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## **Corporate Innovations in Prenatal Health Promotion**

### *Introduction*

The birth of an unhealthy baby can present an employer with considerable health care costs compared with the health care costs associated with a healthy birth. According to a study conducted by the Center for Risk Management and Insurance Research, poor outcome births (that is, babies born unhealthy—for example, those born prematurely or with low birth-weight)<sup>1</sup> cost employers and workers \$5.6 billion annually in addition to the costs attributed to these births had the infants been born full-term and in good health.<sup>2</sup> The authors estimate that this additional cost represents approximately 3 percent of 1990 aggregate after-tax U.S. corporate profits. Costs associated with poor outcome births were also found to be significantly higher

during the first year of life than those for well babies. Moreover, employers face additional economic costs in the form of lost work days and low employee morale, ultimately leading to reduced employee productivity.

Experts generally assert that adequate prenatal care reduces the chances that an infant will be born unhealthy. Hence the advent of corporate-based health promotion programs focused on providing women of childbearing age with adequate prenatal care. This article examines costs associated with poor outcome births, steps employers have taken to reduce these costs, and the effectiveness of these efforts to date.

### ***Incidence and Cost of Poor Outcome Births***

*Incidence*—The U.S. Department of Health and Human Services estimated that, in 1992, of the 4.1 million babies born in the United States, 34,000 died in the first year of life.<sup>3</sup> Premature and low

<sup>1</sup> An infant is considered low birth-weight if he or she weighs less than 5 1/2 pounds at birth.

<sup>2</sup> Deborah J. Chollet, John F. Newman, and Andrew T. Sumner, *The Corporate Cost of Poor Birth Outcomes, Research Report No. 92-2* (Atlanta, GA: Georgia State University, Center for Risk Management and Insurance Research, 1992). This study is based on national claims data from the CIGNA Corporation's national book of business for employer groups. The authors analyzed claims

incurred during a 24-month period between September 1, 1989 and August 31, 1991 and representing nearly 59,000 mother-infant pairs.

<sup>3</sup> U.S. Department of Health and Human Services, *National Center for Health Statistics, "Births, Marriages, Divorces, and Deaths for 1992," Monthly Vital Statistics Report, Vol. 41, no. 12* (Washington, DC: U.S. Government Printing Office, 1993).

birth-weight babies are both strongly related to infant mortality and health complications in infants. One study indicates that low birth-weight babies are 40 times more likely to die during their first month of life than babies of normal weight. They are two to three times more likely to suffer from chronic debilitating conditions such as blindness, deafness, and mental retardation later in life.<sup>4</sup>

**Costs**—The Office of Technology Assessment estimates that physician and hospital charges for the birth of a healthy baby are approximately \$4,300. In contrast, the birth of a low birth-weight baby can cost from \$11,670 to \$39,000. The birth of a very low-birth-weight baby, weighing under 3 1/4 pounds, can cost from \$62,000 to \$150,000.<sup>5</sup>

Because employment-based health insurance plans cover a significant number and portion of women of childbearing age (aged 15–44), employer costs related to childbirth can be significant. Employee Benefit Research Institute tabulations of the March 1992 Current Population Survey indicate that employers provide health insurance coverage to 35.9 million

women of childbearing age (62.0 percent of all women aged 15–44); 53.8 percent of those covered are covered directly, and 46.2 percent are covered indirectly (that is, as dependents of covered workers).

### ***Employer-Based Prenatal Health Promotion Programs***

Employer-based health promotion programs stress early detection of health risks, risk reduction, and utilization of resources for appropriate and timely care. Major goals of health promotion include the prevention and reduction of premature death and disability, health care cost containment, improved employee productivity and morale, and reduced absenteeism and employee turnover.<sup>6</sup> A survey commissioned by the Office of Disease Prevention and Health Promotion indicates that work site health promotion activities have increased, from 66 percent of work sites with 50 or more employees offering at least one health promotion activity in 1985 to 81 percent in 1992.<sup>7</sup> Information and activities related to prenatal care were offered by 9.0 percent of private work sites with 50 or more

employees in 1992 (table 1).<sup>8</sup>

Among work sites with 750 or more employees, 40.4 percent offered information or activities concerning prenatal education in 1992, compared with 5.4 percent of work sites with 50–99 employees (table 1). Nearly 13 percent (12.8 percent) of services industry work sites offered such programs, compared with 3.9 percent of those in the agricultural, mining, and construction industries, and 5.4 percent of those in the manufacturing industry. Efforts on the part of employer-based programs range from simply making information available to employees regarding good nutrition and exercise to extensive case management for those at high risk of poor outcome births. Of the work sites surveyed offering prenatal education (9.0 percent), 93.4 percent offered resource materials; 53.1 percent offered group classes, workshops, lectures, or special events; and 43.9 percent offered individual counseling.

Specific company programs include, for example, Haggar Apparel Company's prenatal education program and Marriott's *Healthy Expectations*.<sup>9</sup> Haggar Apparel Company's program, initiated in

<sup>4</sup> Nancy Saltford, "Health Promotion: Its Role in Health Care," EBRI Issue Brief no. 120 (Washington DC: Employee Benefit Research Institute, November 1991); and U.S. Department of Health and Human Services, National Center for Health Statistics, Health United States, 1990 (Washington DC: U.S. Government Printing Office, 1991).

