in Health Care Surveys, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 6
Annual Individual Contributions to the Account, Among Persons With Family CDHP,[1] 2006–2008



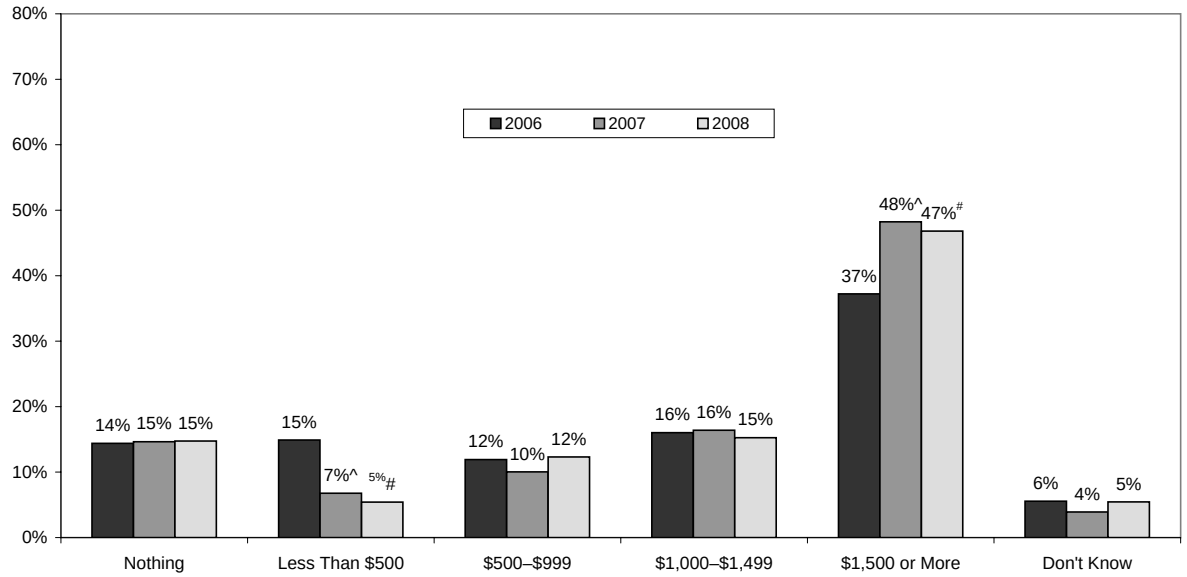
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 7
Annual Individual Contributions to the Account, Among Persons With Employee-Only or Family CDHP[1] and Household Income Under $50,000, 2006–2008



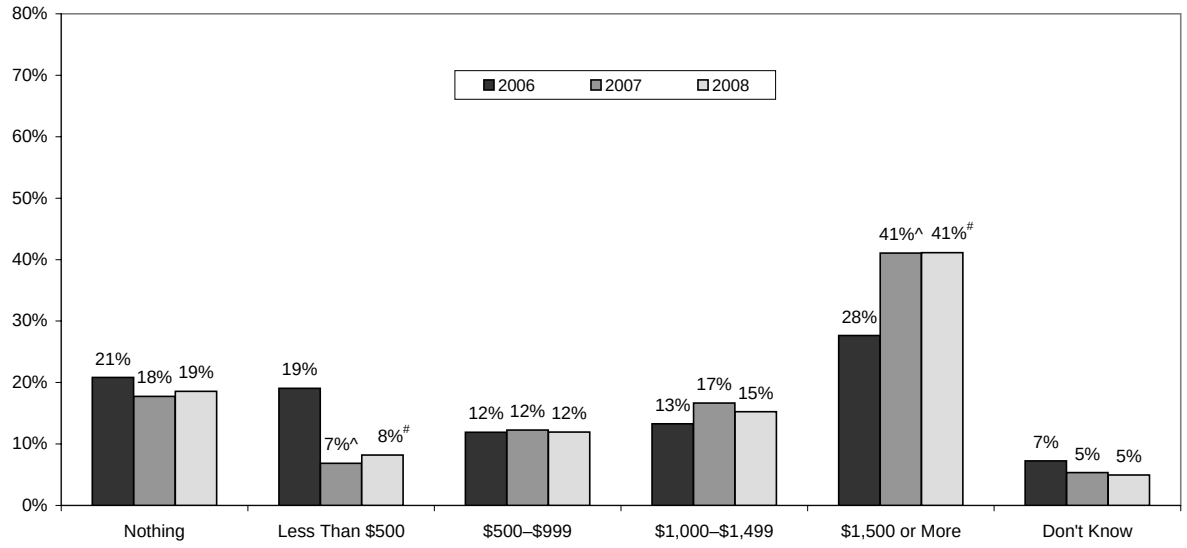
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 8
Annual Individual Contributions to the Account, Among Persons With Employee-Only or Family CDHP[1] and Household Income $50,000 or More, 2006–2008