<sup>5</sup> Office of Technology Assessment, Neonatal Intensive Care for Low Birthweight Infants: Costs and Effectiveness (Washington, DC: Office of Technology Assessment, 1987).

<sup>6</sup> U.S. Public Health Service, "National Survey of Worksite Health Promotion Activities Final Report," no. PB93-100204 (Washington, DC: U.S. Government Printing Office, 1992).

<sup>7</sup> Ibid. A total of 1,507 work sites with 50 or more employees were surveyed in the winter and spring of 1992, representing a broad demographic range with variations in age of employees, union representation, and employment status (i.e., hourly versus salaried).

<sup>8</sup> The 1985 National Survey of Worksite Health Promotion Activities included questions regarding health promotion activities but did not specifically ask about prenatal health promotion activities.

Table 1  
**Percentage of Private Work Sites with 50 or More Employees That Offer  
 Information or Activities Concerning Prenatal Education, by Work Site Size and Industry, 1992**

Prenatal Education	Size of Work Site						
	Total	50-99 employees	100-249 employees	250-749 employees	750 or more employees		
	(percentage)						
Offer Information or Activities Concerning Prenatal Education	9.0%	5.4%	9.0%	16.5%	40.4%		
Type of information or activities offered							
individual counseling	43.9	51.5	35.8	33.4	54.5		
group classes, workshops, lectures, special events	53.1	45.4	44.4	64.0	72.6		
resource materials	93.4	97.8	84.6	96.6	97.5		
	Industry						
	Total	Manufac- turing	Wholesale/ retail	Services	Transportation/ public utilities	Financial	Agriculture/mining/ construction
	(percentage)						
Offer Information or Activities Concerning Prenatal Education	9.0%	5.4%	8.3%	12.8%	6.6%	9.8%	3.9%
Type of information or activities offered							
individual counseling	43.9	30.5	33.8	54.1	35.2	37.8	30.5
group classes, workshops, lectures, special events	53.1	43.0	39.2	67.0	34.3	35.1	30.5
resource materials	93.4	94.7	100.0	91.4	96.1	86.4	81.6

Source: Office of Disease Prevention and Health Promotion, National Survey of Worksite Health Promotion Activities, 1992.

1988, focuses, for the most part, on employee education and includes incentives for employees to attend educational seminars and seek medical care early. The program was initiated following the realization that claims for complications in pregnancy, premature infants, and low birth-weight babies were consistently among the top 50 claims. Haggar considered this high cost for problem pregnancies and poor outcome births to be a result of several factors, including the fact that most of its eligible employees were not seeking out medical care early or in a consistent manner. In addition, the company found that employees were continuing unhealthy lifestyle habits during pregnancy, such as smoking and consumption of alcohol. Haggar

determined that the lack of attention to formal medical care and good health habits was largely a result of lack of money and education. To encourage earlier and consistent visits to the doctor, Haggar redesigned its benefits program. Haggar's medical plan formerly required the patient to leave a payment of \$500 with the doctor following the first visit. Currently, the plan pays 100 percent of prenatal doctors visits, but only if the woman makes her first visit during her first trimester of pregnancy and attends regularly scheduled medical visits thereafter. In addition, at least five prenatal classes/seminars are taught on a quarterly basis. Infant car seats are awarded to women who attend all classes. Classes are conducted in both English and Spanish. The

company reported that health claims costs for pregnancies totaled \$1.8 million in 1992, down from \$2.3 million in 1991, and cost savings amounted to \$542,000, despite an increase in the number of births in 1992.

Marriott's program was initiated in 1989 as a result of an analysis that revealed that the costs for premature deliveries and the care of newborn infants accounted for a significant percentage of total health care expenses. The *Healthy Expectations* program requires women to enroll in the program before the end of their fourth month of pregnancy. Participants must then visit their doctor at least three times in their second trimester and five times in their third trimester. A nurse consultant calls regularly to give participants information and answer questions. Low risk participants proceed with the program by reviewing free educational materials, completing the *Healthy Expectations*

<sup>9</sup> *The Prevention Leadership Forum (PLF) of the Washington Business Group on Health, Washington, DC. PLF compiles and maintains a data base of information regarding maternal and child health. Information was also obtained through specific company communication.*

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workbook, and talking to their nurse consultant throughout the pregnancy. Participants at high risk of delivering a premature or low birth-weight baby are counseled more frequently on how to increase their chances of having a healthy baby. Eligible employees and spouses who successfully complete the program receive \$100.

Some prenatal health promotion programs are offered in conjunction with community organizations and/or insurance companies. For example, AT&T provides prenatal education materials—in the form of literature and a video library—to all active AT&T employees. This material is offered in cooperation with the March of Dimes Birth Defects Foundation *Babies and You* program. This program offers three levels of implementation from which employers may choose. The first level is a companywide information program designed to educate employees regarding the importance of prenatal care. The second level of implementation includes seminars on such topics as nutrition; tobacco, drugs, and alcohol; exercise and pregnancy; stress and pregnancy; and well-baby care. At the third level of implementation, the March of Dimes provides technical assistance in the training of company health professionals.