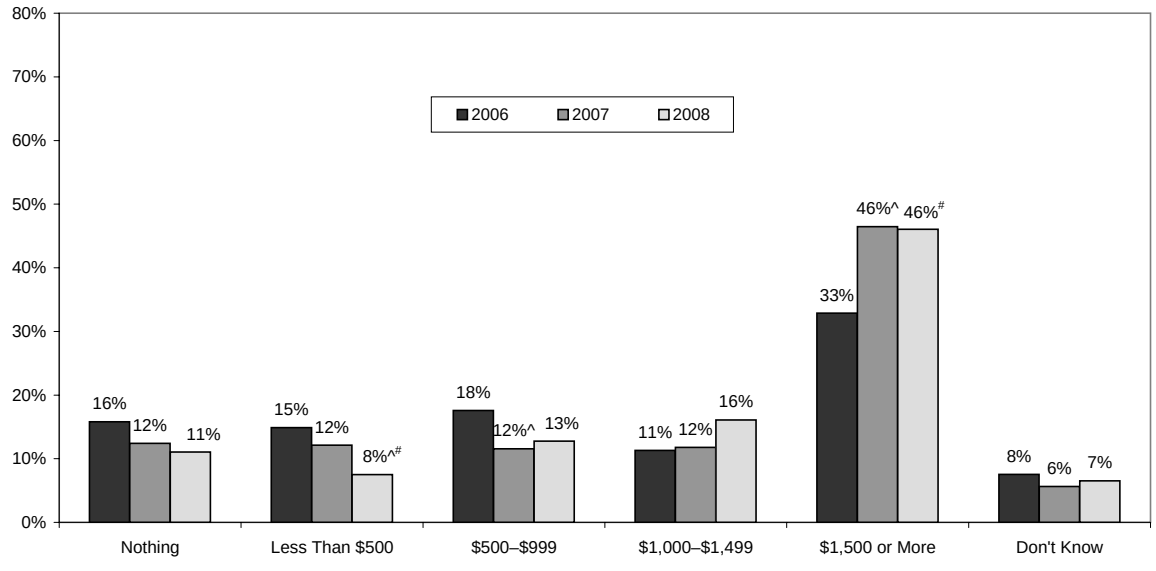
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 9
Annual Individual Contributions to the Account, Among Persons With Employee-Only or Family CDHP[1] and No Health Problems, 2006–2008



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 10
Annual Individual Contributions to the Account, Among Persons With Employee-Only or Family CDHP[1] and Health Problem, 2006–2008



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

increased for both those with and without health problems. Among those without health problems, 15 percent rolled over $1,500 or more in 2006 and 33 percent did so in 2008. Fewer individuals with health problems rolled over $1,500 or more, but the percentage with such a rollover increased from 11 percent in 2006 to 19 percent in 2008.

Conclusion

Rollover amounts and account balances in account-based health plans have increased. This may be due to the fact that individuals have had CDHPs for a longer period of time than in the past. It may also be because both employers and individuals have increased their contributions to the accounts. As shown in prior work, the percentage of persons with a CDHP working for a large employer has increased, which may partly explain the higher employer contribution levels. Higher deductibles may in part explain higher individual contributions.