Aetna Life and Casualty's *Healthy Beginnings* program provides another example of a program through which corporations may provide prenatal education. Aetna's program includes prenatal seminars and prenatal skill-building. The

prenatal seminars focus on a number of subjects, including "the impact of lifestyle choices on fetal development, maternal nutrition, minimizing potential environmental risks, and facts on the advantages of breastfeeding for mother and baby." Prenatal skill-building includes a personal consultation with a dietitian regarding nutrition, a fitness program for mothers-to-be, a self-study stop smoking program, and a workshop with a lactation consultant regarding breastfeeding and procedures for storing milk safely. Overall goals of both the March of Dimes and Aetna programs include educating participants on ways to reduce health risks and detecting and addressing high risk behaviors.

### ***Cost Effectiveness of Employer-Based Programs***

Lower rates of maternal mortality, infant mortality, and low birth-weight—and therefore lower cost births—are clearly associated with comprehensive prenatal care. The Office of Technology Assessment estimates that for every low birth-weight birth averted by early and frequent prenatal care, the U.S. health care system saves between \$14,000 and \$30,000 in newborn, first year, and long-term health care costs.<sup>10</sup>

Overall, in 1992, among work sites indicating they conduct formal evaluations of their health promotion activities, 65.8 percent indicated an increase in employee morale, 55.9 percent indicated an increase in employee productivity, 57.0 percent indicated a reduction in absenteeism, 43.7 percent indicated a reduction in health care costs, and 42.0 percent indicated a reduction in disability.<sup>11</sup> In addition, as indicated above, company experience and data often indicate that prenatal health promotion programs are effective. However, not all work sites report positive results. For example, 15.4 percent of work sites surveyed indicated an increase in health care costs.

Despite survey and specific company data reports indicating, for the most part, that prenatal health promotion programs are beneficial, there still exists a paucity of research data regarding the overall effectiveness and cost saving potential associated with employer-based prenatal health promotion programs. Employer programs focus on education designed to change the mother-to-be's behavior, getting care to the individual early, and targeting those most at risk. To the extent that poor outcomes relate to maternal behavior, their cost may be worthwhile; however, to the extent that

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<sup>10</sup> Nancy Saltford, "Health Promotion: Its Role in Health Care," EBRI Issue Brief no. 120 (Washington DC: Employee Benefit Research Institute, November 1991); and John H. Gibbons, *Healthy Children, Investing in the Future: Summary* (Washington, DC: U.S. Office of Technology Assessment, 1988).

<sup>11</sup> U.S. Public Health Service, *National Survey of Worksite Health Promotion Activities Final Report, no. PB93-100204* (Washington, DC: U.S. Government Printing Office, 1992).

cost differences relate to factors other than behavior, such as to provider practice patterns, these programs may not be cost effective.<sup>12</sup> In addition, not every insured population includes those traditionally most at risk for poor outcome births. Thus, due to the vast heterogeneity of work site populations, a program that is cost effective in one location may not be effective in another.

In addition, implementing a health promotion program without considering the overall design of the health care package and/or the makeup of the insured population may hinder an employer's attainment of his objective/goals. For example, incentives to get women of childbearing age into a program early may be negated by a service requirement that a new employee wait three months before being covered by the employer-based health plan—the equivalent of the entire first trimester of pregnancy. Other considerations might include employee reluctance to reveal pregnancy until absolutely necessary due to perceived concerns regarding career advancement.

Finally, it is often difficult to determine cost effectiveness from

one program to another because employer objectives may vary. For example, one company may measure cost effectiveness in terms of reduced medical costs; another may measure cost effectiveness in terms of increased productivity (for example, through fewer lost work days). Still others may measure success in terms other than in direct dollar savings; for example, increased morale or employee participation.<sup>13</sup>

### **Conclusion**

Despite numerous employer-reported success stories, there still exists a limited amount of data regarding whether employer-based prenatal health promotion programs can reduce costs. Some analysts maintain, however, that the financial debate is of limited importance. Regardless of whether health promotion programs are proven to reduce costs, some analysts and corporate executives suggest that the strength of these programs lies in their ability to improve lives in a *cost effective* manner rather than solely in their ability to reduce costs.<sup>14</sup>

—Sarah Snider, *EBRI*

## **Private Trusteed Pension Assets Reach \$2.5 Trillion by End of Third Quarter 1993**

Between 1983 and 1992, private trusteed pension assets more than doubled, from \$854 billion to \$2,300 billion (chart 1). Between year-end 1991 and year-end 1992, private trusteed pension assets increased 7.8 percent, compared with an average annual growth rate of 12.2 percent between 1983 and year-end 1992. Pension fund assets increased 8.6 percent between year-end 1992 and September 30, 1993 to reach \$2.5 trillion, with nearly one-half the growth (4.2 percent) occurring during the first quarter.