Finally, as more healthy individuals enroll in CDHPs, driving up the average health status of the CDHP population, account balances and rollover amounts will increase. This does not explain why rollover amounts have increased for individuals with health problems, but that can also be explained by rising employer contributions. Ultimately, more research is needed in this area.

Endnotes

[1] See Paul Fronstin, "Can 'Consumerism' Slow the Rate of Health Benefit Cost Increases?" *EBRI Issue Brief,* no. 247 (Employee Benefit Research Institute, July 2002).

[2] _____. "Health Savings Accounts and Other Account-Based Health Plans." *EBRI Issue Brief,* no. 273 (Employee Benefit Research Institute, September 2004).

[3] See www.mercer.com/referencecontent.htm?idContent=1287790

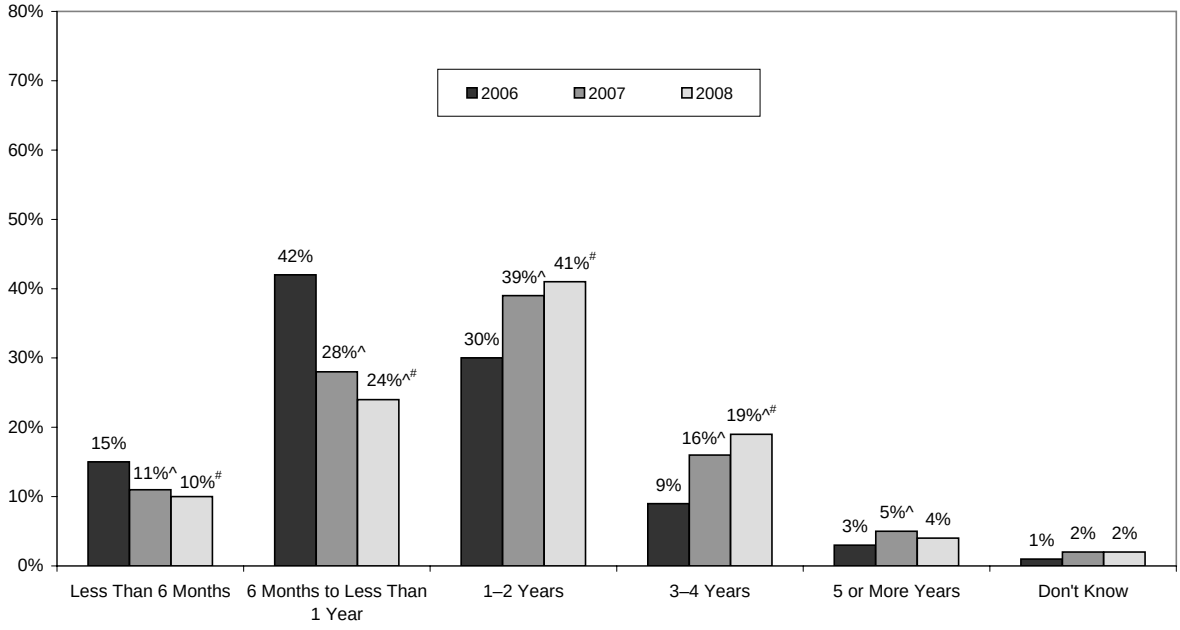
[4] In 2001, employers formed a coalition to report health care provider quality measures, and today the group is composed not only of employers but also includes consumer groups and organized labor (see www.healthcaredisclosure.org/). In 2002, there was interest in tiered provider networks (see Paul Fronstin, "Tiered Networks for Hospital and Physician Health Care Services," *EBRI Issue Brief,* no. 260 (Employee Benefit Research Institute, August 2003). In 2005, employers started to focus on value-based insurance designs that seek to encourage the use of high-value services while discouraging the use of services when the benefits are not justified by the costs (see Michael E. Chernew, Allison B. Rosen, and A. Mark Fendrick, "Value-Based Insurance Design," *Health Affairs* Web Exclusive, (Jan. 10, 2007): w195-w203).