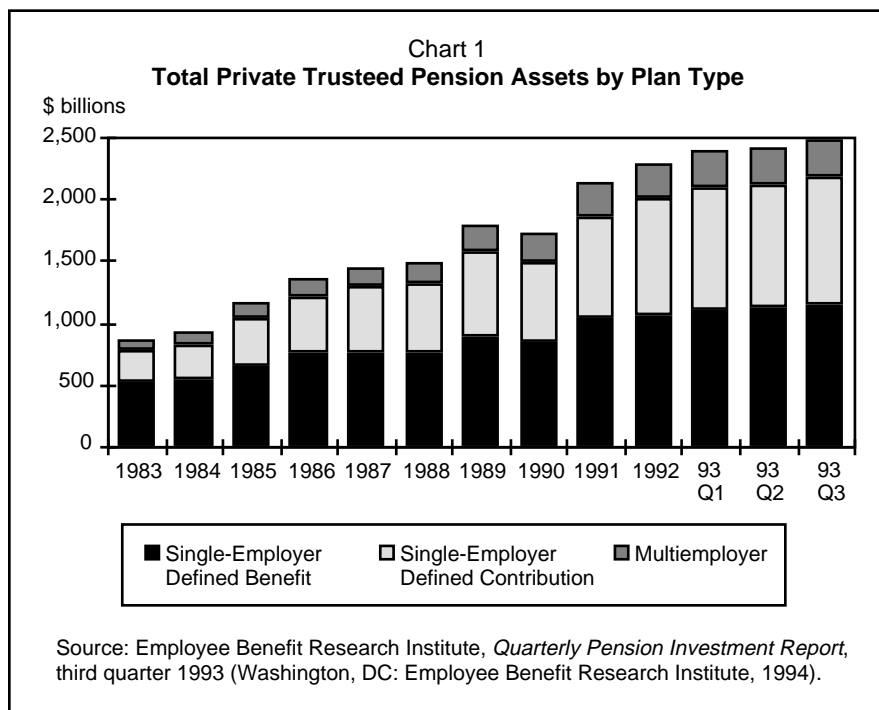
### **Pension Assets by Plan Type**

Between 1983 and 1992, the allocation of pension assets among plan types has shifted gradually, with single-employer defined benefit plan assets growing an average of 8 percent annually, defined contribution plan assets growing 16 percent annually, and multiemployer plan assets growing 15 percent annually. Single-employer defined contribution funds held 29.9 percent, or \$255 billion, of all private trusteed assets at year-end 1983, increasing to 42.2 percent, or \$1,051 billion, as of September 30, 1993. Multiemployer plans held

<sup>12</sup> Deborah J. Chollet, John F. Newman, and Andrew T. Sumner, *The Corporate Cost of Poor Birth Outcomes*, Research Report No. 92-2 (Atlanta, GA: Georgia State University, Center for Risk Management and Insurance Research, 1992).

<sup>13</sup> Kenneth R. Pelletier, ed., *DataBase Research and Evaluation Results: A Review and Analysis of the Health and Cost-Effective Outcome Studies of Comprehensive Health Promotion and Disease Prevention Programs*, *American Journal of Health Promotion* (March/April 1991): 311–313.

<sup>14</sup> *Ibid.*



10.0 percent of all private trusted pension assets at year-end 1983, increasing to 12.3 percent, or \$306 billion, by the end of third quarter 1993. Single-employer defined benefit plan assets decreased as a percentage of total private trusted pension assets, declining from 60.1 percent, or \$514 billion, of total assets in 1983 to 45.5 percent, or \$1,133 billion, of total assets as of the end of third quarter 1993.

### ***Pension Plan Asset Investment Mix by Plan Type***

New data from the Department of Labor has made it possible to include bank pooled holdings of equity, bonds, and cash items in this presentation of private trusted asset invest mix in the aggregate and by plan type. Asset allocation of private trusted pension plans fluctuated between 1983 and September 30, 1993, with investments in equity of 42.2 percent (\$1,051 billion),

investments in bonds of 27.4 percent (\$681 billion), investments in cash of 11.0 percent (\$275 billion), and assets held in other investments of 19.4 percent (\$483 billion) at the end of third quarter 1993 (chart 2). During the period between 1983 and third quarter 1993, investments in equity fluctuated between 37 percent and 42 percent of private trusted assets, and investments in bonds fluctuated between 27 percent and 30 percent. Investments in cash items ranged from the current low of 11 percent to a high of 15 percent in 1988. Investments in other vehicles ranged from 21 percent in 1987 to a low of 16 percent of private trusted assets in 1988.

The investment allocation of assets varies by plan type. A larger percentage of defined contribution plan assets are invested in equity than commonly believed partly due to the large quantity of company stock invested in by many defined contribution plans. Single-employer defined contribution plans allocated 44.2 percent of their assets to equity

investments as of September 30, 1991. Single-employer defined benefit plans allocated 41.5 percent of assets to equity, and multiemployer plans allocated 38.0 percent at the end of the third quarter of 1993. Multiemployer plans hold a greater proportion of assets in bonds (37.4 percent) than single-employer defined benefit plans (28.0 percent) and single-employer defined contribution plans (23.7 percent). Single-employer defined contribution plans held 13.2 percent of assets in cash items, compared with 9.6 percent of single-employer defined benefit assets and 8.9 percent of multiemployer assets. Defined benefit plans allocate 20.8 percent of their assets to other investments, defined contribution plans allocate 19.0 percent, and multiemployer plans allocate 15.8 percent.

### ***Investment Returns***

During the last five years (December 31, 1988 through September 30, 1993), private trusted pension assets returned 14.8 percent overall, returning 16.5 percent in the equity markets and 12.2 percent in the bond markets. The gain in total pension assets largely reflects the earnings realized in the stock market as well as the favorable returns to bonds. Net contributions to private trusted pension funds (total fund contributions less withdrawals) partially offset positive earnings

between 1984 and 1991, with negative aggregate net contributions during this period.

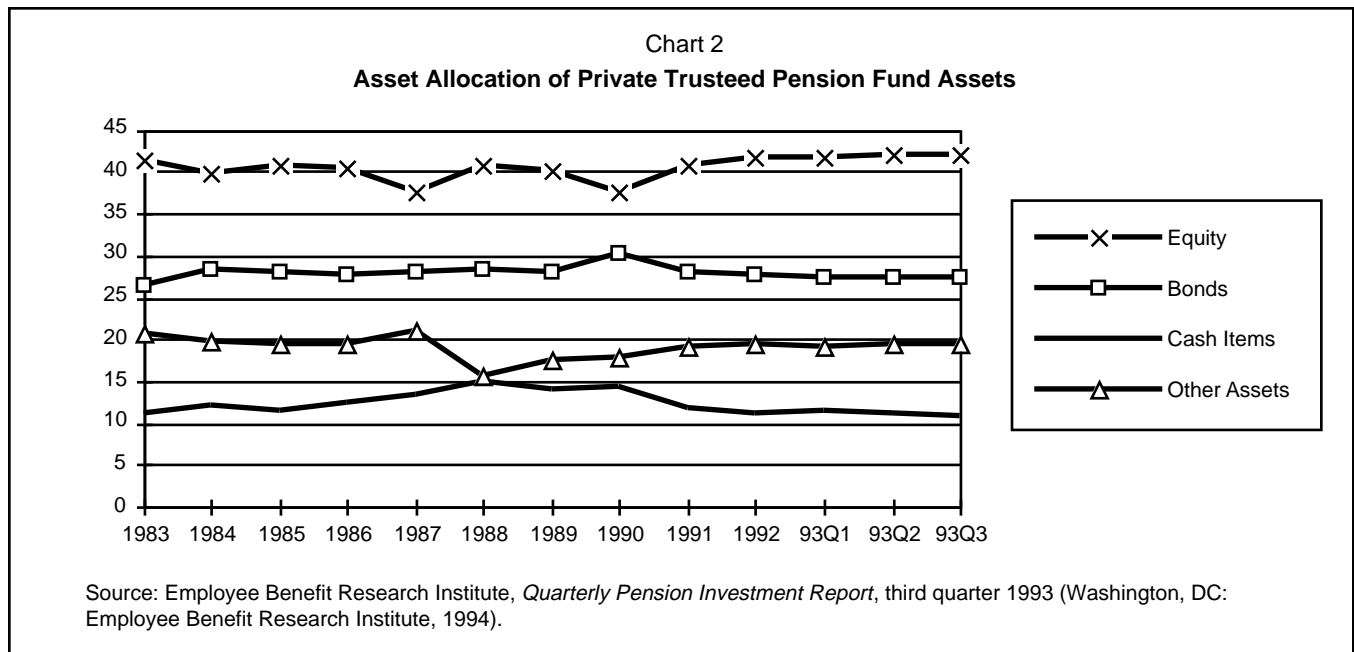
Employee Benefit Research Institute (EBRI) estimates indicate that pension assets have increased slightly since the end of third quarter 1993. Major indices indicate that the equity market showed higher growth after the end of the third quarter than during the third quarter of 1993. At press time, the S&P 500 had increased 7.4 points since September 30, 1993 to reach

466.29 by December 7, 1993. Growth in the bond market declined during November but has increased beyond September levels since then. Shearson Lehman Brothers Kuhn Loeb Government/Corporate Bond Index decreased 4.9 points by the end of November 1993.<sup>15</sup> Other bond indices show that the bond market has risen since that time. The Dow Jones Bond Index increased 2.3 points between November 30 and December 7. EBRI's base line estimates of

the effect of market activity on private trustee pension funds (assuming zero net contributions, dividends, and interest for all assets) show pension assets invested in equity increased from \$1,051 billion to \$1,088 billion (3.5 percent) from the end of the third quarter through December 7, 1993. Private trustee pension assets invested in bonds increased an estimated 1.2 percent, from \$682 billion to \$690 billion, over the same period.

<sup>15</sup> Data for the Shearson Lehman Brothers Kuhn Loeb Government/Corporate Bond Index are released monthly by the Lehman Brothers Division of Shearson Lehman Brothers, Inc.