[5] More information about the surveys can be found in Paul Fronstin and Sara Collins, "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans," *EBRI Issue Brief,* no. 300 (Employee Benefit Research Institute, December 2006); Paul Fronstin and Sara R. Collins, "Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey," *EBRI Issue Brief,* no. 315 (Employee Benefit Research Institute, March 2008); and Paul Fronstin, "Findings from the 2008 EBRI Consumer Engagement in Health Care Survey," *EBRI Issue Brief,* no. 323 (Employee Benefit Research Institute, November 2008).

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

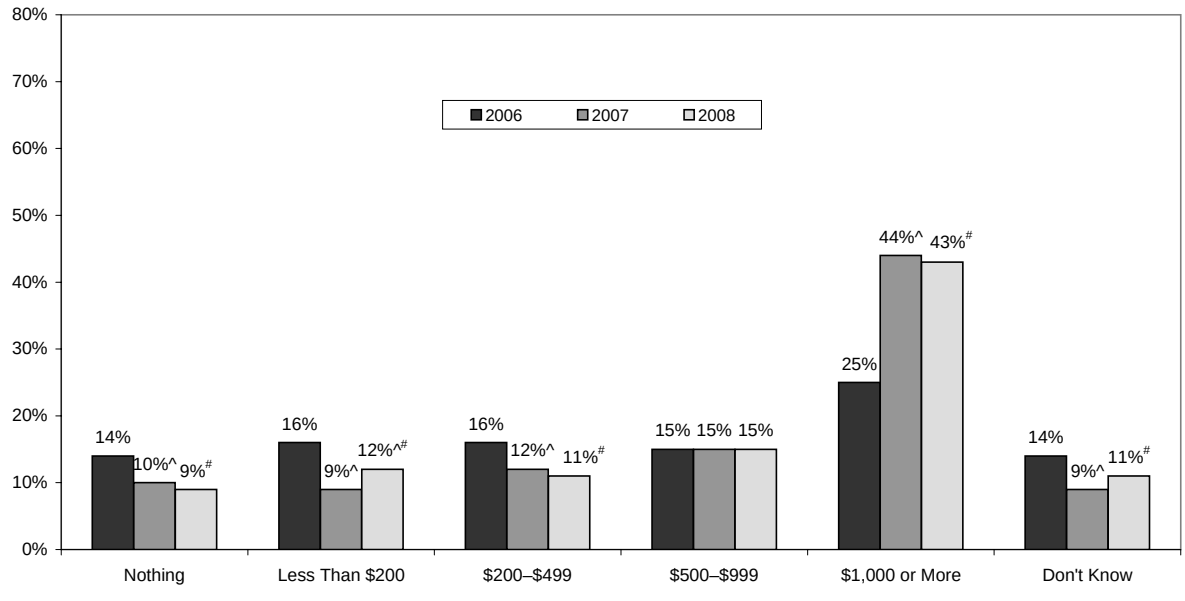
[7] Individuals were defined as having a health problem if they said they were in fair or poor health or had one of eight chronic health conditions (arthritis, asthma, emphysema or lung disease, cancer, depression, diabetes, heart attack or other heart disease, high cholesterol or hypertension, high blood pressure, or stroke).