—Celia Silverman, EBRI



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## Benefits Affect Americans' Job Decisions, According to New EBRI/Gallup Survey

Eighteen percent of Americans say they or a family member have turned down a job offer or stayed in a job they would have preferred to leave solely because of the health benefits, and 12 percent said they or a family member had done so solely because of pension benefits, according to a recent public opinion survey conducted by EBRI and The Gallup Organization, Inc. When asked about the level of salary, 35 percent of Americans said they or a family member had turned down a job offer or stayed in a job they would have preferred to leave solely because of the level of salary.

Of Americans who said they have turned down a job offer within the last five years (20 percent), 7 percent of those said the fact that health benefits were not offered or were inadequate was the most important reason for declining the most recent job they turned down. Thirty-one percent said the most important reason for turning down a job was that the salary was inadequate, 30 percent said they didn't think they would like the new job as much as their current job, and 18 percent said they would have had to relocate.

The second most important reason was that the salary was inadequate (26 percent), didn't

know (23 percent), health benefits were not offered or were inadequate (19 percent), didn't think they would like the new job as much as their current job (16 percent), would have to relocate (9 percent), and pension benefits were not offered or were inadequate (8 percent).

The survey also asked working Americans how important their health insurance, pension benefits, and level of salary are to why they stay in their current job. Of those working Americans who said they have health insurance through their employer (75 percent), 14 percent said their health insurance was one of the most important reasons why they stayed in their current job, and for working Americans who have a pension through their current employer (59 percent), 13 percent said the pension was one of the most important reasons. Of all working Americans, 24 percent said their level of salary was one of the most important reasons why they stay in their current job.

Copies of the survey report, *Public Attitudes on Benefits & Job Decisions, 1994*, (G-53), may be ordered from Malaika Barnes, (202) 775-6338, for the following prices: summary—\$50; full report—\$100; EBRI member prices: summary—\$25; full report—\$50.

—Carolyn Piucci Pemberton, EBRI

## Washington Update

**Health Care Reform**—Congress immediately turned its attention to health care reform as it reconvened in Washington for the second session of the 103rd Congress January 25. Chairman John Dingell (D-MI) of the Energy and Commerce Committee has directed the panel's two subcommittees with jurisdiction to complete markup on the administration's proposal by early March. Rep. Dingell wants the full committee to complete action on the reform bill by May. Both the Energy and Commerce and Education and Labor Committees will likely report out bills that are similar to the Clinton proposal. The Ways and Means Committee, however, appears more open to alternative proposals and has scheduled its first full committee hearing of 1994 on health care reform for Feb. 3 on the topic of employer mandates.

Jurisdictional disputes over the administration's health care reform bill continue in the Senate between the Finance and Labor and Human Resources Committees. Congressional sources have indicated that the committees may write their own reform bills. The Finance Committee would likely produce a cautious, market-oriented bill. The Labor Committee would likely produce a more liberal bill, but Chairman Ted Kennedy (D-MA) has indicated a willingness to work

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## Keeping on Track

**Data Bank Requirements**—Beginning with calendar year 1994, employers must report information relating to the health insurance coverage status of employees and their dependents. The requirement, established through passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), is intended to supply information to a new Medicare and Medicaid Coverage Data Bank that will be used to identify instances in which Medicare and Medicaid beneficiaries have employer-provided health care coverage that should be the primary source of payment in order to prevent mistaken government payments. Any employer that maintains or contributes to a group health plan on behalf of at least one employee must report this information to the Health Care Financing Administration (HCFA). Sen. Joe Lieberman (D-CT) introduced a bill (S. 1719) in the last congressional session to suspend the imposition of penalties for reporting failures until the calendar year that begins at least 90 days after guidance is issued on the information to be reported. The bill saw no action in 1993, but the Senator's staff hopes to see action on the bill this Spring.

**Employee Stock Options**—The Financial Accounting Standards Board (FASB) is considering a proposal announced last June to require employers to assign fair market value to stock options granted to employees (*Notes*, 11/93). The proposal would eliminate the federal tax deduction for stock-based compensation awards for companies and would require them to deduct the expense from their earnings.

Sen. Carl Levin (D-MI) introduced legislation (S. 259/H.R. 2878) in the last session in support of FASB's plan. The Senator contended the bill was introduced to serve as a catalyst for FASB action and that he has no intention of pushing the bill forward. Opponents of the plan introduced legislation aimed at barring FASB from enacting its proposal (S. 1175, H.R. 2759). In the meantime, while President Clinton remains committed to ending executive compensation abuses, he is wary of doing so at the expense of the competitiveness of high-tech companies. He noted in a November letter to Sen. Levin that he would prefer to avoid legislation on the issue. The letter was in response to correspondence from Levin's office asking Clinton not to support legislative efforts aimed at blocking FASB from enacting its proposal.

FASB is scheduled to begin hearings on the controversial proposal in March.