Figure 11
Length of Time With CDHP[1] and Savings Account, 2006–2008



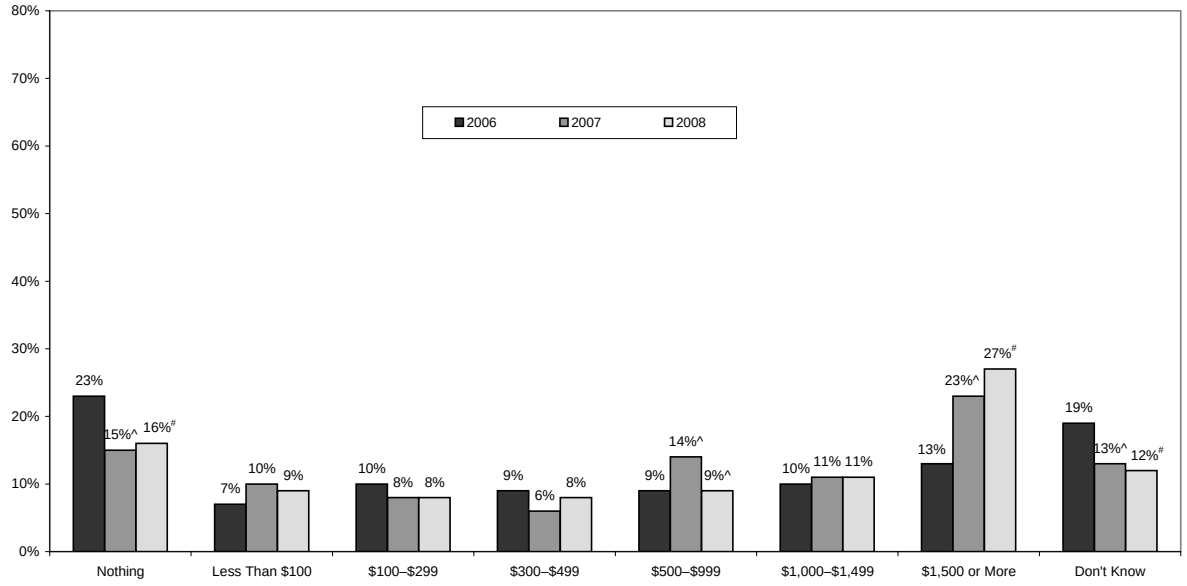
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 12
Amount Currently in Account, Among Persons With CDHP,[1] 2006–2008



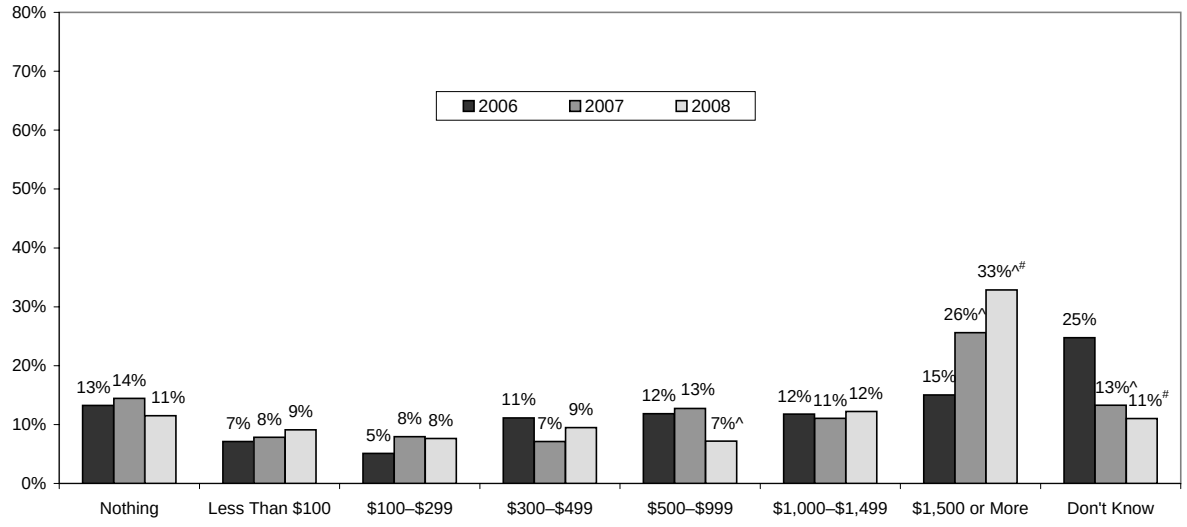
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 13
Amount Rolled Over from Past Year,
Among Persons With Employee-Only or Family CDHP,[1] 2006–2008