**Pension Regulations**—The IRS issued on Dec. 29 proposed rules on sec. 401(a)(17) limits as included in OBRA '93. OBRA '93 reduced the compensation limit for qualified plans from \$235,840 to \$150,000 (*Notes*, 8/93). The agency at the same time issued additional information (revenue procedure 94-13) for employers to comply with the reduced compensation limit. The IRS will accept comments on the proposed rules at a public hearing scheduled for March 17.

**Pension Simplification** —Technical corrections legislation containing pension simplification language (H.R. 3419) is frozen for the time being. The bill's sponsor, Rep. Dan Rostenkowski (D-IL) is wary of the bill picking up extraneous amendments. Even if the bill were to pass the House without amendments, it is unlikely the Senate would follow suit. Rostenkowski will not send the bill to conference in the event amendments from either chamber are added, effectively killing the legislation.

closely with moderate Republicans on the committee to produce a bill that could garner enough bipartisan support to pass in the full Senate.

Hearings on health care reform have begun in earnest in both House and Senate committees. At press time, the Senate Finance Committee has scheduled a Feb. 1 hearing on insurance

reform at which EBRI is slated to testify.

**Outlook** —As the administration continues to define health care as the most significant issue on the country's domestic agenda, debate on health care reform will dominate Congress' attention in the coming session. Some contentious

issues in the debate include the definition of universal coverage, premium caps, mandates, and the size of the benefits package. Along with the competing proposals introduced in the first session, at least two other proposals may join the fray in the coming months. Sen. Phil Gramm (R-TX) is expected to introduce his plan soon,

and a group of lawmakers from the Cooper-Breaux and Chafee camps will continue to meet in an attempt to craft a “mainstream” reform bill (*Notes*, 10/93). The possibility of the two key Senate committees approving quite different pieces of reform legislation adds to the perceived procedural difficulties health care reform will undergo. Optimistic lawmakers still contend that action on a health care reform proposal can be completed by October, but it is likely to look very different in the Clinton proposal.

**Pension Reform (PBGC)** — Treasury Department officials are considering options to modify the proposal to ban age-weighted profit-sharing plans contained in the administration’s Pension Benefit Guaranty Corporation (PBGC) reform bill introduced in Congress last year (*Notes*, 12/93). The administration’s proposal to eliminate cross testing of the plans based on benefits is strongly opposed by plan sponsors and key members of Congress. The department is now reportedly trying to determine the level of disparity it will allow in the amount of benefits

provided to older and younger employees under such plans.

**Outlook** —It is rumored that the administration has been working behind the scenes to drum up congressional support for action on PBGC reform legislation early in the session as part of the budget. Labor Secretary Robert Reich, in the meanwhile, is using PBGC’s most recent underfunding figures to push for passage of pension reform legislation. PBGC reports that lower interest rates caused underfunding in single-employer plans to grow to an estimated \$53 billion in 1992, from \$38 billion in 1991. In addition, pension reform advocate Rep. J.J. Pickle (D-TX), who has announced he will retire at the end of the session, is certain to push for passage of reform legislation before he leaves Congress (*Notes*, 1/94). Look for the fiscal year 1995 budget as a possible vehicle for PBGC reform legislation.

**COLAs**—The Internal Revenue Service (IRS) has announced the 1994 cost-of-living adjustments (COLAs) to the various dollar limits

relating to qualified plans, effective Jan. 1, 1994:

- The dollar limitation under sec. 415 that determines the maximum annual benefit to be funded under defined benefit plans is increased from \$115,461 to \$118,800.
- The limitation for the maximum annual contribution for defined contribution plans remains at \$30,000 for 1994.
- The annual limitation on employee pretax contributions under 401(k) plans and simplified employee pensions is raised from \$8,994 to \$9,240.
- For purposes of the 15 percent excise tax on excess distributions, the threshold amount under the grandfather rule is increased from \$144,551 to \$148,500.
- The limitations used to define a highly compensated employee have been adjusted to apply to an employee who, during the current or preceding year:
  - (1) owned more than 5 percent of the company (unchanged);
  - (2) earned more than \$99,000 (up from \$96,368 in 1993);
  - (3) earned more than \$66,000 (up from \$62,245 in 1993) and was a member of the “top paid” group of employees.
- The annual compensation limit that can be considered for calculating benefit and contribution limits is reduced from \$235,840 to \$150,000.

—Kathy Stokes Murray, *EBRI*

**Correction:**

The January 1994 *Notes* feature article—“Reflecting on 1993: Benefits Issues Take New Shape,” contained an error on the effective date of the Family and Medical Leave Act (FMLA). For employees covered by a collectively bargained agreement in effect on Aug. 5, the FMLA is effective on the earlier of **Feb. 5, 1994** or the date of expiration of that bargaining agreement.

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## New Publications

[Note: To order publications from the U.S. Government Printing Office (GPO), call (202) 783-3238; to order congressional publications, call (202) 275-3030. To order U.S. General Accounting Office (GAO) publications, call (202) 275-6241.]

### 1993 Notes Index Available

Copies of the index for 1993 issues of *EBRI Notes* are available upon request. Contact Malaika Barnes at (202) 775-6338.

A. Foster Higgins & Co., Inc. **Survey on Employee Savings Plans.**

\$100. A. Foster Higgins & Co., Inc., 125 Broad St., New York, NY 10004, (212) 574-9025.

Baker, Dean. **Employment Multipliers in the U.S. Economy.**

\$10. Economic Policy Institute, 1730 Rhode Island Ave., NW, Suite 200, Washington, DC 20036, (202) 775-8810.

Buck Consultants. **1992: The Health of America's Pension Plans.** \$75. Carolee Martin, Buck Consultants, Two Pennsylvania Plaza, New York, NY 10121, (201) 902-2555.

Business Insurance Directory. **1993-1994 Business Insurance Directory of Corporate Buyers of Insurance, Benefit Plans and Risk Management Services.** Eleventh edition. \$95. Business Insurance Directory, 965 East Jefferson Ave., Detroit, MI 48207, (313) 446-1623.

Card, David, and Richard B. Freeman, eds. **Small Differences That Matter: Labor Markets and Income Maintenance in Canada and the United States.** \$29.95. University of Chicago Press, Distribution Center, Billing Office, 11030 South Langley Ave., Chicago, IL 60628-2215, 1-800-621-2736, (312) 568-1550.

Fox, Daniel M. **Power and Illness: The Failure and Future of American Health Policy.** \$20.

California/Princeton Fulfillment Service, c/o University of California Press, 1095 Essex St., Richmond, CA 94801, (800) 777-4726.

Graham, Mary E., and Barry Gerhart. **Starting Salary Differences Between Women and Men: Organization-Level Findings and An Analysis of Current Policy Options.** \$10.

CAHRS, Jo Poole, ILR/Cornell, 393 Ives Hall, Ithaca, NY 14853-3901, (607) 255-9358.

Kingston, Eric R., and Edward D. Berkowitz. **Social Security and Medicare: A Policy Primer.**

\$59.95. Greenwood Publishing Group, 88 Post Road West, Box 5007, Westport, CT 06881, (203) 226-3571.

Milliman & Robertson, Inc. **The Financial Impact of Medical Savings Accounts on Health Care Spending and the Federal Budget.** \$7.50. Council for Affordable Health Insurance, 112 S. West St., Suite 400, Alexandria, VA 22314, (703) 836-6200.

New York Times. **Solving America's Health Care Crisis:**

**A Guide to Understanding the Greatest Threat to Your Family's Economic Security.**

\$10. Times Books/Random House, 201 East 50th St., New York, NY 10022, (212) 572-6015.

Omnigraphics. **The National Directory of Addresses and Telephone Numbers 1994.** \$85.

Omnigraphics, Penobscot Building, Detroit, MI 48226, 1-800-234-1340, (313) 961-1340.

Podhorzer, Michael. **Premiums Without Benefits.** \$25. Citizen Action, 1120 19th St., NW, Suite 630, Washington, DC 20036, (202) 775-1580.

U.S. Congress. House Committee on Energy and Commerce. **Medicaid Managed Care.** Order from GPO.

U.S. Congress. Senate. Committee on Labor and Human Resources. (1) **The Disadvantaged Minority Health Improvement Act.** (2) **Coverage for Mental and Addictive Disorders in Health Care Reform: A Cost-Effective Approach.** Order from GPO.

U.S. Congress. Senate. Special Committee on Aging. (1) **The Aging Network: Linking Older Americans to Home- and Community-Based Care.** (2) **Prescription Drug Prices: Outpricing Older Americans.** Order from GPO.

U.S. Department of Commerce. Bureau of the Census. (1) **An Aging World.** (2) **The Hispanic Population in the United States.** (3) **Measuring the Effect of Benefits and Taxes on Income and Poverty.** (4)

**Money Income of Households, Families, and Persons in the United States.** (5) **Population Profile of the United States.** (6) **Poverty in the United States.** (7) **United States Population Estimates, by Age, Sex, Race, and Hispanic Origin.** Order from GPO.

U.S. Department of Health and Human Services. Health Care Financing Administration. **Report of the Secretary's Advisory Panel on the Development of Uniform Needs Assessment Instrument(s).** Order from GPO.

U.S. Department of Health and Human Services. National Center for Health Statistics. **Health Data on Older Americans: United States.** Order from GPO.

Wolfe, John. **The Coming Health Crisis: Who Will Pay for Care for the Aged in**

**the 21st Century?** \$22.50. University of Chicago Press, Distribution Center, Billing Office, 11030 South Langley Ave., Chicago, IL 60628, 1-800-621-2736, (312) 568-1550.

Workplace Economics. **Municipal Employee Benefits Survey.** \$125.

Workplace Economics, Inc., P.O. Box 33367, Washington, DC 20033-0367, (202) 223-9191.

Williamson, Gordon K. **Sooner Than You Think: Mapping a Course for a Comfortable Retirement.** \$25. Business One Irwin, 1818 Ridge Road, Homewood, IL 60430, (708) 798-6000.

Williamson, John C., and Fred C. Pampel. **Old-Age Security in Comparative Perspective.** \$49.95. Oxford University Press, 2001 Evans Road, Cary, NC 27413, 1-800-451-7556.

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