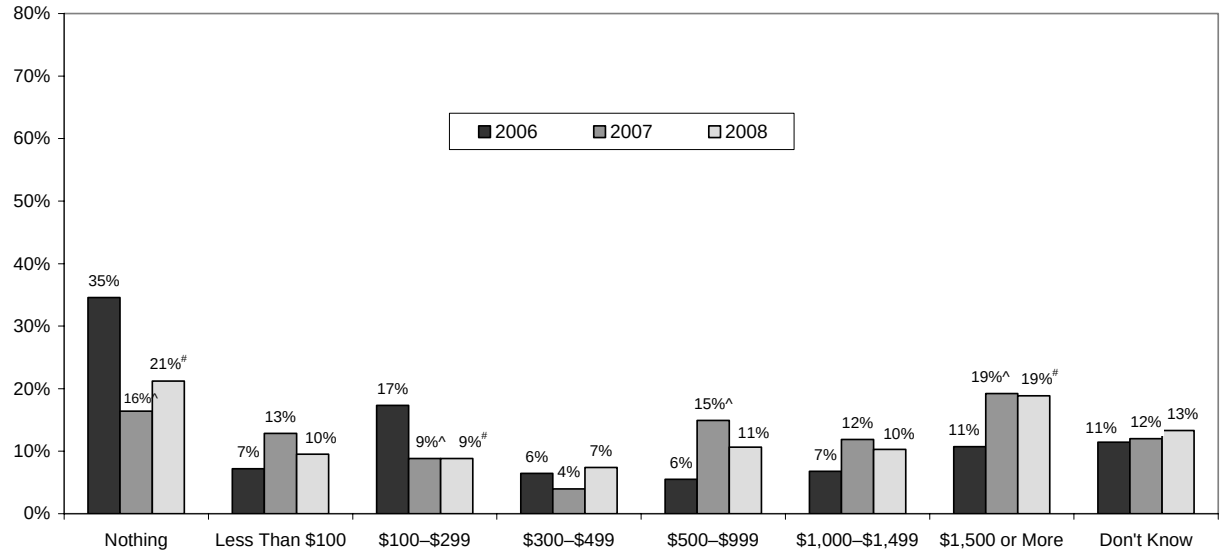
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 14
Amount Rolled Over from Past Year,
Among Persons With Employee-Only or Family CDHP[1]
and No Health Problems, 2006–2008



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 15
Amount Rolled Over from Past Year,
Among Persons With Employee-Only or Family CDHP[1]
and Health Problem, 2006–2008



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006 & 2007; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[#] Difference between 2006 and 2008 is statistically significant at p ≤ 0.05 or better.

New Publications and Internet Sites

[Note: To order U.S. Government Accountability Office (GAO) publications, call (202) 512-6000.]

Aging Issues

Eberts, Randall W., and Richard A. Hobbie. *Older and Out of Work: Jobs and Social Insurance for a Changing Economy*. $18. W.E. Upjohn Institute for Employment Research, Attn: Publications Department, 300 S. Westnedge Ave., Kalamazoo, MI 49007-4686, (888) 227-8569 or (269) 343-5541, fax: (269) 343-7310, publications@upjohninstitute.org

Employee Benefits

The National Underwriter Company. *2008 Benefits Facts Source Book*. $65.35. The National Underwriter Company, Orders Department MP, P.O. Box 14448, Cincinnati, OH 45250-0448, (800) 543-0874, fax: (800) 874-1916, www.nationalunderwriterstore.com

Health Care

Atlantic Information Services, Inc. *Health Plan Facts, Trends and Data: 2008–2009*. Print edition, $398; Print & CD editions, $548 + $5 S&H. Atlantic Information Services (MFB13/ESPEC4), 1100 17th St., NW, Suite 300, Washington, DC 20036-4631, (800) 521-4323 or (202) 775-9008, fax: (202) 331-9542, e-mail: customerserv@aispub.com, www.AISHealth.com/Products/mfbESPEC4.html

Pension Plans/Retirement

U.S. Government Accountability Office. (1) *Federal Pensions: Judicial Survivors' Annuities System Costs*. (2) *Individual Retirement Accounts: Additional IRS Actions Could Help Taxpayers Facing Challenges in Complying with Key Tax Rules*. (3) *Pension Benefit Guaranty Corporation: Need for Improved Oversight Persists*. Order from GAO.

Social Security Reform

Kay, Stephen J., and Tapen Sinha. *Lessons from Pension Reform in the Americas*. $110 + $5.50 S&H. Oxford University Press, Attn: Order Dept., 2001 Evans Rd., Cary, NC 27513, (800) 445-9714, fax: (919) 677-1303, e-mail: custserv.us@oup.com, www.oup.com/us

Flexible Spending Accounts (FSAs) Sites

American Federation of State, County and Municipal Employees
www.afscme.org/issues/6404.cfm

Ceridian
www.ceridian.com/myceridian/printer/friendly/content/1,,11066-53002,00.html

Employee Benefit Research Institute
www.ebri.org/pdf/publications/facts/0507fact-flexspend.pdf

U.S. Bureau of Labor Statistics
www.bls.gov/opub/cwc/cm20031022ar01p1.htm

Web Documents

The 10 Benefits of Conducting a Personal Health Assessment
www.welcoa.org/freeresources/pdf/aa_7.7_10_benefits.pdf?PHPSESSID=b0e2746129adfc5a0ea8222cc647181a

2008 Cumulative List of Changes in Plan Qualification Requirements [Notice 2008-108]
www.irs.gov/pub/irs-drop/n-08-108.pdf

After GASB 45: Solving the Unfunded Liability Problem in Retiree Health Care
www.slge.org/vertical/Sites/%7BA260E1DF-5AEE-459D-84C4-876EFE1E4032%7D/uploads/%7BDCB095C2-16EA-4262-9A5E-2C3266A6911E%7D.PDF

The Age Discrimination in Employment Act (ADEA): A Legal Overview
http://assets.opencrs.com/rpts/RL34652_20080905.pdf

Call to Action: Health Reform 2009
http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf

The Commonwealth Fund 2008 International Health Policy Survey in Eight Countries
www.commonwealthfund.org/usr_doc/Schoen_2008intlhltpolicysurveyeightcountries_chartpack.pdf?section=4039

The Decline of Career Employment
http://crr.bc.edu/images/stories/ib_8-14.pdf

Defined Contribution Plan Distribution Choices at Retirement: A Survey of Employees Retiring Between 2002 and 2007 www.ici.org/pdf/rpt_08_dcdd.pdf

The Family and Medical Leave Act of 1993; Final Rule [as published in the *Federal Register* on November 17, 2008]
http://edocket.access.gpo.gov/2008/pdf/E8-26577.pdf

The Financial Crisis and State/Local Defined Benefit Plans
http://crr.bc.edu/images/stories/Briefs/ib_8-19.pdf

The Fraying Link Between Work and Health Insurance: Trends in Employer-Sponsored Insurance for Employees, 2000-2007
www.kff.org/uninsured/7840.cfm

In It for the Long Haul: The Investment Behavior of Public Pensions
www.nirsonline.org/storage/nirs/documents/In%20it%20for%20the%20Long%20Haul.pdf

Individual Retirement Accounts and 401(k) Plans: Early Withdrawals and Required Distributions [Updated October 27, 2008]
http://assets.opencrs.com/rpts/RL31770_20081027.pdf

Innovations in Prevention, Wellness and Risk Reduction
www.ahip.org/redirect/AHIP_Innovations_Prevention.pdf

PBGC Flat Premium Rates; Notice of Flat Premium Rates [as published in the *Federal Register* on December 1, 2008]
http://edocket.access.gpo.gov/2008/pdf/E8-28411.pdf

Pension Sponsorship and Participation: Summary of Recent Trends [Updated September 8, 2008]
http://assets.opencrs.com/rpts/RL30122_20080908.pdf

Public Fund Survey Summary of Findings for FY 2007
www.publicfundsurvey.org/publicfundsurvey/pdfs/Summary%20of%20Findings%20FY07.pdf

Retirement Security or Insecurity? The Experience of Workers Aged 45 and Older
http://assets.aarp.org/rgcenter/econ/retirement_survey_08.pdf

Social Security: Calculation and History of Taxing Benefits [Updated October 21, 2008]
http://assets.opencrs.com/rpts/RL32552_20081021.pdf

Updated Static Mortality Tables for the Years 2009 through 2013 [Notice 2008-85]
www.irs.gov/pub/irs-drop/n-08-85.pdf

Who Gained the Most Under Health Reform in Massachusetts?
www.urban.org/UploadedPDF/411770_Gained_Massachusetts.pdf

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